ERISA COMPLIANCE CALENDAR

50+ INSURED PLAN | PLAN YEAR: MARCH 1, 2024

DEADLINE	TOPIC / DOCUMENT	EXPLANATION	DETAILS
Upon Hire	Notice of Coverage Options	Employers subject to the Fair Labor Standards Act (FLSA) must provide a written notice informing the employee of the existence of the Marketplace, the potential availability of a tax credit and that an employee may lose the employer contribution if the employee purchases a qualified health plan.	Distribute this notice about Health Insurance Marketplace options to all new employees within 14 days of the date of hire.
When first eligible	SBCs for all coverage options	A template that describes the benefits and coverage under the plan and a uniform glossary defining statutorily and NAIC recommended terms. The SBC must include an internet address where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy. There is a new template to be used on or after 1/1/2021. https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template-new.pdf	When an employee is first eligible for coverage, employer must provide a copy of an SBC for each plan option.
When first eligible	Enrollment Notices	Federal law requires health plans to send a variety of notices to participating employees and dependents, usually concerning their rights under the health plan.	Provide notices to all new employees who are eligible to enroll in the health plan.
Upon Enrollment	COBRA Initial Notice	Notice of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.	Provide to any employee within 90 days after enrollment in a plan subject to COBRA - medical, dental, vision, health FSA. NOTE: spouse must receive the notice within 90 days - delivery to employee does not satisfy delivery to spouse.
Upon Enrollment	Summary Plan Descriptions	Primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise 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.	Provide an SPD for each benefit in which the employee enrolled and/or a wrap summary plan description. The SPD must be provided within 90 days of enrollment.
During Plan Year	Nondiscrimination Testing	Tests are required to be completed by qualified plans and ERISA-403(b) accounts to ensure that plan benefits/contributions do not discriminate in favor of officers, shareholders, employees whose principal duties consist in supervising the work of other employees, or highly compensated employees.	Perform nondiscrimination testing to ensure that all plans pass - should be done prior to the end of the plan year so that adjustments can be made if necessary.

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During Plan Year	Employee Tracking	Apply measurement periods for the purpose of measuring variable hour and seasonal employees to determine if they must be offered coverage based on hours worked. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week (average 130/ month).	Continue tracking employee offer of coverage, enrollment and affordability to prepare for reporting requirements in 2025.
Quarterly	Self-Administered HRA: CMS Reporting Requirement	Self-administered and self-insured HRAs with annual benefit levels of $5,000 or more that cover Medicare-eligible individuals must electronically file a quarterly report to the Centers for Medicare and Medicaid Services (CMS) pursuant to the Medicare Secondary Payment provisions.	HRA coverage must be reported on a quarterly basis if its annual benefit is $5,000 or more.
1/1/2024	Determine which employees are considered full-time under the ACA		On or near this date, determine eligibility using the look-back measurement method (or other method); document and retain calculations.
1/15/2024	Open Enrollment		On or near this date, provide open enrollment notices to eligible employees working 30 or more hours per week. Also distribute the SBC to each participant for the plan in which he/she is enrolled.
1/31/2024	W-2 Reporting of Health Coverage	Employers filing 250 or more W-2s for the previous calendar year are required to include the total cost of employer sponsored health benefits on Form W-2.	For employers issuing 250 or more W-2s, include health coverage costs.
2/1/2024	Plan Documents (wrap and cafeteria plan)	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.	On or near this date, begin to update documents to reflect any changes made for the next plan year.
2/28/2024	Filing of Health Insurance Offer and Coverage Reports	Last day for forms to be mailed to IRS.	Submit Form 1094-C along with all 1095-Cs that were issued to the IRS in paper format (if this is the chosen distribution method. Only available to employers filing 10 or fewer W-2 forms).

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3/1/2024	Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitation (NQTL) Analysis	The Mental Health Parity and Addiction Equity Act (MHPAEA) generally provides that financial requirements (i.e. coinsurance and copays) and treatment limitations (i.e. visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the limitations that apply to substantially all medical/surgical benefits within its set classification. To ensure this, the CARES Act of March 2020 added a new MHPAEA requirement for group health plans to make available a comparative analysis of the design and application of non-quantitative treatment limitations (NQTLs) on the plan's Mental Health (MH) or Substance Use Disorder (SUD) benefits.	Request the non-quantitative treatment limitation (NQTL) analysis from your carriers and review to ensure plan adequacy. Be prepared to furnish these documents to the Secretary of Health and Human Services, the Department of Labor, the IRS (Department of the Treasury), other applicable state authorities, or members upon request.
3/4/2024	Form 1095-C Reporting - Health Insurance Offer and Coverage Reports to Employees Last day for Forms to be mailed to employees.	Form 1095-C is filed and furnished to any employee for one or more months of the calendar year. ALE members must report that information for all 12 months of the calendar year for each employee.	Last day to mail Form 1095-C to each employee who was full-time during the prior year and each former employee who was enrolled in the plan.
4/1/2024	Federal Employer Reporting Requirements	Applicable large employers and small employers with self-funded coverage, must send health-care coverage returns to the Federal Government for the 2021 Tax Year. Filers will transmit coverage returns through the IRS AIR system. Forms are due on this date.	Use IRS form 1095-C to communicate health insurance information to the IRS.
4/1/2024	NJ Employer Reporting Requirements	Applicable large employers and small employers with self-funded coverage, must send health-care coverage returns to the Federal Government for the 2023 Tax Year. Filers will transmit coverage returns through the IRS AIR system. Forms are due on this date.	Use IRS form 1095-C to communicate health insurance information to the state, in addition to the federal responsibilities to FT employees and to the IRS. Other states may follow.

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50+ INSURED PLAN | PLAN YEAR: MARCH 1, 2024

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4/30/2024	Notice to CMS of Creditable Coverage status of prescription drug plan	Applicable large employers and all other providers of Minimum Essential Coverage to New Jersey residents must send health-care coverage returns to the State for the 2023 Tax Year. Filers will transmit coverage returns through New Jersey's system for processing W-2 forms. Out-of-State employers who employ New Jersey residents have the same filing requirements as in-State businesses. These requirements are not limited to businesses that withhold New Jersey payroll taxes. If you are an out-of-State employer, you must ensure that you provide any required 1095 document for each New Jersey resident you employ.	Disclosure to CMS Form *
4/30/2024	Summary of Material Modifications	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.	If plan changes are a material reduction in coverage, SMM must be distributed within 60 days of the start of the plan year; otherwise distribution is not required until 210 days after the end of the plan year.
6/1/2024	Transparency in Coverage -Prescription Drug Cost Reporting (RxDC Reporting)	Employers and issuers must report plan information on a calendar year basis reflecting various prescription drug cost information mostly related to the spending on prescription drugs, in addition to related plan spending. Reports are to be submitted to CMS by this date annually.	Fully insured and self-funded group health plans, including governmental plans and church plans, must complete RxDC filings. Filings are not required for account-based plans (such as health reimbursement arrangements) or excepted benefit plans (e.g. stand-alone dental/vision plans or short-term limited duration insurance). Fully insured groups may use a written agreement with their carrier to ensure the requirements are being met by the carrier. Self-insured employers may institute a written agreement with their TPA, PBAs, or other Prescription Reporting Entities to ensure these requirements are being met, but the responsibility ultimately lies with the employer to ensure it is complete. Plans can rely on multiple vendors to ensure their filings are complete. e.g. example, a plan may use a TPA to submit information about the plan spend, but their PBM to submit the required pharmacy data.

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7/31/2024	PCORI Fee covered life calculations	The Patient-Centered Outcomes Research Institute (PCORI) fee requires employers with self-insured group health plans, including Health Reimbursement Arrangements (HRAs), to pay an annual fee to fund medical research. The PCORI fee has been extended for 10 years, meaning that plan sponsors of self-insured plans will have to continue to pay this fee until 2029 or 2030, depending on the plan year. The amount due per life covered under a policy will continue to be adjusted annually. Employers sponsoring an applicable self-insured plan multiply the fee by the average number of lives covered under the plan.	On or near the deadline, begin to calculate the number of covered lives in preparation of Form 720 and fee transmittal.
7/31/2024	PCORI Fee Filing - HRA	The PCORI fee is due by July 31 of the year following the calendar year in which the plan/policy year ends.	The fee must be reported and paid using IRS Form 720, Quarterly Federal Excise Tax Return.
9/30/2024	Form 5500 Filing	An Annual Return/Report of Employee Benefit Plan is the form used to file an employee benefit plan's annual information return with the Department of Labor (DOL).	File Form 5500 for welfare plan if 100 or more participants on the first day of the plan year for prior year.
10/15/2024	Notice of Creditable or Noncreditable Prescription Drug coverage	Notice to Medicare-eligible individuals identifying whether the plan's prescription drug coverage is creditable coverage, meaning the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage. The notice also explains the penalties (increased cost for coverage and delayed effective date) applied to certain individuals who delay Part D enrollment if they have a gap in creditable coverage of 63 days or more.	Distribute 2024 notice to employees and dependents who are eligible for Medicare, unless this notice has already been distributed.
11/30/2024	Summary Annual Report	Narrative summary of the Form 5500	Distribute a Summary Annual Report to participants in the group plan if a Form 5500 was filed.
12/15/2024	Review plans offered	Review and analyze that at least one plan meets minimum value and affordable status per ACA guidelines.	On or near this date, confirm that at least one plan option for new plan year is minimum value and affordable to all full-time employees (single contribution is less than 8.39% of income for 2024).

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50+ INSURED PLAN | PLAN YEAR: MARCH 1, 2024

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12/31/2024	Gag Clause Attestation	Employers and issuers must report plan information regarding whether or not their plans include gag clauses, which have been prohibited under the CAA. Reports are to be submitted to CMS by this date annually.	Fully insured and self-funded group health plans, including governmental plans and church plans, must complete the attestations. Fully insured groups may use a written agreement with their carrier to ensure the requirements are being met by the carrier. Self-insured employers may institute a written agreement with their TPA or other third party to ensure these requirements are being met, but the responsibility ultimately lies with the employer to ensure it is complete.

LINKS:
Employer Reporting & Compliance Penalties: https://www.savoyassociates.com/media/Marketing/Employer-Reporting-Compliance-Penalties-EC.pdf

*Disclosure to CMS: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

NOTE: The information in this calendar is current as of the date found in the footer but may be subject to change. The calendar is not intended to be an all-inclusive list of all compliance requirements for the employer's group health plan. It is a general calendar of specific requirements with deadlines to assist the employer in complying with the laws that apply to its group health plan. Please contact your Account Manager with any questions.