Provided by BB&T Insurance Services, Inc., McGriff, Seibels & Williams, Inc., BB&T Insurance Services of California, Inc., and Precept Insurance Solutions, LLC

2017 Open Enrollment Checklist

September 13, 2016

Plan Design Issues:	▪ Confirm your plan's out-of-pocket maximum complies with the ACA's limits for 2017. ▪ For HDHPs, confirm that the plan's deductible and out-of-pocket maximum comply with the 2017 limits. ▪ For wellness programs that include HRAs, review compliance with the new EEOC rules.	**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).	**Links and Resources:**	▪ Revenue Procedure 2016-28, which includes the inflation-adjusted limits for HSAs and HDHPs for 2017 ▪ Revised SBC template, instructions and Uniform Glossary (for use on or after April 1, 2017) ▪ EEOC's new rules for wellness programs under the ADA and GINA

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, 2017. 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 2017 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 cost and streamline administration, employers should consider including these notices in their open enrollment materials.

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. Contact Precept if you have questions about changes you have made, or are considering making, to your plan.

- ☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2017 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 2017, 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.

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, 2017, is **$7,150 for self-only coverage** and **$14,300 for family coverage.**

Also, the ACA's self-only out-of-pocket maximum applies to all individuals, regardless of whether they have self-only or family coverage under a non-grandfathered plan. This means that non-grandfathered health plans are required to embed an individual out-of-pocket maximum in the plan's family coverage when the family out-of-pocket maximum exceeds the ACA's out-of-pocket maximum for self-only coverage.

- ☐ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2017 plan year ($7,150 for self-only coverage and $14,300 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 2017, the out-of-pocket maximum limit for HDHPs is $6,550 for self-only coverage and $13,100 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 2017.
- ☐ Group health plans with a family out-of-pocket maximum that is higher than the ACA's self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual's out-of-pocket expenses exceed $7,150 for the 2017 plan year.

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 United States Preventive Services Task Force (USPSTF) and healthcare.gov.

Health FSA Contributions

The ACA imposes a dollar limit on employees' salary reduction contributions to a health flexible spending account (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' pretax 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. The health FSA limit stayed at $2,500 for 2014, but it increased to $2,550 for 2015 and 2016 plan years. The Internal Revenue Service (IRS) has not yet announced the health FSA limit for 2017 plan years. In the past, the IRS has released this limit in October of the preceding year (for example, October 2015 for 2016 plan years).

- ☐ Monitor IRS guidance for the health FSA limit for 2017 plan years.
- ☐ Once the 2017 health FSA limit is announced, confirm that your health FSA will not allow employees to make pre-tax contributions in excess of the limit for the 2017 plan year.
- ☐ Communicate the health FSA limit to employees as part of the open enrollment process.

Transition Policy for Small Group Health Plans

Some non-grandfathered health plans in the small group market have been allowed to renew without adopting all of the ACA's market reforms under a temporary transition policy adopted by the Obama Administration. The transition policy applies to policy years beginning on or before Oct. 1, 2016.

The transition relief is not available to all small group health plans. It only applies to small businesses with coverage that was in effect on Oct. 1, 2013. Also, because the insurance market is primarily regulated at the state level, state governors or insurance commissioners must allow for the transition relief. In addition, health insurance issuers are not required to follow the transition relief and renew plans. If the transition relief no longer applies to your small group plan, confirm that your plan includes the following ACA market reforms for 2017:

- ***Pre-existing Condition Exclusions –*** The ACA prohibits health plans from imposing pre-existing condition exclusions (PCEs) on any enrollees. (PCEs for enrollees under 19 years of age were eliminated by the ACA for plan years beginning on or after Sept. 23, 2010.)
- ***Coverage for Clinical Trial Participants –*** Non-grandfathered health plans cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases, and they cannot deny coverage for routine care that would otherwise be provided just because an individual is enrolled in a clinical trial.
- ***Comprehensive Benefits Package –*** Insured plans in the individual and small group market must cover each of the essential benefits categories listed under the ACA. Each state has a specific benchmark plan for determining the essential health benefits for insurance coverage in that state. More information on the benchmark plans, including the benchmark plan for each state, is available on the Center for Consumer Information & Insurance Oversight (CCIIO) website.

HDHP and HSA Limits for 2017

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 2017 limits. Also, the 2017 HSA contribution limits should be communicated to participants. The following table contains the HDHP and HSA limits for 2017. The minimum deductible and maximum out-of-pocket limits for HDHPs are the same as the limits that applied for 2016. The only limit that changes for 2017 is the HSA contribution limit for individuals with self-only coverage under an HDHP.

	Individual	Family
HDHP Minimum Deductible Amount	$1,300	$2,600
HDHP Maximum Out-of-pocket Amount	$6,550	$13,100
HSA Maximum Contribution Amount	$3,400	$6,750
Catch-up Contributions (age 55 or older)	$1,000	

Wellness Program Design

If your wellness program includes a health risk assessment (HRA) or medical examinations or covers spouses, you should consider your compliance requirements under new rules issued by the Equal Employment Opportunity Commission (EEOC) under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). These new rules are effective for plan years beginning on or after Jan. 1, 2017. For example, under these rules:

- **Incentive Limits –** Incentives that are tied to the wellness program cannot exceed 30 percent of the total cost for self-only coverage. If spouses participate in the wellness program, their maximum incentive also cannot exceed 30 percent of the total cost of self-only coverage.
- **Confidentiality –** Information from the wellness program may be disclosed to employers only in aggregate terms.
- **Employee Notice –** 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 EEOC has provided a sample notice to help employers comply with this ADA requirement.

ACA Disclosure Requirements

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide a summary of benefits and coverage (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 individuals who are newly eligible for coverage and special enrollees).

New SBC Template

The SBC must follow strict formatting requirements. The Departments of Labor, Health and Human Services and the Treasury (Departments) have provided templates and related materials, including instructions and a uniform glossary of coverage terms, for use by plans and issuers.

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 your plan's 2017 open enrollment period, the SBC should be included with the plan's application materials. If plan 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 Precept 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 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, such as open enrollment materials. 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**
  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 HIPAA.
- ☐ **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 a summary of material modifications (SMM).

  Also, an updated SPD must be furnished every five years if changes are made to SPD information or the plan is amended. Otherwise, a new SPD must be provided every 10 years.

HIPAA Privacy Notice

The plan administrator or issuer must provide the Notice of Privacy Practices to new health plan enrollees at the time of enrollment. Also, at least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.
The Privacy Notice requirements for a health plan vary depending on whether the plan is self-insured or fully insured, and, if the plan is fully insured, whether the plan sponsor has access to PHI for plan administration purposes.

- **Self-insured plans:** Must maintain and provide their own Privacy Notices
- **Fully insured plans:** Health insurance issuers have primary responsibility for Privacy Notices

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

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

- 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.

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 in the compliance assistance guide (under Appendix C: Model Notices).

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 at www.cms.gov/creditablecoverage.

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.

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.