UBA
Compliance Advisor

What every HR leader should know about compliance

2019 Compliance Calendar

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
Form W-2		
Employers who filed at least 250 Forms W-2 for the prior calendar year must report the aggregate value of applicable employer-sponsored health coverage on Forms W-2.	The deadline to file and furnish Form W-2 is January 31.	January 31, 2019
Forms 1094-B and 1095-B		
Form 1095-B is used to meet the Section 6055 reporting requirement of having coverage to meet the individual shared responsibility requirement. 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 that was actually 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: January 31 (IRS may grant permissive 30-day extension for good cause) 1094-B: February 28, or March 31, if filing electronically (may file Form 8809 for automatic 30-day extension)	Form 1095-B: March 4, 2019 Form 1094-B: February 28, 2019, or April 1, 2019, if filing electronically

Description	Timing	Due Date
Forms 1094-C and 1095-C		
Form 1095-C is primarily used to meet the Section 6056 reporting requirement relating to the employer shared responsibility / play-or-pay requirement. Form 1095-C is also used to determine whether an individual is eligible for a premium tax credit. Employers with 50 or more full-time or full-time equivalent employees complete much of Form 1095-C to report on coverage that was offered to the employee and eligible dependents. Filers use Form 1094-C as the transmittal to submit the 1095-C return.	1095-C: January 31 (IRS may grant permissive 30-day extension for good cause) 1094-C: February 28, or March 31, if filing electronically (may file Form 8809 for automatic 30-day extension)	Form 1095-C: March 4, 2019 Form 1094-C: February 28, 2019, or April 1, 2019, if filing electronically
Form 8809		
Employers use IRS Form 8809 to get an automatic 30-day extension of time to file Forms 1094-C or 1094-B.	Must be filed on or before the due date of the returns.	February 28, 2019, if filing paper forms April 1, 2019, if filing electronically
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 the Centers for Medicare and Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage." Employers must provide CMS with a "Disclosure to CMS Form" that the employer completes and sends electronically through the CMS website. CMS provides an instruction guide with screen shots for completing the form online.	The form must be provided annually and: 1. For plan years that end in 2007 and beyond, within 60 days after the beginning date of the plan year for which the entity is providing the form 2. Within 30 days after the prescription drug plan's termination 3. Within 30 days after any change in the creditable coverage status of the prescription drug plan	March 1, 2019 (for plan years beginning January 1, 2019)

Description	Timing	Due Date
HIPAA's breach notification rule – involving fewer than 500 individuals		
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.	If the breach involved fewer than 500 individuals, the reporting must be done on the HHS website within 60 days after the end of the calendar year in which the breach occurred. Plan sponsor must notify affected individuals within 60 days of the breach's discovery.	March 1, 2019
Form M-1		
Multiple employer welfare arrangements (MEWAs) and many entities claiming not to be MEWAs due to the exception for collectively bargained plans (entities claiming exception (ECEs)) are required to file Form M-1 with the Department of Labor (DOL) (subject to certain exceptions).	Generally 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, 2019
Form 7004		
Employers use IRS Form 7004 to receive an automatic 6-month extension to file Form 8928.	Generally, Form 7004 must be filed on or before the due date of the applicable tax return. The due dates of the returns can be found in the instructions for the applicable return.	April 15, 2019

Description	Timing	Due Date
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.	The deadline for submitting Form 8928 and paying the tax generally is the deadline for filing the plan sponsor's federal income tax return. In the case of a multiemployer plan, the deadline is the last day of the seventh month following the close of the plan year. However, the deadline for reporting and paying the tax for violating the HSA comparable contributions requirements is April 15 following the calendar year in which the non-comparable contributions were made.	April 15, 2019
Form 5500		
IRS Form 5500 is the annual report that plans make to the DOL and IRS to report required information about the plan's financial condition and operations. Most group and pension plans that are subject to ERISA are required to file Form 5500.	Due on the last day of the seventh month after the plan year, unless an extension is requested on Form 5558 or automatically provided based on extension of the federal corporate income tax return.	July 31, 2019 (for calendar year plans)
Form 5558		
Employers may obtain an automatic extension to file Form 5500, Form 5500-SF, Form 5500-EZ, or Form 8955-SSA 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, 2019 (for an extension to file Form 5500 for a calendar year plan)

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 preferred provider (PPO) plans, health maintenance organization (HMO) plans, point-of-service (POS) plans, high deductible health plans (HDHPs), and health reimbursement arrangements (HRAs).	The fee is due by July 31 of the year following the calendar year in which the plan/policy year ends. The fee applies from 2012 to 2019, based on plan / policy years ending on or after October 1, 2012, and before October 1, 2019.	July 31, 2019
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 or two months after the extended due date for filing the Form 5500.	September 30, 2019 (for calendar year plans)
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Notice		
Employers that provide a QSEHRA must furnish written notice to eligible employees containing information such as the amount of each permitted benefit for which the employee might be eligible and a statement that the eligible employee must provide information about the QSEHRA to the Marketplace or Exchange if the employee applies for an advance premium tax credit.	Employers that provide a QSEHRA must furnish a written notice to eligible employees at least 90 days before the beginning of each plan year. For employees who become eligible to participate midyear, the notice must be sent on or before the first day the employee becomes eligible for a QSEHRA.	October 3, 2019 (for QSEHRAs that start on January 1, 2020)

Description	Timing	Due Date
Application for Retiree Drug Subsidy (RDS) & Attestation of Actuarial Equivalence due to CMS		
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 subsidy. The application deadline is approximately 90 days before the plan sponsor's selected plan year start date (adjusted for federal holidays and weekends). A 30-day extension may be requested.	October 3, 2019 (for plan year beginning January 1, 2020)
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 (ACEP), which runs from October 15 through December 7 of each year; 2. Prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D; 3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; *(continued on next page)*	October 14, 2019

Description	Timing	Due Date
Medicare Part D Notice of Creditable Coverage to Plan Participants (continued)		
	4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and 5. Upon request by the individual. 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.	
Retiree Drug Subsidy 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 are available at https://www.rds.cms.hhs.gov/	The reconciliation must be filed by the last day of the fifteenth month following the last day of the RDS plan year specified in the application.	See https://www.rds.cms.hhs.gov/?q=regulations-guidance/important-reconciliation-deadline-information for upcoming reconciliation deadlines.

The Following Dates are Not Calendar-Specific

Description	Timing
ADA Wellness Program Notice	
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).	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. See our UBA Advisor "Sample Open Enrollment Notices Packet."
Children's Health Insurance Program (CHIP) Notice	
Employer (rather than plan) must inform employees of possible premium assistance opportunities available in the state they reside. Only provide if state provides premium assistance with Medicaid or CHIP.	Notice must be given annually, by the first day of the plan year. See our UBA Advisor "Sample Open Enrollment Notices Packet."
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.

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 by the employer or qualified beneficiary of the qualifying event. If the employer is also the plan administrator, the administrator must provide the notice not later than 44 days after the date on which the qualifying event occurred; or if the plan provides that COBRA continuation coverage starts on the coverage loss date, the date of coverage loss due to a qualifying event.
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."
Notice of Unavailability of COBRA	
Notice must be provided to an individual that is not entitled to COBRA coverage.	The plan administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event.
Notice of Early Termination of COBRA 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.
EBSA Form 700	
A plan sponsor may use EBSA Form 700 to claim an accommodation regarding the requirement to cover certain contraceptive services without cost sharing. Other methods for invoking an accommodation, such as providing a notice to the Secretary of HHS, are also available.	Form or notice must be provided when claiming accommodation.

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.
GINA Wellness Program Authorization	
An employee must provide a prior knowing, voluntary, and written authorization before voluntarily providing genetic information as part of a wellness program. Similarly, an employee's spouse must provide a prior knowing, voluntary, and written authorization before voluntarily providing medical or genetic information as part of a health risk assessment. The authorization must describe the type of genetic information that will be obtained, the general purposes for which it will be used, and the restrictions on disclosure of the information.	Annually
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."
HIPAA's breach notification rule – involving 500 or more individuals	
Group health plans must report to HHS and notify affected individuals of any breaches of unsecured protected health information.	If a breach affects 500 or more individuals, reporting must be done on the HHS website within 60 days of breach's discovery Plan sponsor must notify affected individuals within 60 days of the breach's discovery. Plan sponsor must notify prominent media outlets serving the state or jurisdiction within 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 personal health information and the health plan's privacy practices.	Notice must be provided (or participants must be notified that the notice is available) at least once every three years. See our UBA Advisor "Sample Open Enrollment Notices Packet." In addition, the notice must be given upon enrollment and upon request. When there is a material change to the notice, an updated notice must be posted to the benefits website by the effective date of the change and distributed with the next annual mailing to participants. If the employer does not maintain a benefits website, the updated notice must be distributed within 60 days of the effective date of the change.
Internal Claims and Appeals and External Review 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. See the EBSA website for a link to model notices and guidance.	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.
Medical Child Support Order (MCSO) Notice	
Plan administrator's receipt of a MCSO directing the plan to provide health coverage to a participant's noncustodial children.	Plan administrator, upon receipt of 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.
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.

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 upon request or as otherwise required by other laws.
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. See the EBSA website for model notice.	Notice must be provided if using the cost exemption.
Michelle's Law Enrollment 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 (NMS) 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 MCSO (QMCSO).	Employer must either send Part A to the state agency, or Part B to plan administrator, within 20 days after the date of the notice or sooner, if reasonable. 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 its date or sooner, if reasonable, complete and return Part B to the state agency and must also provide required information to affected persons. Under certain circumstances, the employer may be required to send Part A to the state agency after the plan administrator has processed Part B.

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 (even if they are 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."

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 an SPD—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 MSP Mandatory Reporting	
On a quarterly basis responsible reporting entities (RREs) must submit group health plan entitlement 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. The BCRC will provide the RRE with Medicare entitlement information for individuals in a group health plan that can be identified as Medicare beneficiaries. 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.

Section 1557 Nondiscrimination Notice	
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 HHS' model notice and statement.	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.
Summary of Material Modifications (SMM)	
When a plan is amended or when other information is required to appear in the plan's SPD changes, ERISA requires that notice of the amendment or change be provided through an SMM.	• For modifications to the summary plan description (SPD) that constitute a material reduction in covered services or benefits (SMM distributed within 60 days of the adoption of the change) • Material modification made in any of the plan terms that would affect the content of the most recently provided summary of benefits and coverage (SBC) (SMM distributed 60 days prior to the effective date of the modification) • Modifications that do not affect the SBC and are not a material reduction in benefits (SMM or updated SPD distributed within 210 days after the end of the plan year) 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 is essentially a safe harbor for the 60-day prior / 60-day post notice requirements.
Summary Plan Description (SPD)	
Primary document for informing plan participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to inform covered persons of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents as of the date not earlier than 120 days prior to the date the SPD is disclosed.	Must be furnished to participants within 90 days of becoming covered by the plan. Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise must be furnished every 10 years.

Summary of Benefits and Coverage (SBC)	
A template that describes the benefits and coverage under the plan, and 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. If making a mid-year change that affects the SBC, must provide updated SBC or Summary of Material Modification 60 days before change is effective.
Wellness Program – Notice of Reasonable Alternatives	
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.	Annually, when enrollment materials are provided. See our UBA Advisor "Sample Open Enrollment Notices Packet."
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."

3/15/2019