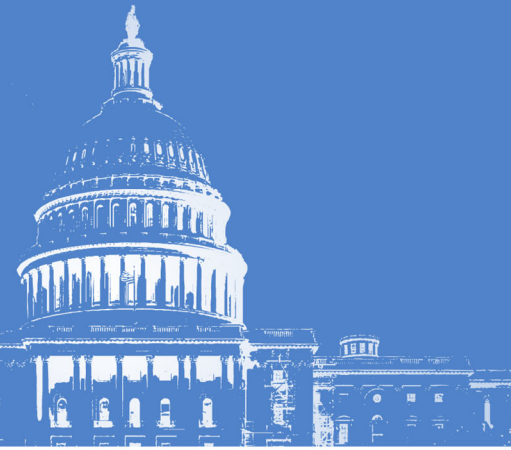


# COMPLIANCE BULLETIN



## Updating Health Plans for Coronavirus Changes

Employers may be considering changes to their group health plans in response to the ongoing COVID-19 pandemic. In some cases, health insurance issuers for fully insured plans may be initiating some of these changes to help individuals impacted by the pandemic. These changes may include:

- Waiving certain eligibility requirements for employees who have been furloughed or laid off or had their hours reduced; and
- Offering a special mid-year enrollment window for employees who did not elect coverage during the last open enrollment period.

In addition, due to COVID-19 relief legislation, employers with health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) can amend these plans to allow for tax-free reimbursement of over-the-counter (OTC) drugs and menstrual care products.

COVID-19 legislation also allows employers with high deductible health plans (HDHPs) to amend their plans to allow coverage of COVID-19 treatment and telehealth and other remote care services, without a deductible.

### Action Steps

Employers that make changes to their plan's eligibility and enrollment rules should obtain prior written approval from their issuer (or stop-loss carrier for self-insured benefits). Also, employers that make health plan changes may need to update their plan documents and must communicate the changes to employees through a summary of material modifications (SMM).

### Highlights

Employers may be considering the following changes to their health plans:

- Waiving certain eligibility requirements for employees who are furloughed or laid off
- Offering a special mid-year enrollment window
- Allowing a health FSA or HRA to reimburse OTC drugs and menstrual care products
- Allowing an HDHP to cover COVID-19 treatment and telehealth without a deductible

### Important Dates

#### Jan. 1, 2020

Health FSAs and HRAs can reimburse OTC drugs and menstrual care products.

#### Jan. 1, 2020

HDHPs can reimburse telehealth and other remote care services without a deductible.



## Waiving Eligibility Requirements

Some health insurance issuers and group health plans are waiving certain eligibility requirements (for example, active employment or hours of service) to provide coverage to employees who would otherwise lose eligibility because they have been furloughed or laid off or had their hours reduced.

Employers that want to make these eligibility changes should take the following steps:

- ☑ To avoid any unintended liability, employers with fully insured health plans should **obtain their issuer's written approval before making any changes in plan eligibility requirements**. For self-insured health plans, employers should obtain this prior approval from their stop-loss carriers.
- ☑ **Review the plan's documents** to determine whether the plan's eligibility rules need to be updated to include these revised eligibility requirements; and
- ☑ **Communicate the changes to employees**. To do this, employers can provide an SMM. See below for more information on the deadlines for providing an SMM.

In addition, as a compliance reminder, employers that are subject to the Affordable Care Act's (ACA) employer mandate rules (or employer shared responsibility rules) and using the look-back measurement method to determine full-time employee status for plan eligibility should continue to follow the same general rules that applied before the COVID-19 outbreak. Under these rules, all paid leave must be taken into account and special rules apply for certain types of unpaid leave, including FMLA leave, and for rehired employees. Federal agencies have not issued any special guidance about the ACA's employer mandate rules in light of the COVID-19 outbreak.

## Offering a Special Mid-year Enrollment Window

Due to the COVID-19 health crisis, some health insurance issuers and group health plans are offering a special mid-year enrollment window to allow employees who did not elect coverage during their regular enrollment period to sign up for coverage. To avoid any unintended liability, employers that want to offer this additional enrollment opportunity should get written approval from their health insurance issuers (or stop-loss carriers for self-insured plans) before making this change.

In addition, employers must consider the tax rules for premium payments under Internal Revenue Code (Code) Section 125 and should take certain steps to implement the special enrollment window.

### *Section 125 Rules for Pretax Premiums*

If an employer allows employees to pay their health insurance premiums on a pre-tax basis, it must comply with the irrevocability rules of Code Section 125. Under these rules, employees must make their pre-tax elections before the first day of the plan year (or period of coverage), and those elections must be irrevocable until the beginning of the plan year. This means that, as a general rule, an employee who does not elect health plan coverage during open enrollment cannot later elect this coverage during the plan year and pay for it on a pre-tax basis.

However, on May 12, 2020, the IRS released [Notice 2020-29](#), which provides temporary flexibility for mid-year election changes under a Section 125 cafeteria plan **during calendar year 2020**. The changes are designed to allow employers to respond to changes in employee needs as a result of the COVID-19 pandemic. This guidance relates to mid-year elections for self-insured and fully insured employer-sponsored health coverage, health FSAs and dependent care assistance programs (DCAPs).

For employer-sponsored health coverage, a Section 125 cafeteria plan may permit an employee to prospectively:

- ☑ Make a new election if the employee previously declined coverage;
- ☑ Revoke an existing election and enroll in different health coverage sponsored by the employer; or
- ☑ Revoke an existing election, if the employee is or will be enrolled in other health coverage.

Employees may also prospectively revoke an election, make a new election or decrease or increase an existing election for a health FSA or DCAP. A plan may permit any of the election changes described above, regardless of whether they satisfy existing mid-year election change rules.

## Action Steps

Employers that want to implement this special enrollment opportunity should:

- ☑ **Determine whether newly enrolled employees' premiums will be paid on a pre-tax or after-tax basis.** Employers may allow employees to pay their premiums on pre-tax basis based on the new guidance provided by IRS Notice 2020-29 (described above).
- ☑ **Review health plan documents to determine if plan amendments are necessary.** Some plan documents may not require updating because they refer to the plan's enrollment opportunities in general terms. Plan documents that include more detail, such as describing the plan's initial enrollment period for newly eligible employees and annual open enrollment period, may need to be updated.
- ☑ **Communicate the special mid-year enrollment window to employees.** Employers should notify eligible employees as soon as possible about the special mid-year enrollment window and explain the relevant details, including the length of the window, the process for electing coverage, the effective date for coverage and the tax rules for premium payments (that is, pre-tax or after tax).

## Health FSAs and HRAs – Covering OTC Drugs and Menstrual Care Products

The [Coronavirus Aid, Relief and Economic Security Act](#) (CARES Act) provides that OTC medicines and drugs are qualifying medical expenses that may be paid for (or reimbursed) on a tax-free basis by an employer-sponsored health FSA or HRA. This change eliminates an Affordable Care Act (ACA) provision that required individuals to have a prescription for an OTC medication (except insulin) to pay for it on a tax-free basis with their health FSA or HRA.

In addition, the CARES Act provides that menstrual care products are qualifying medical expenses that can be paid for (or reimbursed) on a tax-free basis by a health FSA or HRA. Menstrual care products include tampons, pads, liners, cups, sponges or similar products used by individuals with respect to menstruation.

Both of these changes are **effective for expenses incurred on or after Jan. 1, 2020**.

It is expected that many employers will allow their health FSAs and HRAs to cover these new items, but employers are not required to do so. Employers that want to allow their health FSAs and HRAs to reimburse these items should:

- ☑ Consult with their third-party administrators (TPAs) to determine the process and timeline for implementing this change.
- ☑ Update plan documents, as necessary, to reflect that OTC drugs and menstrual care products are eligible expenses.



- Communicate changes to plan participants through an SMM.

### *Additional Flexibility for Health FSAs*

On May 12, 2020, the IRS announced the following options with respect to unused amounts in health FSAs and DCAPs.

- Due to the COVID-19 outbreak, employees may be more likely to have unused amounts in their health FSAs or DCAPs. [IRS Notice 2020-29](#) allows employers to permit employees to apply unused amounts remaining in a health FSA or a DCAP at the end of a plan year ending in 2020 (or a grace period ending in 2020) to pay or reimburse expenses incurred through Dec. 31, 2020.
- [IRS Notice 2020-33](#) increases the health FSA carryover limit for unused funds remaining at the end of a plan year from \$500 to \$550 to reflect indexing for inflation. This change is effective for plan years beginning in 2020 (and reflects the maximum amount that may be carried over to the immediately following plan year beginning in 2021).

## **HDHPs – COVID-19 Treatment and Telehealth Services**

Only individuals who are covered by HDHPs can make contributions to HSAs. To qualify as an HDHP, a health plan cannot pay medical expenses (other than preventive care) until the annual minimum deductible has been reached. However, in response to the COVID-19 crisis, HDHPs can pay for certain benefits before the required minimum deductible is met.

- [IRS Notice 2020-15](#) allows HDHPs to pay for **COVID-19 testing and treatment** before plan deductibles have been met, without jeopardizing their status. Also, according to the IRS, any COVID-19 vaccination costs count as preventive care and can be paid for by an HDHP without cost sharing.
- The CARES Act allows HDHPs to provide benefits for **telehealth or other remote care services** before plan deductibles have been met, for plan years beginning before Jan. 1, 2022.

[IRS Notice 2020-29](#) provides that these coverage changes may be applied retroactively to Jan. 1, 2020.

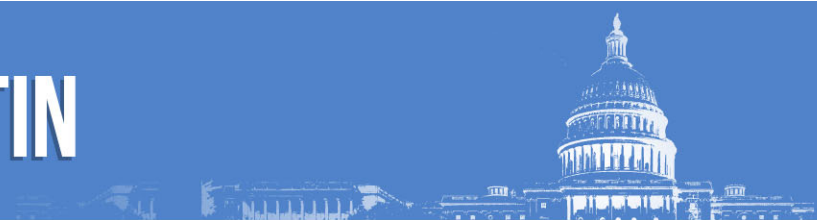
The FFCRA requires all employer-sponsored group health plans, including HDHPs, to pay for COVID-19 testing without a deductible. Employers with HDHPs can decide whether to extend this first-dollar coverage to COVID-19 treatment, as permitted by IRS Notice 2020-15. Employers with HDHPs can also decide whether to cover telehealth and remote care services without a deductible.

Employers with HDHPs should consult with their issuers or TPAs before making any discretionary changes to coverage. If changes are made, plan documents should be amended to reflect the expanded coverage and employers should communicate the changes through an SMM.

## **SMM Deadlines**

An SMM must be provided when there is a material modification in the terms of the plan or any change in the information required to be in the SPD. Because there is no legally required format for an SMM, it can take a variety of different forms, including a letter from an employer to its employees or a participant communication from an issuer or TPA. To help demonstrate compliance, the document should note that it serves as an SMM.

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Plan administrators must generally provide the SMM within **210 days** after the close of the plan year in which the change was adopted. However, if the change is a material reduction in group health plan benefits or services, the deadline for providing the SMM is **60 days after the change is adopted**. In addition, the ACA requires plan administrators and issuers to provide participants with a summary of benefits and coverage (SBC). Plan administrators and issuers must provide **60 days' advance notice** of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the SBC. The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.

The Department of Labor (DOL) has provided a [deadline extension](#) for notices and disclosures required under ERISA, (including SPDs and SMMs), if good faith efforts are made to provide the documents as soon as administratively practicable. The deadlines are extended by disregarding the period from March 1, 2020, until 60 days after the announced end of the National Emergency (or such other date announced by the DOL). Good faith acts include use of electronic means of communicating with plan participants who the employer reasonably believes have effective access to electronic means of communication, including email, text messages and continuous access websites.