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2018 Annual Open Enrollment Is Here – Are Your Health and Welfare Plans Ready?

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It's that time of year again for employers and plan sponsors with calendar-year plans — time for annual open enrollment. Here are some items plan sponsors and plan administrators may wish to consider as they prepare amendments and enrollment materials to comply with applicable legal or regulatory requirements for the 2018 plan year:

FAQ Guidance Regarding Affordable Care Act ("ACA") Compliance

MHPAEA Guidance Q&A 5

On October 27, 2016, further guidance on implementing the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") was issued. Of note for calendar-year group health plans is the requirement to commence compliance with the "fail-first" or "step therapy" requirements issued by the Department of Health and Human Services ("HHS"), Department of Labor ("DOL") and Department of the Treasury ("Treasury") starting on January 1, 2018 (under the FAQs, plans have until the first plan year beginning on or after March 1, 2017 to comply). Under this guidance, such a requirement is considered a "non-quantitative treatment limitation" ("NQTL") and may not be imposed with respect to mental health or substance use disorder ("MH/SUD") benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the limitation are comparable and applied no more stringently with respect to MH/SUD benefits than they would be with respect to medical/surgical benefits in the same classification. For example, a plan may not impose a requirement to try an intensive outpatient program before admission for inpatient treatment unless a comparable limitation also applies to medical/surgical benefits in the same classification. Thus, if no intensive outpatient program is available in an individual's geographic location and this limitation only applies to MH/SUD benefits (i.e., outpatient programs are available to access medical/surgical benefits within the individual's geographic area), the limitation would violate the MHPAEA.

FAQs Part 35

- **Preventive Care, Q&A 2** – On December 20, 2016, the Health Resources and Services Administration updated its Women's Preventive Services Guidelines regarding breast cancer screening for average-risk women, breastfeeding services and supplies, screening

for cervical cancer, contraception, screening for gestational diabetes mellitus, screening for HIV infection, screening for interpersonal and domestic violence, counseling for sexually transmitted infections, and well-woman preventive visits (see this link). Non-grandfathered plans have until the first plan year beginning on or after December 20, 2017 to cover preventive care recommended by the new guidelines without any cost-sharing. For calendar-year plans, the compliance deadline is January 1, 2018.

- **Special Enrollment Right, Q&A 1** – These FAQs clarify that if an individual loses coverage under an individual plan (including an Exchange/Marketplace plan) for reasons other than the failure to timely pay premiums or for cause (e.g., fraud), such individual must be afforded a "special enrollment right" by a group health plan, provided she is eligible to enroll in the plan.

New Summary of Benefits and Coverage Template

As the ACA requires the summary of benefits and coverage ("SBC") to be provided with enrollment materials if plans permit participants to change their coverage options during an open enrollment period, plan sponsors must ensure that the SBCs they distribute follow current content requirements. On April 6, 2016, the enforcement agencies (HHS, DOL and Treasury) jointly issued a new SBC template for use beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 — for calendar-year plans, this is the open enrollment period relating to coverage that commences on January 1, 2018. Taking into account input from consumer groups, the National Association of Insurance Commissioners and other stakeholders, the new template revises and updates the coverage examples and provides more information about cost-sharing. See this link for the new template and related instructions.

HSA Limits

For plans that offer participants a high deductible health plan with Health Savings Account ("HSA") option, the following inflation-adjusted limits apply for calendar year 2018 (see Revenue Procedure 2017-37):

Contribution to HSA Limit:

- Self-Only Coverage — $3,450
- Family Coverage — $6,900

High Deductible Health Plan

- Annual deductible may NOT be less than:
  - Self-Only Coverage — $1,350
  - Family Coverage — $2,700
- Out-of-Pocket Maximum may NOT exceed:
  - Self-Only Coverage — $6,650
  - Family Coverage — $13,300

Disability Benefit Plan Claims Procedures

For disability benefit claims filed on or after January 1, 2018, disability benefit plans must comply with recently finalized regulations that are intended to provide participants with many of the

same protections required by the ACA for health plan participants. For further information about these claim procedure requirements, please see our article from the December 2016 newsletter.

Draft Affordable Care Act Reporting Forms and Instructions

As the employer and individual shared responsibility requirements are still in effect, plan sponsors may wish to review the recent draft forms and related instructions for coverage offered/provided in 2017 [Forms 1094-B, 1095-B (for providers of coverage such as insurers and multiemployer self-insured plans) and Forms 1094-C and 1095-C (employers with 50 or more full-time employees), reporting due in 2018]. See this link.

If you have any questions regarding the foregoing, please contact the author of this article

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