COMPLIANCE OVERVIEW

Provided by Clark & Associates of Nevada, Inc.

Annual Compliance Deadlines for Health Plans

Employers that provide group health plan coverage to their employees are subject to numerous compliance requirements throughout the year, such as requirements for reporting, participant disclosure and certain fee payments. Some of these requirements have been in existence for many years (for example, the Form 5500), while others have been added more recently by the Affordable Care Act (ACA).

This Compliance Overview contains a high-level summary of the various compliance requirements and associated deadlines that health plan sponsors should be aware of throughout the year. It also summarizes annual notice requirements for group health plans. Please note that certain deadlines for non-calendar year plans may vary from what is outlined below.

CALENDAR YEAR DEADLINES

This chart only addresses **recurring calendar year compliance deadlines**. The chart does not include other requirements that are not based on the calendar year. For example, a plan administrator must provide a COBRA Election Notice to a qualified beneficiary after a qualifying event occurs. This type of notice requirement is not addressed in the chart below. Also, state laws may impose additional obligations. Users of this chart should refer to the specific federal or state law at issue for complete information.

HIGHLIGHTS

AFFECTED EMPLOYERS

- Employers that sponsor group health plans are subject to numerous compliance requirements throughout the year.
- Not all of these compliance requirements will apply to every employer.

ACTION STEPS

- Health plan sponsors should work with their advisors to determine which recurring deadlines apply to them.
- In addition to the compliance requirements described in this chart, it's important for plan sponsors to monitor ongoing ACA developments.

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JANUARY

DEADLINE	REQUIREMENT	DESCRIPTION
Jan. 31	**Form W-2**	Deadline for providing Forms W-2 to employees. The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. The purpose is to provide employees with information on how much their health coverage costs. Certain types of coverage are not required to be reported on Form W-2. This Form W-2 reporting requirement is currently **optional for small employers** (those who file fewer than 250 Forms W-2). Employers that file 250 or more Forms W-2 are required to comply with the ACA's reporting requirement.
Jan. 31	**Form 1095-C or Form 1095-B— Annual Statement to Individuals**	Applicable large employers (ALEs) subject to the ACA's employer shared responsibility rules must furnish Form 1095-C (Section 6056 statements) annually to their full-time employees. Employers with self-insured health plans that are not ALEs must furnish Form 1095-B (Section 6055 statements) annually to covered employees. The Forms 1095-B and 1095-C are due on or before Jan. 31 of the year immediately following the calendar year to which the statements relate. Extensions may be available in certain limited circumstances. However, an alternate deadline generally is not available for ALEs that sponsor non-calendar year plans.

FEBRUARY

DEADLINE	REQUIREMENT	DESCRIPTION
Feb. 28 **(March 31, if filing electronically)**	**Section 6055 and 6056 Reporting**	Under Section 6056, ALEs subject to the ACA's employer shared responsibility rules are required to report information to the IRS about the health coverage they offer (or do not offer) to their full-time employees. ALEs must file Form 1094-C and Form 1095-C with the IRS annually. Under Section 6055, self-insured plan sponsors are required to report information about the health coverage they provided during the year. Self-insured plan sponsors must generally file Form 1094-B and Form 1095-B with the IRS annually.

		ALEs that sponsor self-insured plans are required to report information to the IRS under Section 6055 about health coverage provided, as well as information under Section 6056 about offers of health coverage. ALEs that sponsor self-insured plans will generally use a combined reporting method on Form 1094-C and Form 1095-C to report information under both Sections 6055 and 6056. All forms must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year following the calendar year to which the return relates. Reporting entities that are filing 250 or more returns must file electronically. There is no alternate filing date for employers with non-calendar year plans.

MARCH

DEADLINE	REQUIREMENT	DESCRIPTION
March 1 (calendar year plans)	**Medicare Part D Disclosure to CMS**	Group health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether prescription drug coverage is creditable or not. In general, a plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of the Medicare Part D prescription drug coverage. Disclosure is due: ✓ Within 60 days after the beginning of each plan year; ✓ Within 30 days after the termination of a plan's prescription drug coverage; and ✓ Within 30 days after any change in the plan's creditable coverage status. Plan sponsors must use the online disclosure form on the CMS Creditable Coverage webpage.

JULY

DEADLINE	REQUIREMENT	DESCRIPTION
July 31	**PCORI Fee**	Deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year. **For insured health plans**, the issuer of the health insurance policy is responsible for the PCORI fee payment. **For self-insured plans**, the PCORI fee is paid by the plan sponsor.
July 31 (calendar year plans)	**Form 5500**	Plan administrators of ERISA employee benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year, unless an extension has been granted. Form 5500 reports information on a plan's financial condition, investments and operations. Form 5558 is used to apply for an extension of two and one-half months to file Form 5500. Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded, are generally exempt from the Form 5500 filing requirement. The DOL's website and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.

SEPTEMBER

DEADLINE	REQUIREMENT	DESCRIPTION
Sept. 30	**Medical Loss Ratio (MLR) Rebates**	The deadline for issuers to pay medical loss ratio (MLR) rebates for the 2014 reporting year and beyond is Sept. 30. The ACA requires health insurance issuers to spend at least 80 to 85 percent of their premiums on health care claims and health care quality improvement activities. Issuers that do not meet the applicable MLR percentage must pay rebates to consumers. Also, if the rebate is a "plan asset" under ERISA, the rebate should, as a general rule, be used within **three months** of when it is received by the plan sponsor. Thus, employers who decide to distribute the rebate to participants should make the distributions within this three-month time limit.

Sept. 30 (calendar year plans)	**Summary Annual Report**	Plan administrators must automatically provide participants with the summary annual report (SAR) within nine months after the end of the plan year, or two months after the due date for filing Form 5500 (with approved extension). Plans that are exempt from the annual 5500 filing requirement are not required to provide an SAR. Large, completely unfunded health plans are also generally exempt from the SAR requirement.

OCTOBER

DEADLINE	REQUIREMENT	DESCRIPTION
Oct. 14	**Medicare Part D—Creditable Coverage Notices**	Group health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must disclose whether the prescription drug coverage is creditable or not. Medicare Part D creditable coverage disclosure notices must be provided to participants before the start of the annual coordinated election period, which runs from Oct. 15-Dec. 7 of each year. Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of coverage under Medicare Part D. This disclosure notice helps participants make informed and timely enrollment decisions. Disclosure notices must be provided to all Part D eligible individuals who are covered under, or apply for, the plan's prescription drug coverage, regardless of whether the prescription drug coverage is primary or secondary to Medicare Part D. Model disclosure notices are available on CMS' website.

ANNUAL NOTICES

TYPE OF NOTICE	DESCRIPTION
WHCRA Notice	The Women's Health and Cancer Rights Act (WHCRA) requires group health plans that provide medical and surgical benefits for mastectomies to also provide benefits for reconstructive surgery. Group health plans must provide a notice about the WHCRA's coverage requirements at the time of enrollment and on an annual basis after enrollment. The initial enrollment notice requirement can be satisfied by including information on WHCRA's coverage requirements in the plan's summary

	plan description (SPD). The annual WHCRA notice can be provided at any time during the year. Employers with open enrollment periods often include the annual notice with their open enrollment materials. Employers that redistribute their SPDs each year can satisfy the annual notice requirement by including the WHCRA notice in their SPDs.
CHIP Notice	If an employer's group health plan covers residents in a state that provides a premium subsidy under a Medicaid plan or CHIP, the employer must send an annual notice about the available assistance to all employees residing in that state. The annual CHIP notice can be provided at any time during the year. Employers with annual enrollment periods often provide the CHIP notice with their open enrollment materials.
Summary of Benefits and Coverage (SBC)	Group health plans and health insurance issuers are required to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. The purpose of the SBC is to allow individuals to easily compare their options when they are shopping for or enrolling in health plan coverage. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. The issuer for fully insured plans usually prepares the SBC. If the issuer prepares the SBC, an employer is not also required to prepare an SBC for the health plan, although the employer may need to distribute the SBC prepared by the issuer. The SBC must be included in open enrollment materials. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan year. However, for insured plans, if the new policy has not yet been issued 30 days prior to the beginning of the plan year, the SBC must be provided as soon as practicable, but no later than seven business days after the issuance of the policy.