SILBERMAN GROUP

2025 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 2025 compliance deadlines for employer-sponsored group health plans. It also outlines group health plan notices employers must provide each year. The Benefits 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.

2025 Compliance Calendar – Large Group (50 or more)

Compliance Deadlines for Fully and Self-Insured (including level funded) Groups

All deadline dates below are based on a Calendar Year Plan, some reporting deadlines may vary for plans that have a plan start date other than January 1st.

Deadline	Requirement	Applicability	Description
Nov 1 – Dec 31	Measure Plan Affordability	Employers that are An Applicable Large Employer (ALE)	There are three safe harbors that an employer may use to determine affordability for purposes of the employer shared responsibility provisions. Employers are allowed to choose from using either the Form W-2 wages, an employee's rate of pay, or the federal poverty limit to make their affordability determination. The contribution percentage to determine affordability for Plan Years starting in **2025 is 9.02%**.
Jan 31	Reporting health plan costs on Form W2	Employers that filed 250 or more W2 for the prior calendar year	Must report to Social Security Administration and include aggregate cost of employer sponsored health plan coverage on Employee's W2.
Jan 31	Report HSA contributions on Form W2	Employers report health savings account (HSA) contributions on employees' Form W2 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.

Mar 1* *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 Creditable 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).	Must disclose to CMS whether Prescription coverage is creditable or non-creditable within 60 days after the beginning of the plan year using CMS's Online Disclosure Form. In general, to be creditable the Plans Rx actuarial value must be equal or more than Medicare Part D's actuarial value for coverage.
Mar 3	Provide ACA Form 1095-C to Employees	Employers that are ALEs with Fully Insured Health Plan and Self-Insured Health Plan (including level funded)	The code requires ALEs that sponsor health plans, to report information about the coverage to covered employees each year using Form 1095-C. This is an extension from the Jan 31st deadline.
Mar 31	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. **Electronic Filing REQUIRED:** **Third Party Vendor recommended for electronic filing. Reach out to Silberman Group for more information.**
Apr 15	Federal Income Tax Deadline	Health Savings Accounts	Last day to make contributions and corrections for the previous year.
Jun 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)	Requires employer-sponsored health plans and insurers to report information about Rx and healthcare spending to CMS annually. Most employers will rely on third parties, such as Carriers, TPAs, or PBMs to prepare and submit on behalf of the Plan/ Employer but should get guarantees in writing.
Jul 31	Report and pay PCORI fee	Employers with Health FSA, HRA and/or Self-insured plans (including Level Funded)	Employers with self-insured health plans must pay an annual fee to fund the Patient Centered Outcomes Research Institute. HRAs offered with self-insured group medical plans are not subject to separate PCORI fees if the HRA and medical plan have the same plan sponsor that year. Employers use IRS Form 720 to report and pay PCORI fees which are due by July 31st of the year following the last day of the plan year.
Jul 31* *this is the due date for calendar-year plans. Off calendar plan years are due last day of the 7th month after plan year ends	Form 5500	Employers with 100 or more participants on the plan at the beginning of the plan year. (ERISA-covered group health plans that do not qualify for the small plan exemption and MEWAs)	Employers are required to file an annual Form 5500 unless a reporting exemption applies. The form must be filed by the last day of the seventh month following the end of the plan year unless an extension applies via a Form 5558 being filed prior to normal due date of 5500.

Sep 30* *this is the due date for calendar-year plans. Off calendar plan years are due last day of the 9th month after plan year ends	Summary Annual Report (SAR)	Group health plans that are subject to the Form 5500 filing and have not extended the deadline via a Form 5558	Employers that are required to file a Form 5500 must provide participants with a summary of the information in the Form 5500, called a summary annual report (SAR). The plan administrator must provide the SAR within nine months of the close of the plan year.
Sep 30	Watch for MLR Rebates from Carriers	Employers with fully insured health plans that receive MLR rebates	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.
Oct 15	Provide Medicare Part D creditable /non-creditable coverage notices to eligible employees	Group health plans that provide Rx 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.
Nov 1 – Dec 31	ACA Employer Penalty: Identify application and method of compliance	All Employers	Determine ALE Status (i.e., whether the employer has at least 50 full-time employees (FTEs) each calendar year, considering all common law employees in the entire controlled group and counting each part-time employee as a fraction of the FTE). Determine full-time status using monthly measurement method or look-back measurement method. Offer coverage to FTEs and dependent children. Evaluate minimum value, affordability, and elect a safe harbor. Ensure that all plan language accurately reflects the selections.
Dec 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.

2025 Annual Notices

Notice	Applicability	Description
SBC (Summary of Benefits & Coverage) (Available from 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✧ Women's Health and Cancer Rights Act	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✧ Children's Health Insurance Program	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.
COBRA✧ Initial Notice	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 include 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.

This document is provided for general informational purposes and should not be considered as legal or financial advice. We encourage you to consult with a qualified attorney to obtain legal guidance regarding your specific compliance needs. Please be aware that laws and regulations may vary and changes may have occurred since this document's creation. It is your responsibility to verify the accuracy of current information as needed.

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 Internal Revenue Code Sections 105(h) and 125 allow a variance based on bona fide business classifications, provided the result does not favor Highly Compensated Employees (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-Insured Plans (including Level Funded)	Self-insured/Level Funded plans including 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.		