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# HEALTH & WELFARE PLAN LUNCH GROUP

## December 3, 2020

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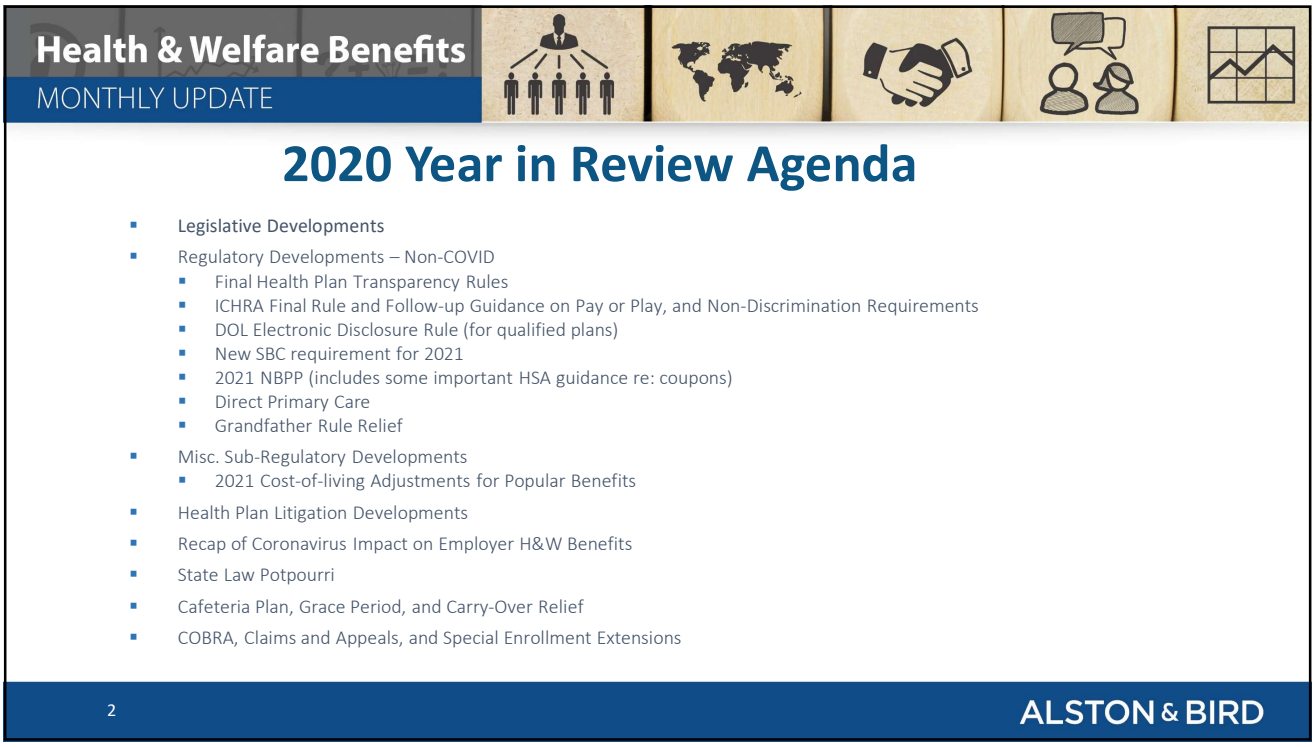


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## 2020 Year In review (Non-COVID)



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## 2019/2020 Pre-COVID Legislative Developments

- Repeal of Cadillac Tax
- Repeal of Health Insurance Tax
  - Effective 2021 (taxes still applicable to insurers and MEWAs in 2020).
- Reinstatement of PCORI
  - Still applies to certain HRAs.



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## Final Rule on Transparency in Health Care Coverage for GHPs

- On October 29, 2020, CMS along with the DOL and the Treasury issued a final rule (F.R.) on price transparency purposed to enable patients to accurately anticipate healthcare costs in order to make more fully informed and value-conscious decisions.
- Not to be confused with HHS hospital price transparency rule finalized in 2019. That rule is in litigation:
  - Federal district court judge upheld;
  - US Court of Appeals for D.C. Circuit heard arguments on October 15, 2020, but has yet to issue a ruling.
- F.R. overlaps HHS rule to some degree, but more expansively covers the entire health-care industry.



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## Final Rule – Required Content

- Regarding disclosure to participants:
  - Estimated cost-sharing liability for a covered item or service.
  - Accumulated amounts.
  - Negotiated rates expressed in a dollar amount.
  - OON allowed amount.
  - Items and services content list.
  - Notice of prerequisites to coverage.
  - Disclosure Notice with specific explanations (i.e., balance billing; actual charges deviation from estimate; estimate not guarantee of coverage; and additional information/disclaimers that plan/issuer determine necessary).
- Regarding public disclosure:
  - Plan/coverage identifier.
  - Billing Codes.
  - In-Network Applicable Amounts; OON allowed amounts; or Negotiated Rates and Historical Net Prices for Rx Drugs.

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## Final Rule: Two Broad Requirements

- First Requirement: Make available to participants, beneficiaries and enrollees (or their authorized representative) **personalized OOP cost information, and the underlying negotiated rates, for all covered health care items and services** (including Rx drugs) through an internet-based self-service tool and in paper form upon request.
  - Initial list of 500 shoppable services will be required to be available via the internet based self-service tool for Plan Years (PYs) that begin o/a January 1, 2023.
  - Remainder of all items and services will be required for these self-service tools for PYs that begin o/a January 1, 2024.



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## Final Rule: Second Requirement

- Make available to the public, including stakeholders (i.e., consumers, researchers, employers, and third-party developers), **three separate machine-readable files that include detailed price information**.
  - **In-network Rate File** showing "negotiated rates" for all covered items and services between plan or issuer and in-network providers.
  - **Allowed Amount File** showing both the historical payments to, and billed charges from, OON providers.
    - "Historical payments" must have a minimum of twenty entries in order to protect consumer privacy.
  - **Prescription Drug File** detailing the in-network negotiated rates and historical net prices for all covered Rx drugs by plan/issuer at the pharmacy location level.

Note: Plans and issuers must display these data files in a standardized format and update the files monthly. Provisions regarding public disclosure apply for PYs beginning o/a January 1, 2022.



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## Final Rule: Preparing for Compliance

- Gain a basic understanding of what the Transparency Rule requires and how it works, 2022 is just around the corner. Check out the DOL webpage for additional information about the Transparency Rule, including a fact sheet.
- Inventory your health plans and determine which are subject to the Transparency Rule. For now, compliance is not required for excepted benefits, grandfathered plans, retiree medical plans, or certain account based plans.
- Assess deliberately which aspects of the Transparency Rule requirements you will assign to insurers and third-party administrators and which (if any) will be addressed in house. Employer plan sponsors are not likely to have access to the cost information required, even with access, maintaining the required communication channels will be burdensome. Early cooperation with insurers and third-party administrators (including PBMs) is a necessity.



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## Final Rule: Preparing for Compliance

- Document carefully which parties are responsible for Transparency Rule compliance. Consider the fully insured safe harbor discussed earlier, and that contracts with self-funded plan TPAs and PBMs should be revised to address compliance. A deliberate compliance plan can demonstrate good-faith efforts and reasonable diligence. Appropriate compliance representations/warranties and indemnification provisions should be sought as well.
- Budget adequately to address Transparency Rule compliance. Issuers and TPAs will undoubtedly pass along costs of compliance to their client plans
- Plan sufficient time for beta testing and participant communication. Plan sponsors should review operational conditions and determine need to establish procedures to ensure participants become and remain informed of how to use the required online tools.

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## ICHRA Final Rule and Follow-up Guidance on Pay or Play and Non-Discrimination Requirements

***ICHRAs -- Reverses ACA era prohibition on individual medical policy reimbursement when requirements met.***

- Considered minimum essential coverage.
- Among other requirements, employers may not offer a traditional group health plan and an ICHRA to the same class of employees.
- New 1095-C reporting requirements related to ICHRAs.



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## ICHRA Final Rule and Follow-up Guidance on Pay or Play and Non-Discrimination Requirements

***EBHRAs***

- May be established without integration as long as GHP is "offered."
- Must satisfy four requirements, the:
  - Maximum annual contribution is $1,800;
  - Employee must also be offered traditional health insurance from the same employer;
  - Employee cannot also be offered an ICHRA; and
  - Terms and conditions must be the same for all "similarly situated" classes of employees.

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## DOL Electronic Disclosure Rule

DOL introduced a revamped electronic disclosure rule under ERISA.

- New rule significantly pushes the electronic communication ball forward for retirement plans. Two new safe harbor methods:
  - Notice and access – allows delivery by posting online.
  - Email delivery – allows delivery directly via email.
- It is not applicable to health and welfare plans (including FSAs and HRAs).
- We expect similar changes coming down the pike for health and welfare plans (perhaps in 2021).
  - Extra time required for tri-agency coordination.



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## New SBC Template

The Tri-agencies introduced a new SBC template to be used for plan years starting on/after January 1, 2021:

- Eliminates reference to individual mandate.
- Changes to coverage examples.
- No further relief for HRAs subject to SBCs.

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## Misc. Regulatory Developments

- 2021 NBPP
  - Final rule for Rx Coupons – plans can count discount or not toward MOOP subject to state law.
    - But . . . What if HDHP plan or state mandate counts discount toward OOP?
      - Serious ramifications for non-conforming HDHPs.
  - 2021 MOOPs ($8550 self only/$17,100 family).
  - Midyear special enrollment allowed for QSEHRAs.
- Direct Primary Care and Healthcare Sharing Ministries Proposed Regulation
  - Ineligible for FSA.
  - Adverse impact on HSAs.
- Grandfather Plan Relief
  - Relief for HDHPs that lose GF status due to IRS deductible increases.
  - Additional cost increase determination allowed based on premium cost increase (rather than general medical inflation).



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## 2021 Cost-of-living Adjustments for H&W Benefits

| BENEFIT | 2020 | 2021 |
|---|---|---|
| HSA contribution max (including employee and employer contributions) | $3,550 ($7,100 family) | $3,600 ($7,200 family) |
| HSA additional catch-up contributions | $1,000 (this is not indexed) | Same |
| HDHP annual deductible minimum | $1,400 ($2,800 family) | Same |
| Limit on HDHP OOP expenses | $6,900 ($13,800 family) | $7,000 ($14,000 family) |
| ACA limit on OOP expenses | $8,150 ($16,300 family) | $8,550 ($17,100 family) |
| Health FSA salary reduction max | $2,750 | Same |
| Health FSA carryover max | $500 | $550 |
| Limit on amounts newly available under an Excepted Benefit HRA | $1,800 | Same |
| QSEHRA max reimbursement | $5,250 ($10,600 family) | $5,300 ($10,700 family) |
| Transit and parking benefits | $270 (monthly) | Same |
| 401(k) employee elective deferral max | $19,500 (Catch-up contributions $6,500) | Same |
| Highly compensated employee | $130,000 (applies for 2021 plan year under look-back rule) | $130,000 (applies for 2022 plan year under look-back rule) |
| Key employee | $185,000 | Same |



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## Health Plan Litigation Developments

- *California v. Texas (Constitutionality of the ACA)*
- Claims process and RBP litigation
  - What is an RBP?
  - Compliance concerns with "settle-up" approaches .
- Other H&W Cases of Interest
  - STLDI regulation upheld by DC Circuit.
  - Cross plan offset litigation.
    - Recent motions based on *Thole.*
  - State law PBM litigation taken up by Sup/Ct in *Rutledge.*
  - *Bostock v Clayton County – Title VII protection applies to gay and transgender.*



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## Health Plan Litigation Developments

- *Asapansa-Johnson Walker v Azar – enjoined* HHS June ACA 1557 regulations removing protections for gender identity and sex stereotyping.
- *Lyn M v Premera – "Secret"* Discretionary language in plan but not SPD not enforceable.
- *Little Sisters v PA* – ACA regulation Contraceptive care exceptions from preventive care mandate upheld.
- *Gonzalez DeFuente et al v Edison* – claims related to "captive reinsurance" dismissed under *Thole* doctrine.

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## Recent COBRA Notice Litigation

- A plaintiffs' firm in Florida has been filing a string of COBRA lawsuits (@ 25 and counting) with copycat actions being filed by other firms.
- The complaints seek class certification, statutory penalties of $110 per participant or beneficiary per day from the date of the alleged failures, injunctive relief, attorneys' fees, costs and expenses, and "other appropriate relief."
- The litigation has hit several large employers such as Citigroup, Lowe's, Pepsi, Amazon, Target, Marriott, and Wal-Mart.
- Litigation is costly and as a result most actions have settled such as Target for $1.6 million, Lockheed Martin for $1.25 million, PetSmart for $500,000, U.S. Foods for $450,000 and FirstFleet, Inc. for $386,000.



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## Recent COBRA Notice Litigation

- The complaints allege that the COBRA election notices are not written in a manner calculated to be understood by the average plan participant for various reasons such as:
  - The employer did not use the DOL Model Notice.
  - The Plan Administrator is not sufficiently identified.
  - Conflicting information on when the election notice and payment is due.
  - Use of more than one document for the election notice.
  - The notice does not include a paper election form.
- DOL has actually filed an amicus brief in support of employers.

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## Recent COBRA Notice Litigation – Next Steps

- Review COBRA Notices and address potential defects with the COBRA Administrator.
  - *Note:* complaints against Amazon and Nestle allege that the mere mention of potential criminal penalties and IRS fines for providing false information means the COBRA notices are deficient.
- Evaluate whether to add venue and forum selection clauses to the SPD.
- Consider arbitration agreements barring employees from participating in class actions against the employer.
- Tighten requirements in the SPD to thoroughly exhaust administrative remedies before filing litigation.



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## RECAP: Coronavirus Impact on Employer Health & Welfare Benefits



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## Coronavirus Legislation Impact on Employer Group Health Plans

- CARES Act –
  - Section 3701 Reverses Affordable Care Act rule on OTC expenses for FSAs, HRAs, and HSAs.
    - Medical OTCs may be an eligible expense without a prescription effective for expenses incurred on or after January 1, 2020.
      - Is an amendment required for your plan?
      - Can this be applied retroactively?
      - Is there any way NOT to adopt the change if OTCs are administered via debit card?



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## Coronavirus Legislation Impact on Employer Group Health Plans

- Menstrual care products qualify as an eligible expense.
  - "For purposes of this paragraph, the term 'menstrual care product' means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.''

- CARES Act
  - Section 3702 allows any telehealth (*and other remote care*) treatment below HDHP deductible without adversely impacting HSA eligibility.

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## Coronavirus Legislation Impact on Employer Group Health Plans

- Coverage for treatment is allowed, but not required (see discussion below regarding COVID *testing* mandate).
- What is telehealth (or other remote care)?
  - Effective for PY commencing before 12/31/2021.
  - Will it be extended?
- Implications far broader than COVID treatment.
  - Wellness programs.
  - Remote monitoring of chronic care.



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## Mandated Testing Coverage: Families First Coronavirus Response Act, as amended by CARES Act

- Effective March 18, 2020 for duration of public health emergency.
  - Public Health emergency extended through January 20, 2021.
- GHPs *must cover* testing—without cost-sharing, preauthorization, or other medical management requirements.
  - Response Act referred only to FDA approved testing.
  - CARES Act requires coverage of the following (in addition to FDA approved):
    - Tests for which the developer has requested or intends to request an emergency use authorization (EUA) from the FDA, unless such request has been denied or the developer does not submit the request within a reasonable period.
    - Tests developed in and authorized by a State that has provided notification to HHS.
    - Any other test as determined by HHS.
    - Changes effective on March 27, 2020.

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## Mandated Testing Coverage: Families First Coronavirus Response Act, as amended by CARES Act

- Coverage must include related services furnished during urgent care, emergency room, or in-person or telehealth provider visits that result in a covered diagnostic test being ordered.
- In addition, related items and services must be covered only to the extent that they relate to the administration or furnishing of the test or to the evaluation of the individual for purposes of determining the need for the test.



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## Mandated Testing Coverage: Families First Coronavirus Response Act, as amended by CARES Act

- OON Charges
  - Response Act was silent.
  - CARES Act requires plans to pay the OON provider of the testing the cash price for the test as listed on a public website of the provider, unless the plan/provider negotiate a lower price.
    - Providers are subject to a fine of $300 per day for failure to post.
    - FAQs further clarify OON charges and services.
- Mandate applies to all GHPs, including grandfathered plans
  - Applies to private, governmental, and church plans.
  - Not applicable to excepted benefits.
  - Not applicable to Retiree only health plans.

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## Agency ACA FAQs 43

- FAQs 1-7 - Diagnostic Testing Coverage Mandate
  - All diagnostic tests listed on the FDA website must be covered.
  - At-home testing generally must be covered.
  - Test must be "ordered" by an "attending health care provider."
  - Testing conducted to screen for general workplace health and safety, public health surveillance, or otherwise not intended for individualized diagnosis or treatment is not within the mandate.
  - Multiple tests must be covered.



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## Agency ACA FAQs 43

- Out-of-Network Coverage for Testing
  - FAQs 8-11 Balance billing is generally precluded for testing covered by the mandate.
    - Plan should be paying the provider's listed cash price for the test, so there should be no balance due.
    - Other out-of-network services may be subject to balance billing
  - FAQ 12 -- CARES Act supersedes the ACA rules on OON emergency care ("greatest of three") to the extent a test is provided in an emergency department.

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## Agency ACA FAQs 43

- FAQ 13 SBC and Notice of Revoked Coverage
  - If a plan reverses enhanced coverage after the pandemic, SBC advance notice requirement will be deemed satisfied if:
    - The plan previously noted the general duration of enhanced coverage, or
    - The plan provides "reasonable" advance notice.
- FAQ 14 Telehealth
  - Plans that solely provide benefits for telehealth services are exempt from certain group market reforms (e.g., annual and lifetime limits and preventive care) for any plan year beginning before the end of the COVID-19 emergency.



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## Agency ACA FAQs 43

  - Other mandates, such as the prohibition on pre-existing condition exclusions, continue to apply.
  - Relief is limited to plans sponsored by large employers (> 50 employees) and offered only to individuals not eligible for coverage under any other GHP offered by the employer.
- FAQ 15: If a grandfathered plan adds benefits or reduces cost-sharing pursuant to the safe harbor in FAQs Part 42, it will not lose grandfathered status solely because those changes are later reversed.
- FAQ 16: For MHPAEA a plan may disregard benefits for the items and services that are covered without cost-sharing under the FFCRA for purposes of compliance with the "substantially all" and "predominant" tests.

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## Agency ACA FAQs 43

- FAQ 17: Plans are permitted to waive a standard for obtaining a reward under a health-contingent wellness program, so long as the waiver is offered to all similarly situated individuals.
- FAQ 18: Employers considering offering an ICHRA for the first time should consider whether they can provide the ICHRA notice far enough in advance that eligible employees have sufficient time to make an informed decision about enrollment.



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## COVID-19 Immunization Required Preventive Care

- CARES Act accelerates the date by which "qualifying coronavirus preventive services" are treated as required preventive care that must be covered without cost-sharing.
- Applies to an item, service or immunization that is intended to prevent or mitigate COVID-19 and that is:
  - An evidence-based item or service that has a A or B rating from the USPSTF, or
  - An immunization that has a recommendation from the Advisory Committee on Immunization Practices of the CDC.
- Such items and services must be covered 15 days after the date of the recommendation.

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## COVID-19 Immunization Required Preventive Care

- 10/28/2020-Tri-Agency Interim Final Regulations (IFR) (expanded coverage of COVID 19 preventive services otherwise required by statute, which connected to existing 2713 rules/regulations).
- Effective November 6, 2020.
- Sunsets at the end of the COVID-19 public health emergency (currently set to expire on January 20, 2021).
- After sunset, the statute/existing regulations apply.



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## COVID-19 Immunization Required Preventive Care

- Under the ACA immunizations were covered if they were approved for "routine use."
  - ***The IFR waives the routine use requirement.***
  - Must be covered without cost sharing (deductible, co-insurance, co-payment) whether in-network or out-of-network.

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## COVID-19 Immunization Required Preventive Care

- Plan payment to out-of-network provider must be meaningful.
  - "..reasonable as determined in comparison to prevailing market rates for such service."
  - Preamble to the IFR provides: "The Departments will consider the amount of payment to be reasonable, for example, if the plan or issuer pays the provider the amount that would be paid under Medicare for the item or service."
  - Medicare payment rates for COVID-19 vaccine administration will be $28.39 to administer single-dose vaccines. For two or more doses it will be $16.94 for the initial dose(s) and $28.39 for the final dose.
  - Out-of-network can still balance bill.
- Toolkit for health and drug plans: https://www.cms.gov/files/document/COVID-19-toolkit-issuers-MA-plans.pdf.



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## HDHPs and Coronavirus Coverage

- IRS Notice 2020-15 (Mar. 11, 2020)
  - HDHPs are permitted to provide benefits for testing and treatment of COVID-19 without a deductible—or with a deductible below the applicable HDHP minimum deductible.
  - Individuals can remain covered under HDHPs that provide such benefits without any adverse effect on HSA eligibility.
    - Note: Many states had mandates such coverage for insured plans.
  - Telemedicine generally (i.e., outside of COVID) not addressed.
    - CARES Act *allows* (but does not require) first dollar coverage.
    - First dollar coverage is *mandated* by Response Act but only for testing.



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## Additional GHP Considerations

- Ongoing GHP eligibility typically requires meeting minimum hours of service requirements.
  - A furlough/layoff or leave of absence may cause an employee to lose GHP eligibility, unless the plan provides otherwise.
    - Affordable coverage likely required for those on furlough (assuming not terminated employment) if in a full-time stability period.
      - If unpaid, typically no hours allocated to the furlough period for measurement period purposes.
      - If paid, hours must be allocated for measurement period purposes.



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## Additional GHP Considerations

- COBRA will typically be available if lose coverage eligibility
  - Coverage should not be voluntarily extended without amending plan language.
    - Approval from any insurer (or stop-loss insurer for self funded) may be required.
- Voluntary "stand-alone" extension of COVID benefits beyond GHP footprint (e.g., telehealth for all or wellness program) may raise ACA compliance concerns.
  - Agencies expanded EAP guidance to allow for COVID testing.

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## State Law Potpourri

Following the elimination of the individual mandate, several states passed individual mandate laws that also require reporting by coverage providers, including employers who sponsor group health plans.

To date, the following states have passed such laws:

- New Jersey,
- Washington D.C.,
- Vermont,
- Rhode Island, and
- California.



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## State Law Potpourri

New Jersey and D.C.'s laws are effective in 2019, which means reporting will be due in 2020. The others become effective in 2020 with reporting to commence in 2021 (for 2020). Insurers and plan sponsors that cover residents in these states should ensure compliance with these requirements.

Additional states have imposed mandates with regard to transit/transportation plans and FSA use/lose requirements.

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# Cafeteria Plan, Grace Period, And Carry-over Relief



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## IRS Notices 2020-29 and 2020-33

- The problem . . .
  - Technically, with a few exceptions, no changes allowed if furlough does not impact eligibility.
- The solution . . . Optional changes allowed *for 2020*:
  - Cafeteria plan elections – but generally only health.
  - FSA elections – but no refunds allowed.
  - Grace period – beware impact on HSA.
  - Carryover – amount increased for 2020 PY.



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## Notice 2020-29 – Cafeteria Plan Elections

- Not a Free For All
  - Prospectively enroll employee or family member in employer sponsored health coverage without an event;
  - Prospectively change to another health plan option of the same employer without an event;
  - Prospectively revoke health coverage but only if attestation is provided that the employee is or will be enrolled in other health coverage not sponsored by the employer.
- Amendment required by December 31, 2021.



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## Notice 2020-29 – FSA Elections

- Prospectively enroll, increase, decrease, or revoke FSA elections for any reason.
- By plan design employers may limit decrease/revoke to the FSA reimbursement already provided (e.g. if elected 2500 and have received 2000, you may limit decrease to 2000 so that salary reductions will cover the reimbursement).
- Although salary reductions must be prospective, any increase may apparently be used for amounts incurred in the plan year prior to the election change.
- Also, as salary reduction contributions are changed, changes likely will need to be made to the available FSA coverage level.
  - IRS guidance on how to address health FSA coverage levels post mid year election changes is not clear (split coverage period, etc.).
- Changes may not be retroactive (i.e. no refunds or retroactive enrollment).
- Amendment required by December 31, 2021.

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## Notice 2020-29 – Grace Period

- Extension of Grace Period for Plan Year or grace period ending in 2020.
  - This means not applicable for 2019 CY plan where plan does not have grace period.
- Grace period ending in 2020 may be extended through December 31, 2020.
- A plan year ending in 2020 without a grace period may extend the plan year through December 31, 2020.
- The extension of the Plan year through December 31, 2020 is allowed even if a plan also has a carryover.
  - Thus effectively allowing a combination of the grace period and carryover for 2020.
- An employer that adopts this rule for a general health FSA will make an employee ineligible for an HSA through at least December 31, 2020.
  - Consideration should be given to ending the grace period as of November 30, 2020 to allow HSA eligibility and a full contribution through the December full contribution rule.



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## Notice 2020-33 - Carryover

- New indexing with carryover amount increased to $550 for plan years beginning on or after January 1, 2020.
  - Thus, the carryover for the 2019 plan year that is used in 2020 is still 500.
- Plan amendment required by December 31, 2021.

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# COBRA, Claims and Appeals, and Special Enrollment Extensions



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## IRS/DOL Joint Notice

- Joint Notice issued by DOL/IRS on April 28, 2020.
  - HHS was consulted and agrees; exercise enforcement discretion but extension of certain deadlines not mandatory for non-federal governmental plans.
  - Extends certain time periods to the end of the "Outbreak Period."
- Employee/Participant extensions ***mandatory*** as opposed to the discretionary changes to cafeteria plans under IRS Notice 2020-29.
- FAQs issued along with the Joint Notice.



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## Timeframe Extensions—General Rule

- When applying certain time frames, the period March 1, 2020 through a date that is 60 days after the end of the National Emergency ("Outbreak Period") is disregarded.
  - Unclear when National Emergency will end.
    - Additional guidance is promised if the National Emergency ends at different dates for different parts of the country.
    - Cannot extend beyond a year under ERISA Section 518.
    - Distinct from Public Health Emergency (scheduled to end January 20, 2021).
  - Technically has a retroactive effect to March 1, 2020.



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## Timeframe Extensions

- 30/60 day HIPAA special enrollment periods (only group health plans that provide other than excepted benefits).
- 60-day COBRA election period.
  - Qualified beneficiaries must elect COBRA within 60 days from the later of the date that coverage is lost as a result of the event or the date the notice is received.
- 45-(initial) and 30-day (subsequent) COBRA premium deadlines (group health plans).
  - Qualified beneficiaries have 45 days from the date COBRA is elected to pay the first premium.
  - Qualified beneficiaries have a 30 day grace period each month thereafter to pay the monthly COBRA premium.

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## Timeframe Extensions

- COBRA Election Notice from Plan Administrator.
- COBRA Qualifying Event Notice from Qualified Beneficiaries.
  - Qualified Beneficiaries must provide notice of the following qualifying events within 60 days of the event to preserve right to COBRA or an extension of COBRA coverage (if a 2nd qualifying event):
    - Divorce.
    - Child ceasing to be a dependent.
    - Covered Employee (retiree)'s Medicare Entitlement.
- 60 day period for Qualified Beneficiaries to provide a notice of a determination of disability by the Social Security Administration.



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## Timeframe Extensions

- Time period for filing claims and appeals under the plan in accordance with ERISA Section 503.
  - Includes Health FSA/HRA runout periods.
- Time period for requesting external review and providing additional information for external review under ACA (only non-grandfathered group health plans).

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| | COBRA election and premium extensions | Claims and appeal extensions | External review extensions | Special enrolment election extensions |
|---|---|---|---|---|
| ERISA Group health plan ( GHP) | Y | Y | Y | Y |
| Church GHP | n/a | Y | Y | Y |
| Governmental GHP | Y | Y | Y | Y |
| Grandfathered GHP | Y | Y | n/a | Y |
| ERISA excepted benefit (vision, dental, FSA) | Y | Y | n/a | n/a |
| Church excepted benefit (vision, dental, FSA) | n/a | n/a | n/a | n/a |
| Governmental excepted benefit (vision, dental, FSA) | Y | n/a | n/a | n/a |
| Other ERISA plan (e.g., disability) | n/a | Y | n/a | n/a |
| Non-ERISA plan (e.g., dependent care or transit) | n/a | n/a | n/a | n/a |



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## Notices/Disclosures/Communications

- What does the Joint Notice require?
  - Joint Notice does not prescribe any communications or disclosures regarding the extensions.
  - Fiduciary duty dictates notice must be furnished.
  - EBSA Notice 2020-01 provides some disclosure relief if acting in good faith.
- Documents/notices that may be affected:
  - HIPAA special enrollment notice.
  - General COBRA Notice.
  - SPD.
  - Welfare plan documents.
  - Cafeteria plan documents:
    - Cafeteria Plan.
    - Health FSA.
  - COBRA Election Notice .
  - EOBs from vendors.



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## Plan of Action

- Minimum defensible plan (as soon as practicable):
  - Post summary of changes on benefits website and notify participants (e.g. email or postcard) that extensions to certain time periods are on the website).
  - Reach out to participants and qualified beneficiaries whose election period and/or premium payment period and/or appeal period have already expired during this Outbreak Period.
    - Website posting likely not accessible to qualified beneficiaries.
  - Reach out to vendors and carriers.
    - Standard approach vs. custom approach?
    - Will there be additional fees?



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## Plan of Action: COBRA

- Complete COBRA Election Notice as usual but provide supplement explaining timeframe extensions.
  - Why not revise notices?
- What about those whose election deadline or COBRA premium deadline would otherwise fall within the Outbreak period but did not receive the supplemental notice?
- Best practices is to send a postcard.
  - Deadlines for electing COBRA coverage and paying premiums have been suspended during the COVD-19 Outbreak Period beginning March 1, 2020
  - We do not know, at this point, when the Outbreak Period will end.
  - If you would have otherwise been required to make a COBRA election or submit a premium payment during the Outbreak Period and failed to do so you may have more time.
  - For more information please contact (telephone number and website).



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## Plan of Action: COBRA

- COBRA regulations have not changed for coverage prior to election and payment of initial premium.
  - Two options:
    - No coverage but retroactively reinstate.
    - Coverage but retroactively terminate.
  - Most are electing the first option.
  - Coordination carriers is critical (fully insured and stop loss).
    - Many previously only allowed 60-90 day retroactive reinstatement.
    - Unclear whether Joint Notice binds fully insured carriers.
    - Anecdotally we hear that most will reinstate in accordance Joint Notice.



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## Plan of Action: COBRA

- Communication with healthcare providers.
  - Regulations provide that the plan must inform the provider that there is no current coverage but coverage can be reinstated retroactively if there is an election and payment of the initial premium.
  - Most fully insured plans and ASOs just have covered/not covered indicators (nothing for pended).
- Failure to pay monthly premium that would have been due but/for the extension.
  - Joint Notice provides that the plan "may not deny coverage, and may make retroactive payments for benefits and services received by the participant."
- Appears to allow coverage to be suspended (not denied) until monthly premiums are actually paid.

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## Plan of Action: COBRA

- Communications to the qualified beneficiary of the coverage "suspension".
  - This is not a notice of early termination of COBRA coverage.
- Communications with health care providers who inquire about coverage.
  - Most insurers/ASOs do not have a "suspended/pended" indicator.
- COBRA election period or premium grace period begins before March 1 but would otherwise end during the Outbreak Period.
  - Example. Bob was sent a COBRA Election Notice on January 14th and election would have otherwise been due on March 14th.
  - Under the Joint Notice Bob would have 14 days after the end of the Outbreak Period to elect COBRA.



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## Plan of Action: COBRA

- If a due date would otherwise fall within the Outbreak Period some COBRA administrators are allowing the full election or grace period after the end of the Outbreak Period.
  - In this example Bob would be provided 60 days to make an election after the end of the Outbreak Period instead of 14.
- Make sure carrier (fully insured or stop loss) agrees to provide coverage beyond what is required in the Joint Notice.
- Communication to qualified beneficiaries.
- Similar Issues with HIPAA special enrollment and not pro-rating days.

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## Plan of Action: Plan Documents/SPDs/SMMs/EOBs

- EBSA Notice 2020-01 provides some disclosure relief if acting in good faith.
  - In the short-term website posting/postcards.
- SMM is not due until 210 days after the end of the plan year.
  - Outbreak Period will presumably be over by then for most plans.
- Best practice is still to send an SMM and amend plan documents.
  - In some plan designs, SMMs also serves as a plan amendment.
- Reach out to carriers/TPAs/ASOs with regard to EOBs and time frames for appeals disclosed in the EOB.



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## DOL Revises Model COBRA Notices

- On May 1 the DOL issued FAQs and revised model COBRA general and election notices .
- The model notices now include a section on the interaction between Medicare and COBRA and explain:
  - The 8-month special enrollment window to elect Medicare.
  - Electing COBRA coverage instead of Medicare when first eligible may lead to Part B late enrollment penalties.
  - When Medicare will be primary and when COBRA coverage may end early after enrolling in Medicare.

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## DOL Revises Model COBRA Notices

- The FAQs reiterate that use the model general and election notices (if properly completed) will be deemed to comply with the notice content requirements of COBRA.
  - *Note:* the DOL model notices are deficient in some aspects and will need further revisions if used.
- This "safe harbor" only applies to enforcement actions by the DOL.
- Participants and beneficiaries may still file suit under ERISA § 502(a)(1)(b) seeking damages and statutory penalties of $110 dollars per day for COBRA notice failures.



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## Thanks!

- Questions?