THE JEFFERSON HEALTH PLAN UPDATE

Volume 9/Issue 9

WELCOME!

As another way to reach out to current Jefferson Health Plan groups and communicate on issues that directly impact our members, we will be providing updates on what is happening in the consortium.

If you have items that you would like to see in these updates, feel free to let us know!

HIPAA Exemption Election Process

Beginning in 2015, all HIPAA Exemption Elections must be made online through the Health Insurance Oversight System (HIOS). Paper elections via mail or fax are no longer accepted. Before making your Exemption Election you should:

1. Make sure that your plan needs to be making an Exemption Election from one or more of the coverages below:

a. *Standards relating to benefits for mothers and newborns*. Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a normal vaginal delivery, and 96 hours for a cesarean section.

b. *Parity in the application of certain limits to mental health benefits*. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefit must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

c. *Required coverage for reconstructive surgery following mastectomies*. Group health plans that provide medical and surgical benefits for a mastectomy must provide certain benefits in connection with breast reconstruction as well as certain other related benefits.

d. *Coverage of dependent students on medically necessary leave of absence*. Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

If your plan meets all of the required benefits as listed above, your plan does not need to file for Exemption. If you are unsure, you should check with your TPA for clarification.

1. If your plan needs to make an Exemption, you must register as an Administrator/Submitter in HIOS before you can make a HIPAA Exemption Election under the Non-Fed Module using the attached HIOS user manual instructions. The instructions are quite lengthy, so you will want to give yourself some time for the registration process.

2. The Names of all group health plans covered by the election must be listed in the online election documents (i.e. classified, certified).

3. Plans must file before the first day of the plan year.

The link to the website for additional information is:

Contact Us

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Semi-Annual Meeting-

October 27th

Hilton Columbus at Easton, Columbus
4:00 pm Meeting

Educational Seminar-

October 28th

Hilton Columbus at Easton, Columbus
Breakout Sessions 7:00 to 2:15

Link to Hotel Reservations:

http://www.hilton.com/en/hi/groups/personalized/C/CMHCHHF-TJH-20161027/index.jhtml?WT.mc_id=POG

http://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html

CMS Online Disclosure for 7/1 Renewals

As you may recall, the Centers for Medicare and Medicaid Services require all employers who offer prescription drug plans to give plan participants annual notice that their current prescription drug coverage is as creditable as the coverage offered to qualified retirees through Medicare Part D plans. The notice for your plan was provided to you for distribution to your participants this past October.

In addition to the distribution of notices to participants, employers are also required to electronically file a confirmation with CMS verifying some general plan information and that the notices were sent to participants on or before October 15, 2015. For CMS

creditable coverage reporting purposes, "plan year" means annual renewal period. Disclosure to CMS must be made within 60 days after the beginning of the "plan year" (annual renewal period).

Therefore, 7/1/2016 renewals must file online on or before August 29, 2016. The website is as follows: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

The CMS Guidance and Screen Prints for the electronic filing can be found to the left of the fields of entry. When reviewing the screen print examples, please note that some sections of the Disclosure Form may not apply to your plan. Only fields relevant to your plan may appear on your screen. Also note that **Total Number of Medicare Part D Eligible Individuals covered as of Plan Year Beginning Date** can be acquired from your TPA.

Flex Contributions and Opt-Out payments May Effect Affordability Calculations

An employer is penalized under the Employer Mandate when a full-time employee receives a subsidy for purchasing marketplace coverage and the coverage offered by the employer is not affordable.

The IRS issued Notice 2015-87 explaining in further detail how the IRS calculates the employee's required contribution in order to determine the affordability of the employer sponsored coverage. The Notice also addresses cash payments available to employees declining coverage.

Per the guidance, employer flex contributions will reduce the amount of the employee's required contribution when calculating affordability. This would benefit the employer, but this is only applicable if the employer contribution meets all of the following:

- The employee may not opt to receive the amount as a taxable benefit and
- The employee must be able to use the amount toward the purchase of ACA qualifying medical coverage and
- The employee can only use the amount to purchase medical care as defined by the IRC section 213

If the employer flex contribution does not meet all the requirements, the IRS will not use the contribution when calculating affordability.

Transition relief is available for Plan years beginning before 1/1/2017, if the contribution arrangement was in place prior to 12/17/2015. This means that for plans existing prior to that date, if the amount of the flex contribution is available to the employee to pay for health coverage, it will count toward reducing the employees required contribution.

Cash payments made available only to employees that decline coverage were also addressed in the Notice, stating that, if an employee is required to give-up a cash payment in order to enroll in an employer's plan, this opt-out cash payment must be included in calculating the employee's required contribution, thereby penalizing employers for having a cash incentive to opt-out.

The link to the IRS Notice is: https://www.irs.gov/irb/2015-52_IRB/ar11.html

PCORI

As a reminder, the Patient-Centered Outcomes Research Institute Fee will be paid and filed using the Form 720. The Jefferson Health Plan will again work with 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, 2015 deadline.

You will be receiving the completed Form prepared for your signature in the coming months. Please review your Form and upon approval, sign and return the documents to Gilmore, Jasion & Mahler per the instructions provided for filing and payment.