Acadia BENEFITS

UBA Compliance Advisor

What every HR leader should know about compliance

2022 Compliance Calendar

Read time: 15 Minutes

This general compliance calendar lists many federal law requirements that apply to employer-sponsored group health plans. An employer should consult with its attorney on applicable state laws that may provide additional requirements and deadlines.

Description	Timing	Due Date
Forms 1095-B and 1094-B		
Form 1095-B is used to meet the Section 6055 reporting requirement to confirm minimum essential coverage. Form 1095-B is used by insurers, plan sponsors of self-funded multiemployer plans, and plan sponsors of self-funded plans that have fewer than 50 employees to report on coverage in effect for the employee, union member, retiree, or COBRA participant, and their covered dependents, on a month-by-month basis. Filers use Form 1094-B as the transmittal to submit the Form 1095-B return.	1095-B to IRS: February 28 for paper filers, or March 31 for electronic filers. 1095-B to employees: January 31 (IRS proposed regs with 30-day automatic extension) 1094-B: February 28 for paper filers, or March 31 for electronic filers.	Form 1095-B to IRS: February 28, 2022 (paper) or March 31, 2022 (electronic). 1095-B to employees: January 31, 2022 (March 2, 2022, if proposed regs finalized) Form 1094-B: February 28, 2022 (paper) or March 31, 2022 (electronic).

Description	Timing	Due Date
Forms 1095-C and 1094-C		
Form 1095-C is used to meet the ACA Section 6056 reporting requirement for Applicable Large Employers (employer shared responsibility/play-or-pay) and to determine whether an individual is eligible for a premium tax credit. Form 1095-C is also distributed to employees to verify coverage offering during the year. Filers use Form 1094-C as the transmittal to submit the 1095-C return to the IRS.	1095-C to IRS: February 28 for paper filers, or March 31 for electronic filers. 1095-C to employees: January 31 (IRS proposed regs with 30-day automatic extension) 1094-C: February 28 for paper filers, or March 31 for electronic filers.	Form 1095-C to IRS: February 28, 2022 (paper) or March 31, 2022 (electronic) 1095-C to employees: January 31, 2022 (March 2, 2022, if proposed regs finalized) Form 1094-C: February 28, 2022 (paper) or March 31, 2022 (electronic)
Form 5500		
Form 5500 is the annual filing to DOL and IRS that plans with 100 participants or more use to report required information about the plan's financial condition. Form 5500-SF can be filed for eligible plans with less than 100 participants. Form 5500-EZ can be filed for one-participant retirement plans or foreign plans. See the IRS Form 5500 Corner for information.	Due on the last day of the seventh month after the plan year end.	July 31, 2022 (for calendar year plans)
Form 5558		
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.	Due on or before the date the return/reports must be filed.	July 31, 2022 (for an extension to file Form 5500 for calendar year plans)
Form 7004		
Employers use IRS Form 7004 to receive an automatic 6-month extension to file Form 8928 and other general business returns.	Generally, must be filed on or before the due date of the applicable tax return.	April 15, 2022

Description	Timing	Due Date
Form 8809		
Employers use IRS Form 8809 to get an automatic 30-day extension of time to file Forms 1094-B or 1094-C.	Must be filed on or before the due date of the returns.	Form 1094-B: February 28, 2022 (paper) or March 31, 2022 (electronic) Form 1094-C: February 28, 2022 (paper) or March 31, 2022 (electronic)
Form 8928		
Employers and plan administrators should self-report any 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.	Deadline to submit form and pay excise tax is plan sponsor's federal income tax return filing deadline. For MEWA, deadline is the last day of the seventh month following the close of the plan year. Deadline for violating HSA comparable contributions requirements is April 15 following the calendar year in which the non-comparable contributions were made.	April 15, 2022 MEWA: July 31, 2022
Form M-1		
Multiple employer welfare arrangements (MEWAs) and Entities Claiming Exception (ECEs) are required to file Form M-1 with DOL to report required information about the MEWA's custodial and financial condition (subject to certain exceptions).	Due by March 1 of the year following the calendar year for which reporting is required. Automatic 60-day extension is available if filed by the normal due date for the Form M-1.	March 1, 2022

Description	Timing	Due Date
Form W-2		
Employers must report the aggregate value of applicable employer-sponsored health coverage on Form W-2 for the prior calendar year. See the IRS page Form W-2 Reporting of Employer-Sponsored Health Coverage for information.	The deadline to file and furnish Form W-2 is January 31.	January 31, 2022
Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice		
Employers that provide an ICHRA must furnish written notice to each participant containing specific information about the ICHRA. See the DOL model notice for information.	Notice must be provided at least 90 days before the start of the plan year. For newly eligible employees, written notice must be provided no later than the date coverage may begin.	October 1, 2022 (for plan years beginning January 1, 2023).
Medicare Part D Creditable Coverage Disclosure to CMS		
Employers with group health plans that provide prescription drug coverage to individuals that are eligible for Medicare Part D must disclose to CMS whether the coverage is creditable prescription drug coverage. Employers must provide CMS with this information via the Disclosure to CMS Form completed and sent electronically through the CMS website. See the CMS instruction guide with screen shots for completing the form online.	Form must be provided annually, within 60 days after the first day of the plan year for the reporting year. Also, within 30 days after the prescription drug plan's termination or within 30 days after any change in the creditable coverage status of the prescription drug plan.	March 2, 2022 (for plan years beginning January 1, 2022)

Medicare Part D Notice of Creditable Coverage to Plan Participants		
The Medicare Modernization Act penalizes individuals for late enrollment in Medicare Part D if they do not maintain "creditable coverage" for a period of 63 days or longer following their initial enrollment period for drug benefits. Plan sponsors must disclose whether prescription drug coverage is creditable or non-creditable. CMS provides model notices for creditable coverage and non-creditable coverage disclosures in both English and Spanish.	Disclosures to individuals must be made: 1. Prior to the Medicare Part D annual coordinated election period – October 15 through December 7 of each year 2. Prior to an individual's initial enrollment period for Medicare Part D 3. Prior to the effective date of coverage for any Medicare-eligible individual that joins the plan 4. Whenever prescription drug coverage ends or coverage changes so that it is no longer creditable or becomes creditable 5. Upon request by a beneficiary If the creditable coverage disclosure notice is provided to all plan participants annually, prior to October 15 of each year, CMS will consider items 1 and 2 above to be met. Please see our UBA Advisor "Sample Open Enrollment Notices Packet" for sample notice language.	October 15, 2022

Description	Timing	Due Date
Patient-Centered Outcomes Research Institute (PCORI) Fee		
All plans that provide medical coverage to employees must file IRS Form 720 and pay the fee. Medical coverage includes PPO plans, HMO plans, POS plans, HDHPs, and HRAs. The fee is effective for plan/policy years ending on or after October 1, 2012, and before October 1, 2029.	The fee is due by July 31 of the year following the calendar year in which the plan/policy year ends.	July 31, 2022
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Notice		
Employers that provide a QSEHRA must furnish written notice to eligible employees including a statement of the amount of each permitted benefit for which the employee might be eligible, a statement that the eligible employee must provide the amount of the permitted benefit to the marketplace if the employee applies for an advance premium tax credit, and a statement that the employee may be liable for any month in which they do not have minimum essential coverage.	Written notice to eligible employees at least 90 days before the beginning of each plan year. For mid-year eligible employees, notice must be sent the date the employee becomes eligible.	October 3, 2022 (for QSEHRAs that start on January 1, 2023)
Retiree Drug Subsidy (RDS) & Attestation of Actuarial Equivalence due to CMS - Application		
The RDS program reimburses plan sponsors for a portion of their qualifying covered retirees' costs for prescription drugs otherwise covered by Medicare Part D. See link for information on the RDS Annual Plan Application.	A plan sponsor must submit an application using the RDS Secure Website for each plan year for which the plan sponsor would like to request a subsidy.	See the RDS Application Deadline page. The application deadline is approximately 90 days before the selected plan year start date (adjusted for federal holidays). A 30-day extension may be requested.

Description	Timing	Due Date
Retiree Drug Subsidy (RDS) & Attestation of Actuarial Equivalence due to CMS - Reconciliation		
Plan sponsors who apply for the Medicare Part D retiree drug subsidy must submit a reconciliation to confirm the list of covered retirees and cost data. Additional information and a User Guide can be found at www.rds.cms.hhs.gov.	The reconciliation must be filed by the last day of the fifteenth month after the plan year end date (adjusted for weekends and federal holidays).	See the RDS Reconciliation Deadline page for upcoming reconciliation deadlines.
Summary Annual Report (SAR)		
An ERISA plan administrator is required to provide covered participants and certain beneficiaries with an annual statement summarizing the latest annual report Form 5500 for the plan.	Due to participants nine months after the plan year; two months after the extended due date for filing the Form 5500.	September 30, 2022 (for calendar year plans); December 15, 2022 if extension filed.

The following requirements are not date specific.

Description	Timing
Children's Health Insurance Program (CHIP) Notice	
Employer must inform employees of possible premium assistance opportunities available. Provide for employees that reside in states with premium assistance programs under Medicaid or CHIP.	Notice must be given annually, no later than the first day of the plan year. See our UBA Advisor "Sample Open Enrollment Notices Packet."
COBRA Election Notice	
Notice must be provided to 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.	The plan administrator must generally provide qualified beneficiaries with this 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). Extended deadline under the DOL and Treasury final rule, clarified by IRS Notice 2021-58. See the EBSA website for the model notice.
COBRA Qualifying Event Notice	
The plan administrator must be notified when a qualifying event occurs.	In general, the employer must notify the plan administrator within 30 days after the date of the following qualifying events (that results in coverage loss): • Death of the covered employee • Termination (other than by reason of gross misconduct) or reduction of hours of the covered employee • The covered employee's Medicare entitlement • The commencement of a bankruptcy proceeding of the employer (causing a substantial elimination of retiree coverage) Unless the plan follows the delayed employer notice rule, the "qualifying event" in this context means the date of the triggering event, not the coverage loss date.

Description	Timing
Continuation Coverage Rights Under COBRA	
Generally, if an employer has 20 or more employees, it is subject to federal COBRA and must provide enrollees 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.	Notice is due to new enrollees, including spouses, within 90 days after coverage begins. See our UBA Advisor "Sample Open Enrollment Notices Packet."
COBRA Notice of Early Termination of Continuation Coverage	
Notice must be provided to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage.	Notice must be provided as soon as practicable following the plan administrator's determination that coverage will terminate.
COBRA Notice of Insufficient Payment of Premium	
Notice must be provided to qualified beneficiary that payment for COBRA continuation coverage premium was less than correct amount.	The plan administrator must provide this notice as soon as practicable and provide reasonable period to cure deficiency before termination. A 30-day grace period will be considered reasonable.
COBRA Notice of Unavailability of Continuation Coverage	
Notice must be provided to an individual that is not entitled to COBRA coverage or for an extension of continuation coverage.	The plan administrator must provide this notice within 14 days after being notified by the individual of the qualifying event or of the request for extension.
External Review Process Disclosure	
Non-grandfathered plans must provide a description of the external review process.	The description of the external review process must be provided in or attached to the summary plan description, policy, certificate, or other evidence of coverage provided to participants, beneficiaries, or enrollees.
Grandfathered Plan Notice	
A grandfathered plan must include a notice about grandfathered plan status in any materials describing the plan's benefits.	Annually, when enrollment materials are provided. See our UBA Advisor "Sample Open Enrollment Notices Packet."

Description	Timing
HIPAA Breach Notification	
Group health plans must report to HHS and notify affected individuals of any breaches of unsecured protected health information.	Affecting 500 or more: Reporting to HHS, affected individuals, and media must be done without unreasonable delay and in no case later than 60 days of the breach's discovery. Affecting fewer than 500: 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 in no case later than 60 days of the breach's discovery.
HIPAA Notices of Privacy Practices	
Health plan must provide notice to plan participants explaining their rights with respect to their protected health information and the health plan's privacy practices.	Notice must be provided upon enrollment, within 60 days of a material revision, and at least once every three years. Notice must also be provided upon request. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Internal Claims and Appeals and External Review Determination Notices	
Internal Claims and Appeals: Non-grandfathered plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination. External Review: After an external review, the independent review organization (IRO) will issue a notice of final external review decision.	For internal claims and appeals, timing of the notices varies based on the type of claim. 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 under the DOL and Treasury final rule and EBSA Disaster Relief Notice 2021-01.
Medical Child Support Order (MCSO) Notice	
Plan administrator's receipt of an MCSO directing the plan to provide health coverage to a participant's noncustodial children.	Plan administrator, upon receipt of an MCSO, must promptly issue notice (including plan's procedures for determining its qualified status). Plan administrator must also issue separate notice as to whether the MCSO is qualified within a reasonable time after its receipt.

Description	Timing
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	
For plans subject to ERISA, notice must provide beneficiaries information 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.	Notice must be provided within 30 days of a plan participant's request. See the optional model disclosure form that plan participants may use to request information.
MHPAEA Claims Denial Notice	
For plans subject to ERISA, notice must provide the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits.	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. See the optional model disclosure form that plan participants may use to request information.
MHPAEA Increased Cost Exemption	
A group health plan claiming MHPAEA's increased cost exemption must furnish a notice of the plan's exemption from the parity requirements.	Notice must be provided if using the cost exemption. See the EBSA website for the model notice.
Michelle's Law Notice	
Must include a description of the Michelle's Law provision for continued coverage for students during medically-necessary leaves of absence.	Notice must be included with any notice regarding a requirement for certification of student status for coverage under the plan.
National Medical Support Notice	
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).	Employer must either send Part A to the state agency, or 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.

Description	Timing
Newborns' and Mothers' Health Protection Act Notice	
Notice must include 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.	Notice must be given annually and upon enrollment. Must be included in the SPD. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Notice to Employees of Coverage Options	
Notice provides employees information about the Health Insurance Marketplace and premium tax credits.	Notice due to all new employees (including part-time, temporary, or ineligible for the plan) within 14 days after hire date if the employer offers coverage to any employee. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")	
Information regarding benefit claim determinations. Adverse benefit determinations must include required disclosures (for example, the specific reasons for the claim denial, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Requirements vary depending on type of plan and type of benefit claim involved.
Notice to Enrollees Regarding Opt-Out	
Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements in Title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from certain requirements for any part of the plan that is self-funded by the employer.	Notice must be provided annually, when enrollment materials are provided. See our UBA Advisor "Sample Open Enrollment Notices Packet."

Description	Timing
Notice of HIPAA Special Enrollment Rights	
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.	Notice must be provided at or before the time an employee is initially offered the opportunity to enroll in a group health plan. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Patient Protection Notice	
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.	The notice must be provided whenever a Summary Plan Description or other similar description of benefits under the plan is provided to a participant or beneficiary. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Plan Documents	
The plan administrator must furnish copies of certain documents upon written request and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated.	Copies must be furnished no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations.
Section 111 Medicare Secondary Payer Mandatory Reporting	
On a quarterly basis, 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. See the Section 111 MSP Mandatory Reporting GHP User Guide.	Section 111 RREs must register with the BCRC and fully test the group health plan data reporting exchange before submitting information. CMS will assign the RRE with a timeframe during which the RRE will submit files on a quarterly basis.

Description	Timing
Section 1557 Nondiscrimination Notice	
Under the 2016 final rule, certain employers 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. See the HHS model notice of nondiscrimination, statement of nondiscrimination, and tagline. On June 12, 2020, HHS announced a final rule implementing Section 1557 that revises or repeals many provisions contained in the prior 2016 rule. Practically speaking, the final rule, and therefore Section 1557, does not apply to self-funded plans and many fully insured plans, as health insurers are not principally engaged in the business of providing health care. The final rule would not apply to a fully insured plan unless the plan received federal financial assistance from HHS or unless the plan is operating a program that is principally engaged in the business of providing health care.	Under the 2016 final rule, employers must include notice and taglines with all significant publications and communications. Covered entities must reasonably determine which of their publications and communications are "significant." See Q22–Q26 from the HHS Section 1557: Frequently Asked Questions for information on what publications and communications are significant. Under the 2020 final rule, the notice and taglines requirements were revised to state that covered entities are required to provide a notice of nondiscrimination and taglines *whenever necessary to ensure meaningful access to language services* for individuals with limited English proficiency. However, parts of the final rule are currently being litigated and HHS has announced it will issue a new notice of proposed rulemaking. Employers should consult with their attorneys when complying with the 2020 final rule.
Summary of Benefits and Coverage (SBC)	
A template that describes the benefits and coverage under the plan, including a uniform glossary defining certain terms. See the DOL SBC template. See the DOL Glossary of Health Coverage and Medical Terms.	Must be provided when enrollment materials are provided, or 30 days prior to start of plan year if no open enrollment. Provide to special enrollees within 90 days. If making a mid-year modification to plan that affects the SBC, must provide updated SBC or Summary of Material Modification no later than 60 days before change is effective. If the change is communicated as part of open enrollment, then it is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment acts a safe harbor for the 60-day prior/60-day post notice requirements.

Description	Timing
Summary of Material Modifications (SMM)	
When a plan is amended or when other information is required to appear in the plan's Summary Plan Description (SPD) changes, ERISA requires that notice of the amendment or change be provided through an SMM.	Changes that constitute a material reduction in covered services or benefits, within 60 days of adoption of the change. Modifications that are not a material reduction in benefits, distributed within 210 days after the end of the plan year in which modification is adopted (if revised SPD not issued). If the change is communicated as part of open enrollment, then it is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment acts a safe harbor for the 60-day prior/60-day post notice requirements.
Summary Plan Description (SPD)	
Summary of plan provisions and certain ERISA-required standard language, written for average participant and sufficiently comprehensive to inform covered persons of their benefits, rights, and obligations under the plan.	Must be furnished to participants within 90 days of becoming covered by the plan. Updated SPD must be furnished every 5 years if changes are made to SPD information or plan is amended. Otherwise, must be furnished every 10 years.
Wellness Program Notice and Notice of Reasonable Alternatives	
A notice must be provided to 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). A health-contingent wellness program must disclose the availability of a reasonable alternative in any materials describing the program. For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.	The notice must be provided annually before the employee provides medical information and sufficiently in advance to allow the employee to make an informed decision about whether to participate. Annually, when enrollment materials are provided. See our UBA Advisor "Sample Open Enrollment Notices Packet."

Description	Timing
Women's Health and Cancer Rights Act Notice	
Notice describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.	Notice must be given annually and upon enrollment. See our UBA Advisor "Sample Open Enrollment Notices Packet."

11/30/2021