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HEALTH & WELFARE PLAN LUNCH GROUP

March 13, 2025

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1. Health & Welfare Benefits Monthly Update Presentation

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Health & Welfare Benefits

MONTHLY UPDATE

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March 2025 Agenda

- Potential Effect of Recent EOs to ERISA Group Health Plans
- OIG MHPAEA Audit Takeaways
- DOL MHPAEA Investigation Update: Ghost Networks
- H&W Compliance Calendar

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Potential Effect of Recent Executive Orders to ERISA Group Health Plans

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Select Executive Orders and Actions Potentially Effecting Health Plans

Regulatory freeze on all regulations pending review. [Regulatory Freeze Pending Review – The White House](#)

- Prohibits agencies from proposing or issuing any rule until a department or agency head appointed or designated by the President after noon on January 20, 2025, reviews and approves the rule.
- Immediately withdraws any rules that have been sent to the OFR but not published in the Federal Register so that they can be reviewed and approved.
- Provides consideration of a 60-day postponement (from January 20, 2025) of any rules that have been published in the Federal Register, or any rules that have been issued in any manner but have not taken effect, for the purpose of reviewing any questions of fact, law, and policy that the rules may raise.
 - HIPAA Proposed Security Rule
 - Does the freeze impact the meaningful benefit rule under final MHPAEA regulations?

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Transparency in Health Coverage

EO 14221 of Feb. 25, 2025, Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information.

- Directs the Secretaries of Treasury, Labor, and HHS to take all "necessary and appropriate action" to "rapidly implement and enforce" the healthcare price transparency regulations issued pursuant to EO 13877, *Improving Price and Quality Transparency in American Healthcare to Put Patients First* (June 24, 2019) <https://www.govinfo.gov/content/pkg/FR-2019-06-27/pdf/2019-13945.pdf>.
- Within 90 days of the date of this EO, the Secretaries must take action to:
 - require the disclosure of the actual prices of items and services (not estimates);
 - issue updated guidance or proposed regulatory action ensuring pricing information is "standardized and easily comparable" across hospitals and health plans; and
 - issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.
- EO: <https://www.govinfo.gov/content/pkg/FR-2025-02-28/pdf/2025-03440.pdf>
- FAQ Sheet:
 - <https://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-announces-actions-to-make-healthcare-prices-transparent/>



In Vitro Fertilization (IVF) Access and Reproductive Health Care

- EO 14216 of Feb. 18, 2024, Expanding Access to In Vitro Fertilization
 - Provides that within 90 days of the EO, the Assistant to the President for Domestic Policy is required to submit a list of policy recommendations to the President on "protecting [in vitro fertilization (IVF)] access" and "aggressively reducing" out-of-pocket and health plan costs for IVF treatment.
 - States that it is the Administration's policy "to ensure reliable access to IVF treatment, including by easing unnecessary statutory or regulatory burdens to make IVF treatment drastically more affordable."
 - Unclear impact as several courts and the IRS have rejected the deduction of expenses for reproductive technologies, like IVF and surrogacy procedures, as medical care under IRC § 213 when the taxpayer (or spouse/dependent) did not personally use the technologies, or if personally used the technologies, deductions are approved only if the taxpayer (or spouse/dependent) had an underlying condition necessitating the use of the technologies.
 - <https://www.govinfo.gov/content/pkg/FR-2025-02-24/pdf/2025-03064.pdf>
- EO 14182 on Jan. 24, 2025, Enforcing the Hyde Amendment
 - Provides it is the policy of the administration to adhere to the Hyde Amendment.
 - Rescinds Executive Order 14076 of July 8, 2022, and Executive Order 14079 of August 3, 2022 promulgated by President Biden related to access to reproductive health care.
 - May impact the HIPAA Privacy Rule and Reproductive Health Care regulations currently being challenged in courts by the States of Texas and Tennessee.
 - May impact ability of group health plans to fund travel costs for reproductive health care.
 - <https://www.govinfo.gov/content/pkg/FR-2025-01-31/pdf/2025-02175.pdf>



Gender Identity

- EO 14148 on Jan. 20, 2025, Initial Rescissions of Harmful Executive Orders and Actions.
 - Rescinds: Executive Order 13988 of Jan. 20, 2021, Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation.
 - Rescinds Executive Order 14075 of Jan. 20, 2021, Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals, which directed HHS to further and promote access to medically necessary gender affirming care, including mental health and substance use disorder services.
 - <https://www.govinfo.gov/content/pkg/FR-2025-01-28/pdf/2025-01901.pdf>
- EO 14168 on Jan. 20, 2025, Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government
 - Provides that it is the policy of the US to recognize two sexes, male and female.
 - Requires Executive Branch to enforce all sex-protective laws to promote two sexes.
 - Establishes definitions to govern Executive interpretation and application of federal laws and administration policy.
 - <https://www.govinfo.gov/content/pkg/FR-2025-01-30/pdf/2025-02090.pdf>



Gender Identity

- EO 14187 of Jan. 28, 2025, Protecting Children From Chemical and Surgical Mutilation
 - Requires agencies to rescind or amend all policies that rely on World Professional Association for Transgender Health (WPATH) guidance.
 - Within 90 days, the HHS Secretary is required to publish a review of existing literature on “best practices for promoting the health of children who assert gender dysphoria, rapid-onset gender dysphoria, or other identity-based confusion.”
 - The HHS Secretary shall also take steps to increase the quality of data “to guide practices for improving the health of minors with gender dysphoria, rapid-onset gender dysphoria, or other identity-based confusion, or who otherwise seek chemical or surgical mutilation.
 - Requires the HHS Secretary to withdraw HHS’s March 2, 2022, entitled “HHS Notice and Guidance on Gender Affirming Care, Civil Rights and Patient Privacy.”
 - The Secretary of HHS must also take action to end “the chemical and surgical mutilation of children,” including regulatory and sub-regulatory guidance, which may involve the following laws, programs, issues, or documents ... section 1557 of the Patient Protection and Affordable Care Act, essential health benefits requirement; and the Eleventh Revision of the International Classification of Diseases and other federally funded manuals, including the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.
 - Heads of each executive department or agency that provides research or education grants to medical institutions—including medical schools and hospitals—must take steps to ensure that institutions receiving Federal research or education grants “end the chemical and surgical mutilation of children.”
 - <https://www.govinfo.gov/content/pkg/FR-2025-02-03/pdf/2025-02194.pdf>



Potential Effect of Gender Identity Executive Orders

Although the EOs do not change any laws or regulations, and their final effect will not be known until the agencies issue the requested regulations and guidance, these are areas of the potential impact for ERISA covered group health plans:

- Ability of private sector ERISA plans to provide gender dysphoria care for individuals under age 19.
 - Under final 2024 MHPAEA regulations, application of an age limit is a NQTL;
 - ACA dependent coverage regulations issued by DOL/IRS/HHS contain a “uniformity requirement” where coverage offered to dependents under age 26 cannot vary based on age.
- EO 14187 directs the Secretary of HHS to take appropriate actions to end chemical and surgical gender identify care for children under age 19, including regulatory and sub-regulatory action that may involve “the Eleventh Revision of the International Classification of Diseases [ICD] and other federally funded manuals, including the Diagnostic and Statistical Manual of Mental Disorders [DSM], Fifth Edition revisions.
 - The 2024 Final MHPAEA regulations use the ICD and DSM to define mental health conditions covered by MHPAEA, and the preamble states: “Because the most current versions of both the ICD and DSM include gender dysphoria as a mental health condition as of the time of the issuance of these final rules, benefits for this condition are currently subject to the protections of MHPAEA.”
- Application of Title VII discrimination “because of sex” to transgender individuals is unclear.
- Fate of final 2024 ACA Section 1557 regulations, which interpret Title IX’s on the “basis of sex” to include gender identity under *Bostock v. Clayton Cnty., GA.*



Executive Actions on Gender Identity Executive Orders

- Feb. 19, 2025: the Administration released guidance entitled, "[Defining Sex: Guidance for Federal Agencies, External Partners, and the Public Implementing Executive Order 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government](#)".
- Feb. 20, 2025: HHS Office for Civil Rights (OCR) [rescinded prior Administration guidance](#) entitled “HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy,” issued March 2, 2022.
- Mar. 5, 2025: the Centers for Medicare & Medicaid Services (CMS) issued an [alert](#) to hospital providers “to the dangerous chemical and surgical mutilation of children, including interventions that cause sterilization.” CMS explained that it may begin to take “steps in the future to align policy, including CMS-regulated provider requirements and agreements,” to prevent this type of care.
 - The Health Resources & Services Administration (HRSA) also issued an alert on March 5, 2025 to stakeholders that it will review its policies, grants, and programs in light of the aforementioned CMS alert. HRSA specifically referenced that it will review its Children’s Hospitals Graduate Medical Education (CHGME) program for consistency with the CMS alert described above. Based on this review, the agency explains that it may “re-scope, delay, or potentially cancel new grants in the future depending on the nature of the work and any future policy change(s) HRSA may make.”
- Mar. 6, 2025: SAMHSA alerted its “colleagues and grantees” stating that it will review its policies, grants, and programs in light of the concerns discussed in the March 5, 2025 CMS alert and may begin to take steps in the future to appropriately update its policies “to protect children from chemical and surgical mutilation.” SAMHSA said it may also consider “re-scoping, delaying, or potentially cancelling new grants in the future depending on the nature of the work and any future policy change(s) SAMHSA may make.
- Agencies receiving instruction include the Secretary of Health and Human Services and the Secretary of Labor.



Litigation Challenges

- The provisions of EOs 14168 and 14187 that would condition or withhold federal funding based on the fact that a healthcare entity or health professional provides gender affirming medical care to a patient under the age of 19 is subject to a preliminary injunction in the U.S. District Court for the District of Maryland, *PFLAG v. Trump*, (case number 8:25-cv-00337).
- The provisions of EOs 14168 and 14187 that would (1) condition or withhold federal funding based on the fact that a healthcare entity or health professional provides gender affirming medical care to a patient under the age of 19; and (2) direct the Attorney General to prioritize “enforcement of protections against female genital mutilation” are subject to a preliminary injunction in the U.S. District Court, Western District Court of Washington at Seattle, *State of Washington v. Trump*, (case number 2:25-cv-00244).
- EO 14168 is the subject of a pending federal lawsuit filed in the U.S. District Court of Columbia (case number 1:25-cv-00471).
- EO 14168 is also the subject of a pending federal lawsuit filed in the U.S. District Court for the Northern District of California (case number 3:25-cv-01824).



Updates

- A&B is tracking and analyzing White House executive orders, proclamations, memoranda, and guidance and providing timely insights into their legal and regulatory impact. Updates are available at the [Executive Order, Action & Proclamation Task Force | Alston & Bird](#)

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OIG Audit Takeaways: EBSA Challenges with MHPAEA Enforcement

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OIG Conducted an Audit of EBSA Enforcement Data

- On February 19, 2025, the U.S. Department of Labor's Office of the Inspector General (OIG) released a [report](#) identifying several challenges that limit EBSA's efforts to enforce MHPAEA, including NQTL requirements.

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Background

- The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity in treatment limitations and financial requirements.
- The Employee Benefits Security Administration (EBSA) is responsible for MHPAEA enforcement of ERISA plans.
- In 2022 and 2023, EBSA reported that health plans and health insurance issuers were unprepared or provided insufficient information when it requested an NQTL comparative analysis.



OIG Conducted an Audit of EBSA Enforcement Data

- Key Question: To what extent did EBSA enforce compliance with mental health parity NQTL laws and requirements?
- Methodology:
 - Review of EBSA's NQTL comparative analysis data from February 10, 2021 – July 25, 2024
 - Review of related statutes, policies, and procedures
 - Interviews with EBSA staff
 - Surveys of key stakeholders nationwide (i.e., consumers, providers, employers, issuers, unions, and state partners)
 - Review of EBSA's use of corrective action tools

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Key Findings

Lack of critical enforcement tools	Not using existing enforcement tools	Delays in completing NQTL comparative analysis reviews (up to 3 years)
<ul style="list-style-type: none"> Inability to assess civil monetary penalties ERISA Section 502(b)(3) Limited to voluntary compliance methods and litigation 	<ul style="list-style-type: none"> Referring plans to Treasury to levy an excise tax Litigation through DOL's statute of limitations Cures Act Audits 	<ul style="list-style-type: none"> 1,177 NQTLs identified with potential violations Statutory Review Timeline Estimate: 238-338 days Actual review timelines: 251-1065 days

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Additional Enforcement Limitations

- Resource Constraints:**
 - Diminishing resources and staff limitations.
 - High caseloads per investigator.
- Impact on Enforcement:**
 - Reduced ability to ensure compliance.

Figure: EBSA Frontline Staff Compared to Health Plans Subject to the Mental Health Parity and Addiction Equity Act

Fiscal Year	Number of Health Plans	Number of Frontline Staff
FY 2018	1,824,595	404
FY 2019	1,888,461	376
FY 2020	1,979,322	366
FY 2021	1,608,646	353
FY 2022	1,866,288	338
FY 2023	2,129,516	326
FY 2024	2,021,808	326

Source: OIG analysis of data provided by EBSA

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Noncompliance Impacts on Participants

Consequences

- Increased risk of out-of-pocket expenses for plan participants.
- Potential lack of access to legally afforded mental health treatments.

Examples

- Delays in accessing mental health services.
- Higher costs for mental health treatments compared to medical/surgical treatments.



OIG Recommendations for EBSA's Assistant Secretary

1

Pursue legislative changes regarding the authority to impose civil monetary penalties for MHPAEA violations to increase compliance with Part 7 of ERISA.

2

Pursue legislative changes regarding the authority to enforce the group health plan requirements of Part 7 of ERISA against service providers, including insurance issuers and TPAs for violations such as designing and applying impermissible NQTLs.

3

Pursue legislative changes regarding provisions that specify remedies available for violations of Part 7 of ERISA, including the ability to force the re-adjudication of wrongfully denied claims or other remedies to restore losses resulting from MHPAEA violations.

4

Develop processes to utilize enforcement tools available to the agency, including referring health plans to the U.S. Department of the Treasury to levy the excise tax for MHPAEA violations, as appropriate.

5

Develop and issue additional guidance to support the implementation of the 2021 CAA NQTL comparative analysis requirement and the [MHPAEA Final Rule](#), such as an updated MHPAEA Self-Compliance Tool or FAQs document.



EBSA's Response

In EBSA's response to the audit, EBSA agreed that the three tools OIG identified can assist in NQTL enforcement, but EBSA also noted the following for each tool:

Referrals to Treasury to Levy an Excise Tax

- No referrals made to date.
- Strategic choice to focus instead on voluntary compliance and make participants whole.
- Levying substantial monetary taxes on single employer plans could negatively affect participants.
- Excise taxes would have greatest positive impact if levied on the service providers themselves, but current law does not provide this authority.

Referrals to Office of the Solicitor (SOL) to Pursue Litigation

- EBSA can pursue litigation against Plan Administrators through SOL for violations of ERISA's fiduciary standards and claims processing rules.
- EBSA and SOL already work closely on investigations w/o a formal referral.
- Formal referrals are based on "facts and circumstances" of each case.
- EBSA is "eager" to litigate where voluntary compliance efforts are not successful.

Cures Act

- Requires Tri-Agency Depts to open an investigation if at least 5 violations were cited.
- EBSA implements this when an investigation closes.
- As a matter of practice, EBSA usually keeps investigations open until full correction of cited violations is achieved.



A Look Ahead

- EBSA's ERISA Management System has updated to improve data reliability since the audit concluded.
- The Departments have not issued any new compliance tools.
- We expect that there will be more challenges to enforcement with CAA supplemental funding set to expire in September 2025.
- We will continue to monitor developments and provide insights on what to expect regarding compliance enforcement.

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DOL MHPAEA Investigation Update: Ghost Networks

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What is a ghost network?

- According to Wikipedia, “Ghost network refers to a form of healthcare insurance fraud where providers are listed as in a health insurance plan, but are unable to provide care. These ghost providers may no longer be eligible to practice, may have retired, may no longer accept new patients, may not actually part of the network, or may not exist. The inclusion of ghost providers may be intentional to exaggerate plan availability to encourage enrollment and falsely meet healthcare network adequacy.”
- National Association of Insurance Commissioners says, “Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.”

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ERISA 720 – Protecting patients and improving the accuracy of provider directory information

- **Requirement:** ERISA Section 720 requires plans to establish:
 - a process to update and verify provider director accuracy at least once every 90 days *and*
 - a protocol for responding to telephone and electronic requests about a provider’s network status (and to retain communication in such individual’s file for at least 2 years).
- **Consequences:** If the individual was provided inaccurate information about network participation, the plan cannot impose cost-sharing greater than that for a in-network provider or facility and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum.



Summary Plan Description Requirements

- SPD must provide a general description of the provider network, as well as the composition of the provider network.
- May be distributed as a separate document that accompanies the plan’s SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect.
- Must be up-to-date, accurate, and complete (using reasonable efforts).

29 CFR 2520.102-3(j)(3); Q/A-10 at [FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39](#)



Enforcement: DOL's Secret Shoppers

- DOL is using independent contractors during plan investigations to determine network adequacy
 - DOL contacted over 700 mental health/substance abuse providers *and* medical/surgical providers listed in a plan's provider directory
 - About 50% MH/SUD and 50% MS
 - 19% of providers "non-responsive" to multiple calls and voicemails
 - 35% had incorrect phone number, provider specialty, or were out-of-network
 - DOL said 74% of sampled providers did not effectively offer the caller a way to receive services because they could not get services within one month
- DOL gives 20 days to explain how plan will fix, confirm which providers are not in network, and provide claims data over past two years for network providers



Mental Health Provider Ghost Networks

- Senate is also using secret shoppers, but so far has focused on mental health
 - <https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-directory-accuracy-to-reduce-the-prevalence-of-ghost-networks>
- DOL's 2024 MHPAEA Report to Congress cites Senate report and notes DOL's focus on Network Adequacy and Network Composition
 - <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf>



MHPAEA Non-Quantitative Treatment Limitation (NQTL)

- NQTLs include “Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage”



Mental Health Parity Non-Quantitative Treatment Limitation (NQTL)

- a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's or issuer's evaluation



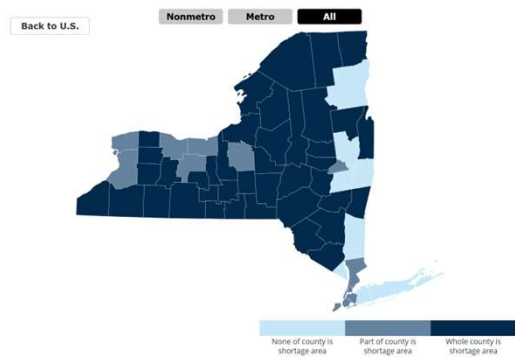
NQTL Relevant Data

- “a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's or issuer's evaluation.”
- Relevant data includes “network adequacy metrics (including time and distance data, and data on providers accepting new patients)”

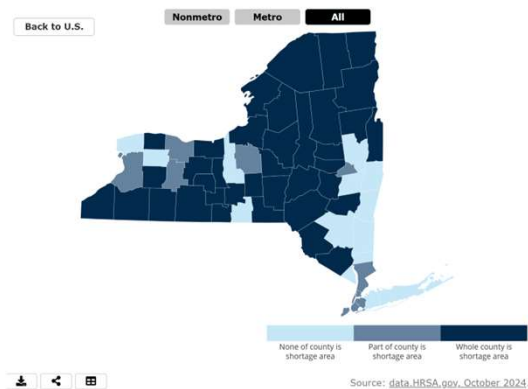


Provider shortages are an issue in rural and urban areas (even New York City)

Health Professional Shortage Areas: Primary Care, by County, October 2024 - New York



Health Professional Shortage Areas: Mental Health, by County, October 2024 - New York



<https://www.ruralhealthinfo.org/charts>



Addressing Material Differences in Network Composition under MHPAEA Regulations

- Reasonable action to address material differences in network composition include:
 - **Provider Recruiting** – “Strengthening efforts to recruit and encourage a broad range of available mental health and substance use disorder providers and facilities to join the plan’s or issuer’s network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network”
 - **Telehealth** – “Expanding the availability of telehealth arrangements to mitigate any overall mental health and substance use disorder provider shortages in a geographic area”
 - **Participant Assistance** - Providing additional outreach and assistance to participants and beneficiaries enrolled in the plan or coverage to assist them in finding available in-network mental health and substance use disorder providers and facilities”
 - **Reliable Provider Directories** – “Ensuring that provider directories are accurate and reliable”



What DOL investigators have liked...

- In its MHPAEA report to Congress, the DOL says a plan “committed to taking significant steps toward actively monitoring its network composition and filling gaps” by providing:
 - **Live Support** - live support for participants who have difficulty finding available in-network providers
 - **Out-of-Network Coverage** - arrangements for the plan to pay for out-of-network care when in-network providers are not available
 - **Ongoing Review of Network Gaps** - identifying network gaps through ongoing review of network composition and utilization data including appointment wait times and out-of-network provider use
 - **Provider Recruitment** - affirmative steps to close network gaps, such as targeted provider recruitment
 - **Data-based Analysis** - measuring progress to close network gaps using the same data-based measures used to identify them,
 - **Telehealth** - expanding telehealth services
 - **Supplemental Networks** - expanding a supplemental network of substance use disorder treatment facilities
 - **RFP** - soliciting proposals to evaluate the suitability of other networks and network administrators outside of the plan’s then-current network administrator



What DOL investigators have liked...

- DOL liked that plan was not “simply pointing to provider shortages, general arguments about market forces, or how its network administrator controlled many aspects of network composition.”
- According to the DOL, “Other plans and issuers should take note of the types of activities this plan is undertaking to monitor and address disparities in access to providers.”



Recent Litigation

- *Doe v. Anthem, 1:24-cv-08012 (S.D.N.Y. October 22, 2024)*
 - Federal Employee Health Benefit Plan (not ERISA)
 - States that OPM’s contract with Anthem requires it to comply with certain ERISA, Code, and PHSA sections
 - Alleges breach of contract, deceptive acts, false advertising, violation of NY Ins. Law, fraudulent misrepresentation, and unjust enrichment
 - Among other things, asks court to declare that Anthem’s actions violate federal law, including the No Surprises Act, PHSA, ERISA, and Code
 - Remains to be seen if and how this proceeds

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H&W Compliance Calendar

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Getting Organized:
Manage Your Calendar



**Specific Deadlines
by Month**

Federal, state and local reporting deadlines; various notices; gag clause attestation, etc.



Periodic Deadlines

Monthly; quarterly; upon hire; upon initial eligibility or enrollment; general annual



**Deadlines
Triggered by Event**

Requests; breaches; plan changes; COBRA; Others






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Specific Deadlines by Month






- January 31:
 - Form W-2-Health Plan Coverage Reporting
 - 2024 Form MA 1099-HC (Massachusetts Creditable Coverage Requirement)
 - 2024 Form 1095-C-furnish to individuals residing in California that are covered under the major medical plan
- HCSO Top-Off calculation and payment: February 28.
- Privacy breaches affecting less than 500 must be reported w/in 60 days of the end of the calendar year in which the breach was discovered.
- Notice of creditable coverage to CMS due within 60 days after the beginning date of the plan year.
- 2024 Form 1095-C to individuals: Jan. 31, but regulations allow automatic 30-day extension (generally March 2, but March 3 in 2025). New relief to provide upon request requires posting notice by March 3. New Form 1095-C relief for furnishing to recipient upon request only applies to federal mandate, not states.

January	2024 Form W-2 Health Plan Reporting Coverage
	2024 MA Form 1099-HC
	2024 Form 1095-C to covered individuals residing in California
February	San Francisco HCSO Top-off calculation/payment due
March	Notice to HHS of Privacy Breaches
	Part D Creditable Coverage Disclosure to CMS
	2024 Form 1095-C to individuals
	2024 Form 1094/1095-C forms to IRS (if electronic)
	Individual Mandate Reporting to NJ and RI

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Specific Deadlines by Month






- Individual Mandate Reporting to DC: No later than April 30.
- HCSO Annual Reporting: May 2, 2025.
- Form 1095-C to CA: Generally, no later than May 31; penalties assessed after. May 31, 2025 is a Saturday; FTB publication states that deadlines falling on a weekend are due the next business day (June 2).
- Form 990 (if you maintain a VEBA): May 15.
- RxDC to CMS: June 1, 2025. Plan is ultimately the responsible party but can through agreement have a TPA file on behalf of Plan.

April	Individual Mandate Reporting to DC
May	EBSA Disaster Relief expires (Hurricanes Helene & Milton)
	San Francisco Health Care Security Ordinance (HCSO)
	Individual Mandate Reporting to CA (extended deadline)
	Form 990 for VEBA
June	Prescription Drug (RxDC) Reporting

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Specific Deadlines by Month






- Form 5500: July 31; Form 5558 extends deadline to October 15.
- Form 720/PCORI Fee: July 31. For plan years that ended on or after October 1, 2024, and before October 1, 2025, the fee is \$3.47 per person covered by the plan.
- Annual report (if Form 5500 not extended): September 30. If extended, December 15. Deliver by same method applicable to SPD.
- Medicare Part D Creditable Coverage Notice: Due no later than October 14. Provide to all Medicare eligible individuals regarding status of Rx coverage as either creditable or non-creditable.
- File Extended Form 5500 (if extended by Form 5558): October 15.

July	2024 Form 5500 for each welfare benefit plan (on a calendar year plan) 2024 Form 5558 (extends Form 5500 deadline)
	PCORI Fee Payment (Form 720)
September	Summary Annual Report (if 2024 Form 5500 not extended)
October	Part D Creditable Coverage Notice
	Form 5500 (if extended)

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Specific Deadlines by Month






- Furnish Summary Annual Report (if Form 5500 extended): December 15. Deliver by same methods applicable to SPDs.
- File Massachusetts HIRD Form: December 15.
- Furnish California Flexible Spending Account Notice: No later than December 31. Preempted for Health FSA.
- File Gag Clause Attestation: No later than December 31.

December	Summary Annual Report (if 2024 Form 5500 extended)
	MA HIRD Form
	CA Flexible Spending Account Notice
	Gag Clause Attestation

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Periodic Deadlines






<ul style="list-style-type: none"> ▪ San Francisco Health Airport Ordinance (HAO): Payments due 15th of each month ▪ SF HCSO: No later than 30 days after the end of each quarter for employers making health care expenditures to the City Option on behalf of HCSO-covered employees. ▪ Vermont Health Care Fund Contribution Assessment: 25th day after each quarter ends (i.e., April 25, July 25, October 25, and January 25). ▪ WAPAL Fund Monthly Assessment: Once every quarter (i.e., November 15, February 15, May 15, and August 15). ▪ Medicare Secondary Payer Data Reporting: Once every quarter. Applies to any medical plan other than retiree medical plans. 	<p>MONTHLY</p> <p>San Francisco HAO Payments to City Option. <i>(Applies only to employers of employees covered by SFO's (San Francisco Airport) Quality Standards Program)</i></p> <hr/> <p>QUARTERLY</p> <p>San Francisco HCSO contributions for eligible employees not enrolled in group health plan</p> <p>VT Health Care Fund Contribution Assessment</p> <hr/> <p>WA Partner Access Lines funding program (WAPAL Fund) Monthly Assessment</p> <p>Medicare Secondary Payer Data Reporting</p>
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Health & Welfare Benefits

MONTHLY UPDATE

Periodic Deadlines






<ul style="list-style-type: none"> ▪ ACA-Based Exchange Notice/Marketplace Notice: Within 14 days of the date of hire. Goes to all employees without regard to whether they are eligible for health coverage. Deliver by same methods as SPD. ▪ Illinois Essential Health Benefits Comparison Chart: Provide to all employees upon hire, annually thereafter, and upon request. ▪ San Francisco HCAO/ HAO "Know Your Rights" Form: "Know Your Rights" forms must be provided within the first pay period an employee becomes a QSP employee, and annually thereafter. 	<p>UPON HIRE</p> <p>ACA-Based Exchange Notice/Marketplace Notice</p> <hr/> <p>IL Essential Health Benefits Comparison Chart</p> <hr/> <p>San Francisco HAO "Know your Rights" Form <i>(Applies only to employers of employees covered by SFO's (San Francisco Airport) Quality Standards Program)</i></p>
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Periodic Deadlines

<ul style="list-style-type: none"> ▪ Generally, notices marked “eligible” must be provided upon eligibility or when first offered enrollment. ▪ WHCRA: Deliver by same methods applicable to SPD; separate notice required in some cases. ▪ Patient protection notices: Provide with the SPD. Applies to GHPs (not excepted benefits) and that require participants to choose a PCP. ▪ HIPAA Privacy Notice: Furnish following enrollment in any GHP maintained by Employer and within 60 days of a material revision to the notice. Every 3 years must notify covered individuals that a privacy notice is available and how to obtain it. ▪ COBRA General Notice: To covered individuals within 90 days after coverage under a group health plan begins. ▪ SPD: Within 90 days of becoming covered in the plan; SPD incorporating all SMMs due every 5 years. If no SMMs, SPD must be again distributed every 10 years. 	<p>UPON INITIAL ELIGIBILITY OR ENROLLMENT</p> <hr/> <p>Part D Creditable Coverage Notice (eligible)</p> <hr/> <p>HIPAA Special Enrollment Notice (eligible)</p> <hr/> <p>Women’s Health and Cancer Rights Act Enrollment Notice (enrolled)</p> <hr/> <p>Summary of Benefits and Coverage (SBC) (eligible)</p> <hr/> <p>Patient Protection Notices (enrolled)</p> <hr/> <p>HIPAA Privacy Notice (enrolled)</p> <hr/> <p>COBRA General/Initial Notice (enrolled)</p> <hr/> <p>Summary Plan Description (SPD) (enrolled)</p> <hr/>
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Periodic Deadlines

<ul style="list-style-type: none"> ▪ CHIPRA: Provide to <u>ALL</u> employees annually. Deliver by same methods applicable to SPD. No due date, no penalty. Model notices posted annually by DOL. ▪ Notice of where HIPAA Privacy Notice is located/right to request: Send by same means as HIPAA Privacy Notice. ▪ SBC: Due at the time the eligible employee is offered an annual enrollment opportunity in the health plan. Deliver by 1st class mail or DOL electronic delivery guidance. ▪ HIPAA Special Enrollment Notice: At or before the time an eligible employee is first offered an annual enrollment opportunity in the health plan. Delivery by same methods applicable to SPD. ▪ Illinois Essential Health Benefits Comparison Chart as required by the Consumer Coverage Disclosure Act: Provide to all employees annually. 	<p>ANNUALLY</p> <hr/> <p><i>- To ALL Employees (regardless of welfare plan eligibility)</i></p> <p>CHIPRA Notice</p> <hr/> <p><i>- To ALL Eligible Individuals (generally during annual enrollment)</i></p> <p>Notice of where HIPAA Privacy Notice is located/right to request</p> <hr/> <p>Women’s Health and Cancer Rights Act Annual Notice</p> <hr/> <p>Summary of Coverage and Benefits (SBC)</p> <hr/> <p>HIPAA Special Enrollment Notice</p> <hr/> <p>IL Essential Health Benefits Comparison Chart</p> <hr/>
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Deadlines Triggered by Event-QMCSO and Privacy Breaches

- QMCSO: “Prompt” notice to participants and alternate participants. Notice of whether MSCO is qualified within “reasonable” time but not later than 40 days.
- NMSN: Notify State agency within 20 business days of NMSN. Prompt notice to affected persons. Return Part B within 40 days.
- Privacy Breaches:
 - Notice to CMS 500+: Concurrently with the notice to individuals (i.e., within 60 days).
 - Notice to Affected Individuals (regardless of size of breach): Without unreasonable delay but not later than 60 days after Employer discovers the breach.
 - Notice to Media for breaches affecting more than 500 covered persons in a state or jurisdiction: Without unreasonable delay but not later than 60 days after Employer discovers the Breach.

EVENT	
Notice of Medical Child Support Order (MSCO)	
National Medical Support Notice (NMSN)	
PHI Privacy Breaches	Notice to CMS of Breach 500+ Notice of Breach to Affected Individuals Notice of Breach to the Media

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Deadlines Triggered by Event-Requested Documents






- Documents or instruments governing the terms of the plan (SPD, Plan document, Form 5500, MHPAEA Comparative Analysis): Within 30 days of the request.
- HIPAA Privacy Notice: Provide upon request; deliver by same methods as privacy notice (or as otherwise agreed).
- SBC: Within 7 business days of the request. May be provided electronically if requested electronically.
- IL Essential Health Benefits Comparison Chart: Provide to all employees residing in Illinois upon request.
- Form 1095-C (federal): For employers using the new relief, provide within 30 days of an employee’s request or by January 31 of the year following the applicable calendar year, whichever is later.

REQUEST(S)	
Documents or instruments governing plan terms (SPD, Plan document, Form 5500)	
HIPAA Privacy Notice	
Summary of Benefits and Coverage (SBC)	
IL Essential Health Benefits Comparison Chart	
Form 1095-C to individuals (federal-if not furnished)	

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Deadlines Triggered by Event-Plan Changes






- SMM (general): Within 210 days of the last day of the plan year in which the change is adopted.
 - Deliver by same methods applicable to SPD.
- Material Reduction in Health Plan Benefits: Notice delivered within 60 days of the date the change is adopted by the plan.
 - Applies to any group health plan subject to ERISA, including plans that provide excepted benefits and stand-alone retiree health plans.
- Material Change in SBC information that is effective other than first day of plan year: Notice must be provided 60 days prior to the effective date of the change.
 - Applies only to group health plans that provide other than excepted benefits. Note: Does not apply to stand alone retiree health plans.

CHANGE(S) TO THE PLAN	Summary of Material Modifications (SMM)
	Material Reduction in Health Plan Benefits
	Material Change in SBC Info Effective Midyear

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Deadlines Triggered by Event-COBRA and Rescissions

- COBRA Election Notice: Notice of the qualifying event within 14 days of receiving notice of qualifying event from qualified beneficiary.
- COBRA – Notice of Insufficient Premium Payment: Notify Qualified Beneficiary of the amount of deficiency; provide reasonable period of time for payment before terminating COBRA. 30-day grace period is considered reasonable.
- Notice of Early COBRA Termination (prior to the end of the maximum period): As soon as practical after a determination to terminate coverage is made.
- Notice that a Qualified Beneficiary is Not Eligible for COBRA: Within 14 days after plan administrator has received a notice from a Qualified Beneficiary of a qualifying event, 2nd qualifying event, and disability determination.
- Rescission of Coverage: Give affected individuals at least 30 days' advance written notice

COBRA	Election Notice for Termination of Employment; Reduction in Hours; Medicare Entitlement
	Election Notice upon Notice from Qualified Beneficiary of Divorce, Dependent Child Aging Out, Death
	Notice of Insufficient COBRA Premium Payment
	Notice of Early COBRA Termination
	Notice of Ineligibility for COBRA Coverage
TERMINATION FOR FRAUD/MIS-REPRESENTATION	Rescission of Coverage

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Deadlines Triggered by Event-Wellness Program

- HIPAA Wellness Program Disclosure:
 - Applies only to group health plans that provide other than excepted benefits. No separate due date
- ADA Wellness Program Disclosure
 - Applies to any wellness program subject to the ADA.
 - Due before the employee provides any health information in connection with a wellness program, if any.
- GINA Wellness Program Consent for Spouse
 - Before the spouse provides health information for a wellness program that requests the spouse's medical history, if any (e.g., before completing a health risk assessment).

OFFER OF WELLNESS PROGRAM

HIPAA Wellness Program Disclosure

ADA Wellness Program Disclosure

GINA Wellness Program Consent for Spouse

Questions