THE JEFFERSON HEALTH PLAN UPDATE

Volume 22/Issue 22 June 2020

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!

Jefferson Health Plan – Account Management Team Updates

The Jefferson Health Plan (JHP) continues to grow and has become a multi-state organization. With this growth comes increasing economies of scale, which helps our membership to realize better vendor contracts and, in turn, maximize savings in fulfilling their self-insurance needs. In an effort to better serve our members, each JHP member group has been entrusted to an assigned Account Manager (AM) to engage, educate and provide service and support. JHP members will continue to have the ongoing support of the entire JHP Team but will now also have the benefit of a dedicated AM to act as your JHP liaison. The AM's are excited to work with their assigned members and their broker, if they have one. During the last couple months of restricted travel, due to the pandemic, the AM's have been working together to create a coordinated service plan to maximize member interaction for education and training purposes. They look forward to getting on the road in the near future and, in the meantime, will be conducting informational sessions on consortium programs. Suggested session topics can be sent to jhpmember@thejeffersonhealthplan.org.

Jefferson Health Plan – Welcome New Members

City of Rochester, MI
Eastern Local – Pike County
Five Rivers MetroParks
HEALTH Consortium – Cincinnati State Technical and Community College
Clark State Community College
Edison State Community College
Shawnee State University

Jefferson HEALTH PLAN

PCORI

You may recall that the Patient-Centered Outcomes Research Institute (PCORI) Fee was supposed to sunset in 2019. In December 2019, the Further Consolidated Appropriations Act, 2020 extended the PCORI fee for 10 years, meaning that insurers and plan sponsors/employers of self-insured health plans will have to continue to pay this fee until 2029 or 2030, depending on their policy/plan year. In IRS Notice 2020-44 (https://www.irs.gov/pub/irs-drop/n-20-44.pdf), released on June 8, 2020, the IRS announced that the adjusted applicable dollar amount for PCOR fees for plan years ending on or after October 1, 2019, and before October 1, 2020, is $2.54. For plan years that end on or after October 1, 2018, and before October 1, 2019, the adjusted applicable dollar amount is $2.45. 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, 2020 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.

2021 Benefits Planning

On May 14, 2020, the Department of Health and Human Services (HHS) published its final rule, the HHS Notice of Benefit and Payment Parameters for 2021 (2021 NBPP Final Rule) (https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf), as part of regulations issued annually to implement selected aspects of the Affordable Care Act (ACA). The cost-sharing limits and some other provisions in the 2021 NBPP Final Rule may be of interest to employers/plan sponsors. The following is a brief summary of these provisions.

Maximum Annual Out-Of-Pocket Limit: The Affordable Care Act (ACA) provides that all non-grandfathered group health plans, including non-grandfathered self-insured and insured small and large group market health plans, 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 ACA. These are known as out-of-pocket maximum limits. For 2021, the out-of-pocket maximum will increase to $8,550 for self-only coverage and $17,100 for family coverage. This is an increase from the 2020 limits of $8,150 and $16,300, respectively.

	2021	2020	Change
ACA Maximum Out-of-Pocket	Self-only: $8,550 Family: $17,100	Self-only: $8,150 Family: $16,300	Self-only: + $400 Family: + $800

Drug Manufacturer Coupons: Some drug manufacturers provide coupons to patients to help reduce their out-of-pocket costs. In response, some plan sponsors/insurers and pharmacy benefit managers (PBMs) adopted accumulator adjustment programs, also known as copay accumulator programs, under which the plan sponsor or PBM will not apply a copay or other manufacturer coupon to an enrollee's deductible or out-of-pocket maximum, meaning the enrollee cannot "count" any of the coupon's amount towards their out-of-pocket costs. Under the 2021 NBPP Final Rule, "to the extent consistent with applicable state law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing." Accordingly, a self-funded group health plan sponsor/employer may decide whether to count the value of drug manufacturers' coupons toward the annual limitation on cost sharing:

- for those who elect to count these amounts toward the annual limit on cost-sharing, the value would be considered part of the overall charges incurred by the enrollee;
- for those who elect not to count these amounts, the value would be considered a reduction in the amount the enrollee incurs or is required to pay.

For plans that choose to exclude drug manufacturer supports from the annual limit on cost-sharing, HHS notes two requirements:

- plans must apply such policies in a "uniform, non-discriminatory manner" consistent with existing obligations; and
- plans should be "clear and transparent in communications with enrollees and prospective enrollees regarding whether the value of drug manufacturer support accrues to the annual limitation on cost sharing," and are expected to "prominently include this information on websites and in brochures, plan summary documents, and other collateral material that consumers may use to select, plan, and understand their benefits."

CONTACT US

The Jefferson Health Plan

2023 Sunset Blvd.

Steubenville, Ohio 43952

www.thejeffersonhealthplan.org

Fall Semi-Annual Meeting

Wednesday,

October 21st, 2020

Educational Seminar

Thursday,

October 22nd, 2020

See website for additional details

Failure to disclose sufficient information on such copay accumulator programs may prompt future rulemaking by HHS "to impose robust disclosure requirements." HHS also notes that while the final rule pertains to direct manufacturer support, it continues to monitor indirect manufacturer support of specific drugs.

2021 Limits for HDHPs/HSAs: In Revenue Procedure 2020-32 (https://www.irs.gov/pub/irs-drop/rp-20-32.pdf), the IRS released 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 2021. The table below summarizes those adjustments and other applicable limits:

Type of Limit	2021	2020	Change
HSA Maximum Annual Contribution	Self-only: $3,600 Family: $7,200	Self-only: $3,550 Family: $7,100	Self-only: + $50 Family: + $100
HSA Maximum Catch-up Contribution (age 55 or older)	$1,000	$1,000	None
HDHP Minimum Annual Deductible	Self-only: $1,400 Family: $2,800	Self-only: $1,400 Family: $2,800	None
HDHP Maximum Annual Out-of-pocket	Self-only: $7,000 Family: $14,000	Self-only: $6,900 Family: $13,800	Self-only: + $100 Family: + $200

COVID-19 Relief and Guidance for Employer-Sponsored Health Plans

IRS Notices 2020-29 and 2020-33: Guidance on Cafeteria Plans and HDHPs: On May 12, 2020, the Internal Revenue Service (IRS) released two Notices, IRS Notice 2020-29 (https://www.irs.gov/pub/irs-drop/n-20-29.pdf), and IRS Notice 2020-33 (https://www.irs.gov/pub/irs-drop/n-20-33.pdf), providing increased flexibility for employers with respect to Internal Revenue Code section 125 cafeteria plans (cafeteria plans) during calendar year 2020 related to employer sponsored health coverage, health Flexible Spending Arrangements (health FSAs), dependent care assistance programs, and also providing clarifications regarding recent COVID-related relief for high-deductible health plans (HDHPs). Here are highlights:

Temporary Flexibility for Midyear Elections Under Cafeteria Plans: Under the current cafeteria plan rules, elections by employees/participants regarding qualified benefits under a § 125 cafeteria plan generally must be irrevocable and must be made prior to the first day of the plan year. Midyear changes to such elections are permitted only under certain circumstances, such as a change in status or a significant change in the cost of coverage. § 1.125-4. Recognizing that employees may need to change their elections for additional reasons due to the unanticipated changes posed by COVID-19 public health emergency, and that some employers may have desire to provide assistance in meeting employees' needs with respect to those changes, the IRS, in Notice 2020-29, provides that an employer may amend its cafeteria plan to allow eligible employees to make prospective midyear elections and changes to existing elections during 2020 as follows:

- With respect to employer-sponsored health coverage, an employer may allow an employee to do any of the following:
    - Make a new election, if the employee initially declined to elect employer-sponsored health coverage.
    - Revoke an existing election and make a new election to enroll in different health coverage sponsored by the same employer (including changing from self-only to family coverage).
    - Revoke an existing election, provided that the employee attests in writing that the employee is enrolled, or immediately will enroll, in other "comprehensive" health coverage not sponsored by the employer. The notice

explains the employer must receive a written attestation from the employee and may rely on the attestation unless the employer has actual knowledge the employee is not, or will not be, enrolled in other comprehensive coverage. The notice provides optional model language that can be used for the attestation (Notice 2020-29, p 8).

- With respect to a health FSA or a dependent care FSA, an employer may allow an employee to revoke an election, make a new election, or decrease or increase an existing election.

Whether to allow these changes is at the discretion of the employer, who may choose to adopt all of them, some of them, or none of them. Notice 2020-29 provides that employers may limit the period during which the election changes may be made. Employers are not required to provide unlimited election changes but may, in their discretion, determine the extent to which election changes are permitted provided that the changes do not result in failure to comply with the applicable nondiscrimination rules. For example, the IRS notes that to avoid adverse selection of health coverage, an employer could decide to allow only election changes that would result in improvements in coverage, such as moving from self-only to family coverage or from a low-option plan covering in-network expenses only to a high-option plan covering expenses in or out of network. Additionally, relief may be applied retroactively to periods between January 1, 2020, and the notice's issue date to address plans that permitted election changes before the issue date that otherwise met the notice's requirements.

Temporary Extended Claims Periods for Certain Health and Dependent Care FSAs: Under existing rules, an employee's unused balance remaining in a health FSA or dependent care FSA at the end of the plan year generally must be forfeited by the end of the plan year in which the funds were contributed. However, there are two exceptions to the use-it-or-lose-it rule: (1) for a health FSA only, a plan may permit a carryover (generally limited to $500, but see IRS Notice 2020-33 summarized below) to the next plan year, and (2) for a health FSA or dependent care FSA, a plan may permit a grace period (under which a participant may apply unused amounts to pay expenses incurred during a period of up to 2 months and 15 days into the next plan year). Under current rules, an employer may choose to incorporate either the carryover feature or the grace period, or neither, but not both in the cafeteria plan(s). Notice 2020-29 provides that an employer may elect to amend its plan to permit employees to apply unused amounts in a Health FSA or dependent care FSA at either the end of a grace period ending in 2020 or the end of a plan year ending in 2020 to pay or reimburse medical care expenses and dependent care expenses, respectively, incurred through December 31, 2020. Also, the notice includes some examples to illustrate the relief, in particular to show how it applies to a health FSA that allows carryover. Further, the notice provides that employers should be aware that such extended periods constitute disqualifying coverage for employees enrolled in an HDHP, making such employee ineligible to make contributions to a health savings account during the extended period unless the employee's health FSA is (or is amended to be) a limited purpose FSA, as opposed to a general purpose FSA.

HDHP Relief: Notice 2020-29 explains that the relief in the IRS's previous Notice 2020-15 regarding HDHPs and COVID-19 expenses and the relief enacted in Section 3701 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. 116-136, allowing telehealth and other remote care services to qualify as expenses reimbursable by HDHPs, may be applied retroactively to Jan. 1, 2020.

FSA Carryover Limit: Notice 2020-33 increases the limit for unused health FSA carryover amounts from $500, to a maximum of $550, as adjusted annually for inflation. The notice provides that for an employer that wishes to allow this increased carryover amount, the plan must be amended. In general, this amendment must be adopted on or before the last day of the plan year from which amounts may be carried over and may be effective retroactively to the first day of the plan year, provided the plan operates in accordance with the guidance under the notice and informs all employees eligible to participate in the plan of the carryover provision. However, for 2020, the amendment must be adopted by December 31, 2021.

Individual Coverage HRAs: In Notice 2020-33, the Treasury Department and the IRS also provide a clarification intended "to assist with the implementation of individual coverage health reimbursement arrangements (individual coverage HRAs)", which are HRAs under

which employers may provide contributions for employees to use to purchase coverage in the individual health insurance market or Medicare. The notice explains the general rule that only payment or reimbursement for medical care expenses incurred by an employee during a plan year is excludable from wages and income, and that medical care expenses are generally treated as incurred when a covered individual is provided medical care that gives rise to the expense, not when the amount is billed or paid. However, the notice stated that this raises administrative issues for an individual coverage HRA, to the extent that a participant must pay, prior to the first day of a plan year, all or part of the premium for individual health insurance coverage or Medicare during that plan year. Notice 2020-33 provides that a plan may treat an expense for a premium for health insurance coverage as incurred on (1) the first day of each month of coverage on a pro rata basis, (2) the first day of the period of coverage, or (3) the date the premium is paid. Thus, an individual coverage HRA with a calendar year plan year may immediately reimburse a substantiated premium for health insurance coverage that begins on January 1 of that plan year, even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

Key COBRA Deadlines Extended during the COVID-19 Pandemic: On May 4, the DOL and IRS jointly issued a Federal Register Notice "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak" (Joint Notice) (https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09399.pdf), providing group health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code) and plan participants and beneficiaries additional time to comply with certain deadlines affecting COBRA continuation coverage, special enrollment periods, claims for benefits, appeals of denied claims, and external review of certain claims.

Relief for Plan Participants, Beneficiaries, Qualified Beneficiaries, and Claimants: The Joint Notice requires that "all group health plans, disability and other employee welfare benefit plans, and employee pension benefit plans subject to ERISA or the Code must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or such other date announced by the Agencies in a future notification (the ''Outbreak Period'')" for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates:

a. COBRA Election – The 60-day deadline to elect COBRA continuation coverage;
b. COBRA Premium Payments – The 45-day period to submit COBRA premiums, once COBRA coverage is elected (the initial payment); and 30-day grace period for a COBRA qualified beneficiary to make monthly COBRA premium payments (ongoing payments);
c. COBRA Qualifying Event and Disability Extension Notices – The 60-day deadline by which qualified beneficiaries must notify the plan of certain qualifying events (e.g., divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the plan) or disability determination (The date for individuals to notify the plan of a qualifying event or determination of disability);
d. HIPAA Special Enrollment Period – The 30-day (in some instances, 60-day) deadline to request enrollment in a group health plan following a special enrollment event (i.e., birth, adoption or placement for adoption of a child, marriage, loss of other health coverage, or eligibility for a state premium assistance subsidy);
e. Benefit Claims and Appeals – The date within which an individual may file a benefit claim under the plan's claims procedure; and The date within which a claimant may file an appeal of an adverse benefit determination under the plan's claims procedure;
f. External Review –The date within which a claimant may file a request for an external review after receiving an adverse benefit determination or final internal adverse benefit determination of a claim subject to external review;
g. Perfecting a Request for External Review – The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

The Joint Notice includes a number of examples to illustrate how the relief works using an assumed Outbreak Period starting on March 1, 2020 and ending on June 29, 2020 (60 days after an assumed national emergency end date of April 30, 2020). With regard to COBRA,

one of the listed examples maintains an employee loses group health plan coverage due to a reduction in hours. If the emergency declaration expires as written on June 29, 2020, the Outbreak Period will end on August 28, 2020. For instance, the employee receives a COBRA notice dated April 1, 2020. Normally, the employee would be required to make a COBRA election by May 30, 2020, 60 days after the notice. However, the "Outbreak Period" is disregarded and the employee would have until August 28, 2020 to make their COBRA election and another 45 days (until October 12, 2020) to make their first COBRA premium payment. Along with the Joint Notice, the DOL posted a new set of "COVID-19 FAQ's for Participants and Beneficiaries" (https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf) to help participants impacted by the COVID-19 pandemic understand their rights under ERISA with regard to health and retirement benefits.

Relief for Group Health Plans Sponsors and Plan Administrators: With respect to group health plans, and their sponsors and administrators, the Outbreak Period shall be disregarded when determining the date for providing a COBRA election notice. It means that plan administrators are not required to provide the COBRA election notice during the Outbreak Period. However, a plan does have to provide COBRA coverage if a participant elects it.

Application to Non-Federal Government Plans: The above extensions apply to all plans subject to ERISA and the Internal Revenue Code. However, the Joint Notice states that the U.S. Department of Health and Human Services ("HHS") "concurs" with the relief specified in the Joint Notice and "encourages plan sponsors of non Federal governmental group health plans to provide relief similar to that specified in this document to participants and beneficiaries, and encourages states and health insurance issuers offering coverage in connection with a group health plan to enforce and operate, respectively, in a manner consistent with the relief provided in this document." On May 14, HHS released a memorandum (https://www.cms.gov/files/document/Temporary-Relaxed-Enforcement-Of-Group-Market-Timeframes.pdf) making clear that:

> While the extension of time frames [specified in the Joint Notice] is not mandatory for non-Federal governmental plans, CMS encourages plan sponsors of non-Federal governmental plans to provide relief to participants and beneficiaries similar to that specified in the Joint Federal Register Notice, and encourages, but does not require, states, Small Business Health Options Programs (SHOP) and health insurance issuers offering coverage in connection with a group health plan to enforce and operate, respectively, in a manner consistent with the relief provided in the Joint Federal Register Notice and EBSA Notice 2020-01. CMS will not consider a state to have failed to substantially enforce the applicable provisions of title XXVII of the PHS Act if the state takes such an approach.

Accordingly, non-Federal governmental plans do not have to implement any of the extensions set out in the Joint Notice. This provides sponsors of such plans with flexibility to provide appropriate relief to plan participants while maintaining sound administrative and fiscal control over their plans. To the extent a plan sponsor of a non-Federal governmental plan chooses to adopt one or more of these extended deadlines, plan participants should be notified of applicable relief.

Updated Model COBRA Notices and FAQs Explain Interactions Between Medicare and COBRA

The DOL has recently issued updated model general COBRA notice and COBRA election notice, both in English and Spanish (https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra). These notices are substantially like the prior notices but add information that could be useful to Medicare-eligible employees and their family members who become eligible for COBRA due to a job loss or other qualifying event. The DOL also posted a FAQ (https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-model-notices.pdf) that discusses the interplay between Medicare and COBRA. The revisions are not directly related to the COVID-19 pandemic, but the DOL explains in a news release that it continues in its efforts to inform

workers and help them avoid unnecessary health care costs as they face economic hardship related to the pandemic. Plans are not required to use the DOL model notices, but the FAQs include a reminder that use of the models, if appropriately completed, will be considered good faith compliance with COBRA's notice content requirements. A plan that does not use the model notices needs to ensure that its notices satisfy the content requirements and that the information is presented in a manner calculated to be understood by the average plan participant. Otherwise, failure to use the model notice could be the basis for legal action.

CMS Online Disclosure for 7/1 and 8/1 Renewals

As you may recall, the Centers for Medicare and Medicaid Services require all employers who offer prescription drug plans 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. 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, 7/1/2020 renewals must file online on or before 8/29/2020 and 8/1/2020 renewals must file online on or before 9/29/2020. 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.

Service Contact Guide

The Jefferson Health Plan has updated its contact information to better serve members. If members have any concerns, comments, or suggestions, please email or call based on the service contact guide below:

TOPIC	EMAIL ADDRESS	PHONE
Billing	billing@thejeffersonhealthplan.org	740.792.4010 ext.250
Investment (US Bank/ Audit)	invest@thejeffersonhealthplan.org	740.792.4010 ext.251
Legal and Compliance	legal@thejeffersonhealthplan.org	740.792.4010 ext.252
Ohio Valley Pool	ovp@thejeffersonhealthplan.org	740.792.4010 ext.253
Quotes	quotes@thejeffersonhealthplan.org	740.792.4010 ext.254
Employee w/Questions (Wellness & EAP)	jhpmember@thejeffersonhealthplan.org	740.792.4010 ext.255
Employer w/Questions	jhpemployer@thejeffersonhealthplan.org	740.792.4010 ext.256
Renewals/Election Sheets	renewals@thejeffersonhealthplan.org	740.792.4010 ext.254
Moratoria Requests	moratoria@thejeffersonhealthplan.org	740.792.4010 ext.251
Broker w/Questions	broker@thejeffersonhealthplan.org	740.792.4010 ext.257

Upcoming EAP Webinars

Beacon will offer two new webinars—one for managers and one for employees each month. The webinars offer timely, relevant, and reliable information for everyday living, and provide participants the opportunity to submit questions and receive an individualized response via email. Here's how the webinars work:

- Employees can access the 30-minute webinars through a link on the home page of your Achieve Solutions website at www.achievesolutions.net/jhp.
- Once logged in, every user can view the webinar and submit questions. All questions will be triaged to the appropriate person for a quick and timely individualized response. Clinical questions will be directed to a Beacon Care Manager.

- After one month, the webinar link will be removed from the Achieve Solutions home page, and a new one will take its place. The former webinar will be archived on the Achieve Solutions website.

Upcoming Webinars:

August 4, 2 p.m. ET – Navigating the Teen Years: It is normal for teens to feel sad, irritable, or discouraged. Being a supportive influence on their lives can help.

September 2, 2 p.m. ET – Suicide Prevention: Help prevent and reduce suicide by learning about suicide and being able to identify suicide risk factors and warning signs, and know about suicide prevention/intervention strategies.

September 9, 2 p.m. ET – Suicide Prevention for Managers: Learn the myths and misconceptions about suicide and how to identify suicide risk factors and warning signs.

October 6, 2 p.m. ET – Depression: Learn to recognize the signs and symptoms—and the resources that can help —a depressed person and their loved ones.

October 14, 2 p.m. ET – Renewing Your Human Resources: Learn to recognize the signs and symptoms—and the resources that can help —a depressed person and their loved ones.

Did You Know???

- JHP offers an Infrastructure Loan Program for qualifying members. Contact Account Management for more information
- Over the last 3 years, JHP has helped members save over $129,335,000.00 in taxes and fees including:
  - a tax savings of $20,625,000.00
  - an administrative savings of $99,000,000.00
  - a Rx Rebates saving of $9,710,000.00

Jefferson HEALTH PLAN

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