
# 2023 Employer-Sponsored Group Health Plans Compliance Calendar

This general compliance calendar lists many federal law requirements that apply to employer-sponsored group health plans, including:

- Notice distributions
- Plan disclosures
- Dates for various plan-related regulatory filings

At the end of the calendar, you will find important, ongoing compliance responsibilities that apply throughout the year. Employers should consult with their attorney on applicable state laws that may provide additional requirements and deadlines.

## January 1

### 1/1 Make price comparison information available online

Group health plans must provide cost-sharing information for 500 items and services through an internet-based self-service tool. Employers with fully insured plans should confirm their insurance carrier will comply with the requirement and self-insured plans should confirm with their third-party administrators (TPAs) or other service providers that they will comply with this requirement on behalf of the plan. Plans should get the issuer or administrator's agreement to provide the self-service tool in writing.

### 1/31 Report health care costs on Form W-2

Employers that filed 250 or more IRS Forms W-2 for the prior calendar year must report the aggregate cost of employer-sponsored health plan coverage on employees' Forms W-2. This reporting is optional for employers that had to file fewer than 250 Forms W-2 for the prior calendar year.

## February

### 2/28 File paper Forms 1094-B, 1095-B, 1094-C, and 1095-C

Applicable large employers (companies with 50+ full time equivalent employees) must report information about health plan coverage to the IRS and employees on Forms 1094-C and 1095-C.

Non-ALEs that are self-funded must report information about health plan coverage to the IRS and employees on forms 1094-B and 1095-B.

## March

### 3/1 File Medicare Part D Disclosure to CMS (calendar year plans)

Group health plans that provide prescription drug coverage to Medicare D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether that coverage is creditable or not creditable. Employers must submit this information electronically on the Disclosure to CMS Form through the CMS website. See the CMS instruction guide with screen shots for completing the form online.

### 3/1 MEWAs file Form M-1 with DOL

Multiple Employer Welfare Arrangements (MEWAs) file Form M-1 electronically with the Employee Benefits Security Administration of the U.S. Department of Labor to report required information about the MEWA's custodial and financial condition.

### 3/2 Provide Form 1095-B or Form 1095-C Annual Statement to Individuals

Form 1095-C must be furnished to individuals who received healthcare coverage from their large employer. Form 1095-B must be furnished to individuals who received insurance through self-funded and small fully insured employer sponsored plans.

### 3/31 File electronic Forms 1094-B, 1095-B, 1094-C, and 1095-C

Applicable large employers (ALEs) must report information about health plan coverage to the IRS and employees on forms 1094-C and 1095-C.

Non-ALEs that are self-funded must report information to the IRS and employees about the health coverage they offer or do not offer to full-time employees and their dependents on forms 1094-B and 1095-B.

## April

### 4/15 File Form 8928 with IRS to report excise tax due

Employers and plan administrators self-report excise tax due for failure to comply with various group health plan requirements, including requirements related to the ACA, COBRA, HIPAA, mental health parity, and the comparable contribution requirement for health savings accounts (HSAs), using IRS Form 8928.

## June

### 6/1 Submit RxDC Report to CMS for 2022

Under the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must annually submit information about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services (CMS).

## July

### 7/31 Pay Patient-Centered Outcomes Research Institute (PCORI) fee; file Form 720 with IRS

Self-insured plans (including HRAs) must file and pay the Patient Centered Outcomes Research Institute fee on IRS Form 720 for the previous year.

### 7/31 File Form 5500 (calendar year plans)

ERISA plans with 100 or more plan participants as of the first day of the plan year are required to file IRS Form 5500 by the last day of the seventh month following the end of the plan year. See the IRS Form 5500 Corner for information.

### 7/31 File Form 5558 to request filing extension

Employers may obtain an automatic extension to file Form 5500, Form 5500-SF, Form 5500-EZ, Form 8955-SSA, or Form 5330 by filing IRS Form 5558. The extension will allow return/reports to be filed up to the 15th day of the third month after the normal due date.

### 7/31 MEWAs file Form 8928 with IRS to report excise tax due

Multiple Employer Welfare Arrangements (MEWAs) self-report failure to comply with various group health plan requirements, including requirements related to the ACA, COBRA, HIPAA, mental health parity, and the comparable contribution requirement for health savings accounts (HSAs), using IRS Form 8928.

## September

### 9/30 Provide Summary Annual Report to covered participants and beneficiaries (calendar year plans filing Form 5500)

Employers that are required to file Form 5500 must provide a Summary Annual Report (SAR) to participants, summarizing the information in Form 5500.

## October

### 10/1 Provide Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice to plan participants (calendar year plans)

Employers that offer an ICHRA must furnish written notice to each participant containing specific information about the ICHRA 90 days before the beginning of the plan year. See the DOL model notice for information.

### 10/15 Provide Medicare Part D Creditable Coverage Disclosure Notices

Group health plans that provide prescription drug coverage to Medicare Part D eligible individuals must disclose whether that coverage is creditable or not creditable before the start of the annual coordinated election period for Medicare Part D. Model disclosure notices are available on the Centers for Medicare & Medicaid (CMS) website.

The following requirements are not date specific.

| When | What |
|---|---|
| **Children's Health Insurance Program (CHIP) Notice** | |
| Annually, no later than the first day of the plan year. | The employer must inform employees of possible premium assistance opportunities available. Provided for employees that reside in states with premium assistance programs under Medicaid or CHIP. |
| **COBRA Election Notice** | |
| Within 14 days after being notified of the qualifying event (44 days for events that are employer's responsibility to report if employer is plan administrator). Dates may be impacted by the extension of the COVID-19 national public health emergency declaration. | The plan administrator must notify qualified beneficiaries of their right to elect COBRA coverage when a qualifying event occurs and about other coverage options available, such as through the Marketplace. |
| **COBRA Qualifying Event Notice** | |
| Within 30 days after the date of qualifying events that result in coverage loss. | The employer must notify the plan administrator when a qualifying event occurs:<br>• Death of the covered employee<br>• Termination (other than by reason of gross misconduct) or reduction of hours of the covered employee<br>• The covered employee's Medicare entitlement<br>• The commencement of a bankruptcy proceeding of the employer (causing a substantial elimination of retiree coverage)<br>Unless the plan follows the delayed employer notice rule, the qualifying event means the date of the triggering event, not the coverage loss date. |
| **Continuation Coverage Rights Under COBRA** | |
| Within 90 days after coverage begins | Generally, if an employer has 20 or more employees, it is subject to federal COBRA and must provide new enrollees, including spouses, with an initial COBRA notice describing the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event. |

| When | What |
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| **COBRA Notice of Early Termination of Continuation Coverage** | |
| As soon as practicable following the plan administrator's determination that coverage will terminate. | Notice must be provided to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage. |
| **COBRA Notice of Insufficient Payment of Premium** | |
| As soon as practicable and allowing reasonable period to cure deficiency before termination. A 30-day grace period will be considered reasonable. | Notice must be provided by the plan administrator to qualified beneficiary that payment for COBRA continuation coverage premium was less than correct amount |
| **COBRA Notice of Unavailability of Continuation Coverage** | |
| Within 14 days after being notified by the individual of the qualifying event or of the request for extension. | Notice must be provided by the plan administrator to an individual that is not entitled to COBRA coverage or for an extension of continuation coverage. |
| **Grandfathered Plan Notice** | |
| Annually, when enrollment materials are provided. | A grandfathered plan must include a notice about grandfathered plan status in any materials describing the plan's benefits. |
| **HIPAA Breach Notification** | |
| Affecting 500 or more in a state or jurisdiction: Report to HHS, affected individuals, and media without unreasonable delay and no later than 60 days of the breach's discovery.<br><br>Affecting fewer than 500 in a state or jurisdiction: Report to HHS within 60 days of the end of the calendar year in which breach was discovered; report to affected individuals without unreasonable delay and no later than 60 days of the breach's discovery. | Group health plans must report to the Department of Health and Human Services (HHS) and notify affected individuals of any breaches of unsecured protected health information. |

| When | What |
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| **HIPAA Notices of Privacy Practices** | |
| Upon enrollment, within 60 days of a material revision, and at least once every three years. Notice must also be provided upon request. | Health plans must provide notice to plan participants explaining their rights with respect to their protected health information and the health plan's privacy practices. |
| **Internal Claims and Appeals and External Review Determination Notices** | |
| For internal claims and appeals, timing of the notices varies based on the type of claim.<br><br>For external review, the timing of the notice may vary based on the type of claims and whether the state or the federal process applies. May be subject to extended deadlines. | Internal Claims and Appeals: Non-grandfathered plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination.<br><br>External Review: After an external review, the independent review organization (IRO) will issue a notice of final external review decision. |
| **Qualified Medical Child Support Order (QMCSO) Notice** | |
| Within a reasonable time following receipt of an QMCSO. | The plan administrator must notify the plan participant and alternate recipient when it receives a QMCSO directing the plan to provide health coverage to a participant's noncustodial children. The plan administrator must provide copies of the plan's procedures for determining whether the QMCSO is qualified and notify the parties of its determination. |
| **Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice** | |
| Within 30 days of a plan participant's request. | For plans subject to ERISA, information must be provided to beneficiaries on medical necessity criteria for both medical/surgical and mental health/substance use benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation. |

| When | What |
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| **MHPAEA Claims Denial Notice** | |
| Notice must be provided in the plan's claim denial notice according to DOL claims procedure regulations, and within a reasonable time and in a reasonable manner upon participant request. | Plans subject to ERISA must provide the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits. |
| **MHPAEA Increased Cost Exemption Notice** | |
| As needed. | A group health plan that makes changes to comply with MHPAEA and incurs increased costs of at least 2% may claim an exemption from MHPAEA for one year. Plan beneficiaries must be notified that MHPAEA does not apply to their coverage. See the EBSA website for the model notice. |
| **National Medical Support Notice (NMS Notice)** | |
| Employer must either send Part A to the state agency, or Part B Part B to plan administrator, within 20 business days after the date of the notice. Plan administrator must promptly notify affected persons of receipt of the notice and the procedures for determining its qualified status. Plan administrator must, within 40 business days after the date of the notice, complete and return Part B to the state agency and provide required notification to affected persons | Depending upon certain conditions, employer must complete and return Part A of the NMS notice to the state agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a Qualified Medical Child Support Order (QMCSO). |
| **Newborns' and Mothers' Health Protection Act Notice** | |
| Annually and upon enrollment. Must be included in the Summary Plan Description. | A statement describing any requirements under federal or state law that relate to a hospital length of stay in connection with childbirth. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the federal or state requirements applicable to each area. |

| When | What |
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| **Notice to Employees of Coverage Options** | |
| Within 14 days after hire date of all new employees (including part-time, temporary, or ineligible for the plan) if the employer offers coverage to any employee. | Notice provides employees information about the Health Insurance Marketplace and premium tax credits. |
| **Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")** | |
| Requirements vary depending on type of plan and type of benefit claim involved. | Information regarding benefit claim determinations. Adverse benefit determinations must specify the reasons for the claim denial, reference the specific plan provisions on which the benefit determination is based, and describe the plan's appeal procedures. |
| **Notice to Enrollees Regarding Opt-Out** | |
| Annually, when enrollment materials are provided. | Provided only if the plan is a self-funded non-federal governmental group health plan that has opted out of some or all of HIPAA. |
| **No Surprises Act Notice** | |
| By Jan. 1, 2022, and ongoing | Health plans and health issuers offering group and individual health insurance coverage must issue a plain language notice regarding employee's rights under the No Surprises Act that contains:<br>• The restrictions on balance billing in certain circumstances<br>• Any applicable state law protections against balance billing (not applicable to self-funded plans)<br>• The requirements under Code section 9816, ERISA, section 716, and PHS Act section 2799A-I<br>• Contact information for appropriate federal agencies if an individual believes that a provider or facility has violated the restrictions against balance billing. |

| When | What |
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| **No Surprises Act Notice (continued)** | The Notice must be:<br>• made publicly available.<br>• posted on a public website of the plan or issuer.<br>• included on each Explanation of Benefits for an item or service to which the requirements of the NSA apply. |
| **Notice of HIPAA Special Enrollment Rights** | |
| On or before the time an employee is initially offered the opportunity to enroll in a group health plan. | Group health plans subject to HIPAA must provide special enrollment such as the right to enroll after the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption. Special enrollment is also available for individuals who lose Medicaid or CHIP coverage and for individuals who become eligible for a state premium assistance subsidy from Medicaid or CHIP. |
| **Patient Protection Notice** | |
| When a Summary Plan Description or other similar description of benefits under the plan is provided to a participant or beneficiary. | A non-grandfathered group health plan that requires a participant or beneficiary to designate a primary care provider must provide a notice to each plan participant that describes the plan's requirements regarding designation of a primary care provider and of the participant's or beneficiary's right to designate certain providers. |
| **Plan Documents** | |
| No later than 30 days after a written request. | The plan administrator must furnish copies of the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated upon written request and must have copies available for examination. |

| When | What |
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| **Section 111 Medicare Secondary Payer Mandatory Reporting** | |
| Quarterly.<br><br>The Centers for Medicare & Medicaid Services (CMS) will assign specific timeframes for reporting. | Responsible reporting entities (RREs) must submit group health plan entitlement information, including drug coverage information, about active covered individuals to the CMS Benefits Coordination and Recovery Center (BCRC). The insurer is the RRE for a fully insured plan. The plan administrator is the RRE for a self-funded plan.<br><br>See the Section 111 MSP Mandatory Reporting GHP User Guide for more information. |
| **Section 1557 Nondiscrimination Notice** | |
| Include with all significant publications or communications. | Covered entities must include nondiscrimination notice and language assistance taglines (in at least the top 15 languages spoken by individuals with limited English proficiency) with all significant publications or communications.<br><br>Visit the Department of Health and Human Services' website for FAQs, a model notice, and statement, tagline, and language resources. |
| **Summary of Benefits and Coverage (SBC)** | |
| When enrollment materials are provided, or 30 days prior to start of the plan year if no open enrollment.<br><br>No later than 60 days prior to the effective date of any mid-year plan modification.<br><br>Provide to special enrollees within 90 days. | Describes the benefits and coverage under the plan, including a uniform glossary defining certain terms.<br><br>See the Department of Labor website for SBC templates. |
| **Summary of Material Modifications (SMM)** | |
| As part of open enrollment, OR<br><br>Within 60 days of adoption of changes that constitute a material reduction in covered services or benefits.<br><br>Within 210 days of the end of the plan year for modifications that are not a material reduction in benefits. | Informs participants when a plan is amended or when other information is required to appear in the plan's Summary Plan Description (SPD) changes.<br><br>(Open enrollment acts a safe harbor for the 60-day prior/60-day post notice requirements.) |

| When | What |
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| **Summary Plan Description (SPD)** | |
| Within 90 days of a participant becoming covered by the plan.<br>Within 120 days of a new plan being adopted.<br>Every 5 years if changes are made to SPD information or the plan is amended. Otherwise, every 10 years. | Summary of plan provisions and certain ERISA-required standard language, written for the average participant and sufficiently comprehensive to inform covered persons of their benefits, rights, and obligations under the plan. |
| **Wellness Program Notice and Notice of Reasonable Alternatives** | |
| Annually, when enrollment materials are provided, before the employee provides medical information. | Informs employees who are eligible to participate in a wellness program that involves a medical examination or a disability-related inquiry (such as a health risk assessment or biometric screening) of the availability of a reasonable alternative. For outcome-based wellness programs, this notice must also be included in any disclosure notifying an individual that they did not satisfy an initial outcome-based standard. |
| **Women's Health and Cancer Rights Act Notice** | |
| Annually and upon enrollment | Describes required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy. |