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COVID-19 Guidance for Health Plans—Putting it All Together

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Agenda: Health and Welfare Plan Topics

- IRS Notice 2020-15 (March 11)
- Families First Coronavirus Response Act (March 18)
- The CARES Act (March 27)
- FAQs about FFCRA and CARES Act Part 42 (April 11)
- Extension of Certain Timeframes—Joint Notice (initially issued April 28, but officially published on May 4)
- EBSA 2020-01 (April 28)
- IRS Notice 2020-29 (May 12)
- IRS Notice 2020-33 (May 12)
- Possible provisions in future legislation (date unknown)

IRS Notice 2020-15 (Issued March 11)

- Provides that a health plan that otherwise satisfies the requirements to be a high deductible health plan (HDHP), will not fail to be an HDHP because the plan provides benefits associated with testing and treatment of COVID-19 without a deductible
- An individual covered by such HDHP will not be disqualified from contributing to an HSA
- No specific time limit in the rule—the Notice just states, "until further guidance is issued"

IRS Notice 2020-15

- This Notice is impacted in a few ways by later guidance
- First, as discussed later, plans are REQUIRED to cover COVID-19 testing at no-cost and prior to the deductible being met
- Second, Notice 2020-29 clarifies that this applies with respect to reimbursement of expenses incurred on and after January 1, 2020

Families First Coronavirus Response Act

- Enacted on March 18, 2020
- Adds a requirement for the Coverage of Diagnostic Testing for COVID-19
- Requires group health plans to provide coverage, and not impose any cost-sharing requirements, prior authorization or other medical management requirements, for the following:
  - #1 – COVID-19 diagnostic testing
  - #2 – Items and services that result in an order for, or administration of, COVID-19 testing (as explained on the next slide)

FFCRA

- Items and services furnished to an individual during:
  - Health care provider office visits (in-person and telehealth);
  - Urgent care center visits; and
  - Emergency room visits

  In each case, that results in an order or administration of the COVID-19 diagnostic testing, but only to the extent that such items and services relate to the furnishing of the COVID-19 diagnostic testing or to the evaluation of such individual for purposes of determining the need for COVID-19 diagnostic testing

FFCRA

- FFCRA does not require that the actual treatment for COVID-19 be covered
- Applies to self-funded plans and fully-insured plans, regardless of whether they are grandfathered
- Excepted benefit group health plans (such as vision-only plans and dental-only plans) and retiree-only health plans are not subject to the new rules
- This requirement became effective on March 18, 2020 and will remain in effect until the Secretary of HHS determines that the public health emergency has expired

The CARES Act

- Enacted on March 27, 2020
- Adds 4 main health plan provisions:
  - Expands on the requirement for the Coverage of Diagnostic Testing for COVID-19
  - Requires rapid coverage of preventive services and vaccines for COVID-19
  - Allows for HDHPs to cover all telemedicine prior to the deductible being met
  - Allows for Health Flexible Spending Accounts (Health FSAs), Heath Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) to reimburse, on a non-taxable basis: (1) over-the-counter (OTC) medicines and drugs and (2) menstrual care products

The CARES Act—Diagnostic Testing

- Expands the requirement for the Coverage of Diagnostic Testing for COVID-19. Must also include tests:
  - for which developers have requested or intend to request emergency use authorization from the FDA, or
  - that have been developed in or authorized by a state, or
  - that are deemed appropriate by HHS
- This is a required provision

The CARES Act—Diagnostic Testing

- Specifies that plans must reimburse health providers of COVID-19 diagnostic tests at:
  - the same rate as previously negotiated before the emergency declaration by HHS; or
  - If no existing negotiated rate with the provider prior to the emergency declaration, the plan must pay the provider's cash price as listed by the provider on a public website (or the parties may negotiate a lower price)
- Basically, this benefit must be covered when provided by in-network providers and out-of-network providers (even if the plan states that it does cover out-of-network providers)

The CARES Act—Preventive Services & Vaccines

- This is the requirement for rapid coverage of preventive services and vaccines for COVID-19
- Requires plans to cover without cost-sharing and before the deductible, any "qualifying coronavirus preventive service"
  - That is defined as an "item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019" that has a rating or A or B in the recommendation of the United States Preventive Services Task Force or is recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention
  - This takes effect 15 days after the date recommendation is made

The CARES Act—Telehealth Services

- Amends Internal Revenue Code ("Code") Section 223 to provide that a plan does not fail to be treated as a HDHP by reason of providing telehealth and other remote care services without imposing any cost-sharing
  - Participants in an HDHP can receive first dollar coverage for telehealth services and still be eligible to contribute to an HSA
- This rule applies for plan years beginning on or before December 31, 2021
- This is a permissive rule—not a requirement
- This is different from IRS Notice 2020-15 because it applies to ALL telehealth services and not just those related to COVID-19

The CARES Act—OTC and Menstrual Care Products

- Allows for participants to use HSA, Health FSA and HRA dollars on the reimbursement of:
  - OTC drugs and medicines without a prescription, and
  - Menstrual care products
- For Health FSAs and an HRAs, this is effective for expenses incurred after December 31, 2019
- This is a permissive change
- In addition, this is a permanent change

FAQS Part 42—FFCRA and CARES Act Implementation

- This FAQ was jointly issued by the Department of Labor (DOL), Health and Human Services (HHS) and the Department of Treasury (Treasury) (collectively, the Departments) on April 11, 2020
- The focus of the FAQ is on the implementation of the FFCRA and the CARES Act
- We will provide an explanation of certain highlights of the FAQ

FAQ 42—FFCRA and CARES Act Implementation

- Coverage of Diagnostic Testing for COVID-19
  - Makes it clear that the "related services" will be covered with no cost-sharing, only if those related services ultimately lead to the administration of a diagnostic test for COVID-19
- This raises a few issues to consider:
  - (1) carefully draft the plan amendment about this provision so it is clear what is covered at no-cost
  - (2) explain this to participants – a participant could go through a battery of tests and the provider determines a COVID-19 test is not necessary, leaving the participant with unanticipated costs

FAQ 42—FFCRA and CARES Act Implementation

- Coverage of Diagnostic Testing for COVID-19
  - Does not answer what types of related services are covered, but defers to the guidance of the Centers for Disease Control and Prevention (CDC) which delegates this decision-making to the individual medical providers
  - Requires coverage of serological tests used to detect the antibodies against SARS-CoV-2 without cost sharing (even though the FDA does not believe that serological tests should be used as the sole basis for diagnosing COVID-19)

FAQ 42—FFCRA and CARES Act Implementation

- Generally, when a plan modifies any of terms of coverage that would impact the content of the Summary of Benefits and Coverage (SBC) and that modification is effective mid-year, the plan must provide notice of the modification to enrollees no later than 60 days PRIOR to the date on which the modification is effective
- The Departments state that they will not take any enforcement action against a plan related to plan modifications to provide GREATER coverage related to the diagnosis and treatment of COVID-19, without providing the 60 days advance notice
- The Departments take the same position for plans that are amended to reduce or eliminate cost-sharing for telehealth services
- HOWEVER, plans "must provide notice of the changes as soon as reasonable practicable"

FAQ 42—FFCRA and the CARES Act Implementation

- For an EAP that otherwise meets the requirements for an excepted benefit for the market reform rules for the Affordable Care Act (ACA), adding benefits for the diagnosis and testing for COVID-19 during this emergency period will not cause the EAP to lose its status as an excepted benefit
- The FAQ does not address the impact of providing diagnosis and testing for COVID-19 to contractors (non-employees)
  - Will need to consider if that creates MEWA issues (and the impact of that) and the tax impact to those contractors (i.e., if the company pays for the cost of those services, is that taxable to the contractors)

Extension of Certain Timeframes—Joint Notice

- Initially released on April 28, 2020 and published in the federal register on May 4, 2020
- The Joint Notice provides that when determining certain ERISA group health plan, disability and employee welfare benefit plan deadlines, the duration of the "Outbreak Period" must be disregarded
  - The Joint Notice also applies to retirement plans subject to ERISA for certain deadlines
  - This webinar does not address issues related to plans other than ERISA group health plans (such as disability plans, group-term life insurance plans, etc…)

Extension of Certain Timeframes—Joint Notice

- The Outbreak Period is the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency
  - The National Emergency means the President's issuance on March 13, 2020 of the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak
- The end of the National Emergency Period has not yet been announced

Extension of Certain Timeframes—Joint Notice

- All group health plans must disregard the Outbreak Period in determining the following periods and dates:
  - The 30-day (or 60-day period, if applicable) to enroll based on a HIPAA special enrollment right
  - The 60-day election period for COBRA coverage
  - The date for making COBRA premium payments
  - The date for individuals to notify the plan of certain COBRA qualifying events (e.g., divorce or legal separation, a dependent child ceasing to be a dependent) or a disability determination
  - The date to file a claim
  - The date to file an appeal
  - The period for a claimant to file a request for external review
  - The period for a claimant to perfect an incomplete request for external review

Extension of Certain Timeframes—Joint Notice

- In addition, with respect to group health plans, the Outbreak Period will be disregarded when determining the deadline for the plan to provide a COBRA election notice
- We will explain some of the issues that will arise under these rules and possible ways to address those issues
- In this webinar, we will not provide examples or discuss each of the events listed in the Joint Notice

Joint Notice—HIPAA Special Enrollment Period

- Employees have a 30-day period to request enrollment in a health plan upon experiencing one of the following events:
  - Loss of eligibility for health insurance (not due to the failure to pay premiums) in which employee (or employee's dependent) were previously enrolled
  - Acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption
- Employees have a 60-day period to request enrollment in a health plan upon experiencing one of the following events:
  - Loss of Medicaid/CHIP eligibility
  - Becoming eligible for a state premium assistance subsidy under Medicaid/CHIP

Joint Notice—HIPAA Special Enrollment

- For the examples, assume that the announced end of the National Emergency is August 1, 2020. The Outbreak Period ends 60 days later, which is September 30, 2020
- Example #1—Employee gives birth on April 1, 2020. Normally, she would have until May 1, 2020 to enroll. In this example, the employee would have until October 30, 2020 (which is 30 days after the end of the Outbreak Period) to enroll and coverage would go back to the date of birth
- Example #2—Employee gives birth on February 5, 2020. Normally, she would have until March 6, 2020 to enroll. In this example, she would have until October 6, 2020 to enroll and coverage would go back to date of birth
  - The first 24 days of the 30-day period to elect coverage was used up before the Outbreak Period began, so there are only 6 days left after the Outbreak Period ends

Joint Notice—HIPAA Special Enrollment

- Assume announced end of the National Emergency is August 1, 2020 & Outbreak Period ends September 30, 2020
- Example #3. Employee gets married on April 15, 2020. Normally, she would have until May 15, 2020 to enroll. In this example, the employee would have until October 30, 2020 (which is 30 days after the end of the Outbreak Period) to enroll
  - Assume that she enrolls on October 15, 2020. Coverage would start on November 1, 2020
  - The HIPAA special enrollment right rules does not require that coverage go back to the date of the event, rather those rules state, "In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance coverage under the plan) receives the request for special enrollment"

Joint Notice—HIPAA Special Enrollment

- Note that this is limited to HIPAA Special Enrollment Rights
- This rule does not require that the enrollment deadlines for other events be disregarded—such as the deadline for new hire to enroll in a plan
- This distinction is important for several reasons:
  - These retroactive HIPAA special enrollment elections can be paid with pre-tax dollars
  - Insurance carriers, HMOs and stop loss carriers must comply with these required HIPAA special enrollment elections

Joint Notice—COBRA Election Period

- Under COBRA, employees and dependents who lose coverage as an result of a qualifying event (such as a termination of employment), have 60 days (starting on the later of the date the person is furnished the COBRA election notice or the date the person would lose coverage) to elect COBRA coverage
- Assumptions for Example – Assume announced end of the National Emergency is August 1, 2020 & Outbreak Period ends September 30, 2020
- Example #1—Employee is terminated from employment on May 15, 2020 and loses coverage on May 30, 2020. He is provided with a COBRA notice on June 1, 2020. He has until November 29, 2020 to elect coverage (which is 60 days after the end of the Outbreak Period)

Joint Notice—COBRA Election Period

- Example #2—Employee is terminated from employment on January 15, 2020 and loses coverage on January 31, 2020. He is provided with a COBRA notice on February 1, 2020. He has until November 1, 2020 to elect coverage (which is 32 days after the end of the Outbreak Period)
  - The first 28 days of the 60 day election period was used up before the Outbreak Period began. So, there are 32 days left after the Outbreak Period ends to elect COBRA coverage

Joint Notice—COBRA Premium Payment Date

- Under COBRA, qualified beneficiaries have 45 days from the COBRA election to make the first premium payment and subsequent monthly payments must be made by the end of the 30-day grace period that starts at the beginning of each month
- Assumptions for Example – Assume announced end of the National Emergency is August 1, 2020 & Outbreak Period ends September 30, 2020
- Example #1—Employee is terminated from employment on May 15, 2020 and loses coverage on May 30, 2020. He is provided with a COBRA notice on June 1, 2020 and elects it that same day. He has until November 14, 2020 to make his initial premium payment (which is 45 days after the end of the Outbreak Period)
  - The premium payment will be for 5 months of coverage (June, July, August, September and October)

Joint Notice—COBRA Coverage

- What happens to COBRA coverage during these time periods in which the person has the right the elect COBRA? Or has elected COBRA, but not made a premium payment?
- We believe that the health plan has several options, including that:
  - (1) it may continue coverage during the election or payment period and then retroactively cancel coverage if either the COBRA election or premium payment is not timely made; or
  - (2) it may cancel coverage as of the date that it would otherwise be lost due to the qualifying event and retroactively reinstate it (as COBRA coverage) upon a timely election and payment for COBRA coverage. (Treas. Reg. § 54.4980B-6, Q/A-3(b))

Joint Notice—COBRA Coverage

- What happens if a provider calls the health plan to inquire about the status of a person's COBRA coverage?
- The IRS regulations require that plans must be transparent with providers regarding the status of the coverage – that means that if the former employee still has time to elect and/or pay for COBRA and during that time period the provider calls the plan, the plan must inform the provider either: (a) the individual is covered, but the coverage is subject to retroactive termination, or (b) the individual currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA is elected and premiums paid (26 CFR § 54.4980B-6, Q/A-3)
- The regulations impose the disclosure obligation on "the plan," without designating who is to act on behalf of the plan. How will the plan comply?

Joint Notice—COBRA Coverage

- A practical solution is for the employer to identify who should respond to inquiries by health care providers, and make sure that all such inquiries are addressed to and answered by that entity only. This is likely to be the COBRA administrator
- To implement this solution, the employer should send a letter to the self-funded TPAs and insurers/HMOs that states that if a provider calls to ask about the status of a person's COBRA coverage, they must redirect that call to the employer's COBRA administrator. The COBRA administrator must then provide full disclosure to the provider (as described in previous slide)
- If that is strategy is implemented, we think it is reasonable for the COBRA administrator to wait to inform the carriers about the status of a person's COBRA coverage until coverage has been elected and the first payment has been made

Joint Notice—Dates to File Claims/Appeal

- The ERISA claims and appeal regulations have specific time periods to file appeals, which are adopted by plans.
- The rules do not provide a time period to file a claim—but plans have adopted deadlines for the time period to file an initial claim
- Assumptions for Examples – Assume announced end of the National Emergency is August 1, 2020 & Outbreak Period ends September 30, 2020

Joint Notice—Date to File a Claim

- Example #1 (Filing a Claim)—The health plan requires benefit claims to be submitted within 365 days of receiving the service/treatment. Employee receives treatment on April 1, 2020 and submits the claim on June 1, 2021. This is still timely because the plan must not count the Outbreak Period
- Most HRAs and Health FSAs have a deadline to file a claim that is shortly after the end of the 12-month coverage period. Those deadlines will be extended
  - Remember to review the claims deadline in retiree-only HRAs—those plans are subject to these rules!

Joint Notice—Date to File a Claim

- Example #2 (Filing a Claim)—The employee is a participant in a Health FSA that is a calendar year plan. For claims incurred in 2019, the plan states that claim must be filed by March 31, 2020. Sophia is a participant in the Health FSA. She has until October 30, 2020 to file her 2019 Health FSA claim.
  - She had 30 days left to file her claim before the Outbreak Period ended—from March 1 to March 31. The plan cannot consider those days because they are during the Outbreak Period. She has 30 days left at the end of Outbreak Period to file her claim

Joint Notice—Date to File Claims/Appeals

- Example #3 (Filing an Appeal)—Employee received a claim denial letter on March 1, 2020. Generally, the employee would have 180 days to file an appeal. That 180-day time limitation does not start until October 1, 2020 (after the end of the Outbreak Period)
- These rules do not apply to plans not covered by ERISA—such as a dependent care flexible spending account (FSA) plan
- We believe that the dependent care FSA could be amended now to match the extended claim filing deadline that must apply to health care FSA

Joint Notice—Disclosure Requirements—COBRA

- The Joint Notice does not specifically address disclosure requirements
- The DOL has stated, informally, that the COBRA initial notice and election forms do not need to be changed, so long as an SMM is delivered to everyone that explains the new rules
- The DOL also stated, informally, that for the notice of early termination of COBRA coverage, those notices should be updated for the new extension of timeframes rule. This can either be done by updating the current notices used by administrators or adding a cover sheet to those notices that explains the new extension of timeframes rule

Joint Notice—Disclosure Requirements—COBRA

- We had come to a similar conclusion as the DOL informal guidance based on: (1) the language in the current COBRA regulations about the contents of the early termination notice and (2) the general fiduciary duties of the ERISA plan administrator
- The current COBRA regulations state that the termination of coverage notice must contain, among other things, information about, "Any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right." (DOL Reg. Section 2590.606-4(d)(2))
- The point of the regulation is that the person must be notified of other ways to get coverage "under the plan or under applicable law" and we believe that would include that the individual still has time to pay for the coverage because the "Outbreak Period" is disregarded

Joint Notice—Disclosure Requirements—In General

- We also think that information about these rules should be included in an SMM sent to employees & participants in order to protect against a future lawsuit
- ERISA's fiduciary obligations require the fiduciary to deal honestly with participants and to convey accurate information that is material to a participant's circumstance. See *Farr v. U.S. W. Commc'ns, Inc.*, 151 F.3d 908, 915 (9th Cir. 1998)
- We also note that recently there has been an increase in litigation over COBRA (with many lawsuits involving an alleged lack of adequate notice), and we anticipate that this trend will only increase in the wake of COVID-19

Joint Notice—Other Considerations

- As stated earlier, there are not deadlines to file claim or appeals during the Outbreak Period
- Plan administrators will need to create a process to flag past denials impacted by the Joint Notice that were based on the failure to timely file a claim or appeal—send a supplementary letter to explain the extended deadline
- For denial letters going forward, explain the deadline extensions—this could be done as an addendum to letters
- Confirm that all of the plan administrators understand these rules and the implications of these rules—and document all communications about the Joint Notice obligations
- Note that the timeframes for plans to adjudicate claims and appeals have not been impacted by these rules

EBSA Disaster Relief Notice 2020-01

- Released April 28, 2020
- In this Notice, the DOL provides extended deadlines (and relaxed electronic disclosure requirements) for furnishing certain notices, disclosures and other documents required under Title I of ERISA
- Notice 2020-01 specifically addresses notices and disclosures required under Title I of ERISA over which the DOL has interpretive and regulatory authority, except for those notices and disclosures addressed in the Joint Notice (such as the COBRA election notice)

EBSA Disaster Relief Notice 2020-01

- An employee benefit plan will not be in violation of ERISA if it fails to timely furnish a notice, disclosure or document that originally was required to be furnished between March 1, 2020 and 60 days after the announced end of the National Emergency
- The plan must act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances
- The plan fiduciary will have acted in "good faith" if it distributes the required ERISA notice/document electronically, provided that the plan fiduciary reasonably believes that the participant has effective access to "electronic means of communication"

EBSA Disaster Relief Notice 2020-01

- This extended deadline (and relaxed electronic disclosure standard) will impact the distribution deadlines for a broad range of plan participant notices and disclosures, such notices as the Summary of Material Modifications and Summary Plan Descriptions
- Remember that it does not apply to the documents referenced in the Joint Notice
  - For example, the COBRA election notice should be mailed and not sent via email
- But it will apply to the SMMs that the plan must send to inform participants of the changes required due to the FFCRA and the CARES Act

EBSA Disaster Relief Notice 2020-01

- The DOL states that participants may face problems due to the COVID-19 outbreak and plans must act "reasonably, prudently, and in the interest of covered workers and their families who rely…on their employee benefits for their physical and economic wellbeing." The Notice instructs plan fiduciaries to make reasonable accommodations to prevent the loss of benefits if a plan participant fails to comply with pre-established timeframes
- The DOL also acknowledges that during this Outbreak Period, there may be times when plans may not be able to achieve full and timely compliance with claims processing and other requirements. During this period, the DOL's approach to enforcement will be to emphasize compliance assistance, where appropriate
  - It is unclear what would happen in a lawsuit—if the court would be as generous

EBSA Disaster Relief Notice 2020-01

- The Notice also discusses the limited extension that has been granted for filing Forms 5500
- Forms 5500 that would otherwise be due on or after April 1st and before July 15, 2020 are now due July 15, 2020. This extension applies to Form 5500 filings for plan years that ended in September, October, or November of 2019. This relief is automatic, and plan sponsors are not required to file an extension form, letter or other request
- The 2019 Form 5500 filing due date for calendar year plans (i.e., July 31, 2020) has not been extended. However, calendar year plans may obtain a regular extension by timely filing a Form 5558

IRS Notice 2020-29—Permitted Election Changes

- The Notice permits an employer to amend a Section 125 cafeteria plan to allow employees to make certain prospective election changes
  - The key is that these are permissive changes and prospective only
- The changes must not result in a failure to comply with the nondiscrimination rules of Code Section 125
  - Example—the election change cannot just be offered to highly compensated individuals
- To prevent adverse selection, an employer can limit election to circumstances in which an employee's coverage will be increased or improved as a result of an election
- With respect to "health FSA and dependent care assistance programs, employers are permitted to limit mid-year elections to amounts no less than amounts already reimbursed"

IRS Notice 2020-29—Permitted Election Changes

- #1—Make a new election for employer-sponsored health coverage on a prospective basis, if the employee initially declined to elect employer-sponsored health coverage
  - The IRS has stated, on an informal basis, that this applies to vision and dental plans also
  - If an employer wants to offer this, it should ensure that the insurance carrier/HMO (if applicable) or a stop loss carrier (if applicable) would permit this
  - Can create an election rule that these newly enrolled people can only elect coverage in a particular benefit options (such as the HDHP, but not the HMO)

IRS Notice 2020-29—Permitted Election Changes

(#1 continued)

- The Notice states that relief may be applied retroactively to prior periods in 2020 to address a cafeteria plan that, prior to the issuance of the Notice, permitted mid-year election changes
- This is good news for employers that allowed employees to enroll mid-year and had them pay the premiums on a post-tax basis (since there was no mid-year enrollment right that would permit a pre-tax election)
- Employers can now go back and make those elections be on a pre-tax basis

IRS Notice 2020-29—Permitted Election Changes

- #2 – Revoke an existing election for employer-sponsored health coverage and make a new election to enroll in different health coverage sponsored by the same employer on a prospective basis (including changing enrollment from self-only to family coverage)
  - Does this mean that employees who elect a different health plan option can—as part of that election—drop a dependent from coverage?
  - Informally we have been told any dropping of coverage requires an attestation by that person that they are getting other coverage
  - Can create an election rule that these newly enrolled people can only elect coverage in a particular benefit options (such as the HDHP, but not the HMO)

IRS Notice 2020-29—Permitted Election Changes

(#2 continued)

- If an employer decides to allow employee participants to add dependents, then under the COBRA regulations, the COBRA participants must also be offered this choice
- "If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members." Treas. Reg 54.4980B-5, Q&A-4(b)

IRS Notice 2020-29—Permitted Election Changes

- #3 – Revoke an existing election for employer-sponsored health coverage on a prospective basis, provided that the employee attests in writing that the employee is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer
  - The Notice provides a sample attestation form and states that the employer may rely on the written attestation unless the employer has actual knowledge that the employee is not, or will not be, enrolled in other health coverage not sponsored by the employer
  - So far, we have not seen employers allowing this election

IRS Notice 2020-29—Permitted Election Changes

- #4 – Revoke an election, make a new election, or decrease or increase an existing election regarding a health FSA on a prospective basis
  - No refunds are permitted! All changes must be on a prospective basis, including the revocation of an election
  - The Notice allows the employer to limit the elections of participants in order for it to protect against large losses
    - This is generally not how a health FSA would work. However, the IRS permits the employer to protect itself because these election changes are not the types of changes that would normally be allowed

IRS Notice 2020-29—Permitted Election Changes

(#4 continued)

- Example (TH Created/Not in Notice): The employee elected $2,000 and as of June, he has deferred $1,000. He does not want to defer any more money into the health FSA because he has not incurred any claims this year. The employer can limit the employee's election choice to:
  - $2,000 for the period from January to June of 2020. Zero coverage after that date
  - $1,000 for the period from January to June. Zero coverage after that date
  - $1,000 for the entire year (no additional money is deferred into the plan after June)
- Assume that the employee has already incurred claims of $1,200
  - Permit the employee to drop coverage to $1,200 (nothing below the amount that he has already been reimbursed)

IRS Notice 2020-29—Permitted Election Changes

- #5 – Revoke an election, make a new election, or decrease an existing election regarding a dependent care assistance program on a prospective basis
  - Again, no refunds permitted!
  - All changes must be made on a prospective basis

IRS Notice 2020-29—Extended Claims Period

- An employer, in its discretion, may amend its cafeteria plan, to permit employees to apply unused amounts remaining in a health FSA or dependent care assistance program as of the end a grace period ending in 2020 or a plan year ending in 2020, to pay or reimburse expenses incurred through December 31, 2020
  - This applies to: (1) fiscal year plans that end in 2020 and (2) 2019 plan grace periods that end in 2020
  - This does not apply to a calendar year plan that does not have a grace period

IRS Notice 2020-29—Extended Claims Period

- Example: The health FSA has a calendar year plan and the 2019 plan provides for a grace period ending on March 15, 2020. The employer may amend the plan to permit employees to apply unused amounts remaining in the employee's health FSA as of March 15, 2020, to reimburse the employee for medical care expenses incurred through December 31, 2020
  - Remember that a grace period is different from a run-out period
  - Remember that the Joint Notice required plans to suspend the deadline for submitting claims until the end of the Outbreak Period. The Joint Notice is about the time period to submit claims – Notice 2020-29 is about the time period to incur claims

IRS Notice 2020-29—Plan Amendments

- If the employer decides to amend its plan for any of these changes, it must adopt a plan amendment. An amendment for the 2020 plan year for any of these permissive changes must be adopted on or before December 31, 2021
  - This Notice permits the amendment to be effective retroactively, which is generally NOT permitted under the 125 plan regulations
- Note that the permitted election changes must be communicated timely to everyone so that they are aware of the ability to make the permitted changes
  - Without this timely communication: (1) it seems unlikely that the nondiscrimination rules would be satisfied and (2) the employer runs the risk of an employee later bringing a lawsuit claiming he did not elect coverage because he was not aware of the ability to do so

IRS Notice 2020-29—HDHPs

- Provides that Notice 2020-15, which provided that HDHPs may cover COVID-19 testing and treatment prior to the satisfaction of the deductible, applies with respect to reimbursements of expenses incurred on or after January 1, 2020
- It also clarifies what is included in testing and treatment for COVID-19 for purposes of Notice 2020-15. It includes the panel of diagnostic testing for influenza A&B, norovirus and other coronaviruses, and respiratory syncytial (RSV) and any other items required to be covered to be covered with zero cost-sharing under the FFCRA and the CARES Act

IRS Notice 2020-29—HDHPs

- The CARES Act allows an HDHP to provide coverage for telehealth and other remote care services, prior to the deductible being met. It applies for plan years that begin on or before December 31, 2021. Notice 2020-29 states that this provision applies retroactively to services provided on or after January 1, 2020
  - This was a needed clarification because the CARES Act was passed on March 27, 2020 and it was unclear if this change could be applied back to January 1, 2020.

IRS Notice 2020-33—Health FSA Carryover

- Background: Since 2013, the IRS has permitted health FSAs to offer a $500 carryover provision
  - This is an optional provision
  - The plan that has a carryover provision cannot also have a grace period—the plan must choose between the carryover and the grace period for the health FSA
  - The carryover provision is not permitted for a dependent care assistance plan

IRS Notice 2020-33—Health FSA Carryover

- New Rule: The Notice increases the maximum $500 carryover amount for a plan year to an amount equal to 20% of the maximum health FSA salary reduction contribution for that plan year. This amount is set under Code Section 125(i) (at $2,500), which is indexed for inflation (for 2020, is $2,750)
- Accordingly, the maximum unused amount from a plan year starting in 2020 allowed to be carried over to the immediately following plan year beginning in 2021 is $550 (20% of $2,750)

IRS Notice 2020-33—Health FSA Carryover

- New Rule (continued): An employer that wants to adopt this increased carryover amount, must amend the plan.
- This amendment must be adopted on or before the last day of the plan year from which amounts may be carried over, provided the plan 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
- This guidance is not time limited or related to COVID-19

Other Potential Future Legislation?

- The House passed their "phase four" COVID-19 legislative proposal. The $3 trillion Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (HR 6800) includes some provisions related to employer group health plans, such as:
  - providing a 100% subsidy for the cost of COBRA premiums through January of 2021; and
  - requiring coverage of items and services related to the treatment of COVID-19 and waives cost-sharing requirements
- The bill is not expected to pass the Senate in its current form because it is not supported by many of the Senate Republicans. In addition, the President said he would veto it
- However, we think any future bill will likely include the two provisions listed above

Summary – Required or Permissive?

- The following table summarizes some of the highlights covered during this webinar and lists certain plan changes that must or may be made as a result of recent federal legislation and guidance issued in response to the COVID-19 pandemic and national emergency. The table identifies whether the relevant change is required or permissive, the applicable effective dates, and notes some additional considerations (which are intended to be high-level, rather than exhaustive).

Summary – Required or Permissive?

Plan Changes	Required / Permissive	Effective Date	Expiration	Additional Considerations
COVID-19 Diagnostic Testing & Related Items and Services (In-Network and Out-of-Network)	Required	March 18, 2020	End of Emergency Period	• This requirement applies to both grandfathered and non-grandfathered group health plans, including HDHPs. Excepted benefit group health plans and retiree-only plans are not subject to this requirement. • Related items and services need only be covered if they ultimately lead to the administration of a COVID-19 diagnostic test.
Coverage of COVID-19 Treatment by HDHPs	Permissive	January 1, 2020	Until further guidance is issued	For expenses incurred on or after January 1, 2020 and until further guidance is issued, under Notice 2020-15, HDHPs may provide COVID-19 treatment (including telehealth services) prior to the deductible being met.
COVID-19 Preventive Services & Vaccines	Required	March 27, 2020	n/a (permanent change)	The CARES Act requires group health plans to cover, without cost-sharing, and before the deductible, any "qualifying coronavirus preventive service."
Coverage of Telehealth and Remote Care Services without Cost-Sharing	Permissive	Services provided on or after January 1, 2020	End of applicable plan year which began on or before December 31, 2020	The CARES Act permits HDHPs to cover all telemedicine services (whether or not they apply to COVID-19) prior to the deductible being met.
Coverage of Over-the-Counter (OTC) Medicines and Drugs and Menstrual Products under Health FSAs and HRAs	Permissive	Claims incurred on or after January 1, 2020	n/a (permanent change)	The CARES Act provides that OTC medicines and drugs may be reimbursed by HSAs, Health FSAs and HRAs, without a prescription. Menstrual products may be reimbursed by these account-based plans as well.

Summary – Required or Permissive?

Plan Changes	Required / Permissive	Effective Date	Expiration	Additional Considerations
Extension of HIPAA Special Enrollment Deadlines	Required	March 1, 2020	End of the "Outbreak Period" (60 days following the announced end of the National Emergency)	The Outbreak Period must be disregarded for the purposes of determining the timeframe in which an employee may request enrollment in a health plan upon experiencing a HIPAA special enrollment event.
Extension of Claims and Appeals Deadlines	Required	March 1, 2020	End of the Outbreak Period	The Outbreak Period must be disregarded for the purposes of determining the timeframe in which participants must submit a claim or appeal.
Extension of Deadlines to File a Request for External Review / Perfect an Incomplete Request for External Review	Required	March 1, 2020	End of the Outbreak Period	The Outbreak Period must be disregarded for the purposes of determining the deadline by which an individual may request external review or perfect a request for an external review.
Extension of COBRA Election and Premium Payment Deadlines	Required	March 1, 2020	End of the Outbreak Period	The Outbreak Period must be disregarded for the purposes of determining the deadline by which an individual may make a COBRA election and pay the premiums.
Extension of Period to Provide Notification of a COBRA Qualifying Event or a Disability Determination	Required	March 1, 2020	End of the Outbreak Period	The Outbreak Period must be disregarded for the purposes of determining the deadline by which an individual must provide notice of a COBRA qualifying event (divorce or dependent ceasing to be a dependent child) or disability determination from the Social Security Administration.

Summary – Required or Permissive?

Plan Changes	Required / Permissive	Effective Date	Expiration	Additional Considerations
Mid-Year Change in Status Elections	Permissive	Prospective (from the date of an amendment)	December 31, 2020	Employers may allow eligible employees to: (1) make a mid-year election in 2020 for employer-sponsored coverage, on a prospective basis, if the employee initially declined such election; (2) make a mid-year election in 2020 to revoke an existing election under employer-sponsored health coverage and make a new election to enroll in different health coverage sponsored by the same employer on a prospective basis; (3) make a mid-year election in 2020 to revoke an existing election for employer-sponsored health coverage on a prospective basis, provided the employee attests in writing that other coverage will be secured; (4) make a mid-year election in 2020 to revoke an election, make a new election, or decrease/increase an existing election applicable to a health FSA on a prospective basis; and (5) make a mid-year election in 2020 to revoke an election, make a new election, or decrease/increase an existing election regarding DCAPs on a prospective basis. Employers can choose amongst these options. In addition, employers can elect to amend Health FSAs to: (i) permit unused amounts remaining in a participant's account as of the end of a grace period that ends in 2020 to be used through December 31, 2020; or (ii) increase the carryover amount (up to $550) to be used in the 2021 plan year.
Extended Deadline for Furnishing Certain Notices, Disclosures and Other Documents Required under Title I of ERISA	Permissive	March 1, 2020	60 days after the National Emergency Ends	The plan must act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances. Relates to notices for which the DOL has jurisdiction, other than the notices and communications addressed in the Joint Guidance (related to certain extensions of plan-related deadlines, such as the COBRA Election Notice).

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