What Employers Need to About Recent Timeframes, Cafeteria Plan, and Account-Based Plan Relief for Group Health Plans Due to COVID-19

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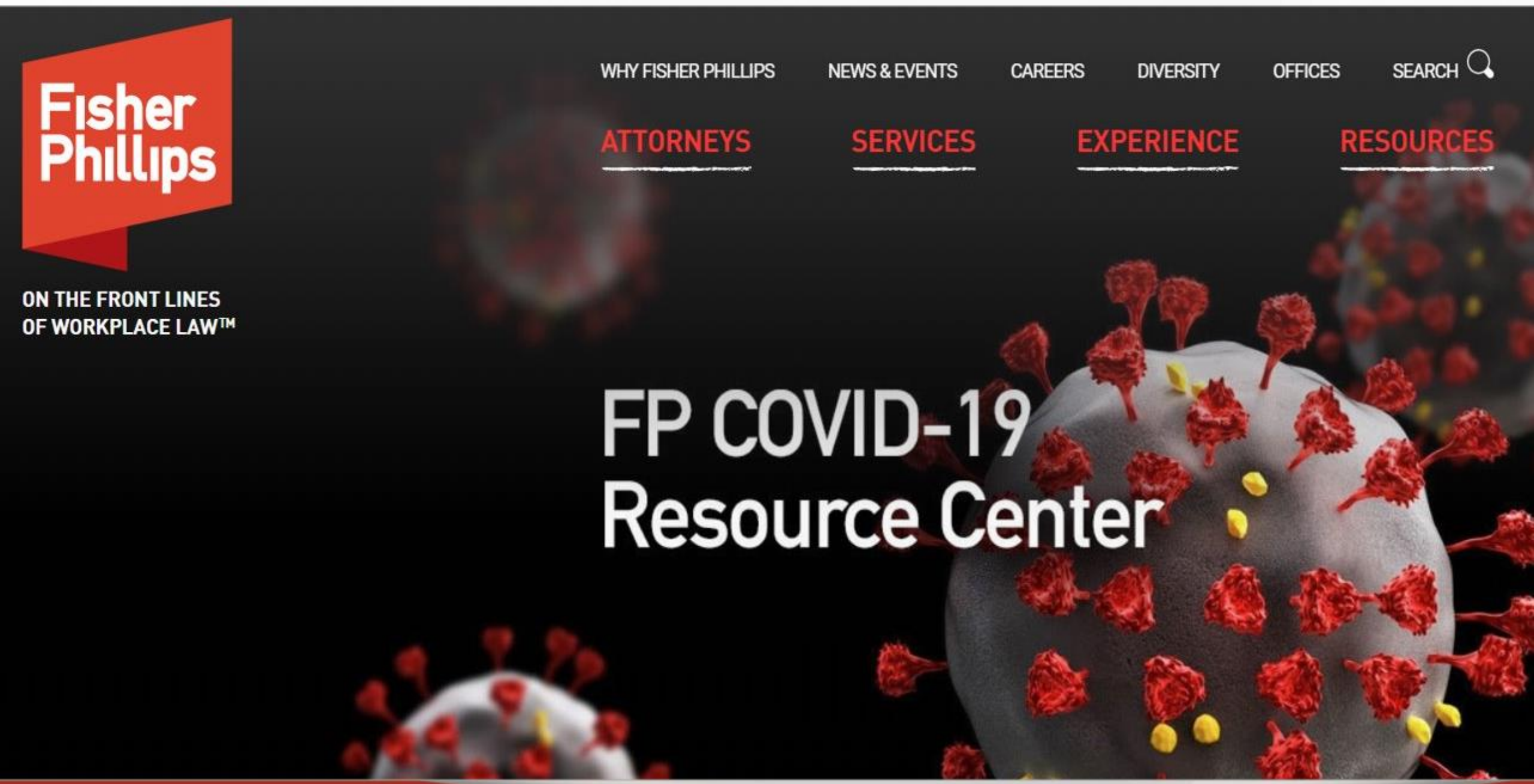

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COVID-19

- On March 13, 2020, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease ("COVID-19") Outbreak and by separate letter made a determination, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, that a national emergency exists nationwide beginning March 1, 2020, as the result of the COVID-19 outbreak

- The federal government has since taken various actions to provide relief to businesses and individuals impacted by the disaster

Agenda

- Review extended group health plan timeframes applicable to HIPAA special enrollment periods, COBRA deadlines, claims procedures, external review process, and governmental plans
- Analyze limited relief from providing ERISA-required notices and disclosures
- Discuss IRS relief for cafeteria plans in response to COVID-19
- Highlight best practices for amending plan documents and notifying plan participants of extended group health plan timeframes and cafeteria plan changes

Extended Timeframes

Extended Timeframes

- The DOL and the IRS issued a final rule on May 4, 2020 that extends certain timeframes under ERISA and the IRC for group health plans during the COVID-19 national emergency
- The new rule intends to help alleviate problems faced by health plans to comply with strict ERISA and IRC timeframes and problems faced by participants and beneficiaries in exercising their rights under health plans during the COVID-19 national emergency
- Generally, for purposes of complying with certain timing requirements, plans must disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency (referred to as the "Outbreak Period")
  - Extensions are based on the end date of the national emergency, which is unknown at this time
    - For purposes of our examples later on, we will assume that the end of the National Emergency is announced on July 31, 2020

Extended Timeframes

- HIPAA Special Enrollment Periods
  - HIPAA allows individuals who previously declined health coverage a special opportunity to enroll in coverage in certain circumstances:
    1. When an employee or dependent loses eligibility for health coverage (including coverage under Medicaid and CHIP); and
    2. Upon certain life events (e.g., when an eligible employee gains a new dependent by birth, marriage, adoption, or placement for adoption)
  - General Rule: Eligible individuals must request enrollment in the group health plan within 30 days of the occurrence of the event (or within 60 days, in the case of special enrollment rights added by CHIPRA)

Extended Timeframes

- HIPAA Special Enrollment Periods
  - COVID-19 Relief: The 30-day period (or 60-day period, if applicable) to request special enrollment is suspended during the Outbreak Period
    - Example: Jane is eligible for, but previously declined participation in, her employer-sponsored group health plan. On March 31, 2020, Jane gave birth and would like to enroll herself and the child into her employer's plan; however, open enrollment does not begin until November 15. When can Jane exercise her special enrollment rights under the extended timeframes?
      - The Outbreak Period must be disregarded for purposes of determining Jane's special enrollment period. Jane and her child qualify for special enrollment into her employer's plan as early as the date of the child's birth, and Jane may exercise her special enrollment rights for herself and her child until October 29, 2020 (30 days after the end of the Outbreak Period), provided that she pays the premiums for any period of coverage

Extended Timeframes

- COBRA Deadlines
  - General Rules:
    - Employers must notify the plan administrator of certain qualifying events within 30 days
    - Individuals must notify the plan administrator of certain qualifying events within 60 days
    - Plan Administrator has 14 days to provide a COBRA election notice to the qualified beneficiary ("QB") after receiving notice of the qualifying event
    - QB has 60 days from the date of the notification to elect COBRA continuation coverage
    - If elected, QB has 45 days to pay the first COBRA premium
    - Subsequent premium payments must be made no later than 30 days after the first day of the period for which payment is being made (or else COBRA coverage may be terminated)
    - Individuals must notify the plan administrator of a disability determination to extend COBRA coverage within 60 days

Extended Timeframes

- COBRA Deadlines
  - COVID-19 Relief: The 60-day period for QBs to elect COBRA, the deadlines for making COBRA premium payments, and the 60-day period for individuals to notify the plan of a qualifying event or determination of disability are all suspended during the Outbreak Period
    - Example: Joe works for ABC Company and participates in ABC's group health plan. Due to the National Emergency, Joe experiences a qualifying event for COBRA purposes as a result of a reduction of hours below the hours necessary to meet the group health plan's eligibility requirements and has no other coverage. Joe is provided a COBRA election notice on April 1, 2020. What is the deadline for Joe to elect COBRA?
      - The Outbreak Period is disregarded for purposes of determining Joe's COBRA election period. The last day of Joe's COBRA election period is November 28, 2020 (60 days after the end of the Outbreak Period)

Extended Timeframes

- COBRA Deadlines
  - Example: On March 1, 2020, John was receiving COBRA continuation coverage under a group health plan. More than 45 days had passed since John had elected COBRA. Monthly premium payments are due by the first of the month. The plan does not permit qualified beneficiaries longer than the statutory 30-day grace period for making premium payments. John made a timely February payment, but did not make the March payment or any subsequent payments during the Outbreak Period. As of July 1, John has made no premium payments for March, April, May, or June. Does John lose COBRA coverage, and if so for which month(s)?
    - The Outbreak Period is disregarded for purposes of determining whether monthly COBRA premium payments are timely. Premium payments made by October 29, 2020 (30 days after the Outbreak Period) for March, April, May, and June 2020 will be considered timely and John is entitled to COBRA continuation coverage for these months if he timely makes payment

Extended Timeframes

- COBRA Deadlines
  - Example: Same facts as the last example, but John only makes a payment equal to two months' premiums by October 29, 2020. For how long does John have COBRA continuation coverage?
    - John is entitled to COBRA continuation coverage for March and April of 2020, the two months for which timely premium payments were made, and John is not entitled to COBRA continuation coverage for any month after April 2020. Benefits and services provided by the group health plan (e.g., doctors' visits or filled prescriptions) that occurred on or before April 30, 2020 would be covered under the terms of the plan. The plan would not be obligated to cover benefits or services that occurred after April 2020

Extended Timeframes

- Claims Procedures
  - ERISA-covered employee benefit plans are generally required to establish and maintain a procedure governing the filing and initial disposition of benefit claims, and to provide claimants with a reasonable opportunity to appeal an adverse benefit determination to an appropriate plan fiduciary
  - General Rule: Group health plans and disability plans must provide claimants at least 180 days following receipt of an adverse benefit determination to appeal (60 days in the case of pension plans and other welfare benefit plans)

Extended Timeframes

- Claims Procedures
  - COVID-19 Relief: The deadline for individuals to file a benefit claim or appeal an adverse benefit determination under a plan's claims procedures is suspended during the Outbreak Period
    - Example: Julie is a participant in a group health plan. On March 1, 2020, she received medical treatment for a condition covered under the plan, but a claim relating to the medical treatment was not submitted until April 1, 2021. Under the plan, claims must be submitted within 365 days of the participant's receipt of the medical treatment. Was Julie's claim timely?
      - Yes. For purposes of determining the 365-day period applicable to Julie's claim, the Outbreak Period is disregarded. Therefore, Julie's last day to submit a claim is 365 days after September 29, 2020, which is September 29, 2021

Extended Timeframes

- Claims Procedures
  - Example: Jamie received a notification of an adverse benefit determination from her disability plan on January 28, 2020. The notification advised Jamie that there are 180 days within which to file an appeal. What is Jamie's appeal deadline?
    - When determining the 180-day period within which Jamie's appeal must be filed, the Outbreak Period is disregarded. Therefore, Jamie's last day to submit an appeal is 148 days (180 *minus* the 32 days from January 28 to March 1) after September 29, 2020, which is February 24, 2021

Extended Timeframes

- External Review Process
  - ERISA provides standards for external review that apply to non-grandfathered group health plans and provides for either a state external review process or a federal external review process
  - General Rule: For plans or issuers that use the federal external review process, the process must allow claimants at least 4 months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination to request an external review. The process must also provide for a preliminary review of a request for external review, and if such request is not complete, provide a notification that describes the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the later of: (A) the 4-month filing period or (B) the 48-hour period following the receipt of the notification

Extended Timeframes

- External review process
  - COVID-19 Relief: The deadline for filing a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination and the deadline for filing information to perfect a request for external review upon a finding that the request was not complete are suspended during the Outbreak Period

Extended Timeframes for Non-Federal Governmental Health Plans

- CMS extended timeframes under the Public Health Service Act (PHS Act) for non-federal governmental plans, similar to that provided in DOL/IRS guidance
- Specifically, between March 1, 2020 and 60 days after the end of the COVID-19 National Emergency (or such other date announced by DOL and/or IRS in future notices), CMS has adopted a temporary policy of relaxed enforcement to extend similar time frames otherwise applicable to non-Federal governmental group health plans, and their participants and beneficiaries
- CMS encourages (but will not require) sponsors of non-Federal governmental plans to provide relief to participants and beneficiaries similar to that specified by the DOL/IRS

Notifying Participants of Extended Timeframes

- Plan administrators should make good faith efforts to provide targeted notices to participants explaining that plan deadlines are being suspended
- Coordinate with appropriate contract administrators or service providers
- Plan amendments are not required because the deadlines are being suspended, not amended

Administrative Issues & Open Questions

- HIPAA Special Enrollment Extensions
  - Employers may need to retroactively provide an employee (and applicable dependents) coverage once finally elected by the employee, possibly back to March 1, 2020
  - Because the DOL/IRS rule was not released until May 4, 2020, plans may have an obligation to identify and enroll employees who submitted late special enrollment requests on or after March 1 (but before the rule was issued)

Administrative Issues & Open Questions

- Benefit Claims and Appeals Extensions
  - As of March 1, 2020 and through the end of the Outbreak Period, there are no deadlines to file claims or appeals; plans should coordinate with any TPAs who decide the plans' claims and appeals to make sure they are complying with these extensions
  - Plans should establish a process to flag past denials based on failure to timely submit a claim or appeal to see if these need to be reviewed or extended
  - Unclear whether plans need to reach out to participants who had denied claims on or after March 1, 2020 to have these claims and appeals re-processed
  - Deadlines under ERISA for plans to adjudicate claims and appeals have not been suspended; plans should follow their current procedures for reviewing claims and appeals in a timely manner

Administrative Issues & Open Questions

- COBRA Extensions
  - Plan administrators are not required to provide COBRA election notice during the Outbreak Period, but should still timely provide election notices to encourage qualified beneficiaries to timely elect and pay for COBRA coverage
  - Because there are no deadlines by which an employee, spouse, or child who loses coverage due to a qualifying event must notify the plan, employers may have to provide COBRA coverage retroactively for many months (which may result in adverse selection if individuals wait to see if they incur claims before electing COBRA)
  - Because COBRA participants are not required to pay premiums, participants might wait to pay for coverage until the Outbreak Period ends, which imposes a significant burden on employers who may be required to front premium payments and/or expend significant resources to recoup those payments
  - Unclear whether employers need to revise COBRA notices to reflect the extended deadlines (DOL issued updated model COBRA notices that do not address these extensions two days after the DOL/IRS rule was issued)

Notices & Disclosures

ERISA Notice and Disclosure Relief

- EBSA Notice 2020-01 provides temporary relief for furnishing required notices and disclosures under Title I of ERISA (to the extent not already addressed in the DOL/IRS joint rule)
- Intended to give plan fiduciaries and plan sponsors additional time to satisfy ERISA's notice and disclosure requirements during the COVID-19 outbreak, such as:
  - Summary Plan Description (SPD) and Summary of Material Modifications (SMM)
  - Summary of Benefits and Coverage (SBC)
  - Summary Annual Report (SAR)
  - COBRA General Notice and Election Notice
  - HIPAA Notice Of Special Enrollment Rights
  - Internal Claims and Appeals
  - Notices under CHIPRA, WHCRA, MHPAEA, Newborns' & Mothers' Health Protection Act
  - Requests for Plan Documents

ERISA Notice and Disclosure Relief

- A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document that must be furnished during the Outbreak Period if the plan and responsible fiduciary act in "good faith" and furnish the notice, disclosure, or document "as soon as administratively practicable under the circumstances"
- "Good faith" acts include use of electronic alternative means of communicating with plan participants and beneficiaries who the plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and websites

COVID-19 Relief for Cafeteria Plans

Cafeteria Plan Relief

- IRS released guidance on May 12, 2020 to provide temporary relief from rules under Code Section 125
- Notice 2020-29 provides increased flexibility for making mid-year elections or changes under a cafeteria plan during the 2020 calendar year related to employer-sponsored health coverage, health FSAs, and DCAPs
- Specifically, employees may:
  - Make a new election for employer sponsored health coverage on a prospective basis, if the employee initially declined to elect employer-sponsored health coverage;
  - 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 coverage to family coverage);
  - 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; and
  - Revoke an election, make a new election, or decrease/increase an existing election regarding a health FSA or DCAP on a prospective basis

Cafeteria Plan Relief

- Relief is effective retroactively to January 1, 2020; provided that election changes must apply on a prospective basis
- Must also comply with the Section 125 nondiscrimination requirements
- For revocations of an existing election for employer-sponsored health coverage, employers may rely on the employee's written attestation that they are enrolled (or will immediately enroll) in other health coverage not sponsored by the employer
  - Employers cannot rely on the employee's attestation if they have actual knowledge that the employee is not, or will not be, enrolled in other health coverage
  - The Notice provides an example of an acceptable written attestation
- Notice 2020-29 also extends the claims period with respect to grace periods/carryovers for employees to apply unused amounts in their health FSA or DCAP account through December 31, 2020
  - For example, if a health FSA plan has a grace period that ends on March 15, 2020, employers may allow employees to apply unused funds to claims incurred through the end of the year
  - Consider impact on HSA eligibility

Cafeteria Plan Relief

- IRS Notice 2020-33 increases the limit for unused health FSA carryover amounts from $500 to $550 (i.e., unused amounts in 2020 that may be carried into 2021)
- Notice 2020-33 also clarifies the ability of a health plan to reimburse individual insurance policy premium expenses incurred prior to the beginning of the plan year
  - A plan is permitted to treat an expense for a health insurance coverage premium as incurred on
    1. the first day of each month of coverage on a pro rata basis;
    2. the first day of the period of coverage; or
    3. the date the premium is paid

Cafeteria Plan Amendments & Participant Notices

- Employers are not required to make changes to their cafeteria plans permitted under Notices 2020-29 and 2020-30; however, if an employer wishes to adopt changes, it must:
  1) amend its cafeteria plan document accordingly and
  2) notify employees eligible to participate in the cafeteria plan of the changes
- When amending the cafeteria plan, consider other administrative changes that may be desirable (e.g., limitation on the period in which new elections can be made, limit election changes for health FSAs and DCAPs to amounts no less than what has already been reimbursed, etc.)
- Deadlines for Cafeteria Plan Amendments:
  - For mid-year election changes and extended periods of reimbursement, employers must adopt an amendment for the 2020 plan year on or before December 31, 2021
  - For an increase in the amount of health FSA carryover, an employer must adopt an amendment on or before the last day of the plan year from which amounts may be carried over
    - For the 2020 plan year, the deadline to amend is extended to December 31, 2021

Final Questions

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Thank You

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