BUTLER | SNOW

BENEFITS BRIEF

COVID-19 RELATED EMPLOYEE BENEFIT PLAN RELIEF: A RECAP (Part 2 of 3)

September 2020

This is the second installment of our overview of the key changes affecting ERISA-governed benefit plans from new legislation and agency guidance brought about by the COVID-19 pandemic. In Part 1, we covered some of the key changes affecting health and welfare benefit plans. In Part 3, we will provide an overview of the key changes affecting 401(k) and other defined contribution retirement plans. In this Part, we will conclude our overview of the key changes affecting ERISA-covered[1] health and welfare benefit plans.

Deadline Extensions for Administrator-Required Notices

The Department of Labor has relaxed the deadlines for making participant disclosures other than the documents pertaining to the extension of the notice and election deadlines during the Outbreak Period (i.e., March 1 to 60 days following the end of the COVID-19 National Emergency) described in Part 1 of this series of *Benefits Briefs*. Examples of the documents eligible for this delay include summary plan descriptions, updates to summary plan descriptions (so-called "summaries of material modification"), summary of benefits and coverage, summary annual reports, and a host of other periodic notices (e.g., Newborns' and Mothers' Health Protection Act notice, Women's Health and Cancer Rights Act notice, etc.). Under this guidance, the failure to timely furnish a notice or disclosure during the Outbreak Period will not be a violation if the plan administrator acts in good faith and furnishes the notice/disclosure as soon as administratively practicable under the circumstances. A relaxed electronic disclosure rule applies for these disclosures; the plan administrator will be deemed to have acted in good faith if the document is delivered electronically (e.g., email, text, or continuous website access) and the plan administrator reasonably believes that the recipient has "effective access."

- Plan sponsors and administrators should contemporaneously document (in writing or electronically), the date and manner disclosures are made, the recipients, and the underlying facts as necessary to support the manner of distribution. To the extent administratively feasible, the disclosures should be made without regard to the relaxed requirements.

Cafeteria Plan Changes

Sponsors of cafeteria plans will need to consider which of the following optional changes should be adopted for their plans.

[1] ERISA-covered plans are 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.

2020 Mid-Year Election Changes. A cafeteria plan participant cannot make mid-year election changes except in limited, specified circumstances. Recognizing the disruption COVID-19 has had on individuals (e.g., the need for different medical plan coverage, the inability to use a health flexible spending account due to suspension of elective surgical procedures, the closure of day care facilities or cancellation of summer camps, etc.), the IRS is providing additional flexibility for mid-year elections for employers who wish to amend their cafeteria plan to permit these changes. These changes will be especially beneficial to employees who may be contributing to a health care or dependent care flexible spending account due to the "use-it-or-lose-it" requirement of those accounts.

For 2020 only, a cafeteria plan may permit employees who are eligible to make salary reduction contributions under the plan to:

- with respect to employer-sponsored health coverage: make a new election on a prospective basis, if the employee initially declined to elect coverage; revoke an existing election and make a new election to enroll in different health coverage sponsored by the same employer on a prospective basis; and revoke an existing election on a prospective basis, provided that the employee attests in writing that the employee is enrolled, or will immediately enroll, in other health coverage not sponsored by the employer; and
- revoke an election, make a new election, or decrease or increase an existing election applicable to a health flexible spending account (FSA) or dependent care FSA on a prospective basis.

These changes are retroactively effective to January 1, 2020, although election changes can only be implemented prospectively. So long as there is no violation of the cafeteria plan nondiscrimination rules and the employer does not discriminate among classes of employees, the employer can determine which election changes may be permitted and can limit elections to prevent adverse selection. An employer may also limit FSA elections to amounts no less than amounts that have already been reimbursed.

A participant must provide a written attestation to the employer that he/she is enrolled or will immediately enroll in other comprehensive health coverage not sponsored by the employer before the employee can revoke an existing election for employer-sponsored health coverage. The employer can rely on that attestation absent actual knowledge to the contrary. No proof of adverse consequences or impact is needed to modify flexible spending account elections.

> ➢ Before implementing permitted changes to employer-sponsored health coverage, the plan sponsor will want to consult with its insurer (in the case of a fully-insured plan) and its stop-loss carrier (in the case of a self-funded plan) to assure the changes are permitted and if so, the additional costs that may result.

Extended Grace Period for Flexible Spending Account Balances. An employer may amend its cafeteria plan to permit employees with unused balances in a health care flexible spending account (other than a health FSA with a carryover provision) or in a dependent care flexible spending account at the end of a grace period ending in 2020 or a plan year ending in 2020 to be used for the payment of the same qualified benefit expenses incurred

by December 31, 2020. For example, a calendar year plan with a grace period can be amended to provide that amounts unused in the account as of March 15, 2020 can be used for expenses incurred by December 31, 2020, provided health FSA balances can only be used for qualifying health expenses and dependent care FSA balances can only be used for qualifying dependent care expenses.

Carryover Limit Increase for Unused Health Flexible Spending Balances. Presently, a health flexible spending account under a cafeteria plan may permit the carryover of unused balances of up to $500 from one plan year to another to pay or reimburse a participant for qualifying medical expenses *incurred* in the subsequent year. For 2020, this amount has been increased to $550 and for subsequent years, the limit is subject to a cost-of-living adjustment.

- Amendments to permit mid-year election changes, the extended grace period, and the increased carryover may be executed by December 31, 2021 and may be retroactively effective to January 1, 2020, provided the plan has operationally complied and eligible employees have been apprised of the changes. An amendment for the carryover limit increase is not needed if the plan language simply incorporates the statutory limit. Sponsors will need to consult with the plan's TPA to assure operational compliance.

Expansion of Expenses Eligible for Reimbursement from a Health Flexible Spending Account. Over the counter drugs, even if not prescribed, and menstrual care products became eligible for reimbursement under a health flexible spending account beginning January 1, 2020 for amounts incurred and paid on or after January 1, 2020.

- An amendment to designate these expenses as eligible expenses may be required, depending upon whether the existing plan language lists the eligible expenses or incorporates the statutory definition of eligible expenses. The deadline for an amendment is less clear so plans should be amended, if needed, before those expenses are reimbursed. In either case, eligible employees must be notified of this change to the plan.

Mandatory Coverage of COVID-19 Diagnostic Testing

Most group health plans, including Affordable Care Act grandfathered plans, self-funded plans, and group health insurance policies, must cover COVID-19 diagnostic testing starting March 18, 2020 and continuing through the end of the public health emergency declared by the Secretary of Health and Human Services.[2]

These services must be provided without cost sharing (i.e., deductibles or copayments) or prior authorization requirements, and cannot be subject to medical management requirements, even if an out-of-network provider is used. This includes costs for related services for in-patient visits (including telehealth sessions) and include in vitro testing as well as home testing. There is no maximum limit on the number of tests determined by the

[2] Note, this period of time is different from the Outbreak Period relating to the extension of the participant notice and election deadlines described in Part 1 of these *Benefits Briefs*, which is based on a Presidentially-declared national emergency.

individual's attending physician in accordance with current accepted medical practices. Department of Labor guidance provides specific details as to the testing items required to be covered.

Screening for general workplace health and safety (e.g., for return to work programs) are not required to be covered.

The costs to be paid or reimbursed must equal the negotiated rate with the provider or in the absence of a negotiated rate, the cash price for the service listed on the provider website. (Providers are subject to substantial penalties for failure to post the price of these services on their websites.)

- The deadline for a plan amendment to reflect this change is unclear under current guidance. Participants need to be notified of the change as soon as reasonably practicable through an updated Summary of Benefits and Coverage or other notice.

Mandatory Coverage of COVID-19 Vaccines

Most group health plans, other than ACA grandfathered plans but including group health insurance policies, must cover COVID-19 vaccines and related preventive care starting fifteen days after approval by certain U.S. government agencies. These services must also be provided without any cost sharing.

- Normally, a group health plan has one year after government approval before the preventive service must be covered. The deadline for a plan amendment to reflect this change is unclear under current guidance.

- Aside from the mandatory coverage of COVID-19 diagnostic testing and COVID-19 vaccines and related preventive care, federal law does not impose a specific requirement to cover COVID-19 treatment. Nevertheless, most group health plans provide coverage for the types of treatment needed for COVID-19, subject to normal plan cost sharing obligations. As explained below, some states have mandated treatment of COVID-19 complications under insurance policies issued in those states.

Group Health Plan Coverage Requirements During FFCRA Leaves

The Families First Coronavirus Response Act ("FFCRA") requires most employers with 500 or fewer employees to provide employees with paid sick leave or expanded family and medical leave for specified reasons relating to COVID-19 through December 31, 2020. A brief summary of the Act can be found at the Department of Labor website: https://www.dol.gov/agencies/whd/ffcra. The DOL position is that a participant under an employer-sponsored group health plan who utilizes one or both of the new leave provisions is entitled to retain his/her group health plan coverage for the leave period on the same terms as if the employee had continued to work.

- Plan sponsors and administrators should review their internal procedures and consult with the plan's service providers to assure compliance.

High Deductible Health Plans (HDHPs)

COVID-19 Testing and Preventive Services. A high deductible health plan will not be disqualified for providing COVID-19 diagnostic testing or preventative services (discussed above) without a deductible or with a deductible below the deductible for a HDHP, applicable until further guidance by the Internal Revenue Service.

Telehealth. A HDHP can be amended to provide for coverage of telehealth and other remote services without prior satisfaction of a deductible or out of pocket limit without disqualifying the HDHP or precluding contributions to a health savings account. This applies for the period starting March 27, 2020 until the first day of the first plan year beginning after December 31, 2021 and covers all telehealth care, not just COVID-19 related care.

- The deadline for a plan amendment to reflect this change is unclear under current guidance.

Health Savings Accounts - Expansion of Expenses Eligible for Reimbursement

Health Savings Accounts must permit the reimbursement of over the counter drugs and menstrual products starting January 1, 2020 for amounts paid after December 31, 2019.

Health Reimbursement Accounts - Expansion of Expenses Eligible for Reimbursement

Health Reimbursement Accounts may be amended to permit the reimbursement of over the counter drugs and menstrual products starting January 1, 2020 for amounts incurred and paid after December 31, 2019.

- An amendment to designate these expenses as eligible expenses may be required, depending upon whether the existing plan language lists the eligible expenses or incorporates the statutory definition of eligible expenses. The deadline for an amendment is less clear so plans should be amended, if needed, before those expenses are reimbursed. In either case, eligible employees must be notified of this change to the plan.

Grandfathered Group Health Plans and Group Health Insurance Policies

A grandfathered group health plan or a grandfathered group health insurance policy under the Affordable Care Act will not lose grandfather status by adding COVID-19 testing and treatment benefits (including reduction of cost-sharing) during the COVID-19 emergency period. Likewise, the later removal of those provisions upon the expiration of the emergency and the restoration of the terms of the plan or coverage prior to those changes will also not result in a loss of grandfather status.

Providing Telehealth Services to Employees not Covered by a Group Health Plan

As a general rule, the provision of telehealth or remote care services to employees or their dependents is a group health plan subject to the requirements of ERISA and the Affordable Care Act. Under temporary relief, a large employer for ACA purposes may provide telehealth services to employees and their dependents not covered by another group health plan of the employer without being subject to the ACA group market reforms (e.g., the prohibition on annual and lifetime benefits, the prohibition on cost sharing for preventative health services, the imposition of maximum waiting periods, the required coverage for dependents through age 26, etc.) so long as the coverage does not impose pre-existing conditions limitations or discriminate based on health status, satisfies the mental health parity requirements, and complies with the ACA rules governing rescissions of coverage.

State Mandates Applicable to Fully-Insured Group Health Plans

A State may impose more expansive requirements on group health insurance policies sold in their State so long as they do not undermine or interfere with federal requirements. A number of States have implemented COVID-19 related requirements that are more extensive than those required under federal law for both testing and treatment purposes, including requiring coverage for treatment without cost sharing. Self-funded group health plans are exempt from these provisions, as self-funded plans are not subject to State insurance regulation.

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.