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BENEFITS BRIEF

COVID-19 RELATED EMPLOYEE BENEFIT PLAN RELIEF: A RECAP (Part 1 of 3)

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A veteran teacher recently asked me, "How do you keep up with all this stuff? I have been teaching anatomy and physiology for forty years but thank goodness there haven't been any new organs added or any bodily functions changed during that time." Alas, plan sponsors, administrators, and benefits professionals have not enjoyed the luxury of a similar static subject matter. Indeed, keeping current with seemingly constant changes in employee benefits law is a challenge, and it has become even more arduous during the COVID-19 pandemic, as Congress, the Internal Revenue Service, and the Department of Labor have all been prolific in passing legislation or issuing regulations and other guidance to address actual and anticipated benefit plan problems arising as a result of the pandemic. Additionally, many of the States are mandating particular coverages under group health insurance policies.

In a series of *Benefits Briefs*, we will provide an overview of the key changes in the law and agency guidance occasioned by the pandemic affecting ERISA-governed benefit plans and suggest actions to be taken by plan sponsors and administrators.[1] With this information, plan sponsors and administrators can assess their plans' administration for operational errors and needed changes in procedures to mitigate the risk of liability and can consider the desirability of adoption of the permissive changes authorized by this guidance.

In the first of this series, we will highlight some the key changes affecting health and welfare benefit plans. In Part 2, we will complete our overview of the changes affecting health and welfare benefit plans and in Part 3, we will provide a similar overview of the key changes affecting 401(k) and other defined contribution retirement plans.

Extension of Participant Notice and Election Deadlines

Exercising its newly granted authority under the CARES Act, the Department of Labor and the Internal Revenue Service issued a joint notice in late April 2020 extending many of the otherwise applicable election deadlines in group health and disability benefit plans. Under this guidance, those plans **must disregard the period commencing March 1, 2020 and ending 60 days after the announced end of the Presidentially-declared COVID-19 National Emergency** (the "Outbreak Period") for purposes of making the elections or taking the actions listed below. Importantly, an employee or participant does not have to establish any adverse circumstances or inability to timely act due to COVID-19 to obtain the benefit of these extensions; rather, this relief applies to all employees, participants, and beneficiaries and all plan sponsors uniformly.

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[1] Our discussion in this series will be limited to changes affecting employee benefit plans subject to the labor code provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This generally includes plans of for-profit employers and tax exempt employers but excludes plans of governmental entities and churches that have not affirmatively elected to be subject to ERISA. Note, a discussion of benefit issues arising under Paycheck Protection Program loans is beyond the scope of these *Benefits Briefs*.

This tolling of the election, notice, or payment deadlines for the Outbreak Period applies to:

- An employee's exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 – which apply when an employee or dependent loses eligibility for a group health plan or other medical coverage for which he/she was previously eligible; when one or more of them become eligible for a state premium assistance subsidy; or when a person becomes a dependent (including a spouse) of an eligible employee by birth, marriage, adoption, or placement for adoption. If coverage is timely elected, coverage for a non-spouse dependent by reason of birth, adoption, or placement for adoption is retroactive to the date of birth, adoption, or placement for adoption.
- A participant's COBRA election.[2]
- A participant's payment of the COBRA premium.
- A participant's notice of a COBRA qualifying event or notice of disability.
- A claimant's initial benefit claim.
- A claimant's request for appeal of an adverse benefit determination.
- A claimant's request for external review or request for perfection of a previously filed deficient request for external review.

The deadline for these actions prior to tolling under the Joint Notice are listed in the Appendix.

The authority of the DOL and IRS to permit these extensions cannot exceed one year from the effective date and the DOL and the IRS have the authority to declare an earlier end of the National Emergency for these purposes. In addition, the agencies also have the authority to treat different parts of the country differently, depending upon the severity of the outbreak in different locales.

> ***Plan Sponsor and Administrator Action Items***. It should go without saying that these extensions have the potential to significantly complicate benefit plan administration, especially the longer the National Emergency continues. Unfortunately, the Joint Notice is scant on details for even the most common practical issues that are likely to arise. It is therefore imperative that plan sponsors and administrators who have not already done so to consult with their plans' insurer, claims administrators, COBRA administrator, and advisors and other service providers (as applicable) and make a good faith effort to assure the affected plans are being operated in accordance with these rules. At a minimum, those discussions should address updating procedures for the revised deadlines, updating necessary forms and notices, appropriately notifying affected individuals (which may include notifying those employees or beneficiaries whose election or similar period may have expired before the DOL and IRS adopted this retroactive relief), and the need for re-processing claims made between the start of the Outbreak Period and the date the plan's procedures have been updated to reflect the extended deadlines. While the Joint Notice does not explicitly require notification of affected individuals, a plan fiduciary has a general obligation to provide appropriate plan information to participants and to apprise them of their rights, so it is conceivable a court could find a fiduciary breach in a failure to notify participants and beneficiaries of these changes.

[2] The Joint Notice only addresses COBRA under federal law and not the "mini-COBRA" state continuation requirements applicable to plans not subject to federal COBRA.

Exposure to an increased risk of adverse selection will occur with respect to the tolling of certain of the special enrollment rights. Nothing in the new guidance alters the special enrollment election for birth, adoption, or placement for adoption from being retroactive back to that event, subject to the participant's premium payment for the applicable period. Plan sponsors and administrators should consider notifying affected participants in these circumstances of their right to elect coverage promptly after knowledge of the birth, adoption, or placement for adoption to encourage an election.

The extension of the COBRA deadlines raises particularly thorny administrative issues and likewise greatly increases the risk of adverse selection, especially given the expected increase in the number of COBRA-eligible beneficiaries in the near term (due to furloughs and terminations) and the retroactive coverage requirement of a timely COBRA election (assuming payment of the retroactive premium). We strongly recommend prompt discussions of these extensions with the plans' claims processor and COBRA administrator. Under existing law, a plan may defer the payment of claims during the COBRA election period pending payment of the premium. The Joint Notice did not explicitly restrict the "pend claims" ability so plan sponsors and administrators would be prudent to discuss this option with their claims and COBRA administrators.

"Pending" claims until the premium is paid may mitigate COBRA-related risk but it also has the potential to create problems with "prompt pay" obligations under state insurance laws (applicable to insured plans) and in-network provider agreements (which usually require prompt payment of claims as a condition of discounted rates). In the case of an insured plan, the insurance company may require the employer to pre-fund the premiums for potential COBRA beneficiaries to avoid a loss in coverage, in which case the employer would be forced to later recoup the advanced premiums from the COBRA beneficiary.

"Pending" claims until the COBRA premium is paid also creates potential problems with stop-loss policies under self-funded group health plans. Because stop-loss policies mandate payment of the underlying claim within specific time parameters, the pending of claims could result in the payment of a large-dollar claim being delayed beyond the deadline for recovery under the policy, thereby leaving the plan sponsor with a substantial and wholly unanticipated liability. Faced with that prospect, plan sponsors could be forced to pay claims before collecting the premiums from a COBRA beneficiary and later have to pursue collection efforts against the beneficiary. Plan sponsors and administrators in self-funded plans need to consult with their advisors and carriers about these extensions and their impacts.

Administrative headaches are likely to also result from the extension of the claims procedure deadlines. The extension means claims handled since the beginning of the Outbreak Period on March 1 but before the publication of the Joint Notice in late April 2020 that were dismissed for untimeliness will need to be reprocessed. It also means runout periods will be extended. For example, health flexible spending accounts under a cafeteria plan and health reimbursement accounts (HRAs) are usually subject to a run-out period after the end of the plan year. If the runout period for a 2019 calendar year account had not expired by February 28, 2020, the runout period would be extended under the Joint Notice.

Plan sponsors and administrators will need to exercise ongoing oversight over the claims administrator and other service providers to assure compliance with these provisions. The level of oversight needed will depend upon whether the service provider is exercising ministerial functions (as many service agreements provide), which will require significant oversight, or the service provider has expressly assumed fiduciary responsibility, in which case the level of required oversight may be diminished.

Plan sponsors and employers should designate one or more contact persons to field participant and beneficiary questions, of which there will likely be many. Doing so will minimize the risk of errors and will help assure a consistent communication strategy.

Plan sponsors contemplating a change in carriers or plan service providers will need to factor in the impact of these extensions on those changes.

Further guidance from the DOL and IRS on these issues is badly needed. Until that arrives, plan sponsors and administrators must act reasonably, prudently, and in the best interests of plan participants and beneficiaries. The Department of Labor expects plan fiduciaries will make reasonable accommodations to prevent the loss of benefits or undue delay in benefit payments and for plan fiduciaries to attempt to minimize the possibility of a loss of benefits for failure to comply with pre-established timeframes.

Extension of Employer COBRA Notice Deadline

A plan administrator is generally required to provide the COBRA election notice to a COBRA-eligible beneficiary with 14 days after notice of the qualifying event and loss of group health plan coverage. This deadline is extended in the same manner as applicable to the participant COBRA notice and elections described in the preceding section.

- Despite this extension, plan administrators should provide COBRA election notices without regard to the extension to the extent administratively feasible.

Appendix

Election or Other Participant Action	Pre-Joint Notice Deadline
Special enrollment election under HIPAA	Group health plans must allow those individuals to enroll if they are otherwise eligible and if the enrollment is elected within 30 days of the event (60 days in the case of enrollment under the Children's Health Insurance Program).
COBRA continuation election	A qualified beneficiary generally has 60 days from the later of termination of coverage or notice of COBRA rights to elect COBRA continuation coverage under a group health plan.
COBRA payment deadline	A plan must permit an electing beneficiary to pay COBRA premiums monthly and cannot require payments earlier than 45 days after the date of the initial COBRA election. A COBRA premium is considered timely if paid not later than 30 days after the first day of the period for which the payment is made unless the plan provides a longer period.
COBRA notice of qualifying event/notice of disability	A beneficiary must notify the plan administrator within 60 days of a divorce or legal separation of the employee from his/her spouse or a dependent child losing dependent eligibility status. A beneficiary must also notify the plan administrator within 60 days of the date of his/her SSA disability determination and within 30 days after SSA determines he/she is no longer disabled.
Initial benefit claim	Each benefit plan subject to Title I of ERISA is required to have and maintain a claims procedure. Different deadlines apply for different types of claims and plans.
Request for appeal of adverse benefit determination	Group health and disability plans must provide claimants at least 180 days following receipt of an adverse benefit determination to appeal the determination. In the case of all other welfare benefit plans (e.g., a life insurance plan), a minimum of 60 days is required.

Election or Other Participant Action	Pre-Joint Notice Deadline
Request for external review/request for perfection of request for external review	Non-ACA grandfathered plans must offer an external review process for reviews of adverse benefit determinations involving medical judgment or rescission of coverage. Plans subject to the federal review standard must allow at least four months from the notice of adverse benefit determination or final benefit determination for a request for external review to be filed. Plans subject to a state review standard must offer the period required under applicable state law. Furthermore, a claimant must be permitted to perfect an incorrect or incomplete request for external review within the period of time permitted under state law, or, if the plan is subject to the federal review standard, by the later of the expiration of four months from the request or 48 hours from notification of the deficient request.

Gilbert C. Van Loon is an attorney in the Ridgeland office of Butler Snow LLP. He has represented clients in in all aspects of retirement and health and welfare benefit plans – design, administration, compliance, taxation, employee communications, fiduciary responsibility, defense of benefit claims, examinations, ruling applications, correction program filings, and merger and acquisition transactions. Gilbert can be contacted by phone at 601.985.4556 or via email at gilbert.vanloon@butlersnow.com.