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Health & Welfare Plan Reporting & Disclosure Obligations

The checklist below provides simple explanations of the various required reporting & disclosure obligations of employer-sponsored health & welfare plans (federal law).

Any Size	SPD	Summary of employee rights and benefits under an employer-sponsored plan. All participants should receive a copy of this within 90 days of becoming covered by the plan and then at least every 5 years after that. Must meet certain content requirements.
Any Size	SMM	Describes material modifications to a plan and reflects changes made to the SPD before the SPD is revised. No later than 210 days after the end of the plan year in which the change is adopted, unless a revised SPD is provided.
Any Size	Notification of Benefit Determination	Claims notices or EOBs.
Any Size	Plan Documents	Must be maintained by the plan administrator (usually the employer) and provided within 30 days of a written request. A copy must be available at the business location. Generally includes, among other things, most recent SPD (and any interim SMMs) and Form 5500 filing, and any contracts or other instruments governing the plan and the plan's operations. This should be updated annually.
Any Size	Summary of Material Reduction in Covered Services or Benefits	Summary of group health plan amendments, provided within 60 days of adoption of material reduction in benefits, unless earlier notice is required pursuant to ERISA fiduciary obligation. Consistent with the SBC requirements (see below), any advance notification of a material modification to the SBC will satisfy this requirement.

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Any Size	**HIPAA Notices:** There are various required notifications and some are issued from the insurer although the ultimate responsibility for disclosure is the plan sponsor's.	
	Special Enrollment Rights	Include with enrollment materials.
	Notice of Privacy Rights	Include with initial enrollment materials; again within 60 days after a material change; upon request; send a reminder every three years. However, if health benefits are provided through an insurance contract with a health insurance issuer or HMO, the plan must merely maintain a notice and provide such notice upon request.
	Wellness Program Disclosure	Where required, within 180 days of the end of the COBRA coverage period.
Any Size	WHCRA Notice	This should be provided upon initial enrollment and on an annual basis.
Any Size	QMCSO or NMS	Includes various requirements when a medical child support order has been received and describes the plan's qualification process. Should be included in the certificate/SPD.
Any Size	NMHPA (Newborn's and Mother's Health Protection Act)	This should be included in the certificate/SPD.
Any Size	Michelle's Law	If a plan covers dependents past age 26 or certain dependents such as grandchildren based on student status, Michelle's Law will apply and the disclosure will be required. This disclosure should be included in the certificate and the SPD.
Any Size	Medicare Part D: Participant Notice	Discloses the "creditable" status of prescription drug coverage to participants. Must be provided in specific time frames, including annually and at initial enrollment. Your insurance carrier will let you know if your plan is Creditable or Non-Creditable. It is important to note that the font and page requirements for this notice are very specific, so it is best to use the sample notice from the government website.
Any Size	Medicare Part D: Disclosure to CMS	This disclosure must be sent through the CMS website within the first 60 days of the plan year; within 30 days after termination of the prescription drug plan; and 30 days after any change in creditable status of the prescription drug plan.
Any Size	MSP Reporting	This disclosure is to CMS for purposes of coordination of benefits for Medicare-enrolled individuals. Unless the plan is both self-funded and self-administered, the carrier or TPA will be doing this disclosure.
Any Size	CHIPRA	This notice must go out before the first day of the plan year on an annual basis. Usually included in the enrollment materials. Disclosure to the state Medicaid or CHIP programs must also be completed once model forms are available from the respective states.
Any Size	Broker Disclosure Notice	Fiduciaries of group health plans must receive a disclosure of direct and indirect commissions from brokers and consultants receiving at least $1,000 in compensation in advance of renewal date.
Any Size	Machine Readable Files- Posting*	Plans and carriers must make public three machine-readable files disclosing (1) in-network rates, (2) out-of-network (OON) allowed amounts and billed charges (3) negotiated rates and historical net prices for covered prescription drugs. (1) and (2) should already be posted and updated monthly. (3) TBD-pending guidance
Any Size	Price Comparison Tools*	Group health plans must provide for the disclosure of cost sharing information in advance of receiving care through an internet-based self-service tool, in paper form or by telephone to participants and beneficiaries.

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Any Size	No Surprises Act Disclosure*	Notice of the protections under the NSA. Model NSA disclosure is available and should be posted on public website and included in EOB of NSA related claims.
Any Size	RxDC Reporting**	Plan sponsors of group health plans must submit information annually about prescription drugs and health care spending to CMS via HIOS system by June 1st of each year.
Any Size	Gag Clause Attestation**	Group health plans and carriers must annually submit an attestation that the plan or carrier complies with the prohibitions on gag clauses to CMS via HIOS- GCPCA by Dec. 31st each year to cover the period since the last attestation.
Any Size	Grandfathered Health Plans	This notice should be provided to all plan participants in all plan materials (including the SPD and enrollment materials).
Any Size	Patient Protection Disclosure	Non-grandfathered plans that require designation of a primary care provider; can be provided with the open enrollment materials.
Any Size	Claims, Appeals and External Review Process	Non-grandfathered plans are subject to new and additional requirements including, among other things, new notices of adverse benefit determinations and external review decisions. These changes should be documented in the certificate of insurance/SPD (self-insured plans need to coordinate with TPAs).
Any Size	Advance Notice of Rescissions	Notice of at least 30 calendar days is required to an individual before coverage may be retroactively cancelled (rescinded). Coverage may only be rescinded in limited circumstances (e.g., fraud).
Any Size	SBC and Uniform Glossary	This is a summary of the health plan benefits that must be provided to all participants and beneficiaries. The DOL provides a model template. Plans must provide to newly eligible individuals (e.g., new hires, special enrollees) and in connection with renewal.
Any Size	Comparative Effectiveness/PCOR Fee	For self-funded plan or level funded plan must file and pay the fee. Employers with Health Reimbursement Arrangement (HRA) alongside a fully insured plan or offering an ICHRA and/or QSEHRA are responsible for filing and paying the fee. The fee is multiplied by the average number of lives insured under a group health plan policy. The second quarter IRS Form 720 should be filed by each July 31st for the calendar year immediately following the last day of the plan year. The insurance carriers are responsible for paying and reporting this fee for fully-insured plans. PCOR reauthorized in Dec 2019 for 10 years. This will extend through September 30, 2029.
Any Size	6055	Information return and statement to the IRS and to a primary insured reporting which individuals are enrolled in minimum essential coverage. Handled by the carrier for an insured plan and by the employer for a self-funded plan or level-funded plan.
Any Size	Individual Coverage HRA (ICHRA) Notice	Describes for participants the basics of an ICHRA, getting individual health insurance coverage and information about the premium tax credit. Must be given to employees eligible for the ICHRA if the ICHRA is established less than 120 days before the start of the first plan year, on or before the ICHRA's effective date. No later than the date a newly eligible individual becomes eligible and no later than 90 days before the beginning of the ICHRA plan year.
All Employers Subject to the FLSA	Notice of Coverage Options	Notice of the new Marketplace, regardless of whether the employer offers a health plan, to each new employee at the time of hire. Since 2014, the DOL will consider a notice to be provided at the time of hire if the notice is provided within 14 days of an employee's start date.

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20+ employees	COBRA Notices: If you have a COBRA administrator, it is probably handling all these notices on your behaf. However, you should be familiar with the requirements as the employer is ultimately responsible for COBRA compliance. These notifications requirements include the following:	
	COBRA Reasonable Procedures	Included in the SPD and General COBRA Notice.
	General COBRA Notice (Initial Notice)	No later than 90 days after the date on which such individual's coverage under the plan commences.
	COBRA Election Notice	Within 44 days after the qualifying event date or loss of coverage if provided by the plan.
	Notice of Unavailability of COBRA	Notice that individual is not entitled to COBRA coverage. Provided within 14 days after the plan administrator (employer) receives notice of a qualifying event.
	Notice of Early Termination of COBRA	As soon as practicable after determining that coverage will end.
	COBRA Conversion Notice	Where required, within 180 days of the end of the COBRA coverage period.
2-49 Lives	Qualified Small Employer HRA (QSEHRA) Notice	Employers must supply the notice to employees eligible for the QSEHRA no later than 90 days before the beginning of the year in which the QSEHRA is funded. The notice informs participants the reimbursement amount for the year as well as important information regarding minimum essential coverage requirements and effect on premium tax credits in the marketplace.
50+ FT Employee	6056 Reporting	First effective in 2016 for the 2015 calendar year: • An information return and statement to the IRS and to all full-time employees that reports the terms and conditions of the employer-sponsored health plan coverage, handled by large employers for employer penalty purposes.
51+	MHPA/MHPAEA	Employers claiming a cost exemption must provide notice to the DOL and participants. Group health plans must conduct a comparative analysis of the design and application of Non-Quantitative Treatment Limits (NQTLs). Fiduciaries must verify engagement in a prudent process for selecting service provider performing the analysis and monitoring service providers.
Generally, 100+ participants	Form 5500	Generally, applies to employee welfare plans covering 100 or more employees at the beginning of the plan year must submit this electronically to the DOL by the end of the 7th month after the end of the plan year. A one-time 2½ month extension is available by submitting Form 5558 to the IRS by the date the Form 5500 would have otherwise been due.
Generally, 100+ participants	SAR	Narrative summary of information on Form 5500. Distributed to all participants within 9 months of the end of the plan year, or 2 months after the Form 5500 is due. Not required for a plan under which benefits are paid solely from the general assets of the employer or employee organization.
Generally employers filing 250+ Form W-2	W-2 Reporting	Many employers will be required to report the value of health insurance coverage provided to employees on the employee's Form W-2. Employers that file fewer than 250 Form W-2s for the preceding calendar year are not subject to the report requirement in the current calendar year.

*Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. Liability rests with the carrier. Self-funded plans (including level-funded) are responsible for compliance. Some TPAs and PBMs will assist in the process however the plan is ultimately responsible.

**For fully insured plans, the carrier will often submit this information on behalf of the plan. Seek written assurances from the carrier so the liability rests with the carrier. Some carriers may not handle this obligation. Self-funded plans (including level-funded) are responsible for compliance. Some TPAs and PBMs will assist in the process however the plan is ultimately responsible.

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General Employment Law Notices Not required to be issued by group health plans specifically; not an exhaustive list.[1]		
15+ employees for 20+ calendar weeks (current or preceding year)	ADEA (20 employees)	Usually posted.
	ADA	
	PDA	
	GINA	
50+ employees	FMLA Notices	If you have an FMLA administrator, it is probably handling all of these notices on your behalf. However, the employer is ultimately responsible for FMLA compliance. These notification requirements include the following:
	General Notice	In addition to the posted notice requirement, notice of employer and employee general rights and responsibilities with respect to FMLA.
	Nonpayment of Premiums	When an employee's premium payment is more than 30 days late and employer intends to drop coverage.
	Other Notices	Examples are: Eligibility notice, Rights and Responsibilities notice, Certification form, Designation notice.
Any Size	USERRA Notices	In addition to the posted notice requirement, this notice should be provided at the beginning of any leave for uniformed service and may be provided along with the COBRA election notice.

Other Document Requirements		
Any Size	Cafeteria Plans	Written plan document is required if offering benefits on a pre-tax basis. Annual nondiscrimination testing must be performed.
Any Size	Self-Insured Reimbursement Plans	Any self-insured reimbursement plan (e.g., major medical, dental, FSA, HRA) must have a written plan document and is subject to nondiscrimination rules under Code Section 105(h).
Any Size	HIPAA Privacy & Security Policies	All self-insured health plans and fully insured group health plans that create or receive PHI/e-PHI (other than summary information) must implement privacy and security procedures. Does not apply to fully-insured plans that do not create or receive PHI/e-PHI.
Any Size	HIPAA Privacy and Security Plan Amendments	For plans subject to the HIPAA privacy and security rule (see above), ensure plan documents contain information on privacy and security rules rule.
Any Size	HIPAA Business Associate Agreements	Health plans should have business associate agreements with their business associates who use and disclose PHI/e-PHI for certain health plan functions including claims processing, legal advice, consulting and actuarial determinations.
Any Size	Medicare Part D Application for Subsidy	Applies only to retiree health plans providing prescription drug coverage. Plans may apply for a retiree subsidy from CMS within 90 days from the start of the plan year.
Any Size	Record Retention	ERISA plans are subject to record retention requirements. General rule is to retain records for 8 years.
Any Size	Record Retention – Grandfathered Plans	Grandfathered group health plans must retain record of grandfathered status for as long as the plan claims that status.

1 Discuss these notices with your employment counsel.

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