

COMPLIANCE OVERVIEW

Provided by Benefit Administration Company, LLC.

2018 Open Enrollment Checklist

To prepare for open enrollment, group health plan sponsors should be aware of the legal changes affecting the design and administration of their plans for plan years beginning on or after Jan. 1, 2018. Employers should review their plan documents to confirm that they include these required changes.

In addition, any changes to a health plan's benefits for the 2018 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, when applicable—for example, the summary of benefits and coverage (SBC). There are also some participant notices that must be provided annually or upon initial enrollment. To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

LINKS AND RESOURCES

- [Revenue Procedure 2017-37](#), which includes the inflation-adjusted limits for HSAs and HDHPs for 2018
- Revised [SBC template](#), [instructions](#) and [uniform glossary](#) (for use on or after April 1, 2017)
- [FAQs](#) addressing coverage of eating disorders under mental health parity law

HIGHLIGHTS

PLAN DESIGN ISSUES

- Confirm that your plan's out-of-pocket maximum complies with the ACA's limits for 2018.
- For HDHPs, confirm that the plan's deductible and out-of-pocket maximum comply with the 2018 limits.
- Communicate any plan design changes to employees as part of the open enrollment process.

NOTICES TO INCLUDE

- Annual CHIP notice
- Medicare Part D creditable coverage notice
- Notice of grandfathered status (if applicable)
- Annual notice regarding coverage requirements for mastectomy-related benefits (WHCRA notice)

This Compliance Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.



PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was in existence when the Affordable Care Act (ACA) was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered.

- If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2018 plan year. Grandfathered plans are exempt from some of the ACA's requirements. A grandfathered plan's status will affect its compliance obligations from year to year. If your plan will maintain its grandfathered status, make sure you provide the notice of grandfathered status in your open enrollment materials. See the "ACA Disclosure Requirements" section below for more information on this notice.
- If your plan will lose its grandfathered status for 2018, confirm that the plan has all of the additional patient rights and benefits required by the ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

Status of ACA: Because Congress has not approved an ACA repeal or replacement bill, the ACA remains current law, and employers must continue to comply with all applicable ACA provisions.

Out-of-pocket Maximum

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). The ACA's out-of-pocket maximum applies to all non-grandfathered group health plans, including self-insured health plans and insured plans.

The annual limit on total enrollee cost sharing for EHB for plan years beginning on or after Jan. 1, 2018, is **\$7,350** for self-only coverage and **\$14,700** for family coverage.

- Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2018 plan year (\$7,350 for self-only coverage and \$14,700 for family coverage).
- If you have a high deductible health plan (HDHP) that is compatible with a health savings account (HSA), keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2018 plan years, the out-of-pocket maximum limit for HDHPs is \$6,650 for self-only coverage and \$13,300 for family coverage.
- If your plan uses multiple service providers to administer benefits, confirm that the plan coordinates all claims for EHB across the plan's service providers or divides the out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2018.

Preventive Care Benefits

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (that is, deductibles, copayments or coinsurance) for the services. Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. If you have a non-grandfathered plan, you should confirm that your plan covers the latest recommended preventive care services without imposing any cost sharing.

More information on the recommended preventive care services is available through the [U.S. Preventive Services Task Force](#) and www.HealthCare.gov.

Health FSA Contributions

The ACA imposes a dollar limit on employees' salary reduction contributions to a health FSA offered under a cafeteria plan. An employer may impose its own dollar limit on employees' salary reduction contributions to a health FSA, as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year.

The ACA's limit on employees' pre-tax health FSA contributions first became effective for plan years beginning on or after Jan. 1, 2013. The ACA set the health FSA contribution limit at \$2,500. For years after 2013, the dollar limit is indexed for cost-of-living adjustments. For 2017 plan years, the health FSA limit is \$2,600. For 2018, the health FSA limit increases to **\$2,650**.

- Confirm that your health FSA will not allow employees to make pre-tax contributions in excess of \$2,650 for the 2018 plan year.
- Communicate the health FSA limit to employees as part of the open enrollment process.

HDHP and HSA Limits for 2018

If you offer an HDHP to your employees that is compatible with an HSA, you should confirm that the HDHP's minimum deductible and out-of-pocket maximum comply with the 2018 limits. The IRS limits for HSA contributions and HDHP cost sharing will all increase for 2018. The HSA contribution limits will increase effective Jan. 1, 2018, while the HDHP limits will increase effective for plan years beginning on or after Jan. 1, 2018.

- Check whether your HDHP's cost-sharing limits need to be adjusted for the 2018 limits.
- If you communicate the HSA contribution limits to employees as part of the enrollment process, these enrollment materials should be updated to reflect the increased limits that apply for 2018.

The following table contains the HDHP and HSA limits for 2018 as compared to 2017. It also includes the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2017	2018	Change
HSA Contribution Limit	Self-only	\$3,400	\$3,450	Up \$50
	Family	\$6,750	\$6,900	Up \$150
HSA Catch-up Contributions <i>(not subject to adjustment for inflation)</i>	Age 55 or older	\$1,000	\$1,000	No change
HDHP Minimum Deductible	Self-only	\$1,300	\$1,350	Up \$50
	Family	\$2,600	\$2,700	Up \$100
HDHP Maximum Out-of-pocket Expense Limit <i>(deductibles, copayments and other amounts, but not premiums)</i>	Self-only	\$6,550	\$6,650	Up \$100
	Family	\$13,100	\$13,300	Up \$200

Mental Health Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical coverage. MHPAEA's parity requirements apply to group health plans sponsored by employers with more than 50 employees. However, due to an ACA reform, insured health plans in the small group market must also comply with federal parity requirements for MH/SUD benefits.

The [21st Century Cures Act](#), which was signed into law on Dec. 13, 2016, clarifies that if a group health plan or issuer provides coverage for **eating disorder benefits**, including residential treatment, the coverage must comply with the federal parity requirements for MH/SUD benefits. A set of [frequently asked questions \(FAQs\)](#) issued by the Departments of Labor, Health and Human Services, and the Treasury (Departments) confirm that MHPAEA's parity requirements apply to any benefits a plan or issuer may offer for treatment of an eating disorder.

- If your health plan covers treatment for eating disorders, confirm that any financial requirements or treatment limitations that apply to the coverage comply with MHPAEA's parity mandate.

ACA DISCLOSURE REQUIREMENTS

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees to help them understand their coverage and make coverage decisions. Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period. The SBC also must be provided to participants and beneficiaries who enroll other than through an open enrollment period (including those who are newly eligible for coverage and special enrollees).

New SBC Template: On April 6, 2016, the Departments issued a [new template and related materials](#) for the SBC. Plans and issuers must start using the new SBC template as follows:

- ✓ Plans with annual open enrollment periods must start using the new template on the first day of the first open enrollment period that begins on or after **April 1, 2017**, with respect to coverage for plan or policy years beginning on or after that date.
- ✓ Plans without an annual open enrollment period must start using the new template on the first day of the first plan or policy year that begins on or after **April 1, 2017**.

- In connection with a plan's 2018 open enrollment period, the SBC should be included with the plan's application materials. If coverage automatically renews for current participants, the SBC must generally be provided no later than 30 days before the beginning of the new plan year.
- The new SBC template should be used for health plans with open enrollment periods or plan years beginning on or after April 1, 2017.
- For self-funded plans, the plan administrator is responsible for providing the SBC. For insured plans, both the plan and the issuer are obligated to provide the SBC, although this obligation is satisfied for both parties if either one provides the SBC. Thus, if you have an insured plan, you should confirm that your health insurance issuer will assume responsibility for providing the SBCs. Please contact your representative at Awesome Agency for assistance.

Grandfathered Plan Notice

If you have a grandfathered plan, make sure to include **information about the plan's grandfathered status** in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. [Model language](#) is available from the Department of Labor (DOL).

Notice of Patient Protections

Under the ACA, non-grandfathered group health plans and issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate

any available participating primary care provider (including a pediatrician for children). Also, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If your plan is subject to this notice requirement, you should confirm that it is included in the plan's open enrollment materials. [Model language](#) is available from the DOL.

OTHER NOTICES

Group health plan sponsors should consider including the following enrollment and annual notices with the plan's open enrollment materials.

Initial COBRA Notice

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees that sponsor group health plans. Group health plan administrators must provide an initial COBRA notice to new participants and certain dependents within 90 days after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. A [model initial COBRA Notice](#) is available from the DOL.

Notice of HIPAA Special Enrollment Rights

At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). This notice may be included in the plan's SPD.

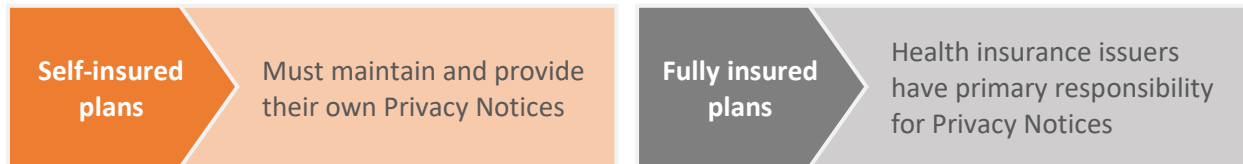
Summary Plan Description

Plan administrators must provide an SPD to new participants within 90 days after plan coverage begins. Any changes that are made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or if the plan is amended. Otherwise, a new SPD must be provided every 10 years.

HIPAA Privacy Notice

The HIPAA Privacy Rule requires covered entities (including group health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who is the subject of protected health information (PHI). Health plans are required to send the Privacy Notice at certain times, including to **new enrollees at the time of enrollment**. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans are required to maintain and provide their own Privacy Notices. Special rules, however, apply for fully insured plans. Under these rules, the health insurance issuer, and not the health plan itself, is primarily responsible for the Privacy Notice.



Special Rules for Fully Insured Plans: The plan sponsor of a fully insured health plan has limited responsibilities with respect to the Privacy Notice.

- If the sponsor of a fully insured plan has access to PHI for plan administrative functions, it is required to maintain a Privacy Notice and to provide the notice upon request.
- If the sponsor of a fully insured plan does not have access to PHI for plan administrative functions, it is not required to maintain or provide a Privacy Notice.

A plan sponsor's access to enrollment information, summary health information and PHI that is released pursuant to a HIPAA authorization does not qualify as having access to PHI for plan administration purposes.

[Model Privacy Notices](#) are available through the Department of Health and Human Services.

Annual CHIPRA Notice

Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual notice about the available assistance to all employees residing in that state. The DOL has provided a [model notice](#).

WHCRA Notice

Plans and issuers must provide notice of participants' rights to mastectomy-related benefits under the Women's Health and Cancer Rights Act (WHCRA) at the time of enrollment and on an annual basis. Model language for this disclosure is available on the DOL's [website](#).

Medicare Part D Notices

Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the health plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage. The notice generally must be provided at various times, including when an individual enrolls in the plan and each year before **Oct. 15** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' [website](#).

Summary Annual Report

Plan administrators that are required to file a Form 5500 must provide participants with a narrative summary of the information in the Form 5500, called a summary annual report (SAR). Group health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file the Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period.

Michelle's Law Notice

Group health plans that condition dependent eligibility on a child's full-time student status must provide a notice of the requirements of Michelle's Law in any materials describing a requirement for certifying student status for plan coverage. Under Michelle's Law, a plan cannot terminate a child's coverage for loss of full-time student status if the change in status is due to a medically necessary leave of absence. Due to the ACA's age 26 mandate for dependent coverage, most health plans no longer condition dependent eligibility on full-time student status and, thus, are not subject to Michelle's Law.

HIPAA Opt-out for Self-funded, Non-federal Governmental Plans

Sponsors of self-funded, non-federal governmental plans may opt out of certain federal mandates, such as the mental health parity requirements and the WHCRA coverage requirements. Under an opt-out election, the plan must provide a notice to enrollees regarding the election. The notice must be provided annually and at the time of enrollment. [Model language](#) for this notice is available for sponsors to use.

Wellness Program Notices

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations.

- **HIPAA Wellness Program Notice**—HIPAA imposes a notice requirement on health-contingent wellness programs that are offered under group health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (for example, not smoking) in order to obtain rewards. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program. [Final regulations](#) provide sample language that can be used to satisfy this requirement.
- **ADA Wellness Program Notice**—Employers with 15 or more employees are subject to the Americans with Disabilities Act (ADA). Wellness programs that include health-related questions or medical examinations must comply with the ADA's requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what

information will be collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure and the way information will be kept confidential. The Equal Employment Opportunity Commission has provided a [sample notice](#) to help employers comply with this ADA requirement.