COVID-19 Compliance Considerations for Group Health Plans in 2021

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COVID-19

- In October, HHS renewed its determination that a public health emergency exists nationwide as a result of the COVID-19 pandemic
  - Jan. 20, 2021 expiration unless extended or terminated. The original determination, which declared that a public health emergency existed as of January 27, 2020, was previously renewed in April and July. Many key compliance deadlines are tied to the duration of the public health emergency.
- Pertinent Legislation for Today's Webinar:
  - Families First Coronavirus Response Act (FFCRA) (3/18/2020)
  - Coronavirus Aid, Relief, and Economic Security (CARES) Act (3/27/2020)
  - Consolidated Appropriations Act, 2021 (CAA) (12/27/2020)

Agenda

- Review FFCRA and CARES Act requirements for cost sharing on COVID testing and COVID preventive services
- Review wellness program updates relating to COVID
- Review HSA telehealth exception
- Discuss OTC and Menstrual Care Product reimbursement guidelines
- 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 Cafeteria Plan relief in response to COVID

GHP Coverage Requirements for COVID

Covering Diagnostic Testing - Related Items and Services

COVID Coverage Requirements

- FFCRA §6601, as amended and expanded by CARES Act §3201 et seq., generally requires GHPs to cover COVID-19 related diagnostic testing and related items and services to employees and covered dependents at no cost and with no pre-authorization or medical management requirements

- Temporary law effective 3.18.20 through the expiration of the HHS public health emergency

- Applies to GHPs, including self or fully-insured plans, grandfathered plans, church plans, non-federal government plans, but not to excepted benefit plans (e.g. stand-alone dental, vision or retiree-only plans) - Grandfathered plans will not lose grandfathered status when legally-required benefits are cut back to pre-COVID levels after the pandemic

COVID Coverage Requirements

- Diagnostic Testing of COVID-19 must cover FDA-approved tests, tests a developer has submitted to the FDA for emergency use authorization, tests authorized by a state and any other tests HHS deems appropriate – diagnostic testing also includes serological tests to detect antibodies to the virus

- To be covered without cost-sharing, agency FAQ guidance (Part 43) issued in June provides that test must be medically-appropriate for the individual as determined by "attending health care provider" based on CDC guidelines - Return to work or other screenings not based on individual determination need not be covered

- Includes diagnostic testing in any setting (doctor's office, urgent care, emergency room, telehealth, home testing, etc.) – and whether in network or out of network

- Includes the evaluation of COVID-19, even if the actual COVID test is deemed unnecessary

- No limit on the number of diagnostic tests covered if meet requirements

COVID Coverage Requirements

Other Items and Services:

- A GHP may impose cost-sharing on the *treatment* of COVID-19 and coverage for treatment by large GHPs or self-insured plans not mandated (EHB in small group)
- No cost sharing for:
  - Items and services provided during a visit resulting in order of a COVID diagnostic test
  - Facility fees, including emergency room charges

COVID Coverage Requirements

- GHPs may rely on negotiated rates with providers in place as of January 27, 2020 for cost of testing for the entire duration of the public health emergency declared by HHS – but GHPs without negotiated rates
  - Must pay the cash price for the diagnostic test published by the provider on a publicly accessible website (failure to post cash price of testing subject to fines)
  - A lower rate may be negotiated (but not a higher rate)
- CARES Act reimbursement rates for COVID testing at OON emergency rooms supersedes ACA OON emergency services reimbursement requirements
- No balance billing for test itself under CARES Act, but balance billing for testing-related items and services was not prohibited – "No Surprises Act" included in CAA and provides a dispute resolution following mandated negotiation where no state law applies.

COVID Coverage Requirements

Next Steps Relating to Diagnostic Testing Requirement

- Ensure GHP is amended to provide for the waiver of cost sharing
- Provide Notice to Participants/SMM
- Review SBC for required updates
- Consider directing participants to in network testing facilities or those with transparent pricing to avoid negotiation or balance billing disputes
- Exclude additional costs associated with testing coverage requirement from Mental Health Parity analysis

Covering the COVID Vaccine Preventive Care Requirements

COVID Coverage Requirements

- CARES Act amended ACA Preventive Care Requirements to provide accelerated coverage of COVID vaccines and other preventive items and services with no cost sharing – an agency Interim Final Rule effective 11.2.2020 provide guidelines for implementation
- Applies to all non-grandfathered GHPs and issuers.
- The CARES Act preventive care mandate for COVID vaccines, items and services has no expiration date. The Interim Final Rule implementing the rule sunset at the end of the declared public health emergency.

COVID Coverage Requirements

- The CARES Act requires non-grandfathered group health plans and issuers to cover COVID-19 vaccines and other preventive services without cost sharing beginning just **15 business days** after a recommendation from Centers for Disease Control and Prevention (CDC)'s Advisory Committee on Immunization Practices (ACIP) or an "A" or "B" recommendation from US Preventive Services Task Force (USPSTF).

- As background, ACA requires coverage of new preventive services without cost sharing by the first plan year starting on or after one year from the end of the month when USPSTF or ACIP made the recommendation and for vaccines apply only to those designated for routine use.

COVID Coverage Requirements

- Non-grandfathered GHPs must cover the COVID-19 vaccine without cost-sharing, regardless of whether the plan member receives the vaccine in-network or out-of-network.
- OON reimbursements must be reasonable and preamble to Interim Final Rule suggests the Medicare reimbursement rate would be reasonable – HHS has provided a toolkit for providers to aid in this determination

COVID Coverage Requirements

- Even if federal government or a third party pays for cost of vaccine, GHPs must pay for costs of administration – applies to all preventive care services under ACA, not just COVID
- Specifically, guidance prohibits cost sharing for an office visit if patient receives covered preventive service, but only if visit not billed separately and primary purpose to provide preventive care
- Next steps –
  - review plan document to determine if amendment to preventive care language is required (most likely)
  - provide notice to participants
  - Seek legal counsel on vaccine policies for the workplace, including wellness programs

Wellness Considerations

Wellness Updates

- COVID FAQs Part 43 (June 23, 2020) clarify an employer may waive a standard, including a reasonable alternative standard, to receive an award if circumstances related to the COVID-19 public health emergency make meeting the health contingency difficult.
  - Must be offered to all similarly-situated employees
  - Individual waivers are permitted, but if the reason for the waiver is COVID related, employer should extend to all employees
- New EEOC Proposed Wellness Regulations just released – caution for employers planning to incentivize proof of COVID-19 vaccine
  - Only de minimis incentives for programs that are not health-contingent/group health plan related
  - Incentives for health-contingent align with HIPAA/ACA rules

HSAs & Telehealth

COVID-19 – Telehealth Relief

- Permitted expansion of telehealth services and other remote care services through CARES Act and IRS Notice 2020-15 - CARES Act - Temporary safe harbor allowing HDHP participants to remain HSA-eligible even if receive telehealth services before satisfying the plan's statutory minimum deductible.
  - CARES Act relief applies to COVID-19 related and non-COVID-19 related telehealth
  - Expires last day of plan year beginning on or before 12.31.21
  - Per IRS Notice 2020-29, applies to services provided on or after 1.1.2020
- IRS Notice 2020-15 – Allows HDHPs to cover COVID-19 testing and treatment prior to meeting deductible without affecting HSA eligibility. No expiration date. Per IRS Notice 2020-29 applies to services on and after 1.1.2020
- Employers should amend plans as this is optional relief and notify participants

Medical Reimbursements

Medical Reimbursement Updates

The following items of services may be covered by various account-based health plans as of January 1, 2020

- Over-the-counter drugs without a prescription (under the ACA, OTC drugs—other than insulin—could only be covered with a prescription)
- Menstrual care products (tampons, pads, liners, cups, sponges or similar products)

- Applies to reimbursements under health FSAs, HSAs, HRAs, as well as other accident and health plans
- These changes generally apply to expenses incurred after December 31, 2019; except in the case of HSAs, it applies to amounts paid after that date. No expiration date.

Medical Reimbursement Amendments

Next Steps:

- Amend plan
- Review plan terms and consider whether retroactive effective date permitted under plan terms (IRS granted relief retroactively, however)
- Provide Notice to Employees
- Coordinate with vendors on administration of plans

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 January 20, 2021

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. 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 April 18, 2021 (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 May 19, 2021 (60 days after the end of the Outbreak Period)

Extended Timeframes

- COBRA Deadlines
  - Example: On February 1, 2020, John began 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 March 1, 2021 John has made no premium payments. 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 April, 18, 2021 (30 days after the Outbreak Period) will be considered timely and John is entitled to COBRA continuation coverage for those months for which he timely makes payment (commencing as of March 1, 2020)

Extended Timeframes

- COBRA Deadlines
  - Example: Same facts as the last example, but John only makes a payment equal to two months' premiums by April 19, 2021. 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
    - Benefit claims include all reimbursement request - not just official appeals (e.g. claims for services or FSA reimbursements)
- 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, however, notice is recommended

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 – CAA expanded on this relief
- 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 (CAA extends to plan years ending in 2021)
- 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
- CAA increases the maximum age of a dependent for purposes of incurring eligible DCAP expenses to 14, from 13 for dependents who attain age 13 during the last plan year whose enrollment period ended on or before January 31, 2020

Cafeteria Plan Relief

- 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 – expanded by CAA for plan years ending in 2021
  - 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 – no relief
- For plan years ending in 2020 or 2021, the CAA permits cafeteria plans offering Health Care FSAs and/or DCAPs with a grace period to extend the grace period to 12 months after the end of the plan year.
- CAA also permits FSAs to reimburse terminated participants for expenses incurred through the end of the plan year in which the participant ceased participation in the FSA, provided the participant terminated participation in the calendar year 2020 or 2021.

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) – CAA expanded the carryover and appears no limit on amount
- For plan years ending in 2020 or 2021, the CAA permits Health Care FSAs and/or DCAPs to include a carryover feature. For plan years ending in 2020, may allow participants to carry over unused amounts remaining in the FSA at the end of the plan year to the plan year ending in 2021. For plan years ending in 2021, the FSA may allow participants to carry over unused amounts remaining in the FSA at the end of the plan year to the plan year ending in 2022.
- 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 for coverage provided during 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

Plan Amendments & Participant Notices

- Employers are not required to make changes to their cafeteria plans permitted under CAA and 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 (However, as extended by CAA, amendment required by last day of first calendar year beginning after end of plan year in which amendment is first effective)
    - 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 calendar year plan year, the deadline to amend is extended to December 31, 2021

Final Questions

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Thank You

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