Volume 30
Number 05
May 2020

Insider

Health and welfare plan time frames extended due to COVID-19

By Ben Lupin and Kathleen Rosenow

The Departments of Labor (DOL) and Treasury (the departments) have issued **regulations** extending certain deadlines under ERISA and the Internal Revenue Code for group health plans; disability and other welfare plans; pension plans; and their participants and beneficiaries affected by the COVID-19 pandemic. The final rule provides extra time to meet deadlines affecting COBRA continuation coverage, special enrollment periods under the Health Insurance Portability and Accountability Act (HIPAA), claims for benefits, appeals of denied claims and external review of certain claims.

The "frozen period" is effective from March 1, 2020, until 60 days after the end of the national emergency (defined in the regulations as the "Outbreak Period"), so there is no set "end date" at this time. In the event end dates differ throughout the country, the departments will issue additional guidance.

The DOL also issued **Frequently Asked Questions** to help plan participants, beneficiaries, sponsors and employers affected by the COVID-19 outbreak understand their rights and responsibilities under ERISA.

The Department of Health and Human Services will extend similar time frames to non-federal governmental group health plans and health insurance issuers offering coverage under the Public Health Service Act.

Background

On March 13, President Trump declared a national emergency due to the COVID-19 outbreak. As a result, participants and beneficiaries covered by group health plans, disability or other employee welfare benefit plans, and employee pension benefit plans may have difficulty exercising their health coverage portability and continuation coverage rights, or filing or perfecting their benefit claims. Affected plans may also face challenges in complying with certain notice obligations. In response, the departments have provided extra time for meeting certain deadlines, detailed as follows.

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Time frames extended

All group health plans as well as disability and other employee welfare benefit plans subject to ERISA or the tax code must disregard the Outbreak Period for the following time frames:

HIPAA special enrollment periods

- The 30-day period to request special enrollment
- The 60-day period for those who lose coverage under a state Children's Health Insurance Program or Medicaid or who are eligible to receive premium assistance under those programs

COBRA

- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments (typically 45 days for the initial premium and made no later than 30 days after the first day of the period for which payment is being made for subsequent premiums)
- The date for individuals to notify a group health plan of a qualifying event or determination of disability under COBRA
- The date for employer plan sponsors to provide a COBRA election notice under ERISA and the tax code

Generally, an employer has 30 days from the loss of group health plan coverage to notify the plan administrator, then the plan administrator has 14 days to provide a COBRA election notice to the qualified beneficiary. While the regulations allow for the extension, employers are encouraged to provide the notices within the normal statutory time frames, when possible, to make continued coverage available to affected employees as soon as possible and to allow employees to elect and start paying for COBRA coverage before owing multiple months' worth of back premiums.

Claims procedures

- The date within which individuals may file a benefit claim under a plan's ERISA claims procedures
- The date within which claimants may file an appeal under a plan's ERISA claims procedures

External review process

- The date within which claimants may file a request for an external review under a group health plan
- The date within which a claimant may file information to substantiate a request for external review if the initial request was not complete

Examples

Following are a few examples provided in the regulations based on the assumption that the national emergency ends on April 30, 2020, with the Outbreak Period ending on June 29, 2020 (the 60th day after the end of the national emergency).

***Insider* is a monthly newsletter developed and produced by Willis Towers Watson Research and Innovation Center.**

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While the regulations allow for the extension, employers are encouraged to provide the notices within the normal statutory time frames, when possible.

- **Electing COBRA:** Employee A participates in an employer-sponsored group health plan. Due to the national emergency, A has a COBRA-qualifying event when his hours are reduced, and he loses plan eligibility and has no other coverage. A is provided a COBRA election notice on April 1, 2020, and under COBRA must make an election for COBRA within 60 days. Under the departments' regulations, the deadline for A to elect COBRA is 60 days after June 29, 2020 (the end of the Outbreak Period), which is August 28, 2020.
- **HIPAA special enrollment period:** Employee B is eligible for, but previously declined participation in, her employer-sponsored group health plan. On March 31, 2020, B gave birth and wants to enroll herself and the child in her employer's plan midyear. B and her child qualify for HIPAA special enrollment in her employer's plan as early as the date of the child's birth. Under the departments' regulations, B may exercise her HIPAA special enrollment rights for herself and her child until 30 days after June 29, 2020, which is July 29, 2020, provided that she pays the premiums for any period of coverage.
- **Group health plan claims:** Employee C is a participant in an employer-sponsored group health plan. On March 1, 2020, C received medical treatment for a condition covered under the plan but did not submit a claim until April 1, 2021. Under the plan, claims must be submitted within 365 days of the date of service. C's claims are timely because under the departments' regulations, C's last day to submit a claim is 365 days after June 29, 2020, which is June 29, 2021.

Going forward

Employers should update their benefit administration systems and procedures or work with their third-party administrators and insurance carriers (for fully insured plans) to administer their benefit plans within the extended time frames.

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IRS guidance on cafeteria plan elections and other account-based plans

By Anu Gogna and Ben Lupin

In response to the COVID-19 pandemic, the IRS issued **Notice 2020-29**, which allows employers to amend their cafeteria plans to permit plan participants to make midyear changes during calendar year 2020 and extend the claims period for unused amounts in health flexible spending arrangements (health FSAs) and dependent care assistance programs (DCAPs) (also commonly referred to as dependent care flexible spending arrangements or DC FSAs) until December 31, 2020. In addition, the notice provides that previous temporary relief for health savings account (HSA)-qualifying high-deductible health plans (HDHPs) may be applied retroactively to January 1, 2020.

The IRS also issued **Notice 2020-33,** which increases the carryover amount for health FSAs from $500 to $550 and clarifies that an individual coverage health reimbursement arrangement (ICHRA) may reimburse premiums even if they are paid before the first day of the plan year.

Cafeteria plan amendments for the 2020 plan year implementing any of the changes set forth in the notices must be adopted on or before December 31, 2021. They may apply retroactively to January 1, 2020, provided that the cafeteria plan operates in accordance with the guidance and the employer informs all eligible employees of the changes.

Notice 2020-29

Expands midyear election changes during calendar year 2020

Notice 2020-29 allows employers to amend their cafeteria plans to allow taxpayers to make midyear election changes for health coverage, health FSAs and DCAPs due to the COVID-19 pandemic. For calendar year 2020, employees who are eligible to make salary reduction contributions under a cafeteria plan may make prospective midyear election changes as follows:

- **Employer-sponsored health coverage** (including both self-insured and fully insured):
  - Make a new election if the employee initially declined to enroll in coverage
  - Change an existing election to enroll in a different plan option
  - Revoke an existing election (attesting in writing[1] that the employee is enrolled or will be enrolling in other health coverage)
- **Health FSAs** (including limited purpose FSAs):
  - Revoke an existing election
  - Make a new election
  - Increase/decrease an existing election
- **DCAPs:**
  - Revoke an existing election
  - Make a new election
  - Increase/decrease an existing election

With respect to health FSAs and DCAPs, employers may limit midyear elections to amounts no less than amounts already reimbursed in 2020.

The guidance makes it clear that these changes are discretionary. Employers can also pick and choose which changes, if any, to make as well as limit the number of changes and limit the period during which changes may be made (e.g., through September 2020).

[P]revious temporary relief for HSA-qualifying HDHPs may be applied retroactively to January 1, 2020.

Further, an employer may limit elections to those that will increase or improve an employee's coverage. All changes should be communicated to employees as soon as decisions are made; formal written amendments must be adopted by December 31, 2021. Changes must also be reflected in a summary of material modifications or updated summary plan description, pursuant to ERISA.

Extends claims periods for health FSAs and DCAPs

Notice 2020-29 extends claims periods for taxpayers to apply unused amounts remaining in a health FSA or DCAP as of the end of a grace period or plan year ending in calendar year 2020, for expenses incurred for qualified benefits through December 31, 2020. The extension is available both

[1] Notice 2020-29 includes an example attestation statement.

to cafeteria plans that have a grace period and plans that provide for a carryover. An individual with unused amounts remaining, and who is allowed an extended period to incur expenses under a health FSA pursuant to a plan amended in accordance with the notice, will not be eligible to contribute to an HSA during the extended period (except in the case of an HSA-compatible health FSA, such as a limited-purpose or post-deductible health FSA).

Clarifies HDHP guidance effective date

As background, previously issued IRS guidance in **Notice 2020-15** provides that an HSA-qualifying HDHP may cover testing and treatment for COVID-19 with reduced cost sharing or without any cost sharing (i.e., on a first-dollar basis).[2] Notice 2020-29 provides that this relief can be applied retroactively to January 1, 2020.

Notice 2020-29 further clarifies that, for purposes of the relief in Notice 2020-15, COVID-19 testing and treatment includes the panel of diagnostic testing for influenza A and B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), and any items or services required to be covered with zero cost sharing under the Families First Coronavirus Response Act — as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The provision in the CARES Act that allows HDHPs to temporarily cover telehealth and other remote care services without cost sharing (or at reduced cost sharing) can also be applied retroactively to January 1, 2020.

Notice 2020-33

Indexed health FSA carryover amount

Notice 2020-33 increases the limit for unused health FSA carryover amounts from $500 to a maximum of $550, which reflects indexing for inflation.

If an employer elects to increase the carryover amount for its cafeteria plan under Notice 2020-33, individuals who, during 2020, wish to increase their health FSA contributions or begin to make health FSA contributions as a result of the increased carryover amount may do so in accordance with Notice 2020-29. Although only future salary may be reduced under the revised election, amounts contributed to the health FSA may be used for any medical care expense incurred during the first plan year that begins on or after January 1, 2020.

Timing of ICHRA reimbursements

The notice allows an ICHRA to reimburse premiums even if they are paid before the first day of the plan year. For example, an ICHRA with a calendar-year plan year could reimburse individual insurance policy premiums for coverage that begins on January 1 if an employee paid the premiums in December.

Going forward

Employers should review the guidance in the IRS notices, and to the extent they want to adopt any of the changes, which require plan amendments, they should timely do so.

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[2] See "**IRS guidance on first-dollar coverage for COVID-19 testing and treatment**," *Insider*, March 2020.

News in Brief

DOL issues updated COBRA model notices

By Anu Gogna and Kathleen Rosenow

The Department of Labor (DOL) has issued updated **COBRA model notices** and a set of related **FAQs**. The updated model notices are intended to help Medicare-eligible individuals make key decisions regarding their health care coverage by addressing COBRA's interaction with Medicare. The model general and election notices explain that there may be advantages to enrolling in Medicare before, or instead of, electing COBRA. They also point out that if an individual is eligible for both COBRA and Medicare, electing COBRA may affect enrollment in Medicare as well as certain out-of-pocket costs.

Plan administrators may use the updated COBRA model notices to notify plan participants and beneficiaries of their rights under COBRA and to notify qualified beneficiaries of their rights to elect COBRA, but they are not required to do so. The notices may be used immediately.

Plan administrators electing not to use the model notices should consider updating their current COBRA general and election notices to clarify how COBRA interacts with Medicare, as detailed in the model notices.

CARES Act amends substance use disorder confidentiality statute

By Maureen Gammon and Kathleen Rosenow

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted on March 27, 2020, makes a number of changes affecting employer-sponsored group health plans.[1] The CARES Act also makes significant changes to the federal statute governing the confidentiality of substance use disorder (SUD) records, more commonly known by its implementing regulations as 42 C.F.R. Part 2 (Part 2). The CARES Act amends Part 2 to more closely align its confidentiality requirements with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules.

The CARES Act amendments applicable to SUD patient records are effective for uses and disclosures of information occurring 12 months after the date the CARES Act was enacted. The secretary of the Department of Health and Human Services (HHS) is required to issue implementing regulations by March 27, 2021.

Background

SUD patient records maintained in connection with federally assisted SUD programs (Part 2 programs) are subject to specific confidentiality rules that substantially limit how such records may be used or disclosed. The law and its implementing regulations significantly restricted the ability of Part 2 programs to share SUD records, requiring written patient consent for each disclosure of SUD records and prohibiting re-disclosure of such records except in very limited circumstances.

These regulations had been amended in recent years to provide greater flexibility to those needing to use and disclose SUD patient records for purposes of payment and health care operations; however, the ability to use and disclose patient records, even in these limited circumstances, required lawful holders to enter into written agreements with their contractors, subcontractors or legal representatives.

CARES Act amendments

While patients must still provide written consent to the disclosure of their SUD treatment records and have the right to revoke that consent in writing, the amendments made by the CARES Act will allow those records to be used or disclosed by covered entities, business associates and Part 2 programs for purposes of treatment, payment and health care operations, as permitted by the HIPAA regulations. Any information so disclosed may then be redisclosed, in accordance with the HIPAA regulations, without the covered entity needing to obtain additional patient consent or having to enter into written agreements with vendors that specifically include language regarding Part 2 compliance.

The CARES Act amends Part 2 to more closely align its confidentiality requirements with HIPAA privacy rules.

The CARES Act also:

- Requires Part 2 programs to provide a patient with an accounting of disclosures made through an electronic health record for purposes of treatment, payment or health care operations in the three years prior to the patient's request
- Allows the disclosure of patient information to public health authorities as long as the information is de-identified in accordance with HIPAA requirements
- Applies breach notification requirements under the Health Information Technology and Clinical Health Act to Part 2 programs
- Prohibits the use of Part 2 records in criminal, civil or administrative proceedings conducted by federal, state or local authorities against a patient, except as otherwise authorized by a court order meeting certain statutory requirements or by consent of the patient
- Prohibits discrimination against any individual on the basis of information contained in SUD records in:
  - Admission, access to or treatment for health care
  - Hiring, firing or terms of employment, or receipt of workers compensation
  - The sale, rental or continued rental of housing

[1] See "**The CARES Act: Health and benefit implications for plan sponsors,**" *Insider*, April 2020.

  - Access to federal, state or local courts
  - Access to, approval of or maintenance of social services and benefits provided or funded by federal, state or local governments
- Applies the same statutory penalties for violations of the law that are imposed for HIPAA privacy violations

As directed by the CARES Act, the secretary of HHS must revise applicable regulations as necessary to implement and enforce the changes made by the act as well as update the HIPAA regulation regarding the notice of privacy practices for protected health information (PHI) by March 27, 2021. Covered entities and entities creating or maintaining SUD treatment records will need to provide notice of their privacy practices regarding SUD treatment records. The notice must include a statement of the patient's rights with respect to PHI and descriptions of how the individual may exercise these rights and each purpose for which the covered entity is permitted or required to use or disclose PHI without the patient's written authorization. Once regulations are issued, covered entities will need to review their current privacy practices notice and amend as necessary to incorporate any required language regarding the use and disclosure of SUD treatment records.

The CARES Act does not limit a patient's right to request restrictions on the use or disclosure of a SUD record for purposes of treatment, payment or health care operations, or limit a covered entity's choice to obtain the consent of the individual to use or disclose a SUD record to carry out treatment, payment or health care operations.

Going forward

Employers should be prepared to review and amend, as necessary, their HIPAA privacy materials, including their notice of privacy practices, to comply with applicable regulations when they are issued.

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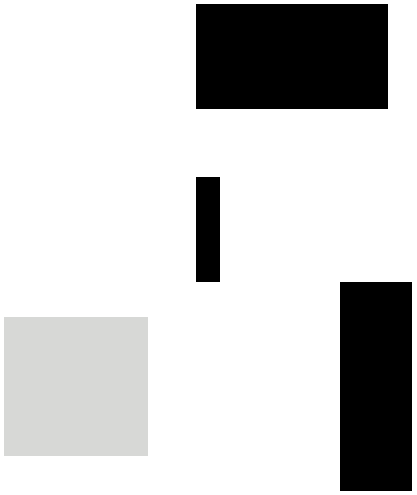

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