# 2019 Open Enrollment Compliance 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, 2019. 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 2019 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.

## PLAN DESIGN CHANGES

### *Grandfathered Plan Status*

- ☐ If your plan is grandfathered, determine whether it will maintain grandfathered status. If so, provide the Grandfathered Plan Notice – see "Notice and Disclosure Requirements" section.
- ☐ Keep records to support the qualification of grandfathered status for applicable years, including that all relevant requirements were/are met.
- ☐ If your plan will lose its grandfathered status for 2019, confirm that the plan complies with the additional patient rights and benefits required by the ACA, e.g., coverage of preventive care without cost-sharing requirements.

***ACA Affordability Standard*** *–Applicable large employers* must offer affordable, minimum value health coverage to their full-time employees (and dependent children) or risk paying an ACA employer shared responsibility penalty.

- ☐ Affordability: 9.86% of income (9.56% for 2018)
- ☐ Select appropriate affordability safe harbor: W-2, Rate of Pay or Federal Poverty Level

***Out-of-pocket Maximum*** (OOP Max)

- ☐ *Non-grandfathered health plans* must meet ACA's OOP Max limits on Essential Health Benefits (EHB): $7,900 single/$15,800 family. If your family OOP max is more than $7,900, your plan must embed an individual OOP max of $7,900 or less.
- ☐ 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 OOP Max across the categories of benefits, with a combined limit that does not exceed the maximum.
- ☐ *A high deductible health plan (HDHP) with a health savings account (HSA)* is subject to a lower limit: $6,750 single/$13,500 family. See *HDHP and HSA Limits* section below.

***Preventive Care Benefits*** – *Non-grandfathered plans* must cover the latest recommended preventive care services without imposing any cost sharing (i.e., deductibles, copayments or coinsurance). Check for updates at U.S. Preventive Services Task Force and www.HealthCare.gov.



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***Health FSA Contributions***

- ☐ IRS has not released the 2019 limit. The 2018 limit is $2,650.

***HDHP and HSA Limits** - A HDHP with an HSA* must meet minimum deductible and OOP Max plan year requirements. HSA contribution limits are based on an individual's tax year and will increase on Jan. 1, 2019.

- ☐ HDHP's minimum deductible: $1,350 single/$2,700 family (no change from 2018). If your plan has an embedded individual deductible for family coverage, the embedded amount must be at least $2,700.
- ☐ HDHP's OOP Max: $6,750 single/$13,500 family (increase $100/$200 from 2018). A plan with an embedded individual deductible should have an umbrella deductible or express limit on OOP expenses; otherwise, a family with 6+ members would exceed the OOP max ($2,700 x 6) > $13,500.
- ☐ HSA contribution limits: $3,500 single/$7,000 family (increase $50/$100 from 2018) $1,000 Catch-up for age 55+

## NOTICE AND DISCLOSURE REQUIREMENTS

***Summary of Benefits and Coverage (SBC)*** SBC template and related materials

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).

- ☐ The SBC should be included with the plan's application/enrollment 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.
- ☐ For self-funded plans, the plan administrator is responsible for providing the SBC.
- ☐ For fully-insured plans, you should confirm that your health insurance issuer will assume responsibility for providing the SBCs.

***Grandfathered Plan Notice** – Grandfathered plans only* Model language

Include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials.

***Notice of Patient Protections** – Non-grandfathered plans only* Model language

Plans that require participants to designate a participating primary care (PCP) provider must provide a notice of ACA patient protections whenever the SPD or similar description of benefits is provided to a participant and include in open enrollment materials. Patient protections include permitting each participant to designate any available participating PCP (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.

***Initial COBRA Notice*** Model 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. Best practice is to mail first class to the home addressed to covered employee (and covered spouse) with proof of mailing.



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### *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 (SPD)*

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* Model Privacy Notices

The HIPAA Privacy Rule requires covered entities (including group health plans and issuers) to provide a Notice of Privacy Practices 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.
- ☐ For fully insured plans, the health insurance issuer is primarily responsible for the Privacy Notice. The plan sponsor has limited responsibilities:
    - If the plan sponsor 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 plan sponsor does not have access to PHI for plan administrative functions, it is not required to maintain or provide a Privacy Notice.

  *Note: 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.*

### *Annual CHIPRA Notice* Model 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.

### *WHCRA Notice* Model language

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.

### *Medicare Part D Notices* Model 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 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).



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### *Summary Annual Report (SAR)*

Plan administrators that are required to file a Form 5500 must provide participants with a narrative summary of the information in the Form 5500 -- a 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 was given for the Form 5500, then the SAR must be furnished within two months after the close of the extension period.

### ***Michelle's Law Notice*** *- Health plans that require full-time student status for dependent eligibility*

Group 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, Nonfederal Governmental Plans* Model language

Sponsors of self-funded, nonfederal 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.

### *Wellness Program Notices*

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design. Generally, 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** Sample language in Final regulations
  - Applies to health-contingent wellness programs that require individuals to satisfy standards related to health factors, e.g., not smoking, to earn 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.
- ☐ **ADA** Sample 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.

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