CONNER STRONG & BUCKELEW

New Benefit Compliance Issues Related to COVID-19

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Welcome and Introductions

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About the Webinar

Due to COVID-19 pandemic, various federal regulations have been updated and changed, creating new obligations for employers and plan sponsors

From COBRA to cafeteria plan updates, new changes are confusing and complex

Webinar will outline actions employers and plan sponsors may need to take

We will discuss:

- Plan design changes and insurer issues
- Need to amend plans based on furlough and other temporary benefit changes made
- New COBRA/HIPAA notice timeline extensions
- New cafeteria plan options

Participant Questions/Requests:

- *I'd like to have a PowerPoint of the presentation to utilize for reference after the call*
  - Will be provided to all registrants
- *Please provide some step-by-step guidance as keeping up with all of the new changes is becoming overwhelming*
  - Presentation is designed to provide step-by-step guidance

Coverage of COVID-19 Diagnostic Testing Without Cost Sharing

- Group health plans must cover FDA-approved COVID-19 testing along with health care items and services necessary for tests, without any cost-sharing, prior authorization, or medical management requirements
  - Applicable to services provided by out-of-network providers at cost listed by provider on a public website or as negotiated by plan with provider
  - Applies during period 3/18/20 through end of COVID-19 National Emergency
  - Coverage required by this provision is temporary, but could be continued voluntarily by insurers or self-insured plan sponsors as matter of plan design beyond requirement's end date

Next steps

- Plan/policy should be amended if plan/policy does not contain a catch-all provision automatically including any legally required coverage
- Communicate coverage expansion to employees - SMM or SBC should be distributed as soon as reasonably practicable
  - Carriers and TPAs should provide materials describing these COVID-19 plan changes (employers be cautious in creating their own materials to ensure there are no inconsistencies with plan terms)

Participant Questions

What items and services must plans provide benefits for?

- Plans must provide coverage for following items and services.
  - An in vitro diagnostic test (e.g., nasal swab) for detection of SARS-CoV-2 or diagnosis of COVID-19 and administration of test
  - Items and services related to office visit, telehealth session, urgent care visit, or emergency rooms visit for COVID-19 diagnostics that result in an order for or administration of a COVID-19 test
  - Must be related to COVID-19 diagnostics/testing

May a plan impose any cost-sharing requirements, prior authorization requirements or medical management requirements for benefits?

- No. Plans may not impose any cost-sharing requirements (including deductibles, copayments and coinsurance), prior authorization requirements or other medical management requirements for these items and services.
  - These items and services must be covered without cost sharing when medically appropriate for individual, as determined by individual's health care provider

HSA-Qualifying HDHPs May Provide COVID-19 Treatment

Employers may choose to design their HSA-qualifying HDHPs to provide coverage for COVID-19 testing and treatment at reduced or no cost sharing without affecting HSA tax-advantaged contributions beginning 1/1/20

- So HSA-qualifying HDHPs may provide COVID-19 with no deductible or reduced deductible without destroying HSA tax-advantaged contributions

- Plan amendment and SMM may be required
- Contracts with carriers should be updated accordingly

This provision applies until further guidance is issued

Expansion of Telehealth and Remote Health Care Services

HSA-qualifying HDHPs may provide (first dollar) telehealth or other remote health care services for all medical conditions (not just COVID-19) with no deductible or reduced deductible without destroying HSA tax-advantaged contribution

- With respect to services provided on or after 1/1/20
- *This provision only applies to telehealth services provided in plan years beginning on or before 12/31/21*

These are optional provisions (not required) - simply permitted without causing loss of HSA eligibility

- If fully-insured it is up to insurance carrier to make determination to add first- dollar telehealth/remote care
- Self-insured employers can work with TPA and stop-loss provider to make this plan design decision
  - Contracts with carriers should be updated accordingly

COVID-19 Vaccination

Group health plans and issuers must cover COVID-19 vaccination without any cost-sharing

- Free coverage of preventive services or vaccines for COVID-19, should items or services become available
- To qualify, item, services, or immunization must be designed to prevent or mitigate COVID-19 and must be recommend by CDC
- Coverage mandate takes effect 15 business days after CDC recommendation

This provision accelerates normal one year deadline by which newly recommended preventive services have to be covered

Changes to Eligible HSA/FSA/HRA Expenses

HSA, HRA, and health FSA participants may be reimbursed for over the counter (OTC) medical products, without a prescription

- Expanded definition of medical products includes menstrual products (tampons, pads, liners, cups, sponges, or similar products)
- Applies for expenses incurred after 12/31/19

This is a permanent change

Next Steps

- Change will automatically apply to HSAs, but HRAs and health FSAs will need to be amended if plan includes a provision limiting OTC reimbursements to prescription medications
  - If plan refers to list of eligible expenses, it will not need to be amended since updated list will reflect expanded definition
- Prepare employee communications - SPD language should be reviewed to determine whether an SMM or other employee communication should be issued
- Advise FSA administrator to update system

Carrier Insurance Premium Relief

- Insurance commissioners across country urged carriers to be flexible with premium payments and not issue cancellations of policies for non-payment reasons
  - For example, NJ directing carriers to provide insureds experiencing COVID-19 related hardships minimum 90-day grace period to pay premiums and to continue paying claims during this period
- Not intended to change terms of issued policy/contract or be considered forgiveness of premium
  - Intended that insurer grant an extended grace period for payment of premium without penalty or interest

New/Updated State by State Responses

- CSB works closely with Council of Insurance Agents and Brokers on monitoring state legislation. To assist in keeping track, see updated state by state trackers, including new state re-opening legislation tracker:
  - State Reopening Orders & Application to Retail and Non-Retail Operations
  - State Regulatory Responses to COVID-19
  - State Legislative Action on Business Interruption Coverage
  - State Insurance Regulatory COVID-19 Updates
  - State Legislative Action on Presumption of Workers' Compensation Eligibility

CSB will continue to keep you updated as new information becomes available

Premium Reductions / Credits from Carriers

- With total claims now expected to be lower in 2020 due to COVID-19, health insurers may seek to offer policyholders discounted premiums, such as premium holidays or applying credits (against premiums due for future periods)

  Situation 1 - 100% employee paid dental plan

  - Options are suspend employee payroll deductions and apply credit until exhausted or where credit is not substantial enough to warrant administrative challenges of suspending contributions, continue employee payroll deductions but be sure all payroll deduction amounts are ultimately applied to premiums or other plan expenses
  - Or apply premium credit in next contract year to pay for benefits enhancements

  Situation 2 - contributory dental (only portion of premium is attributable to employee contributions)

  - Employer can't solely benefit - need to determine value of "reduction" to employees based on their share
  - E.g., carrier cuts bill by 25% for two months, employer needs to value that and determine what percent of 25% reduction is attributable to employee contributions
  - It is likely best employers take that value and simply apply it to employee contributions at next renewal
    - assuming carrier will agree, perhaps delay increasing employee contributions next contract year to keep pace with premium increases, or apply premium credit in next contract year to pay for a benefits enhancement

Employer cannot retain amount of premium credit attributable to participant contributions

Reduction in Hours and Furlough

Many employers have or will make difficult decisions to furlough, layoff, or reduce employee hours

- Raises eligibility questions under health, STD, LTD, long-term care, life insurance, EAP, dependent care, health FSA

Employer Actions Needed

- Review plan document to see how affected employees are to be treated under plan
- Amend plan as necessary to provide desired level of coverage
- Confirm coverage with insurers (or stop-loss carrier if self-insured)
- Review impact of furloughs or changes in employee status for compliance with ACA employer mandate
- Continue to track employee hours and evaluate through monthly or look-back methods and review options for offering coverage to FTEs during stability period to satisfy employer mandate
- If coverage will continue, determine how employee contributions will be paid for coverage during furlough
- If coverage will terminate, offer COBRA as required

Employers must maintain active health plan coverage for an employee on a protected leave (e.g., FMLA)

- Employee cannot be required to pay more than active employee-share of premium while on protected leave (cannot charge employees at 102% COBRA rate)

Layoff – COBRA, LOA and Extensions of Coverage

What happens to employees' health care coverage if they are on unpaid leave, layoff or furlough?

- Terms of health plan, insurer or TPA contract will determine whether active employee coverage can continue during short-term LOA
  - The health plan/policy may have language that allows for extension of coverage while employees are temporarily out of work, before eligibility is lost. Policy may refer to employees on furlough, standby, temporary layoff, or unpaid LOA, and coverage may be extended for limited period, usually 30-90 days
- Many plans have minimum hour requirements to maintain active coverage. If terms of plan do not permit coverage to continue during LOA, plan could be amended to do so. However, important to coordinate expansion of coverage with plan's insurer, TPA and/or stop loss carrier. Employers who expand coverage for ineligible employees outside terms of plan/policy without consent from insurer could lead to claims by newly-eligible employees not being covered

Does COBRA apply if employees are on unpaid leave, layoff or furlough?

- It depends. A reduction in hours can trigger loss of eligibility under health plan. In that case, coverage will often end (and COBRA coverage would start) at end of month, but if policy looks to number of hours worked in prior month, loss of eligibility may be delayed

Does COBRA apply if employees are terminated, and when?

- Yes, for employers with more than 20 employees an employee who is terminated and loses eligibility for health coverage must be offered up to 18 months of COBRA. Normally, employer-provided coverage usually ends at end of month in which termination occurs

Termination of Coverage - Subsidy Options

Furloughed and reduced hours employees may be eligible for COBRA if they lose coverage due to reduction in hours.

- COBRA is usually at employee's expense, although employers may choose to subsidize part or all of coverage to ensure employees do not lose coverage immediately
  - COBRA subsidies are common as part of severance benefits and for extended non-protected leave
  - Also common form of assistance upon loss of active coverage during COVID-19 emergency

- If employer subsidy will be offered, COBRA election notice will need to be tailored and plan amendment may be needed (depending upon plan terms)

- Discrimination will need to be considered for any COBRA subsidy offered for self-insured group health coverage

Participant Questions

Have any rules been released for employees that were newly hired prior to the pandemic and had not yet reached their initial eligibility for enrollment and are rehired as business resumes? Does their waiting period start all over again? Do they get credit for time previously worked?

- No special rules have been issued for COVID-19 for hours of service tracking for purposes of ACA counting rules
- Generally the waiting period would not start over and the employee gets credit for time previously worked if period of LOA is under 13 weeks

I am not sure if this will be touched upon during the webinar but I wanted to know if employees are out of work due to COVID-19, as the employer, am I allowed to charge them their sick time or do their days out of work not count towards their PTO if out due to COVID?

- An employer may require an employee with COVID to use PTO for the absence but this is subject to (a) provisions of employer's current vacation time, paid time off (PTO), and other applicable policies, and (b) any state laws restricting an employer's ability to interpret or amend those policies. However, employers with fewer than 500 employees should review obligations under the Families First Coronavirus Response Act (FFCRA), such as prohibition of requiring employees to use vacation or other PTO before using additional paid sick leave benefits afforded by FFCRA.
  - See DOL Questions and Answers Guidance at https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

Prescription Drug Copay Coupons and OOP Limit

- IRS current position is that prescription drug discounts must be disregarded in determining whether a HDHP deductible has been met
  - Therefore, it appears sponsors of HSA-compatible HDHPs must adopt a copay accumulator program in order to preserve participants' eligibility to make or receive HSA contributions
- A copay accumulator program tracks participants' use of prescription drug copay coupons and prevents prescription drug copay coupons from being credited toward a participant's deductible and OOP limit

COVID-19 and HIPAA

HIPAA applies only to protected heath information (PHI) obtained from health plan

- Employees are free to share their health information with anyone and for any reason

If my employee informs my company of COVID-19 diagnosis is this a HIPAA issue?

No. This information did not derive from a covered entity (the health plan) or a business associate

- Once employer receives COVID-19 diagnosis information from employee, employer still has non-HIPAA legal constraints - particularly under Americans with Disability Act (ADA)

May an employer take its employees' temperatures to determine whether they have a fever?

- Yes, employers may measure employees' body temperature during the pandemic

May an employer ask employees questions about exposure to COVID-19 upon return from travel during the pandemic?

- Employers may ask whether employees are returning from specified locations with heightened risk, even if employee displays no symptoms, and even if travel was personal

Employer Next Steps

- Review HIPAA policies and procedures, provide training as needed, and follow minimum necessary standard
- Look at technical, physical and administrative safeguards - focus on information access management procedures for remote access and contingency plan to protect confidentiality, integrity and availability of PHI

HIPAA Disclosures

HIPAA does permit covered entity's (health plan) disclosure of PHI to public health authority (such as CDC or state/local health department) in certain situations

- *Non-HIPAA Medical Inquiries*. If employees test positive for COVID-19, employer may be contacted by public health authorities seeking information about worker's symptoms, who they may have interacted with in workforce, and where they may have traveled
  - These types of inquiries are not governed by HIPAA because request does not include request to health plan (covered entity) for PHI
- *Health Plan Disclosures to Public Health Entities*. CDC, HHS or a state agency may directly request information from health plan to determine whether other persons have experienced symptoms consistent with COVID-19. HIPAA generally permits health plan to disclose PHI to public health authority to prevent or control the spread of an infectious disease. If health plan is unsure whether this permitted use exception applies, it could always seek an authorization from participant to disclose information
  - Even though an exception would permit health plan sponsor to disclose PHI without participant's consent, other HIPAA rules continue to apply, including minimum necessary rule (limiting scope of disclosure) and record-keeping requirements (tracking disclosures and making them available upon request)

Form 5500 Filing Deadline Extended Due to COVID-19

Limited automatic extension to 7/15/20 for filing certain Forms 5500 granted in connection with COVID-19

- Depends on plan year - does not extend deadline for 2019 calendar year plans
  - Due date for 2019 calendar year plans is still 7/31/20 (or 10/15/20 with Form 5558 extension)
- For PYs ending in September, October, or November 2019 (regular due dates 4/30, 5/31 and 6/30 respectively) - **filings now due 7/15/20**
- Automatically applies to previously filed extension requests
  - PY ended 6/30/19 (regular due date was 1/31/20 and extended to 4/15/20 due to Form 5558 extension request) – filing now due 7/15/20
- Form 5558 extension still available - measured from regular due date rather than 7/15 (e.g., PY ends 10/31/19 and normally due 5/31/20 would be extended by Form 5558 to 8/15/20)
  - Might be that due to automatic extension, filing Form 5558 by 7/15/20 may be acceptable

Good Faith Relief for Notice and Disclosure Deadlines

New guidance provides employee benefit plan and plan fiduciary will not be in violation of ERISA for failure to timely furnish a notice, disclosure, or other document that must be furnished during the "**outbreak period**" if they act "in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances."

- Outbreak Period is from 3/1/20 through 60 days following announcement of end of COVID-19 National Emergency
- Includes, among others, summary annual reports (SARs), SPDs, SMMs, etc.
  - Employer must act in good faith to furnish disclosures or notices as soon as administratively practicable
  - Employers should keep records of delays and their good faith distribution efforts
  - Good faith distribution includes electronic distribution if employer believes employee has access to email, text messaging, and employer website

Extended Timeframes Impacting COBRA/HIPAA

New rule tolls existing statutory deadlines for electing COBRA coverage (generally, 60 days) and making COBRA premium payments (generally, 45 days from election for the first payment and then generally 30 days thereafter). Applies to HIPAA 30 and 60 day special enrollment election periods also.

- For purposes of determining/calculating those deadlines, plans must **disregard** Outbreak Period (from 3/1/20 until 60 days after announced end of National COVID-19 Emergency)
- In terms of ending tolling period, DOL expects it will be tied to a Federal announcement and will not be state-by-state, although unclear if/how DOL will handle states that keep an emergency declaration in place after federal emergency is declared over
- To date, no COBRA premium amount relief has been provided (e.g., no government COBRA premium subsidy)

COBRA coverage that was cancelled due to non-payment of premiums prior to 3/1/20 will need to be retroactively reinstated if premiums are remitted by the newly extended deadline

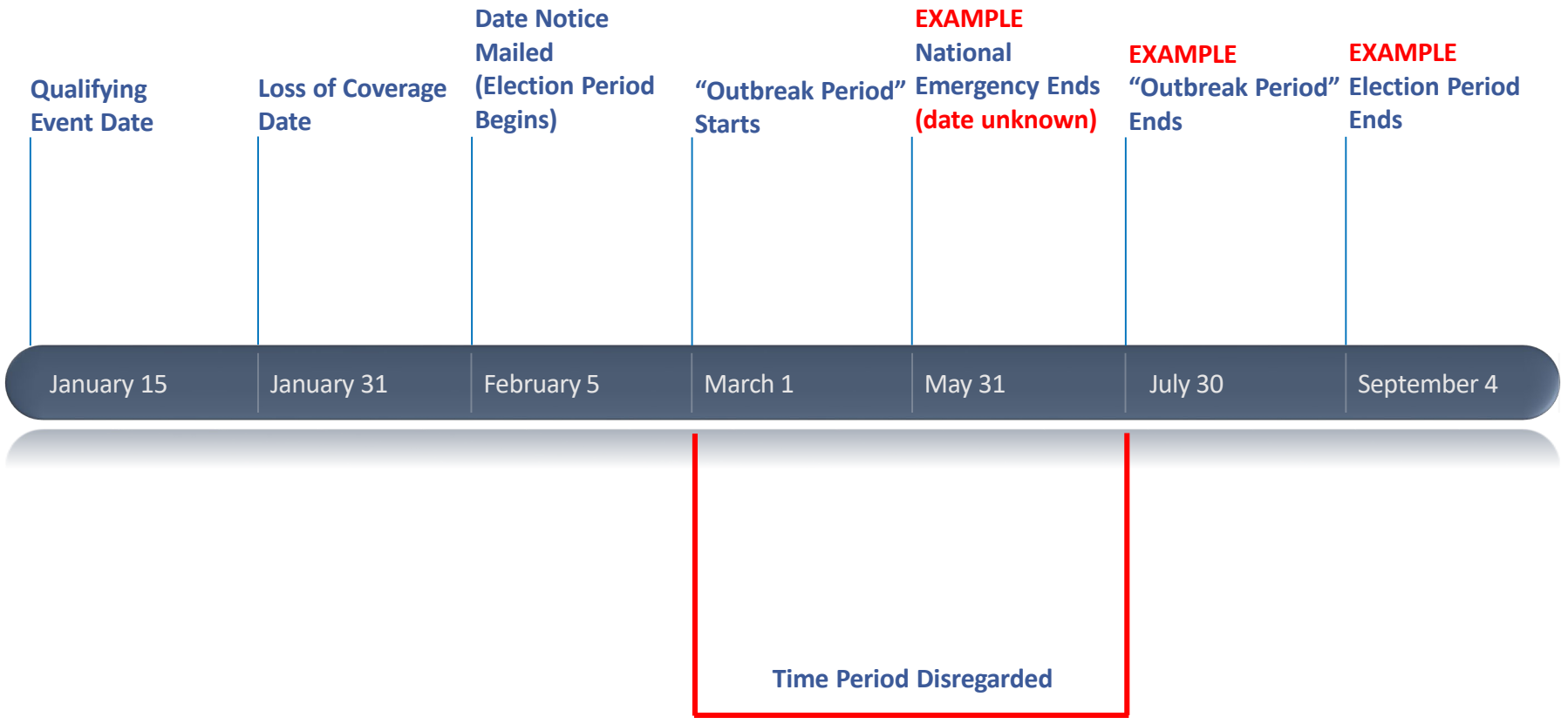
Previously expired COBRA election periods must be similarly extended

COBRA/HIPAA Election Period Chart

NOTICE/ ELECTION PERIOD	NORMAL TIME PERIOD	RELIEF PROVIDED
COBRA election period	Generally, begins at termination of coverage and ends not earlier than 60 days after notice to qualified beneficiary	**Election period ends 120 days after end of National Emergency** Example: Tom loses coverage based on a termination of employment and receives COBRA election notice on 4/1/20. Typically, Tom would have 60 days, or until 5/31/20 to elect coverage. Now, Tom has the Outbreak Period PLUS 60 days. So, assuming the Outbreak Period ends 6/29/20, Tom has until 8/28/20 to elect coverage. Note Tom can also elect COBRA immediately and in that case can defer all premium costs until after the Outbreak Period.
	First monthly payment typically due 45 days after election; subsequent payments typically due every 30 days	Tom's premium payments for the period of the National Emergency will be due no earlier than 90 days after end of National Emergency
HIPAA special enrollment (SEP) for new dependent due to marriage, birth or adoption	30 days after marriage, birth or adoption	**Enrollment period extended to 90 days after end of National Emergency** Example: Mary is eligible for, but previously declined participation in the group health plan. On 3/31/20, Mary gave birth and would like to enroll herself and the child into her employer's plan; however, open enrollment does not begin until 11/15/20. The Outbreak Period is disregarded for purposes of determining Mary's special enrollment period. Mary and her child qualify for special enrollment into her employer's plan as early as the date of the child's birth. Assuming the Outbreak Period ends 6/29/20, Mary may exercise her special enrollment rights for herself and her child into her employer's plan until 30 days after 6/29/20, which is 7/29/20, provided that she pays the premiums for any period of coverage.

COBRA Election Period Example

Election Period Example (End of National Emergency and "Outbreak Period" is still unknown)



Current COBRA Rules Apply During Tolling Period

Nothing in new guidance is intended to revise or undo any existing COBRA rules, except calculation of election and premium payment deadlines

- Current COBRA rules allow plans to:
  - Notify healthcare providers of beneficiary's COBRA status (e.g., "has not yet elected coverage and/or paid premiums, but still has opportunity to do so and will be covered when timely payment is made")
  - "Pend" beneficiary's claims until satisfaction of election and premium payment requirements
  - When (or if) beneficiary elects and pays within allowed timeframe – retroactively pay any claims back to when COBRA eligibility was triggered
- Alternatively, as allowed under COBRA rules, plans may pay claims during tolling period and notify providers that beneficiary is covered but that coverage will be retroactively terminated if beneficiary ultimately does not make timely payment
- DOL guidance did not change these rules - just dramatically extended timeframe in which elections can be made and premiums can be paid

Participant Question

A former employee who elected dental COBRA has asked if she can extend her continuation period since she couldn't get routine dental care during the COVID-19 emergency. Can former employees extend their COBRA periods from 18 months to a longer timeframe under the new law?

- No, extensions of COBRA coverage period are not provided for under extension rules

COBRA Tolling Period Process

Employer should determine process during tolling period

- Continue following normal processes regarding COBRA coverage during election period and following payment period
  - If coverage is normally continued during election and payment period and then terminated retroactively if COBRA election or payment is not timely received, coverage should be continued during tolling period, OR
  - If coverage is normally pended or terminated and then reinstated retroactively upon receipt of COBRA election and payment, same process should be following during tolling period

COBRA coverage cannot be terminated for nonpayment during tolling period

- All missed payments will be due within 30 days (or such longer period specified by the plan) following end of tolling period
- To extent payments are not made, COBRA coverage can be terminated retroactively to first coverage period for which payment in full is not received by extended deadline

Coordination of COBRA/HIPAA Administration

- Plan sponsors need to make proper adjustments in established COBRA/HIPAA procedures, and should contact COBRA/enrollment vendors to see how they are implementing this new temporary requirement and administering delayed deadlines (including not canceling COBRA coverage due to non-payment of premiums)
  - Guidance does not get into details on logistics for implementation
  - Employers need to work with COBRA administrators and other service providers to COBRA administrators/vendors have widely varying interpretations of DOL guidance on extension of COBRA deadlines to elect coverage and to pay premiums
- Employers need to communicate with COBRA administrators regarding whether to postpone provision of COBRA election notices during Outbreak Period
  - Although employers may delay sending COBRA election notices, employers may want to provide COBRA election notices as soon as possible (so that employees may elect and begin paying for COBRA if they so choose – rather than paying large premium later)
- Agency guidance is unclear as to whether these deadline extensions must be proactively and affirmatively communicated to employees
  - Employers probably have fiduciary obligation in this regard
  - Rules do not require employers to issue new notices (or reissue old notices)
  - Employers may issue notices with new information, add a standardized insert that explains the extended time frames, and/or direct individuals to DOL's online resources – see COVID-19 FAQs for participants

Extension of Timeframes for ERISA Plan Benefit Claims

DOL and IRS announce extension of ERISA claims procedure deadlines from 3/1/20 to 60 days following end of COVID-19 National Emergency

- Employer must honor delayed deadlines (e.g., accepting delayed filings of claims, appeals and, if applicable, external review requests beyond otherwise applicable deadline)
- If any claim, appeal or external review request was made on or after 3/1/20 and was previously denied due to untimeliness, denial should be reviewed to determine if claim, appeal or external review request must be considered based upon extended deadlines
- *Health FSAs are subject to ERISA claims procedures*
  - If run-out period within which to submit health FSA claims for 2019 would have expired on or after 3/1/20, employees must be given additional time to submit claims
- Employers need to work with TPAs for all ERISA plans to ensure proper administration of delayed deadlines

New COBRA Model Notices

Agencies issued Frequently Asked Questions under COBRA and revised COBRA model notices

- Plan administrators can use these model notices to notify plan participants and beneficiaries of their rights under COBRA and qualified beneficiaries of their rights to elect COBRA
  - COBRA Model Notice FAQs
  - COBRA Model General Notice
    - Spanish
  - COBRA Model Election Notice
    - Spanish
- Revised model notices provide additional information to address COBRA's interaction with Medicare
  - Explain there may be advantages to enrolling in Medicare before, or instead of, electing COBRA
  - Highlight that if an individual is eligible for both COBRA and Medicare, electing COBRA coverage may impact enrollment into Medicare as well as certain out-of-pocket costs
- Employers need to update their notices and should work with their COBRA vendors to review notice content, supplement as needed, and confirm notices are written in simple, straightforward language

Note these model notices do not include updated COBRA election timelines to address extended notice, election and COBRA premium payment periods in light of the COVID-19 National Emergency

Additional Flexibility for Cafeteria Plans

Temporary flexibility for cafeteria plans to permit employees to make certain prospective mid-year election changes during calendar year 2020, regardless of whether they satisfy existing mid-year election change rules

Specifically, an employer *may* amend cafeteria plans to allow each employee who is eligible to make salary reduction contributions to make prospective election changes during the entire calendar year 2020

- With respect to self-insured or fully insured employer-sponsored health coverage, an employer *may* allow an employee (with carrier approval) to do any of following on prospective basis:
  - Make new election, if employee initially declined to elect employer-sponsored health coverage
  - Revoke existing election and make new election to enroll in different health coverage sponsored by same employer (including changing from self-only to family coverage)
    - Requires cafeteria plan amendment no later than 12/31/21
    - Requires eligible employees be informed of opportunity to enroll

Example:

Pat enrolls in "low-plan option" that has 25% coinsurance requirement, but employer also has "high-plan option" (with higher employee premium) with 10% coinsurance requirement. If Pat now anticipates more medical expenses Pat could switch to high option to cover medical expenses and then later drop back down to low option when better coverage is no longer needed. To mitigate against risk, employer could (with carrier approval) only allow one election change under new IRS rules or could limit new rules to new enrollments or modifications to improve coverage.

Additional Flexibility for Cafeteria Plans

- With respect to self-insured or fully insured employer-sponsored health coverage, an employer *may* allow an employee (with carrier approval) to revoke existing election, provided employee attests in writing that employee is enrolled, or immediately will enroll, in other "comprehensive" health coverage not sponsored by employer
  - Written attestation/IRS model language available (see below)
  - Employer may rely on attestation unless employer has actual knowledge employee is not, or will not be, enrolled in other comprehensive coverage
    - Requires cafeteria plan amendment no later than 12/31/21
    - Requires eligible employees be informed of opportunity to enroll

Written attestation template from IRS:

Name:_____ (and other identifying information requested by the employer for administrative purposes).

I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer- sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan).

Signature: _____

Health and Dependent Care FSA Changes

2020 Mid-Year Health FSA Election Changes

With respect to general and limited purpose health FSAs, employer *may* allow employee to revoke an election, make new election, or decrease or increase existing election on prospective basis *for any reason*

2020 Mid-Year Dependent Care FSA Election Changes

With respect to a dependent care FSA, employer may allow employee to revoke election, make new election, or decrease or increase existing election on prospective basis *for any reason*

- Employers can choose to limit revocation or decrease to amounts no less than amounts already reimbursed to employee by FSA in plan year (helps to avoid potential experience losses from overspent health FSA)
- Requires plan amendment no later than 12/31/21
- Requires eligible employees be informed of opportunity to make FSA election changes
- Employer should coordinate implementation and communication with TPA

Extended Period to Incur FSA Claims in 2020

New temporary cafeteria plan rules allow employers to permit employees to incur reimbursable claims through end of calendar year 2020 for any FSA plan year or grace period that ends in 2020

- For amounts that are unused and that remain in health or dependent care FSA as of end of grace period or plan year ending in 2020, cafeteria plan may permit employees to apply those unused amounts to pay or reimburse medical care or dependent care expenses, respectively under each FSA, incurred through 12/31/20
  - A 2020 calendar plan year health FSA with a carryover provision will not benefit from this extended period in 2021 because its plan year ends 12/31/20
- Must inform employees if extended coverage period is implemented for 2020 and must amend cafeteria plan document by 12/31/22 to reflect change
- Note: This provision may be applied to a 2019 non-calendar year health FSA with a rollover provision - in spite of rule that prohibits health FSAs from including both a carryover and a grace period provision
- Caution: If employer chooses to extend a general purpose health FSA coverage period for 2020, any covered employee will not be able to contribute to a HSA in 2020

Participant Question

I was hoping for direction for FSA programs with most summer camps potentially not opening and daycares closed?

- Employer may allow employee to revoke or decrease an existing dependent care FSA election on prospective basis and might also be able to extend the period to incur claims in 2020

Examples - Extended Period to Incur FSA Claims in 2020

Example 1 - Health FSA and Dependent Care FSA Grace Period, Calendar Plan Year

- *Employer sponsors calendar plan year health and dependent care FSA, both with grace periods ending 3/15/20. Many employees did not incur sufficient claims for 2019 plan year by end of grace period ending 3/15/20 to cover their full election. Employer will amend its cafeteria plan by 12/31/21 to permit new extended period to incur FSA claims through end of calendar year 2020. Employer informs all eligible employees of extended period to incur claims through end of calendar year 2020.*
- *Employees with amounts remaining in their 2019 plan year health FSA can incur reimbursable health expenses through 12/31/20 (not standard 3/15/20 grace period deadline).*
- *Employees with amounts remaining in their 2019 plan year dependent care FSA can incur reimbursable dependent care expenses through 12/31/20 (not standard 3/15/20 grace period deadline).*

Example 2 - Health FSA Carryover, July 1 Plan Year

- *Employer sponsors July 1–June 30 plan year health FSA with $500 carryover. Many employees have more than $500 remaining in their health FSA at end of plan year ending 6/30/20 because they had to delay elective surgeries during the COVID-19 pandemic. Employer will amend its cafeteria plan by 12/31/21 to permit new extended period to incur FSA claims through end of calendar year 2020. Employer informs all eligible employees of extended period to incur claims through end of calendar year 2020.*
- *Employees with amounts in excess of $500 remaining in 2019 plan year health FSA ending 6/30/20 can incur reimbursable health expenses up to full amount of their remaining account balance through 12/31/20 (not standard $500 cap).*

Health FSA Carryover Now $550

Employers can amend a health FSA to increase carryover cap from $500 to $550 for carryovers from a plan year starting in 2020 to be carried over to immediately following plan year beginning in 2021

- Plan amendment must be adopted by last day of plan year from which amounts may be carried over, i.e., by 12/31/20 for a calendar plan year, or by 6/30/21 for a 7/1-6/30 plan year

Employer Next Steps

- *The cafeteria plan items are all optionally available*
  - Employers are not obligated to enact any of these changes
  - Relaxed rules are intended to give employers flexibility to enact these changes to assist employees as a result of COVID -19 pandemic
- If employer is considering adopting these measures, they should evaluate whether to:
  - Offer new mid-year election change opportunities during calendar year 2020
  - Offer extended period to incur FSA claims in calendar year 2020
  - Offer increased $550 health FSA carryovers for 2020 and beyond

What's Next

- Next wave of federal aid passed?
  - Subsidies for Continued Employer Coverage?
  - Expanded Paid Leave for Large Employers?
  - Increased Flexibility for Cafeteria plans, Health FSAs and Dependent Care FSAs?
  - New Group Health Plan Requirements?
- Continued carrier rebates/credits?
- Carrier premium extensions and grace periods?
- Expanded CSB wellness services
- More return to work strategies, solutions, issues

As further details, rules, solutions and strategies emerge, Conner Strong & Buckelew we will provide updates accordingly

COVID-19 Helpful Resource Links

- Conner Strong COVID-19 Resource page
- CDC COVID-19 page
- DOL FMLA FLSA COVID-19 page
- EEOC: What You Should Know
  - EEOC General Engagement with EEs on Health Status
  - EEOC New Guidance on COVID-19
- IRS COVID-19 page
- NJ Labor Coronavirus page
- NY Labor Coronavirus page
- OSHA COVID-19 page
- Small Business Assoc (SBA) COVID-19 page
- World Health Organization page
- City of Phila COVID Resources for Small Business page

*to open links above and elsewhere in PowerPoint, right click on item and click on “open hyperlink”

THANK YOU

Questions? Comments?

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