2024 Health Plan Compliance Deadlines

There are numerous reporting and disclosure requirements with which Employers must comply when it comes to their Group Health Plans. This Compliance overview explains key 2024 compliance deadlines for employer-sponsored group health plans. It also outlines group health plan notices employers must provide each year. The Benefit Guide that we prepare for clients includes a link to these annual notices (as noted with ✧).

Some compliance deadlines summarized below are tied to a group's health plan's ***plan year***. For these requirements, the chart below shows the deadline that applies to calendar-year plans. For non-calendar-year plans, these deadlines will need to be adjusted to reflect each plan's specific plan year.

Determining Your Plan Year

The "plan year" is the calendar, policy, or fiscal year on which records of the plan are kept. Many employers operate their group health plans on a calendar-year basis from January 1 through December 31 of each year. Other employers operate their plans on a non-calendar-year basis, which may be consistent with the company's taxable year or with an insured plan's policy year.

2024 Compliance Calendar

Deadline	Requirement	Applicability	Description
January 31	Report health plan costs on Form W2	Employers that file **250 or more** IRS Form W2s for the prior calendar year must include health coverage cost in box 12 using "DD" code.	Employers that filed 250 or more IRS Forms W-2 for the prior calendar year must include 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.
January 31	Report HSA contributions on Form W2	Employers report health savings account (HSA) contributions on employees' Form W-2 in Box 12, using code "W".	IRS instructions say to report "employer contributions" to HSAs but because the IRS views employee pretax payroll deductions as employer dollars, employers should also report employee pretax contributions to their HSAs if the contributions are made through payroll.

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2024 Compliance Calendar

Deadline	Requirement	Applicability	Description
February 28	File ACA Forms 1094/1095-B (Paper Filing Deadline)	Employers that are not ALEs and have self-insured health plans (including Level Funded) Beginning in 2024, paper filing is no longer an option for employers filing 10 or more returns without a waiver*	Non-ALEs with self-insured health plans must report information about their health plan coverage to the IRS using Forms 1094/1095-B. This deadline applies only to filing paper versions of these forms.
February 28	File ACA Forms 1094/1095-C (Paper Filing Deadline)	Employers that are Applicable Large Employers (ALEs). Beginning in 2024, paper filing is no longer an option for employers with 10 or more returns without a waiver.*	ALEs must report information about their health plan coverage to the IRS using Forms 1094/1095-C. This deadline applies only to filing paper versions of these forms.
February 29* *this is the due date for calendar-year plans. Off calendar plan years are due 60 days from the beginning of the plan year	Submit Online Disclosure of Credible Medicare Part D Coverage to CMS	Group health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D (prescription drug coverage).	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 non-creditable. Employers must make the disclosure to CMS annually using CMS's online disclosure form.
March 1	Provide ACA Form 1095-B to Employees	Employers that are not ALEs and have self-insured health plans (including Level Funded)	Non-ALEs with self-insured health plans must provide information about their health plan coverage to their employees each year using IRS Form 1095-B.
March 1	Provide ACA Form 1095-C to Employees	Employers that are ALEs	ALEs must provide information about their health plan coverage to their employees each year using IRS Form 1095-C.
April 1	Electronically file ACA Forms 1094/1095-B*	Employers that are not ALEs and have self-insured health plans (including Level Funded)	Non-ALEs with self-insured health plans must report information about their health plan coverage to the IRS using Forms 1094/1095-B.
April 1	Electronically file ACA Forms 1094/1095-C*	Employers that are ALEs	ALEs must report information about their health plan coverage to the IRS using Forms 1094/1095-C.
Beginning in 2024, most employers subject to ACA reporting must file their returns electronically. Paper filing is an option only for very small employers (i.e., employers that file fewer than 10 information returns during the year). A waiver may be requested from the electronic filing requirement by submitting Form 8508 to the IRS.* *See the **Silberman Group January Blog for more details.*			
April 15	Federal Income Tax Deadline	Health Savings Accounts	Last day to make contributions and corrections for previous year.

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Deadline	Requirement	Applicability	Description
June 1	Submit Prescription Drug Data Collection Report (RxDC) for prior Calendar Year	Group health plans and health insurance issuers (including Self Insured and Level Funded Employers)	The CAA transparency law requires employer-sponsored health plans and health insurance issuers to report information about prescription drugs and health care spending to the federal government annually.
July 31	Report and pay PCORI fee	Employers with Health FSA, HRA and/or Self-insured plans (including Level Funded)	Employers use IRS Form 720 to report and pay PCORI fees, which are due by July 31 of the year following the last day of the plan year.
July 31* *due date for calendar-year plans. Off-calendar plan years are due by the end of the 7th month following the end of the plan year	File Form 5500	ERISA-covered group health plans that do not qualify for the small plan exemption.	Employers with ERISA-covered welfare benefit plans are required to file an annual Form 5500 unless a reporting exemption applies. 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.
September 30	Watch for MLR Rebates from Carriers	Employers with fully insured health plans	Employers with insured health plans may receive rebates if their issuers did not meet their applicable Medical Loss Ratio (MLR) percentage. Any rebate amount that qualifies as a plan asset under ERISA must be used for the exclusive benefit of the plan's participants and beneficiaries.
September 30* *due date for calendar-year plans. Or for off-calendar plan years, 2 months after filing Form 5500	Provide SAR	Group health plans that are subject to the Form 5500 filing requirement	Employers that must file a Form 5500 must provide participants with a summary of the information in the Form 5500, called a Summary Annual Report (SAR). The SAR must be provided within nine months of the close of the plan year.
October 14	Provide Medicare Part D creditable /non-creditable coverage notices to eligible employees	Group health plans that provide prescription drug coverage to individuals eligible for Medicare Part D	Employers with group health plans that provide prescription drug coverage must notify Medicare Part D-eligible individuals each year about whether the drug coverage is at least as good as Medicare Part D coverage (in other words, whether their prescription drug coverage is "creditable" or as good as or "non-creditable"). Model disclosure notices are available on this CMS website.

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2024 Compliance Calendar

Deadline	Requirement	Applicability	Description
December 31	Submit Gag Clause Attestation	Group health plans and health insurance issuers (including Level Funded)	The CAA transparency law requires health plans and issuers to submit attestations of compliance with the prohibition on gag clauses by Dec. 31 each year. If the issuer for a fully insured health plan provides the attestation, the plan does not also need to provide an attestation. Employers with self-insured (or Level Funded) health plans can enter into written agreements with their TPAs to provide the attestation, but the legal responsibility remains with the health plan.

2024 Annual Notices

Notice	Applicability	Description
SBC (Summary of Benefits & Coverage) (Available from Medical Carrier)	Group health plans and health insurance issuers	Group health plans and health insurance issuers are required to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees each year at open enrollment or renewal.
SPD (Summary Plan Description) (Available from Medical Carrier or drafted as part of Wrap Documents)	Group health plans subject to ERISA	A Summary Plan Description (SPD) must be provided to new health plan participants within 90 days of the start of their plan coverage.
WHCRA✧	Group health plans that provide medical and surgical benefits for mastectomies	Group health plans must provide a notice about the coverage requirements of the Women's Health and Cancer Rights Act (WHCRA) at the time of enrollment and on an annual basis after enrollment.
CHIP✧	Group health plans that cover residents in a state that provides a premium assistance subsidy under a Medicaid plan or CHIP	If an employer's group health plan covers residents in a state that provides a premium subsidy under a Medicaid plan or Children's Health Insurance Program (CHIP), the employer must send an annual notice about the available assistance to all employees residing in that state.
Surprise Billing Notice✧	Group health plans and health insurance issuers	Describes the restrictions against balance billing in certain circumstances, including any applicable state law balance billing protections, and information on contacting appropriate state and federal agencies.

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2024 Annual Notices

Notice	Applicability	Description
COBRA✧	Group health plans subject to COBRA	Group health plans must provide a written General Notice of COBRA Rights to covered employees within 90 days after their health plan coverage begins.
Grandfathered Plan	Health plans that have grandfathered status under the ACA	To maintain a plan's grandfathered status, the plan sponsor or issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the SPD and open enrollment materials). Grandfathered plans are those that were in existence on March 23, 2010 and have stayed basically the same.
HIPAA Privacy✧	Self-insured (and Level Funded) group health plans	The HIPAA Privacy Rule requires self-insured health plans to maintain and provide their own privacy notices (which includes insured plans with self-funded components such as Health Reimbursement Arrangements and stand-alone Employee Assistance Programs). Special rules, however, apply for fully insured plans. Under these rules, the health insurance issuer, not the health plan itself, is primarily responsible for the privacy notice.
HIPAA Special Enrollment	All group health plans	At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of their special enrollment rights under HIPAA. It is often included in the health plan's SPD or insurance booklet.
Wellness - HIPAA	Group health plans with health-contingent wellness programs	Employers with health-contingent wellness programs must provide a notice that informs employees there is an alternative way to qualify for the program's reward.
Wellness - ADA	Wellness programs that collect health information or include medical exams	To comply with the Americans with Disabilities Act (ADA), wellness plans that collect health information or involve medical exams must provide a notice to employees that explains how the information will be used, collected and kept confidential.

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Benefit Plan Nondiscrimination Rules

Nondiscrimination testing is implicated any time an employer varies plan eligibility, benefits, contributions, waiting periods or plan design cost-sharing (e.g., deductibles and co-insurance). Generally, both Sections 105(h) and 125 allow a variance based on bona fide business classifications, provided the result does not favor HCEs.

At a high level, the assessment of a potentially discriminatory plan design breaks down into two questions:

1) Is the variance based on a business classification; and
2) Does the result of the variance favor HCEs?

IRS Code Testing	Applicability	Description
Section 125: Cafeteria Plans	Section 125 applies to both self-insured and fully insured plans if employees can pay any required cost-share contribution to the plan on a pre-tax basis via salary reduction.	Under Section 125, highly compensated employees, and key employees are not entitled to receive pre-tax benefits under a cafeteria plan if the plan discriminates in favor of those individuals with respect to benefits or eligibility to participate. If the plans are determined to be discriminatory, the value of the taxable benefit must be included in the gross income of what the regulation defines to be highly-compensated employees.
Section 105(h): Self Funded Plans (including Level Funded)	Self-insured/Level Funded plans include any type of major medical plan (HMO, PPO, HDHP, etc.), health FSAs and HRAs.	Under Section 105(h), plans may not discriminate in favor of highly compensated individuals as to eligibility to participate or benefits. If the plans are determined to be discriminatory, the value of the taxable benefit must be included in the gross income of what the regulation defines to be highly-compensated employees. These rules only affect whether reimbursements made under the plan are taxable. Plans that are offered under a cafeteria plan (which is generally the case) must also pass Section 125 nondiscrimination testing, which determines whether the salary reductions for coverage under these plans are taxable.

When to Perform Nondiscrimination Testing: The rules do not prescribe a specific date or timeframe for performing nondiscrimination testing; they simply provide that the plan must not be discriminatory as of the last day of the plan year. To help ensure that the plan will pass testing, a general best practice is to perform nondiscrimination testing early in the plan year. This gives employers ample time to determine whether additional steps must be taken before the end of the plan year. Employers should also monitor and revisit the testing particularly if there are significant changes in employee composition, such as new hires, salary changes, etc. Finally, employers should perform the tests (or confirm prior tests) at the end of the year to confirm compliance by the last day of the plan year. Also, if the employer is involved in a business reorganization (such as a merger or acquisition), the testing should be reviewed as part of the reorganization process.

Due to the complexity of testing plans for compliance with these nondiscrimination rules, any employer that is considering offering health benefits to only certain classes of employees should carefully review all the provisions of the applicable regulations, and seek specific guidance on its particular plan.