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Outbreak Extension Period — When Does It End?

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MARCH 2021

On February 26, 2021, the Department of Labor (DOL) issued Employee Benefits Security Administration (EBSA) Disaster Relief Notice 2021-01 ("2021 Relief Notice")[1], which explains how employee benefit plans must administer the end date of the tolling period for certain plan deadlines due to the COVID-19 national emergency that began on March 1, 2020 (the "National Emergency Period"). As the tolling period cannot exceed one year under ERISA Section 518 and Internal Code Section 7508A(b), there had been an open question as to what would happen with regard to the tolling period on February 28, 2021 (i.e., one year after March 1, 2020). The 2021 Relief Notice provides an answer, albeit a complicated one that is different for each plan — and each impacted individual — because the expiration of the one-year tolling period must be applied on an individual-by-individual basis, as explained below.

Prior Guidance

In 2020, the DOL, Department of Treasury and the Internal Revenue Service (IRS) (collectively, the "Agencies") issued a joint notice ("Joint Notice") that requires ERISA-covered plans to disregard the period beginning March 1, 2020 and ending 60 days after the National Emergency Period terminates (the "Outbreak Period") in determining deadlines for: (1) HIPAA special enrollment; (2) COBRA 60-day election period; (3) COBRA premium payments (both initial

and ongoing); (4) Notification to the Plan by an individual of a qualifying event or determination of disability under COBRA; (5) Filing a claim for benefits; (6) Filing an appeal of an adverse benefit determination; (7) Requesting external review of a final adverse benefit determination by a health plan; and (8) Filing information to perfect a request for external review. The Joint Notice also contained limited relief for group health plans in that it permitted them to disregard the Outbreak Period when determining the date that a group health plan must provide a COBRA Election notice to a qualified beneficiary. Further relief for benefit plans was contained in last year's Employee Benefits Security Administration (EBSA) Disaster Relief Notice 2020-01 ("Notice 2020-01") which grants delays and other relief to welfare plans and retirement plans related to notices, disclosures, and documents due under ERISA Title I during the Outbreak Period.

As noted above, the statutory authority that the Agencies relied on for the Joint Notice and Notice 2020-01 stated that for a plan affected by a Presidentially declared disaster, the Agencies could prescribe a period of up to one year that may be disregarded in determining the date by which action is required. The disregarded period started on March 1, 2020.[2]

The One-Year Tolling Period

The 2021 Relief Notice provides that the one-year tolling period will be applied on an individual-by-individual basis. Specifically, the tolling period ends on the ***earlier*** of:

(1) one year from the date the individual was first eligible for relief, or

(2) 60 days from the end of the National Emergency Period (i.e., the end of the Outbreak Period).

To better understand this concept, we have provided examples below.

Examples from the Notice

The first 2 examples below are from the 2021 Relief Notice.

Example #1 — Assume that a COBRA qualified beneficiary (QB) would have been required to make a COBRA election by March 1, 2020. The Joint Notice delays that requirement until February 28, 2021, which is the earlier of one year from March 1, 2020 or the end of the Outbreak Period (which remains ongoing). Note: This means that the tolling period ends on February 28, 2021, and the QB has until March 1, 2021 to make the election.

Note that in this example, we are told that the QB's last day to make a COBRA election was March 1, 2020 — the first day of the tolling period under the Joint Notice. The general COBRA election rule is that COBRA must be elected 60 days after the date that the health plan coverage is lost or, if later, 60 days after the date of the election notice. In this example #1, it is assumed that on March 1, 2020, the QB was on the last day of that 60-day period — this matters because there is no additional time period to add at the end of the one-year tolling period.

Example #2 — Assume that a QB would have been required to make a COBRA election by March 1, 2021. The Joint Notice delays that election requirement until the *earlier* of one year from that date (March 1, 2022) or the end of the Outbreak Period.

Additional Examples

Below are additional examples which we have created (and which are not from the 2021 Relief Notice).

Additional COBRA Example

Below we explain what happens if part of the QB's election period elapsed prior to March 1, 2020.

Example #3 — Assume that the QB's 60-day COBRA election period began on February 1, 2020. Without the Joint Notice, the QB's COBRA election deadline was April 1, 2020. However, under the Joint Notice, the QB's election period began to toll on March 1, 2020 — when the QB still had an additional 31 days to make the COBRA election. In this example, the COBRA election deadline started to toll on March 1, 2020 and the tolling ends one year later on February 28, 2021. However, the QB was only 29 days into his/her COBRA election period at the time the tolling began. The remaining 31-day period starts to run again after the one-year tolling period ends, which means the deadline to elect COBRA for this QB is April 1, 2021.

Note that the plan administrator could also have come to the April 1, 2021 date by determining that without the tolling period, the QB's COBRA election period should have ended on April 1, 2020. When one year is added to the "original" last day to take action (April 1, 2020), the new COBRA election period ends on April 1, 2021. This appears to be a simpler method for making this calculation.

Special Enrollment Example

Example #4 — Assume an employee had a new baby on September 1, 2020. Per the terms of the health plan, the employee must enroll the child within 60 days of the date of birth, which is October 31, 2020.

The entire one-year period is tolled, from September 1, 2020 to August 31, 2021. The employee has 60 days from the end of the one-year tolling period to elect coverage for the baby — October 31, 2021. (This example assumes that the Outbreak Period has not ended at an earlier date.)

Again, note that the plan administrator could come to the October 31, 2021 date by determining that without the tolling period, the employee's last day to elect coverage for the baby should have ended on October 31, 2020. When one year is added to that "original" last day to take action (October 31, 2020), the new election deadline is October 31, 2021.

However, assume that the National Emergency ends on May 1, 2021 so that the Outbreak Period ends sixty days later on June 30, 2021. In that case, the employee would have 60 days after July 1, 2021 to elect coverage for the newborn child (because the 60 days to make the election does not start running until July 1, 2021).

Health Flexible Spending Account Plan Claim Examples

Example #5 — Assume that a Healthcare Flexible Spending Account Plan ("Health FSA") has a calendar plan year and that the run-out period for the 2019 plan year ends on March 31, 2020 (i.e., an initial claim for the 2019 plan year must be filed no later than March 31, 2020). Under the 2021 Relief Notice, the deadline to file an initial claim for the 2019 plan year is March 31, 2021 (i.e., one year from March 31, 2020).

Example #6 — Assume that a Health FSA has a calendar plan year and that the run-out period for the 2020 plan year ends on March 31, 2021 (i.e., an initial claim for the 2020 plan year must be filed no later than March 31, 2021). Under the 2021 Relief Notice, the deadline to file an initial claim for the 2020 plan year is the earlier of March 31, 2022 or the end of the Outbreak Period.

Observations

In certain cases the new extended deadline may be the same for all participants, such as with the runout period for a Health FSA (as described in Examples #5 and #6 above). However, for most deadlines, such as for a HIPAA special enrollment or a COBRA election, the tolling period/deadline will need to be determined on an individual-by-individual basis.

Guiding Principle

The 2021 Relief Notice states that the guiding principle for administering ERISA-covered plans is to act reasonably, prudently and in the interest of workers who rely on the benefits for their physical and economic well-being. Many employees will continue to encounter difficulties due to COVID-19, even after the one-year tolling period ends. This means that plan fiduciaries should make reasonable accommodations to prevent loss of benefits.

Communications and Notices

The 2021 Relief Notice states that if a plan fiduciary knows, or should reasonably know, that the end of the relief period is coming for an individual, such fiduciary should consider affirmatively sending a notice regarding the end of the relief period. In addition, if notices were sent out with the wrong information (i.e., contained the wrong deadline to take action), new disclosure notices may need to be issued. Lastly, the 2021 Relief Notice states that plans should consider ways to ensure that participants are made aware of other coverage that is available to them, such as the opportunity in many states to obtain coverage under the Health Insurance Marketplace under a special enrollment period that ends on May 15, 2021.

Suggested Actions

We suggest that the ERISA plan administrator take the following actions:

1. Make a list of the impacted plans and the vendors associated with those plans.

2. Determine which deadlines under the plans listed in #1 above were impacted. For example, for a long-term disability plan, the deadline to file an initial claim for certain plan years may be impacted. For a major medical plan, numerous deadlines may be impacted, such as the deadline to enroll a newborn child and the deadline to file an initial claim for an out-of-network claim.

3. For the plans with impacted deadlines determined under #2 above, identify which groups of individuals need to receive a notice and the information that must be contained in that notice.

4. Determine which entity will send the notices identified in #3 above. For example, for the insured plans, will the insurance carrier send notices? With regard to the impacted COBRA deadlines, will the COBRA vendor send all former employees who terminated on and after January 1, 2020, a notice regarding the end of the tolling period? (The ERISA plan administrator may want to obtain an email or letter from vendors that sets forth what action it will take in response to the 2021 Relief Notice.)

5. Determine if the employer should send all employees a notice that provides a general explanation of how the end of the tolling period works. This notice could include examples of how the end of the tolling period impacts various plans under different scenarios. We think this would be a prudent action as a way to ensure that people are informed of upcoming deadlines. This notice should also be posted on benefit websites and portals.

In the event that adminstrative compliance with these individualized tolling periods proves too difficult, the Plan Administrator could choose to voluntarily extend the tolling period until the end of the Outbreak Period for all impacted deadlines. Should the Plan Administrator wish to explore this option, it will need to keep in mind that for fully-insured coverage, the carrier would need to agree (which may be unlikely); and for self-funded plans with stop loss coverage, it would need to be permitted under the stop loss policy. A Plan Administrator may decide not to explore this option given that it would likely cause adverse selection issues and may increase overall plan costs.

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[1] While the 2021 Relief Notice was issued by the DOL, it states that the guidance was coordinated with and reviewed by the Department of the Treasury, IRS, and the Department of Health and Human Services (HHS) and that all concur with the guidance provided in the 2021 Relief Notice.

[2] ERISA section 518 and Code section 7508A(b) generally provide that, in the case of an employee benefit plan, sponsor, administrator, participant, beneficiary, or other person with respect to such a plan affected by a Presidentially declared disaster, notwithstanding any other provision of law, the Secretaries of Labor and the Treasury may prescribe (by notice or otherwise) *a period of up to one year* that may be disregarded in determining the date by which any action is required or permitted to be completed.

New FAQs Clarify Coverage Requirements for COVID-19 Testing and Vaccines

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MARCH 2021

On February 26, 2021, the Departments of Labor, Health and Human Services (HHS) and Treasury (collectively the "Departments") released *FAQs About Families First Coronavirus Response Act (the "FFCRA") and Coronavirus Aid, Relief and Economic Security Act (the "CARES Act") Implementation Part 44* (the "FAQs").[1] These FAQs provide much-needed clarity regarding the kinds of restrictions that group health plans and health insurance issuers can place on coverage for COVID-19 testing, particularly for asymptomatic individuals who have not been exposed to COVID-19. The FAQs also provide detail regarding the coverage requirements for COVID-19 vaccines. Additionally, the FAQs confirm that an Employee Assistance Program (EAP) may offer benefits for COVID-19 vaccines and still maintain its status as an excepted benefit.

I. COVID-19 Diagnostic Testing

The FFCRA and CARES Act generally require that group health plans ("Plans") must provide benefits for a broad range of items and services related to the detection of SARS-CoV-2 (i.e., the virus that causes COVID-19) or the diagnosis of COVID-19 (collectively, COVID-19 testing or tests) from March 18, 2020 until the end of the applicable emergency period.[2] This Plan coverage must be provided without any cost-sharing requirements, prior authorization or other medical management requirements.

The FAQs clarify the following regarding the coverage of COVID-19 testing:

Medical screening criteria cannot be used to deny (or impose cost-sharing on) a claim for diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19. When an individual seeks and receives a COVID-19 test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 test, Plans must generally assume that the receipt of the test reflects an "individualized clinical assessment," and the test should be covered without cost-sharing, prior authorization or other medical management. The FAQs note that state and local public health officials retain the authority to direct providers to limit eligibility for testing based on clinical risk or other criteria in order to manage testing supplies and access to testing, but that the responsibility for implementing limits of this kind falls on health care providers, and not on Plans or health insurance issuers.

Plans can distinguish between COVID-19 testing of asymptomatic individuals versus coverage of testing for other purposes not primarily intended for individualized diagnosis or treatment of COVID-19. Plans are not required to provide coverage for COVID-19 testing when the purpose of the test is not for individualized diagnosis or treatment of COVID-19 (e.g., testing for public health surveillance, or employment purposes). Plans may choose to provide coverage for these kinds of tests.

TH COMMENT: Plan sponsors should clearly communicate to participants/beneficiaries the circumstances in which the Plan will cover COVID-19 testing.

Plans must cover COVID-19 testing provided through a state- or locality-administered testing site and point-of-care tests. Plans must cover COVID-19 diagnostic tests received from a licensed or authorized provider,

including tests from a state- or locality-administered site, a "drive through" site, and/or a site that does not require appointments. Plans must cover point-of-care COVID-19 tests (meaning a test that delivers rapid results without having to be sent to a lab) in the same way they cover other kinds of COVID-19 tests.

Plans should maintain claims processing and other information technology systems in ways that protect participants, beneficiaries, and enrollees from inappropriate cost-sharing related to the items and services associated with COVID-19 testing.[3] The Departments are also seeking feedback from stakeholders regarding additional steps that Plans should take to ensure there is no inappropriate cost-sharing, while stating that they may take enforcement action where appropriate.

TH COMMENT: When the CARES Act was passed, some Plan vendors were denying coverage for certain costs related to COVID-19 testing. These FAQs should clarify the scope of Plan coverage for COVID-19 testing. Plan sponsors should confirm that the claims administrator is aware of this requirement and has steps in place to comply with it.

II. Rapid Coverage of COVID-19 Vaccines

Under the CARES Act, Plans (except grandfathered group health plans) must cover, without cost sharing requirements, any "qualifying Coronavirus preventive service" which includes:

- An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); or
- An immunization that has in effect a recommendation from the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) (regardless of whether immunization is recommended for routine use).

As of the date of the FAQ publication (February 26, 2021), only the Pfizer-BioNTech (for individuals age 16 and up) and Moderna (for individuals age 18 and up) vaccines met the above criteria. On February 28, 2021, the CDC director authorized the use of the Johnson & Johnson vaccine (adopting ACIP's recommendation) for individuals age 18 and up.

The FAQs clarify the following with regard to the coverage of COVID-19 vaccines:

Plans must cover all COVID-19 vaccines that have been recommended by ACIP (and the associated administrative costs) without cost-sharing. Plans are not permitted to exclude coverage of (or impose cost-sharing on) any qualifying coronavirus preventive service. For example, a plan cannot cover just the Pfizer-BioNTech vaccine, but not cover the Moderna or Johnson & Johnson vaccines.

Plans must begin providing coverage for qualifying COVID-19 va ccines no later than 15 business days after the date the CDC director adopts ACIP's recommendation regarding the vaccine.

- The requirement to cover the Pfizer-BioNTech vaccine became effective on January 5, 2021 (the CDC director adopted ACIP's recommendation on December 12, 2020).
- The requirement to cover the Moderna vaccine became effective on January 12, 2021 (the CDC adopted ACIP's recommendation on December 20, 2020).
- The requirement to cover the Johnson & Johnson vaccine will become effective on March 19, 2021 (the CDC Director adopted ACIP's recommendation on February 28, 2021).

Plans may not deny coverage for a COVID-19 vaccine because a participant, beneficiary or enrollee is not in a category recommended for early vaccination.[4] Plans may communicate with participants/beneficiaries/enrollees about which individuals will be vaccinated first when vaccine supply is limited. However, Plans may not communicate that *coverage* is limited only to individuals who are recommended for early vaccination. Additionally, decisions by an individual provider (including a provider integrated with a Plan) to decline to give the vaccine to someone because she or he is not within a prioritization category is not an adverse benefit determination made by

a Plan, and therefore it is *not* subject to ERISA's internal claims and appeals procedure and external review.

Summary of Benefits and Coverage (SBC) Notice Requirement Relief. Normally, a Plan is required to provide notice of any material modification in any of the terms of the Plan that would affect the contents of the SBC not later than 60 days *prior* to the date on which the modification will become effective. Consistent with prior guidance[5], this FAQ states that the Departments will not take enforcement action when a Plan covers a COVID-19 vaccine prior to satisfying the SBC notice of modification requirements. Plans must provide any required notice of the changes as soon as reasonably practicable.

III. EAPs May Offer COVID-19 Vaccines and Remain Excepted Benefits

The market reform rules of the Patient Protection and Affordable Care Act generally do not apply to certain types of benefits, known as "excepted benefits." Excepted benefits include (among other categories not applicable here): on-site medical clinics, and "limited excepted benefits." EAPs are considered limited excepted benefits if they meet the following requirements:

(A) The EAP does not provide significant benefits in the nature of medical care;

(B) The benefits under the EAP are not coordinated with benefits under another group health plan;

(C) No employee premiums or contributions are required as a condition of participation in the EAP; and

(D) There is no cost-sharing under the EAP.

Previously, the Departments had stated that an employer may offer benefits for diagnosis and testing for COVID-19 under an EAP that constitutes an excepted benefit, as long as the Public Health Emergency declaration or National Emergency declaration remain in effect.[6]

These FAQs clarify the following:

- ***An employer may offer benefits for COVID-19 vaccines (and their administration) under an EAP that constitutes an excepted benefit.*** An EAP will not be considered to provide benefits that are "significant in the nature of medical care" solely because it offers benefits for COVID-19 vaccines and their administration, including when offered in combination with COVID-19 testing. The EAP must still comply with the applicable requirements, including no cost-sharing.
- ***An employer may offer benefits for a COVID-19 vaccine (and their administration) at an on-site medical clinic.*** Coverage of on-site medical clinics is an excepted benefit in all circumstances.

If you have any questions regarding this article, please contact its authors.

See footnotes on page 8

[1] The FAQs contain the following disclaimer, "[t]he contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law."

[2] This emergency period refers to the public health emergency that was declared by the Secretary of HHS in January 2020, and which was renewed most recently on January 7, 2021. HHS has stated publicly that it has determined that the public health emergency will likely remain in place for the entirety of 2021.

[3] FFCRA requires plans to provide coverage for items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for, or administration of, an in vitro diagnostic product, but only to the extent that the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for that product.

[4] Although the CDC and ACIP have made recommendations regarding the categories of individuals to prioritize for vaccination during the initial phases of the COVID-19 vaccination program (e.g., based on age, health conditions, and whether the individual is an essential worker), ACIP does not currently recommend against vaccinating individuals in other prioritization categories. ACIP recommends vaccination of all individuals in the specified age groups (as explained above).

[5] In the previously released *FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42* (released on April 11, 2020), the Departments relaxed the SBC notice of modification requirements for plans that added benefits, or reduced or eliminated cost-sharing, for COVID-19 testing and telehealth.

[6] *FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42*, Q-11.

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