2019 OPEN ENROLLMENT CHECKLIST

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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.

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.

Below is a compliance checklist for employers for the 2019 open enrollment, including some administrative items to prepare for in 2019.

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 2019 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 2019, 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, 2019, is **$7,900 for self-only coverage** and **$15,800 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 2019 plan year **($7,900 for self-only coverage and $15,800 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 2019 plan years, the out-of-pocket maximum limit for HDHPs is **$6,750 for self-only coverage and $13,500 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 2019.

☐ 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 $7,900 for the 2019 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 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. **The health FSA limit has been increased to $2,700 for 2019 plan years.**

- ☐ Confirm that your health FSA will not allow employees to make pre-tax contributions in excess of the limit for the 2019 plan year

- ☐ Communicate the health FSA limit to employees as part of the open enrollment process.

-HDHP and HSA Limits for 2019

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 2019 limits. The IRS limits for HSA contributions and HDHP cost sharing will all increase for 2019. The HSA contribution limits will increase effective Jan. 1, 2019, while the HDHP limits will increase effective for plan years beginning on or after Jan. 1, 2019.

The following table contains the HDHP and HSA limits for 2019:

HDHP Minimum Deductible Amount	
Individual	$1,350
Family	$2,700
HDHP Maximum Out-of-pocket Amount	
Individual	$6,750
Family	$13,500
HSA Maximum Contribution Amount	
Individual	$3,500
Family	$7,000
Catch-up Contributions (age 55 or older)	
$1,000	

ACA EMPLOYER MANDATE AND OTHER REQUIREMENTS

-Applicable Large Employer Status (ALE)

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

To qualify as an ALE, an employer must employ, on average, **at least 50 full-time employees, including full-time equivalent employees (FTEs)**, on business days during the preceding calendar year. All employers that employ at least 50 full-time employees, including FTEs, are subject to the ACA's pay or play rules.

- ☐ Determine your ALE status for 2019
- ☐ Calculate the number of full-time employees for all 12 calendar months of 2018. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.

- ☐ Calculate the number of FTEs for all 12 calendar months of 2018 by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.

- ☐ Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2018.

- ☐ Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.

- ☐ If your result is 50 or more, you are likely an ALE for 2019.

-Identify Full-time Employees

All full-time employees must be offered affordable minimum value coverage. A full-time employee is an employee who was employed on average at least 30 hours of service per week. The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status—the **monthly measurement method** and the **look-back measurement method.**

- ☐ Determine which method you are going to use to determine full-time status

- ☐ Monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.

- ☐ Look-back measurement method allows an employer to determine full-time status based on average hours worked by an employee in a prior period. This method involves a measurement period for counting/averaging hours of service, an administrative period that allows time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement period.

-Offer of Coverage

An ALE may be liable for a penalty under the pay or play rules if it does not offer coverage to "substantially all" full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is **affordable** and provides **minimum value** are generally not eligible for these

Exchange subsidies.

- ☐ Offer minimum essential coverage to all full-time employees
- ☐ Ensure that at least one of those plans provides minimum value (**60%** actuarial value)
- ☐ Ensure that the minimum value plan offered is affordable to all full-time employees by ensuring that the employee contribution for the lowest cost single minimum value plan does not exceed **9.86%** of an employee's earnings based on the employee's W-2 wages, the employee's rate of pay, or the federal poverty level for a single individual.

-Reporting of Coverage

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage on Form 1095-C. The IRS will use the information that ALEs report to verify employer-sponsored coverage and to administer the employer shared responsibility provisions (**Code Section 6056).**

In addition, the ACA requires every health insurance issuer, *sponsor of a self-insured health plan*, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS and individuals reporting information for each individual who is provided with this coverage (**Code Section 6055).**

- ☐ Determine which reporting requirements apply to you and your health plans
- ☐ Determine the information you will need for reporting and coordinate internal and external resources to help compile the required data for the 1094-C and 1095-C
- ☐ Complete the appropriate forms for the 2018 reporting year. Furnish statements to individuals on or before January 31, 2019, and file returns with the IRS on or before February 28, 2019 (March 31, 2019, if filing electronically).

-Comparative Effectiveness Research Fee (PCORI)

Sponsors of self-funded plans and health insurance issuers of fully insured plans are required to pay a fee each year, by July 31st, to fund comparative effectiveness research. Fees will increase to $2.39 per covered life in 2019 and are next due July 31, 2019.

-W-2 Reporting

Healthcare Reform requires employers to report the aggregate cost of employer-sponsored group

health plan coverage on their employees' Forms W-2. This reporting requirement was originally effective for the 2011 tax year. However, the IRS later made reporting optional for 2011 for all employers.

The IRS further delayed the reporting requirement for small employers (those that file fewer than 250 Forms W-2) by making it optional for these employers until further guidance is issued. For the larger employers, the reporting requirement was mandatory for the 2012 Forms W-2 and continues.

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).

The SBC template and related materials are available from the Department of Labor (DOL).

- ☐ In connection with a plan's 2019 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.
- ☐ 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 Lawley 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. 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. 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. This notice may be included in the plan's SPD. Model language for this disclosure is available on the DOL's website.

☐ ***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.

☐ ***NMHPA Notice***

Plan administrators must include a statement **within the Summary Plan Description (SPD) timeframe** describing requirements relating to any hospital length of stay in connection with childbirth for a mother or newborn child under the Newborns' and Mothers' Health Protections Act. 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. 15th** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' website.

☐ ***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.

Model Privacy Notices are available through the Department of Health and Human Services

☐ ***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.

☐ ***Summary Annual Report***

Plan administrators that are required to file a Form 5500 (> 100 participants in plan) must provide participants with a narrative summary of the information in the Form 5500, called a summary annual report (SAR). 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.

☐ ***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 (EEOC) has provided a sample notice to help employers comply with this ADA requirement.