Brought to you by Customized Benefit Solutions, Inc.

2013 Open Enrollment Checklist

To prepare for open enrollment, health plan sponsors should become familiar with the legal changes affecting their plans for the 2013 plan year. These changes are primarily due to the federal health care reform law, the Affordable Care Act (ACA). Plan sponsors 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 2013 plan year should be communicated to plan participants.

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices. The most significant notice requirement for this year is the **summary of benefits and coverage** under ACA, which must be provided for open enrollment periods that begin on or after Sept. 23, 2012.

There are also some participant notices that must be provided annually or upon initial enrollment. To minimize cost and streamline administration, employers should consider also including these notices in their open enrollment materials. In addition, employers that will include the cost of health coverage on their employees' 2012 Forms W-2 may want to describe this reporting change to their employees and remind them that it does not affect the taxation of their employee benefits.

HEALTH PLAN CHANGES

☐ ***Grandfathered Plan Status***

A grandfathered plan is one that was in existence when health care reform 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 your Customized Benefit Solutions, Inc. representative 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 2013 plan year. Grandfathered plans are exempt from some of the health care reform requirements. A grandfathered plan's status will affect its compliance obligations from year-to-year.
- If you **move to a non-grandfathered plan**, confirm that the plan has all of the additional patient rights and benefits required by ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

☐ ***Annual Limits on Essential Health Benefits***

Effective for plan years Jan. 1, 2014, health plans will be prohibited from placing annual limits on essential health benefits. Until then, however, restricted annual limits are permitted.

Unless your plan received an annual limit waiver, its annual limit on essential health benefits for the 2013 plan year cannot be less than **$2 million**. (This limit applies to plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.)

☐ ***Preventive Care Services for Women***

If your plan is non-grandfathered, effective for plan years beginning on or after **Aug. 1, 2012**, it must cover specific preventive care services for women without cost-sharing requirements.

The covered preventive care services for women include: well-woman visits; gestational diabetes screening; human papillomavirus (HPV) testing; sexually transmitted infection (STI) counseling; human immunodeficiency virus (HIV screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling. Exceptions to the contraceptives requirement apply to certain religious employers.

The preventive care guidelines for women are available at: www.hrsa.gov/womensguidelines/.

☐ ***$2,500 Contribution Limit for Health FSAs***

If you offer your employees a health flexible spending account (FSA) to pay otherwise unreimbursed medical expenses, you must limit their annual pre-tax salary reduction contributions to the health FSA to **$2,500**. This ACA change is effective for plan years beginning on or after Jan. 1, 2013. (The $2,500 limit will be indexed for cost-of-living adjustments for 2014 and later years.)

Health FSA plan sponsors are free to impose an annual limit that is lower than the ACA limit for employees' health FSA contributions. Also, the $2,500 limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

☐ ***HSA Limits for 2013***

If you offer a high deductible health plan (HDHP) to your employees that is compatible with a health savings account (HSA), you should confirm that the HDHP's minimum deductible and out-of-pocket maximum comply with the 2013 limits. Also, the 2013 increased HSA contribution limits should be communicated to participants. The following table contains the HDHP and HSA contributions limits for 2013.

HDHP Minimum Deductible Amount	
Individual	$1,250
Family	$2,500
HDHP Maximum Out-of-Pocket Amount	
Individual	$6,250
Family	$12,500
HSA Maximum Contribution Amount	
Individual	$3,250
Family	$6,450
Catch-up Contributions (age 55 or older)	$1,000

2013 Open Enrollment Checklist

ACA DISCLOSURE REQUIREMENTS

☐ ***Summary of Benefits and Coverage -*** 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 beginning with the **first open enrollment period that begins on or after Sept. 23, 2012**. 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) effective for plan years beginning on or after Sept. 23, 2012. A SBC template, instructions and related materials are available at: http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

In connection with your plan's 2013 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.

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 work with your health insurance issuer to determine which entity will assume responsibility for providing the SBCs. Please contact your Customized Benefit Solutions, Inc. representative 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 summary plan descriptions (SPDs) and open enrollment materials. Model language is available from the Department of Labor (DOL) at: www.dol.gov/ebsa/grandfatherregmodelnotice.doc.

☐ ***Annual Limit Waiver -*** If your plan received a waiver of ACA's annual limit requirements for the 2013 plan year, it must distribute to participants a **notice of the annual waiver**. The notice must be included in plan materials that describe coverage under the plan, such as the SPD and open enrollment materials. The required model language for the waiver is available at: http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf

Also, a different notice applies to stand-alone health reimbursement arrangements (HRAs) that are exempt from ACA's annual limit requirements until 2014. This notice must be provided at the beginning of each plan year and to new participants during the plan year. Model language for this notice is available at: http://cciio.cms.gov/resources/files/annual%20_limit_waivers_technical_instructions_update_081911.pdf.

☐ ***Notice of Patient Protections -*** Under 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.

The DOL's model language for this notice is available at: www.dol.gov/ebsa/patientprotectionmodelnotice.doc.

2013 Open Enrollment Checklist

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 participants and certain dependents within 90 days after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. The DOL's model initial COBRA Notice is available at: www.dol.gov/ebsa/modelgeneralnotice.doc.

- ☐ ***HIPAA Privacy Notice* –** If a group health plan is required to maintain a privacy notice, it must be distributed to new participants when they enroll for coverage. For fully insured plans, the issuer is generally responsible for providing the privacy notice to new enrollees.

- ☐ ***Notice of HIPAA Pre-existing Condition Exclusions* –** Plans with pre-existing condition exclusions must distribute a notice that describes the exclusions and how prior creditable coverage can reduce the exclusion period. The notice must be provided to participants with any written enrollment materials. (If the plan or issuer does not distribute written enrollment materials, the notice must be provided as soon as possible following a participant's request for enrollment.)

- ☐ ***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.

- ☐ ***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, which is available at: www.dol.gov/ebsa/pdf/chipmodelnotice.pdf.

- ☐ ***WHCRA Notice* –** Plans and issuers must provide notice of participants' rights 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 at: www.dol.gov/ebsa/publications/CAG.html (in the compliance assistance guide).

- ☐ ***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 at: http://cciio.cms.gov/resources/files/model_enrollee_notice_04072011.pdf.

W-2 REMINDER

ACA 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 is mandatory for the 2012 Forms W-2 (that must be issued by the end of January 2013).

Employers that will include the cost of plan coverage on their employee's Forms W-2 for 2012 should consider reminding employees that this reporting is intended to provide information on how much health coverage costs, and does not affect the taxation of their health benefits.