The Jefferson Health Plan

The latest JHP news and announcements

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On May 16, 2023, the Internal Revenue Service (IRS) issued IRS Revenue Procedure 2023-23, which announced the inflation-adjusted maximum contribution limits for health savings accounts (HSAs), along with minimum deductible and maximum out-of-pocket expenses for high-deductible health plans (HDHPs) for calendar year 2024. The IRS also announced that for plan years beginning in 2024, the maximum amount that may be made newly available for the plan year for an excepted-benefit health reimbursement arrangement (HRA) will be $2,100 (up from $1,950 in 2023). The table below summarizes those adjustments and other applicable limits:

2024 Contribution and Out-of-Pocket Limits Health Savings Accounts and High-Deductible Health Plans			
Type of Limit	**2024**	**2023**	**Change**
HSA Maximum Annual Contribution	Self-Only: $4,150 Family: $8,300	Self-Only: $3,850 Family: $7,750	Self-Only: +$300 Family: +$550
HSA Maximum Catch-Up Contribution (Age 55 or older)	$1.000	$1,000	No change
HDHP Minimum Annual Deductible	Self-Only: $1,600 Family: $3,200	Self-Only: $1,500 Family: $3,000	Self-Only: +$100 Family: +$200
HDHP Maximum Annual Out-of-Pocket Amounts	Self-Only: $8,050 Family: $16,100	Self-Only: $7,500 Family: $15,000	Self-Only: +$550 Family: +$1,100

Legal Update

Annual PCORI Fee Adjustment and Filing

You may recall that the Affordable Care Act (ACA) imposes a fee on health insurance issuers and plan sponsors of self-insured health plans to help fund the Patient-Centered Outcomes Research Institute (PCORI), and Further Consolidated Appropriations Act, 2020 has extended the PCORI Fee through plan years ending before October 1, 2029. The fee is calculated by multiplying the average number of lives covered under the plan by a dollar amount. The dollar amount is adjusted for inflation each year based on increases in the projected per capita amount of national health expenditures. In Notice 2022-04, the IRS provided the adjusted PCORI fee for plan years ending in October 2021 through September 2022 as $2.79 per covered life. The IRS recently published Notice 2022-59 (https://www.irs.gov/pub/irs-drop/n-22-59.pdf), announcing that the adjusted PCORI fee is $3.00 per covered life for plan years ending on or after October 1, 2022, and before October 1, 2023. The IRS put together a **chart** (https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates) showing applicable fee amounts depending on the plan year end date.

Employers that sponsored self-insured health plans are required to report and pay this fee on the second quarter Form 720, Quarterly Federal Excise Tax Return due by July 31 of the year following the last day of the plan year. The Form 720 is updated annually in the spring to reflect the updated PCORI fee.

The Jefferson Health Plan will work with CliftonLarsonAllen (formerly known as Gilmore, Jasion and Mahler) to prepare the Form 720 used for filing the PCORI fee. They will coordinate payment by issuing checks from each member group's reserve account for the amount of the fee. Filing and payment will be submitted for each member organization prior to the July 31, 2023 deadline. You will be receiving the completed Form prepared for your signature in the coming months in an email. Please review your Form and upon approval, sign, scan, and return the documents electronically per the instructions in the email provided for filing and payment.

Maximum Out-of- Pocket Limits for 2024 Benefit Year

The Affordable Care Act (ACA) provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under sections 1302(c)(1) and (c)(2) of the Affordable Care Act. These are known as out-of-pocket maximum limits. The U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) annually adjust the ACA's out-of-pocket maximum for inflation and publish the limits by January of the year preceding the applicable benefit year. The ACA's cost-sharing limits apply to all non-grandfathered health plans, including self-insured health plans and fully insured health plans of any size. On December 12, 2022, HHS and CMS issued the 2024 out-of-pocket maximums for non-grandfathered group health plans, which are effective for plan years beginning on or after January 1, 2024. Click the link for more information. https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf?mc_cid=0b5ea6aa89&mc_eid=30c09dce27

ACA Maximum Out-of-Pocket	2024	2023	Change (+3.8%)
Self-only	$9,450	$9,100	+ $350
Family	$18,900	$18,200	+ $700

End of Covid Emergency for Benefit Adjustments

On Jan. 30, 2023, the White House announced it would end the COVID-19 National Emergency and Public Health Emergency declarations on May 11, 2023. However, on March 29, 2023, the U.S. Senate passed H.J. Res. 7, which terminates the "National Emergencies Act" declaration concerning COVID-19 that President Trump enacted on March 13, 2020. President Biden signed this into law on April 10, 2023, officially terminating the National Emergency as of that date.

While the National Emergency ended early, the presidential action did not affect the Public Health Emergency, which expired on May 11. The Emergency Declarations resulted in several forms of relief relating to employee benefit plans during the pandemic. The Public Health Emergency (PHE), which had been declared and renewed by the Secretary of HHS since January 2020, affects requirements to cover COVID-19 testing and related services. The COVID-19 National Emergency (NE), which was in effect since March 1, 2020, directly affects the extended plan-related deadlines. On March 29, 2023, the United States Departments of Labor (DOL), Health and Human Services (HHS), and the

Treasury (collectively, the Departments) issued "FAQs about Families First Coronavirus Response Act (FFCRA), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and Health Insurance Portability and Accountability Act Implementation (HIPAA) Part 58" (FAQs). This guidance provides Q&As addressing how group health plans will be impacted by the end of the NE and PHE. Here is a summary of some of the key points from the FAQs guidance relevant to employer-sponsored group health plans.

COVID-19 Diagnostic Testing: After the end of the PHE on May 11, 2023, mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests end, though coverage will vary depending on the group health plan (plan). If any plan chooses to cover these items or services, they may impose cost sharing, prior authorization, or other forms of medical management requirements. *See* Q 1 of the FAQs. The requirement for plans to pay the cash price of a COVID-19 test listed on an out-of-network provider's website will no longer apply after the end of the PHE. *See* Q 3 of the FAQs.

Participant Notification: Plans are encouraged to notify participants and beneficiaries of any changes to the terms of coverage for COVID-19 diagnosis and treatment, including testing after the end of the PHE. This includes the date when the plan will stop coverage if the plan chooses to no longer cover COVID-19 diagnostic tests or when the plan will begin to impose cost-sharing requirements, prior authorization, or other medical management requirements on COVID-19 tests, to the extent applicable under the plan or coverage. If a plan reduces, or adds cost sharing to testing benefits after the PHE, and those changes would affect the content of the summary of benefits and coverage (SBC), that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan must provide notice of the modification to participants not later than 60 days prior to the date on which the modification will become effective. However, plans that increased benefits or reduced cost-sharing for the diagnosis or treatment of COVID-19 or for telehealth or remote care services and revoke these changes upon expiration of the PHE will be deemed to have satisfied their obligation to provide advance notice of the material modification if they previously notified participants of the general duration of the increased benefits (such as, that they applied only during the PHE), or notify participants reasonably in advance of the reversal. The FAQs clarify that previous notices satisfy the advance notice requirement only if provided during the current plan year. *See* Q 2 of the FAQs.

Preventive Services and COVID-19 Vaccine Coverage: After the end of the PHE on May 11, 2023, non-grandfathered group health plans must continue to cover qualifying coronavirus preventive services, including COVID-19 vaccines from in-network providers at no cost to the participant as a preventive service under Affordable Care Act standards. The coverage must be provided within 15 business days after a recommendation is made by the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP). After the PHE ends,

plans are not required to cover vaccines from an out-of-network provider if the plan has a network of providers and may impose cost-sharing if such coverage is provided. If a plan has no provider in its network who can provide a qualifying coronavirus preventive service, the plan must cover the service out-of-network without cost-sharing. *See* Q 4 of the FAQs.

Coverage under HDHPs: In general, and in order for an individual to remain eligible to contribute to a health savings account (HSA), a high-deductible health plan (HDHP) cannot provide medical care services without cost-sharing prior to an individual's satisfaction of the applicable minimum deductible. Under a 2020 IRS notice, a HDHP can offer pre-deductible coverage for COVID-19 testing and treatment without disqualifying participants from contributing to HSAs. The Departments indicated that until further guidance is issued, an individual covered by an HDHP that provides medical care services and items for the purpose of diagnostic testing and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible may continue to contribute to an HSA until further guidance is issued. Also, under existing HSA eligibility rules, COVID-19 vaccinations are considered preventive care that would not disqualify participants from contributing. The FAQs indicate that any future modifications generally will not require HDHPs to make changes in the middle of a plan year. *See* Q 8 of the FAQs.

Extended COBRA, Special Enrollment, and Claims and Appeals Deadlines: Under a joint notice issued by the Departments in 2021, certain time periods and dates for HIPAA special enrollment, COBRA continuation coverage, and internal claims and appeals and external review must be disregarded (*i.e.*, tolled) (disregarded periods) until the earlier of (a) 1 year from the date each plan or participant was first eligible for relief, or (b) 60 days after the announced end of the NE (*i.e.*, the end of the Outbreak Period). This means that during the COVID-19 emergency, the following plan-related deadlines were extended:

1) the 30-day period (or 60-day period, if applicable) to request special enrollment,
2) the 60-day election period for COBRA continuation coverage,
3) the date for making COBRA premium payments,
4) the date for participants to notify the plan of a disability determination or a COBRA-qualifying event,
5) the date within which individuals may file a benefit claim under the plan's claims procedure,
6) the date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure,
7) the deadlines within which participants requesting internal and external appeals for adverse benefit determinations,
8) the date for a plan providing a COBRA election notice.

Legal Update continued . . .

The FAQs guidance provides that plans can stop tolling relevant deadlines at the end of the Outbreak Period (July 10, 2023, 60 days after the end of the NE). Since the NE now has been determined to end on April 10, 2023, the 60 day period would end on June 9, 2023 (rather than July 10, 2023 as previously predicted). But based on informal comments from the DOL, it appears that the tolling of benefit plan deadlines will still end on July 10, 2023, as provided in the FAQs.

The FAQs guidance also provides that deadline extensions can end sooner in cases where participants have had a full one-year extension—for example, someone who had a COBRA qualifying event and lost coverage on May 1, 2022. Deadlines that begin during the Outbreak Period would still be subject to the IRS and DOL extension. For instance, participants who have COBRA qualifying events on May 12, 2023, would have a deadline that is sixty days after the end of the Outbreak Period, which is September 8, 2023. The FAQs guidance emphasizes that plans are allowed to offer longer timeframes than the minimum required by law, which could ease the transition period for employers and employees. *See* Q 5 of the FAQs. The guidance also provides examples illustrating how the outbreak period's end affects COBRA elections and premium payments and HIPAA special enrollment deadlines.

Employers/Plan Sponsors are recommended to begin preparing for the above anticipated changes, and to ensure plan participants are aware of the impact of the end of Emergency Declarations. For example, employers are recommended to:

- Coordinate with TPAs/PBMs concerning any coverage changes for COVID-19 diagnostic testing-related services, vaccines, or treatments; and communicate any changes to participants and distribute Summary of Material Modifications (SMM) or an updated Summary Plan Description (SPD), as needed, at renewal (or within 60 days of the adopted changes if there has been a material reduction in covered services).
- Coordinate with COBRA administrator to understand any COBRA administration changes, if they can identify individuals who may be impacted by this change, and how communications will be handled.
- Prepare employee communications noting how previously extended deadlines will be impacted.
- Revise Plan Documents and Summary Plan Descriptions to reflect the end of extended timeframes.

JHP Announcements

Medical Mutual Awards Scholarships

Through the Medical Mutual Scholarship Fund for customer schools, MMO offers scholarships to senior students graduating from Ohio school districts that carry Medical Mutual insurance. Each year, MMO vets thousands of applications from across Ohio, and because of these students' commitment to education and community, the following students from JHP member schools have been selected to receive a financial award in the amount of $1,000 to help ease the challenges of higher education.

Amelia Alexander - Ada High School

Nathaniel Streby - East Knox High School

Emanuel Wilson - Kenton High School

Raven Holloway - Toronto Junior/ Senior High School (Jefferson County JVS)

Eleanor Curlis - Hardin Northern High School

Liberty Cummings - Riverdale High School

Brionna Bonar - Steubenville High School

Jewel Persinger - Waynedale High School (Southeast Local Schools)

The Columbus Foundation will begin notifications in the coming weeks by sending award letters directly to the scholarship recipients including their schools. I'm sure they will be excited to hear the good news. Congratulations to these students for their hard work!

VSP Renewal Information

We are pleased to announce that JHP secured a 0% rate increase guaranteed for four years for the July 1, 2023 VSP renewal. Member groups that currently have the VSP vision plan will see no increase to their billed rates and the rates are guaranteed until 6/30/27. VSP also enhanced some plan benefits such as increased allowances for frames and contact lenses and added more brands to the VSP Eyeconic on-line retail shop. Your JHP Account Manager will send the updated VSP Vision Benefits Summary in the next couple weeks. If you currently do not offer vision and would like to add it to your benefit plan, please see your JHP Account Manager for plan options available to JHP member groups.

RxBenefits Response to GLP-1 Off-Label Prescribing

Across the country, there is a dramatic increase in prescriptions being written and dispensed for a class of medications called glucagon-like peptide 1 (GLP-1) agonists. Originally created and approved by the FDA to treat type 2 diabetes, many drugs in this class (including Ozempic, Trulicity, and Mounjaro) have become wildly popular for weight loss recently, despite not being approved yet for such use by the FDA. At this point, the only two GLP-1s approved for weight loss are Wegovy and Saxenda.

RxBenefits is working with their PBM partners to expand the Utilization Management (UM) edits for clinical solutions to shield self-funded clients from off-label prescribing of GLP-1 drugs such as Ozempic® and Mounjaro™. These glucagon-like peptide 1 (GLP-1) drugs are designed to treat type 2 diabetes, but in many cases they're being prescribed solely for weight loss, which is increasing client spend, causing drug shortages, and creating service issues.

The plan cost for GLP-1 drugs across the RxBenefits book of business in 2021 was $55M; it rose to $107M in 2022. Given current prescription volume, RxBenefits projects spending related to GLP-1s could exceed $160M this year. Their analysis indicates up to 40% of utilization may be driven by off-label usage, not treatment of type 2 diabetes. This is also causing a shortage of GLP-1's at the pharmacy forcing diabetic patients to go without medication that has been working well to improve their blood sugar and hemoglaobin A1-C.

RxBenefits goal is to minimize off-label use of GLP-1's quickly and substantially to reduce spend for self-funded clients and ensure diabetic patients who need these medications can access them. RxBenefits is reviewing and enhancing the Utilization Management edits to expand coverage of GLP-1s. Drugs impacted are: Bydureon Bcise, Byetta, Mounjaro, Ozempic, Rybelsus, Trulicity, and Victoza. The new GLP-1 drug edits will require a review process for medical necessity before a prescription for these drugs can be filled, which will help reduce off-label utilization. Edits will be put in place for groups with Protect or Standard Utilization packages in June. Groups with Custom Utilization Management will have the option to include this edit for a July 15th effective date. If your group currently has Custom Utilization Management in place, you received notification from your JHP Account Manager of the option to add this edit. Please contact your JHP Account Manager if you have questions.

The new Carelon EAP brochures are available. Contact your JHP Account Manager if you would like brochures sent to you.

Don't know who to contact? Reach out to any JHP ACCOUNT MANAGER!

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