2018 OPEN ENROLLMENT CHECKLIST FOR EMPLOYERS

INFORMED ON REFORM

All plans must comply with these benefit requirements for 2018 plan years.	
Essential Health Benefits	All plans that cover benefits designated as Essential Health Benefits (EHBs) have been required to cover in-network benefits with no annual dollar limits or lifetime maximums since 2014. Annual and lifetime dollar limits on out-of-network EHBs were prohibited beginning in 2017.
Transgender benefits	Health services typically or exclusively available to one gender cannot be denied or limited due to an individual's sex assigned at birth, gender identity or recorded gender. › Cigna is removing categorical coverage exclusions or limitations for all health services related to gender transition from its insured benefit plans. Cigna's self-funded clients will be responsible for making the determination to remove these exclusions and should consult with their legal counsel regarding this decision.
Wellness programs and rewards	› Incentives must be limited in accordance with applicable Affordable Care Act (ACA), Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA) rules.* › Incentives are generally capped at 30% of the total cost of employee-only coverage, with an additional 30% incentive if the spouse participates. Incentives may be increased to 50% for programs that ask about (but do not test for) tobacco use.* › If enrollment in a health plan is required to participate in the wellness program, the incentive is based on the health plan in which the employee is enrolled. Otherwise, the incentive is based on the lowest cost medical plan offered by the employer. › Under the ADA regulations, an employee cannot be denied access to all group health coverage or a specific health plan option based on failure to participate in a wellness program. › A reasonable alternative must be available for outcome-based and activity-based wellness programs. Reasonable accommodations must be available to any employee with a disability. › Information about reasonable alternatives must be included in every communication tied to a wellness program. › Notices describing the handling of medical information and procedures for safeguarding information privacy must be distributed to all wellness program participants.

*On Dec. 20, 2017, the D.C. District Court issued an order in the matter of AARP vs. EEOC vacating the EEOC's final rules on wellness under the ADA and GINA (finalized in May 2016). This order is not effective until Jan. 1, 2019. The Court further ordered the EEOC to release new proposed rules, which are expected to be published before Aug. 31, 2018.

For more information, visit Cigna's health care reform website, **www.InformedonReform.com**, where we continuously update information as it becomes available.

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All non-grandfathered plans must comply with these benefit requirements for 2018 plan years.	
Cost sharing	› For 2018 plan years, in-network out-of-pocket (OOP) maximums cannot exceed $7,350 individual and $14,700 family. Proposed amounts for 2019 are $7,900 individual/$15,800 family. › OOP expenses include any deductibles, copays and coinsurance costs paid by a consumer. › Plans that have a family OOP maximum greater than $7,350 must apply an individual OOP limit for each person enrolled in family coverage, as no individual can pay more than $7,350 for in-network OOP expenses. › For High Deductible Health Plans (HDHPs) with Health Savings Accounts (HSAs), the 2018 OOP maximums are $6,650 for individual coverage and $13,300 for family coverage. Individuals with HDHP family coverage cannot pay more than $7,350 for in-network OOP expenses.
Preventive care	Preventive care, including the additional women's preventive care services that took effect in 2012, must be covered at 100%.**
Doctor choice	Individuals can choose any doctor as their primary care physician and see an OB-GYN without a referral.
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.	
Employer mandate	Employers must offer health coverage to full-time employees and their children up to age 26, or they may 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 50 or more full-time or full-time equivalent employees. 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 9.56% of an employee's W-2 wages. › "Minimum value" means that the plan pays for at least 60% of covered health services.
Individual mandate	For 2018, 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. The Tax Cuts and Jobs Act passed on Dec. 20, 2017 included permanent effective repeal of the individual mandate by zeroing out the penalty beginning in 2019.
Employer mandate and individual mandate reporting Note: On Dec. 22, 2017, the Internal Revenue Service (IRS) announced extended deadlines for 2017 reporting to individuals from 01/31/2018 to 03/02/2018.	**Large Employer Reporting (Employer Mandate Reporting)** Early each year, all "applicable large employers" (i.e. employers with 50 or more full-time and/or full-time equivalent employees) must report information to the IRS and to employees about how the health coverage they offered during the previous calendar year met the employer mandate requirement. Employers are responsible for completing this reporting for both insured and self-funded plans. **Minimum Essential Coverage Reporting (Individual Mandate Reporting)** Early each year, insurers and employers must report information to the IRS and to employees about whether the health coverage they offered during the previous calendar year met the individual mandate requirement. 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. › In order to complete this reporting, Social Security Numbers (SSNs) are required for all covered employees and dependents. Employers who do not have this information must make "reasonable attempts" to obtain any missing SSNs in accordance with IRS guidelines.
Notice of coverage options	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.

**Interim Final Rules (IRFs) issued on Oct. 6, 2017 allowed employers to exclude contraceptive coverage based on moral or religious objections. On Dec. 15, 2017, a federal court temporarily blocked this change. The contraceptive rules in place before Oct. 6 remain in effect unless and until the injunction is removed.