OPEN ENROLLMENT 2016

INFORMED ON REFORM

2016 Open Enrollment checklist for employers

Non-grandfathered plans must comply with these benefit requirements for 2016 plan years.

1 ☐	**Cost sharing**	› For 2016 plan years, in-network out-of-pocket (OOP) maximums cannot exceed $6,850 individual and $13,700 family. For High Deductible Health Plans (HDHPs) with Health Savings Accounts (HSAs), the 2016 OOP maximums are $6,550 individual and $13,100 family. › The in-network individual OOP maximum must apply to each person, even if they are enrolled in family coverage. For example, if a plan has a family OOP maximum of $10,000, the individual OOP maximum cannot be more than $6,850. Once any covered person's out-of-pocket expenses reach the individual OOP maximum, services for that family member will be covered at 100% for the remainder of the plan year. › For HDHPs with HSAs, this means that the plan must have a collective deductible and a non-collective OOP maximum. For example, if an HSA plan has a $1,500 individual deductible, a $3,000 family deductible, a $6,000 individual OOP maximum and a $12,000 family OOP maximum, the entire $3,000 family deductible must be met before any family member is covered at plan coinsurance. However, once any one family member reaches the $6,000 individual OOP maximum, that family member will be covered at 100% for the remainder of the plan year. › All in-network copays, deductibles and coinsurance for essential health benefits (EHBs) provided through the same carrier (e.g., medical, mental health/substance use disorder, prescription drug, non-excepted dental and vision) must accumulate to a single OOP maximum. › Prescription drug benefits carved out to a separate vendor can have a separate out-of-pocket maximum, as long as the sum of the medical and prescription drug out-of-pocket maximums doesn't exceed the allowable limit.

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If your plan will lose grandfathered status in 2016, you must add these benefits, if you do not already offer them.

2 ☐	**Preventive care**	Preventive care, including the additional women's preventive care services that took effect in 2012, must be covered at 100%.
3 ☐	**Doctor choice**	Individuals can choose any doctor as their primary care physician and see an OB-GYN without a referral.
4 ☐	**Emergency care**	Emergency care must be covered at the in-network level, even if received from an out-of-network provider.

Additional health care reform requirements you should be aware of.

5 ☐	**Employer mandate**	Employers must offer health coverage to full-time employees and their children up to age 26, or face penalties. At least one medical plan option must offer coverage for children through the end of the month in which they reach age 26. This applies to employers with 100 or more full-time employees in 2015 and expands to include employers with 50 or more full-time employees in 2016. The coverage must be "affordable" and provide "minimum value." › "Affordable" means that the employee-only contribution for the lowest-cost plan is no more than 9.5% of an employee's W-2 wages. › "Minimum value" means that the plan pays for at least 60% of covered health services.
6 ☐	**Individual mandate**	Effective January 1, 2014, all individuals (with a few exceptions) are required to have "minimum essential coverage" or pay a penalty. Employer coverage, a government plan such as Medicare or Medicaid, or individual health insurance meets this requirement.
7 ☐	**Employer mandate and individual mandate reporting**	**Large Employer Reporting (Employer Mandate Reporting)** In early 2016, employers must report information to the IRS and to employees about how the health coverage they provided in 2015 met the employer mandate requirement. For 2015, employer mandate reporting only applies to employers with 100 or more employees. Employers with 50 to 99 employees won't have to file until 2017 for the 2016 calendar year. Employers are responsible for completing this reporting for both insured and self-funded plans. **Minimum Essential Coverage Reporting (Individual Mandate Reporting)** Information about whether coverage met the individual mandate must be reported to the IRS and individuals in early 2016. This reporting applies to employers of all sizes. Insurers are responsible for this reporting for insured plans. Employers are responsible for reporting for self-funded plans..
8 ☐	**Wellness programs and rewards**	The maximum wellness program reward is 30% of the total cost of medical coverage, including both employer and employee contributions. The maximum reward may be increased to 50% for programs related to tobacco use. Rewards can be provided through premium discounts or surcharges, reduced costs or enhanced benefits. If an individual does not qualify for a health-contingent reward, a reasonable alternative standard or waiver must be available.
9 ☐	**Health Insurance Marketplace notice**	Employers must provide a notice about the Health Insurance Marketplace to all new employees. The notice must be provided regardless of company size, whether the employer offers health coverage or whether the employee will be eligible for health coverage from the employer.