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Insider

Departments issue new FAQs on FFCRA and CARES Act implementation

By Anu Gogna and Ben Lupin

The departments of Labor (DOL), Health and Human Services (HHS), and Treasury have issued a new set of **FAQs** on implementing the requirements in the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act as well as other health coverage issues related to COVID-19.

The guidance, which is effective immediately, covers: 1) the testing mandate in the FFCRA and the CARES Act, 2) group health plan notice requirements, 3) telehealth and other remote care services, 4) "grandfathered health plans,"[1] 5) mental health parity testing, 6) wellness programs, and 7) individual coverage health reimbursement arrangement (ICHRA) notice requirements.

In This Issue

FFCRA and CARES Act

The FAQs clarify several provisions in the FFCRA and CARES Act regarding the COVID-19 testing mandate:

- **Self-insured group health plans.** The FAQs clarify that the COVID-19 testing mandate applies to both fully insured and self-insured group health plans.
- **COVID-19 tests that must be covered.** The FAQs specify the types of COVID-19 tests that must be covered and provide links to Food and Drug Administration webpages that list approved tests. The covered tests fall into four categories:
  1. A test approved, cleared or authorized under the Federal Food, Drug, and Cosmetic Act
  2. A test where the developer has requested, or intends to request, emergency use authorization under the Federal Food, Drug, and Cosmetic Act, unless and until the emergency use authorization request has been denied or the developer of such test does not submit a request under such section within a reasonable time frame
  3. A test that is developed in and authorized by a state that has notified the secretary of HHS of its intention to review tests intended to diagnose COVID–19
  4. Other tests that the secretary of HHS determines appropriate in guidance
- **Attending health care provider.** Under the FFCRA, certain items and services must be covered "when medically appropriate for the individual, as determined by the individual's *attending health care provider.*" The departments clarify that an attending health care provider need not be "directly" responsible for providing care to the patient, as long as the provider makes an individualized clinical assessment to determine whether the COVID-19 test is medically appropriate in accordance with current accepted standards of medical practice. A plan, issuer, hospital or managed care organization is *not* an attending provider.

[1] This term is defined in Section 1251(e) of the **Affordable Care Act** (ACA) and is used by the IRS, DOL, Centers for Medicare & Medicaid Services, and HHS in regulations and other agency guidance to refer to certain group health plans and health insurance coverage existing as of March 23, 2010 (the ACA's date of enactment).

- **At-home testing.** The FAQs clarify that at-home COVID-19 tests must be covered without cost sharing, prior authorization or other medical management requirements when ordered by an attending health care provider and deemed to be medically necessary.
- **COVID-19 testing for surveillance or employment purposes.** The FAQs specify that COVID-19 testing to screen for general workplace health and safety, public health surveillance, or any other purpose not primarily intended to diagnose or treat COVID-19 or another health condition is beyond the scope of the FFCRA testing requirements.
- **Multiple COVID-19 diagnostic tests.** The guidance clarifies that if an individual receives multiple diagnostic tests for COVID-19, then each test must be covered under the testing mandate, provided they are diagnostic and deemed medically appropriate by the attending health care provider in accordance with current accepted standards of medical practice.
- **COVID-19 testing facility fee.** The FAQs specify that a facility fee for a visit that results in an order for or administration of a COVID-19 diagnostic test must be covered by the plan or issuer with no cost sharing. A facility fee is a fee for the use of facilities or equipment not owned by a provider or that are owned by a hospital.
- **Balance billing for COVID-19 diagnostic tests.** Under the CARES Act, a plan must reimburse a provider for COVID-19 testing at either the negotiated rate or the cash price listed on a public website. The FAQs clarify that this reimbursement should be considered payment in full, with no cost sharing or other balance due; this applies only to items and services related to the COVID-19 testing mandate.

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Under the CARES Act, a plan must reimburse a provider for COVID-19 testing at either the negotiated rate or the cash price listed on a public website.

- **Reimbursements for out-of-network providers.** Plans may seek to negotiate a determined rate for COVID-19 testing furnished by out-of-network providers, and state laws governing reimbursements may apply. For example, many states have balance billing laws that set forth dispute resolution processes for issuers and providers that would continue to apply.

  The FAQs also clarify that an out-of-network provider of COVID-19 testing that does not have a negotiated rate with a plan and has not published the cash price on a public website could be subject to a penalty of up to $300 per day.
- **Reimbursements for out-of-network emergency room services.** The FAQs provide that when an individual receives a COVID-19 test in an emergency room of an out-of-network hospital, a plan is only required to reimburse the cash price listed on a public website (or an otherwise negotiated rate).

Group health plan notice requirements

In previously issued FAQs, the departments announced they would not take enforcement action against any plan for failing to give at least 60 days' advance notice of plan changes to provide greater coverage for the diagnosis and/or treatment of COVID-19, or for telehealth and other remote care services, provided the notice is given as soon as reasonably practicable. The new FAQs clarify that if a plan reverses these changes after the COVID-19 public health emergency is no longer in effect, it will have satisfied its advanced notification requirement under the summary of benefits and coverage rules if 1) the plan previously notified participants of the general duration of the additional benefit coverage or reduced cost sharing, or 2) the plan notifies participants within a reasonable time frame in advance of the reversal.

Telehealth and other remote care services

The FAQs provide relief from certain ACA group market reforms for the duration of any plan year beginning during the COVID-19 public health emergency, for a group health plan that solely provides telehealth and other remote care services. This relief will be limited to large employers that offer telehealth and other remote care services only to employees who are not eligible for coverage under any

other group health plan offered by that employer. However, such arrangements must still comply with the following ACA market reforms: 1) prohibition on preexisting condition exclusions, 2) prohibition on discrimination based on health status, 3) prohibition on rescissions, and 4) reforms relating to mental health or substance use disorder benefits.

Grandfathered health plans

The guidance clarifies that a grandfathered health plan that adds benefits, or reduces or eliminates cost-sharing requirements, for the diagnosis and treatment of COVID-19 or for telehealth and other remote care services during the public health emergency will not lose its status solely because it later reverses those changes.

MHPAEA

The FAQs provide that plans can disregard the items and services required to be covered under the FFCRA's COVID-19 testing mandate when performing the "substantially all" or "predominant" tests for financial requirements and quantitative treatment limitations under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, HHS encourages states to adopt a similar approach with respect to health insurance issuers.

Wellness programs

The FAQs clarify that a health-contingent wellness program may waive the standard for obtaining a reward (including a reasonable alternative standard) if participants have difficulty meeting the standard due to COVID-19.

ICHRA notice requirements

ICHRA rules require that a notice be provided to participants (generally at least 90 days before the start of the plan year) that includes important information about the ICHRA requirements, terms and certain consequences of accepting ICHRA coverage. The DOL recently issued relief that extends the deadline to furnish an ICHRA notice to as soon as administratively practicable, between March 1, 2020, and 60 days after the announced end of the COVID-19 National Emergency. The FAQs discuss the consequences of delaying the ICHRA notice and encourage employers to give as much advance notice as possible before the first day of coverage so employees have enough time understand the notice, make informed decisions on whether to enroll in the ICHRA, and exercise their special enrollment right to individual health insurance coverage.

Employers should review the FAQs to ensure they are complying with the COVID-19 testing mandate in the FFCRA, as amended by the CARES Act.

Going forward

Employers should review the FAQs to ensure they are complying with the COVID-19 testing mandate in the FFCRA, as amended by the CARES Act.

Employers that are offering telehealth services to employees who are not eligible to enroll in their medical plan(s) should be aware of the temporary relief from certain ACA group market reforms.

In addition, when conducting mental health parity testing, employers may disregard the benefits they are required to provide to comply with the COVID-19 testing mandate in the FFCRA, as amended by the CARES Act.

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IRS issues guidance on coronavirus-related distributions and loans

By Gary Chase, Stephen Douglas and Maria Sarli

The IRS has issued **Notice 2020-50**, which provides guidance relating to the special distribution and loan provisions in the CARES Act. The notice expands the definition of who qualifies for coronavirus-related distributions and loans, provides that a coronavirus-related distribution will be treated like a hardship distribution for purposes of suspending executives' deferrals to a nonqualified plan, and clarifies certain areas such as the one-year loan suspension provision. The notice also addresses many administrative and tax reporting questions in connection with the coronavirus-related distributions and loans.

Background

Under the Cares Act, "qualified individuals" are eligible for favorable tax treatment with respect to 2020 coronavirus-related distributions from eligible retirement plans. A coronavirus-related distribution is not subject to the 10% additional tax required under the Internal Revenue Code, generally can be included in income over a three-year period, and in most cases can be recontributed to an eligible retirement plan within a three-year period to avoid income taxation. The Cares Act also increases the allowable plan loan amount for loans made from March 27, 2020, to September 22, 2020, to "qualified individuals" and permits a suspension of payments for plan loans that would otherwise be due from March 27, 2020, through December 31, 2020, by "qualified individuals."

Definition of a qualified individual

The CARES Act generally allows distributions and loan relief to an individual who meets one of the following criteria:

1. Was diagnosed with COVID-19, or whose spouse or other dependent was diagnosed with COVID-19, by a test approved by the Centers for Disease Control and Prevention (including a test authorized under the Federal Food, Drug, and Cosmetic Act)
2. Experiences an adverse financial consequence as a result of being quarantined; being furloughed, laid off or having hours reduced; being unable to work due to a lack of childcare; or closing or reducing the hours of a business owned or operated by the individual
3. Satisfies other criteria as determined by the secretary of the Treasury

Notice 2020-50 expands the definition of a "qualified individual" in item (2) to an individual who has his or her pay (or self-employment income) reduced due to COVID-19 or has a job offer rescinded or start date for a job delayed due to COVID-19. The notice also provides that an individual qualifies if the adverse financial consequences noted in item (2) are experienced by the individual's spouse or a member of the individual's household.

Coronavirus-related distributions

Qualified individual can designate distributions as coronavirus-related. A qualified individual is permitted to designate a distribution as coronavirus-related without regard to whether the plan treated the distribution as such. This provision ensures that a qualified individual is able to receive favorable tax treatment for a 2020 distribution that he or she receives regardless of whether the plan administrator is aware that a participant is a qualified individual or the employer elects for the plan to specifically offer coronavirus-related distributions.

Distribution by qualified pension plans. The CARES Act does not change the rules for when plan distributions are permitted to be made from qualified "pension plans" (i.e., defined benefit plans and money purchase defined contribution plans). For example, a pension plan is not permitted to make a distribution before an otherwise permitted distributable event merely because the distribution, if made, would qualify as a coronavirus-related distribution. Further, a pension plan is not permitted to make a distribution under a distribution form that is not a qualified joint and survivor annuity without spousal consent merely because the distribution, if made, could be treated as a coronavirus-related distribution.

By contrast, coronavirus-related distributions from qualified defined contribution plans of 401(k) or 403(b) deferrals as well as match and nonelective contributions can be made irrespective of whether there is a distributable event.

Plan treatment of distribution. An employer may choose whether, and to what extent, to treat plan distributions as coronavirus-related distributions (as well as whether, and to what extent, to apply the coronavirus-related plan loan rules); however, a plan must treat similar types of distributions consistently.

Certifications. The administrator of an eligible retirement plan may rely on an individual's certification that he or she is a qualified individual in determining whether a distribution is a coronavirus-related distribution, unless the administrator has actual knowledge to the contrary. The Notice clarifies that the "actual knowledge" standard does not mean that the plan administrator has an obligation to inquire whether an individual satisfies the conditions to be a qualified individual. Rather, it means that the administrator must already possess the information.

Individual tax reporting. A qualified individual receiving a coronavirus-related distribution is entitled to favorable tax treatment regarding the distribution by reporting the distribution on his or her federal income tax return for 2020 and on the new Form 8915-E, Qualified 2020 Disaster Retirement Plan Distributions and Repayments (or if there is no federal income tax return for 2020, by filing just Form 8915-E). Qualified individuals will also use Form 8915-E to report any recontribution made during the taxable year and to determine the amount of the coronavirus-related distribution includible in income for the taxable year.

Plan tax reporting. An eligible retirement plan must report the payment of a coronavirus-related distribution to a qualified individual on Form 1099-R. This reporting is required even if the qualified individual recontributes the coronavirus-related distribution to the same eligible retirement plan in the same year. If a payor is treating a payment as a coronavirus-related distribution and no other appropriate code applies, the payor is permitted to enter in box 7 of Form 1099-R either distribution code 2 (early distribution, exception applies) or distribution code 1 (early distribution, no known exception).

Plan not required to accept recontribution. A recontribution of a coronavirus-related distribution is treated like a rollover contribution. Eligible retirement plans generally are not required to accept rollover contributions. So if a plan does not accept any rollover contributions, the plan would not be required to change its terms to accept recontributions. However, for a plan that does accept rollover contributions, the notice is not clear on whether it must accept repayments of coronavirus-related distributions.

Application of the CARES Act to plan loans

CARES Act loan provision optional. An employer may choose whether, and to what extent, to apply CARES Act plan loan rules regarding increased plan limits and/or suspension of loan repayments, regardless of how coronavirus-related distributions are treated.

Suspension of loan repayments and extension of loan term. The CARES Act provides that loan payments otherwise due from March 27 through December 31, 2020, may be delayed for one year and any subsequent repayments will be adjusted to reflect the delayed payments and any interest accruing during that period. Unfortunately, the law is not clear regarding how the suspension and reamortization process should work administratively. The notice provides a relatively simple safe harbor approach, while acknowledging that other approaches may also be reasonable legal interpretations. Under this safe harbor, a qualified individual's obligation to repay a plan loan is suspended under the plan for any period between March 27, 2020, and December 31, 2020 (i.e., the suspension period). The loan repayments must resume after the end of the suspension period, and the term of the loan may be extended by up to one year from the date the loan was originally due to be repaid. Interest accruing during the suspension period must be added to the remaining principal of the loan. The loan is then reamortized and repaid in substantially level installments over the remaining period of the loan — that is, five years from the date of the loan (assuming that the loan is not a principal residence loan) plus up to one year from the date the loan was originally due to be repaid. The notice also permits the use of other approaches, though for many employers the safe harbor will be the simplest to implement and administer.

Permitted cancellation of deferral election

Cancellation of election. Under the Internal Revenue Code, a nonqualified deferred compensation plan subject to section 409A may cancel a participant's deferral election due to an unforeseeable emergency or a hardship distribution. If a participant receives a distribution from an eligible retirement plan that constitutes a coronavirus-related distribution, that distribution will be considered such a hardship distribution, permitting cancellation of the deferral election. The notice points out, however, that, in this event, the deferral election under the nonqualified deferred compensation plan must be cancelled, not merely postponed or delayed.

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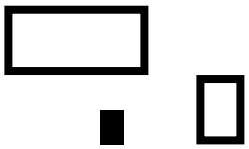

Supreme Court upholds ACA contraceptive coverage mandate exemptions

By Maureen Gammon and Rich Gisonny

On July 8, 2020, in a 7 – 2 **ruling**, the U.S. Supreme Court upheld regulations exempting certain employers with religious and moral objections from the Affordable Care Act's (ACA's) contraceptive coverage mandate. In *Little Sisters of the Poor v. Pennsylvania,* the Supreme Court reversed an opinion by the Third Circuit Court of Appeals and concluded that:

- The final rules were validly issued by the departments of Health and Human Services, Labor and Treasury because the departments satisfied the procedural requirements under the Administrative Procedure Act.
- The departments had broad statutory authority to define preventive services and exempt those with religious or moral objections to contraceptive coverage from having to comply with the ACA mandate.

Under the ACA, non-grandfathered group health plans are required to provide participants with certain preventive care services without imposing any cost sharing. With respect to women, these services include preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration. These include, in part, all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider (collectively referred to below as contraceptive services).

Following previous Supreme Court decisions and a 2017 executive order from President Trump, the departments issued a pair of interim final regulations (IFRs) that significantly expanded on available exemptions from the ACA's contraceptive coverage mandate. The IFRs exempted:

- Non-governmental, nonprofit and for-profit employers (including publicly traded companies) with sincerely held religious objections to contraceptive coverage
- Non-governmental, nonprofit and for-profit employers (without publicly traded ownership interests) that have a moral objection to contraceptive coverage

The IFRs also provided an optional accommodation process that allowed eligible entities to comply with the ACA contraceptive coverage mandate but avoid having to actually provide contraceptive services directly to participants.

While the Supreme Court's decision [allows] the final rules to go into effect, litigation over the ACA's contraceptive coverage mandate is expected to continue.

Final regulations, which were issued in 2018, did not significantly differ from the IFRs.[1] Legal challenges against the rules resulted in a nationwide preliminary injunction, preventing them from going into effect. The Third Circuit Court of Appeals affirmed the injunction, a decision that was appealed to the Supreme Court by the Trump administration and Little Sisters of the Poor, which had intervened in the litigation.

While the Supreme Court's decision lifts the nationwide injunction imposed by the Third Circuit, allowing the final rules to go into effect, litigation over the ACA's contraceptive coverage mandate is expected to continue. Employers should review the final regulations and discuss next steps with legal counsel.

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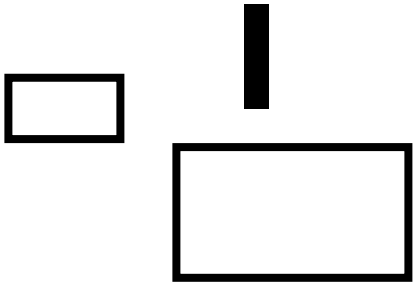

[1] See "**Agencies issue final regulations on contraceptive coverage exemptions**," *Insider*, November 2018.

Default e-delivery safe harbors for retirement plan disclosures

By Gary Chase and Bill Kalten

On May 27, the Department of Labor (DOL) released a **final rule** that will allow electronic delivery of retirement plan disclosures required under ERISA to plan participants, beneficiaries and other individuals with valid electronic addresses unless they opt out. The final regulation establishes two new optional safe harbor methods for sponsors; the DOL's current safe harbor method for electronic delivery will not change. These new alternative safe harbors do not apply to employee welfare benefit plans.

The final regulation takes effect July 27, 2020; however, plan administrators may rely on the new safe harbors before that date without penalty. Note that during the COVID-19 emergency, EBSA Disaster Relief Notice 2020-01[1] allows notices to be provided through email, text message and a continuous access website. It is likely that many plans will rely on this disaster relief as long as it remains available before transitioning to the safe harbors.

Background

In general, disclosures required under ERISA must be furnished using delivery methods that reasonably ensure the intended recipient receives the information, for example, by hand at a workplace or by first-class mail.

In 2002, the DOL established a safe harbor that permits electronic delivery as the default method only for those participants who can effectively access electronic documents at work and who have access to the employer's or plan sponsor's electronic information system as an integral part of their work duties. This group is sometimes referred to as being "wired at work." Individuals who do not fit into the "wired at work" category must opt in to receive documents electronically.

In October 2019, the DOL issued a proposed rule[2] in response to President Trump's Executive Order 13847, **Strengthening Retirement Security in America**, with the aim of making required retirement plan disclosures more understandable and useful for participants and beneficiaries, while also reducing administrative costs and burdens on employers and other plan fiduciaries.

Both [safe harbors] are available regardless of whether an individual is "wired at work" or "affirmatively consents" to the electronic disclosure.

Changes and clarifications from the proposed regulation

Following is a summary of the key changes and clarifications to the proposed rule that are included in the final regulation.

Two safe harbors

The final regulation establishes two separate safe harbors. The first, which was included in the proposed regulation, is a "notice and access" safe harbor that allows for disclosure of covered documents to be made available through an application or website and by furnishing a Notice of Internet Availability (NOIA) of these disclosures to covered individuals. The second is a "direct email" safe harbor that allows for covered documents to be emailed directly to covered individuals.

Both new safe harbors provide for electronic distribution to be the default method of distributing required notices. Both are also available regardless of whether an individual is "wired at work" or "affirmatively consents" to the electronic disclosure.

The direct email safe harbor incorporates all applicable provisions of the notice and access safe harbor, discussed below, but with the following changes in compliance requirements:

- The covered document must be sent to a covered individual's email address (mobile phone numbers may not be used).
- An email, instead of an NOIA, is sent to a covered individual:
  - The covered document must be included in the body of the email or as an attachment.

[1] See "**IRS, PBGC and DOL provide retirement-related COVID-19 extensions**," *Insider*, June 2020.

[2] See "**DOL proposes new 'notice and access' style of electronic delivery for retirement plan disclosure**," *Insider*, November 2019.

- The subject line of the email must read "Disclosure About Your Retirement Plan."
- If the document is an attachment, the email must specify:
  - The name of the covered document and a brief description if the nature of the document is not reasonably conveyed (for example, a blackout notice would need an additional description)
  - A statement of the right to request and obtain a paper version of the covered document, free of charge, and an explanation of how to exercise this right
  - A statement of the right to opt out of receiving a covered document electronically, free of charge, and an explanation of how to exercise this right
  - A telephone number to contact the administrator or other designated plan representative
- The email must be written in a way that can be understood by the average plan participant.

Employer-provided electronic address

The final rule continues to require, as a condition of reliance on the safe harbors, that a plan administrator possess an electronic address that enables electronic communication with a covered individual. The proposal would have allowed a plan to use an electronic address assigned by the employer to an employee, including one used solely for the delivery of covered documents. Under the final regulation, however, an electronic address must be assigned for employment-related purposes not limited to the delivery of disclosures. It can be assigned only by the employer (not a plan administrator or service provider), and an employer may not assign an electronic address to a participant's current or former spouse or beneficiary.

In addition, personal electronic addresses may not be collected through a commercial search service. When a phone number is to be used as the electronic address for the notice and access safe harbor, the plan administrator must confirm that the number can receive and read the NOIA (e.g., it is not a landline).

Covered documents

The final regulation expands the definition of a covered document to include participant-level fee disclosure-related information required under ERISA. The proposed regulation had originally excluded documents that must be furnished upon request. The final regulation provides that a disclosure is only excluded if an administrator is “only” required to furnish it upon request. This change was intended to clarify that documents that are required to be furnished both automatically and upon request are included under the new safe harbors. Examples of such documents include summary plan descriptions (SPDs) and summaries of material modifications (SMMs).

[D]ocuments that are required to be furnished both automatically and upon request are included under the new safe harbors.

The safe harbor would not apply to any disclosure required by the Internal Revenue Code unless the Treasury Department specifies otherwise. In the preamble, the DOL noted that the Treasury Department and the IRS have indicated that they intend to issue guidance relating to the use of electronic delivery for participant notices under their jurisdiction. It is possible (perhaps likely) that such guidance will align with the new DOL rule, but that was not stated definitively.

Notice of Internet Availability

Under the notice and access safe harbor, in general, an NOIA must be furnished when a covered document is made available on the internet website. The following changes to the NOIA are included in the final regulation:

- The statement “Important information about your retirement plan is now available” is now technologically neutral (i.e., it no longer references information being available on a website) to allow for future technologies.
- The NOIA must now include the name of the covered document and is only required to include a brief description if the nature of the document is not reasonably conveyed by its name.
- The NOIA must specify that the right to receive a paper copy of a document or to opt out of electronic distribution are both available free of charge.
- The NOIA must include a cautionary statement that the documents are not required to be available more than a year from the date that the document is made available on the internet website, or if later, when superseded by a subsequent version of the covered document.
- The NOIA may (but is not required to) contain a statement regarding whether action is invited or required in response to the document, and how to take action.
- The final regulation clarifies that a hyperlink may be used to identify the website address where the document is posted.
- The NOIA must satisfy the SPD standard for readability and is no longer required to satisfy a specific Flesch reading score.

A plan administrator may combine NOIAs for one or more of the following: 1) SPD (although not clear, this appears to also include an SMM), 2) any covered document that must be furnished annually and does not require action by a deadline, 3) any document specified by the DOL in the future, and 4) any document required under the tax code if authorized by the Treasury Department. The final regulation (unlike the proposed regulation) does not allow quarterly benefit statements to be included in a combined NOIA.

The system for furnishing the NOIA must alert the administrator of an invalid or inoperable electronic address, and the individual would be treated as opting out if a new electronic address is not promptly obtained. The final regulation clarifies that the safe harbor does not require the plan administrator to monitor whether covered individuals visit or log on to the specified internet website.

Standards for the internet website

Under the final regulation, documents posted to an internet website under the notice and access safe harbor must remain available at least one year from the date of initial posting or, if later, after it is superseded by a subsequent version of the covered document. In addition, the definition of an internet website was expanded to include additional and new technologies, including mobile apps.

Right to receive a paper document and opt out of electronic delivery

The final regulation clarifies that the safe harbor only requires a plan administrator to provide a single copy of a specific covered document free of charge. Whether a plan is able to charge for additional copies of the same document will depend on the terms of the plan and other legal requirements.

The proposed regulation had allowed a covered individual to opt out of receiving one or more types of documents electronically. The final regulation requires only a global opt-out from receiving all documents electronically (although plans are permitted to offer an "a la carte" option, where participants could pick and choose which documents to receive in paper).

Initial paper notification of default electronic delivery and right to opt out

For the notice and access safe harbor, the initial paper notification must specify the electronic address that will be used to furnish the covered documents to the covered individual. The initial notice must also include instructions on how covered documents will be accessed, and the notice must be written in a manner that is calculated to be understood by the average participant.

[T]he definition of an internet website was expanded to include additional and new technologies, including mobile apps.

Special rule for severance from employment

The proposed regulation would have required a plan administrator to confirm a participant's electronic address or obtain a new electronic address following an active participant's severance from employment. Under the final regulation, these additional steps are only required when a participant's electronic address is assigned by the employer and not when it is a personal email address.

Temporary website outages

The proposed regulation specified that if certain requirements were satisfied, unforeseeable events that temporarily interfered with access to a covered document would not prevent compliance with the safe harbor. The final regulation expands this exception to include interruptions in access to covered documents due to technical maintenance.

Severability

The final regulation adds a severability rule, so that if any part of the regulation is found invalid, the remaining portions of the rule would remain in effect. This was presumably added in anticipation of litigation challenging the final rule.

New transition rules

During an 18-month transition period following the effective date of the final regulation, the DOL will not take enforcement action for the use of the special electronic distribution rules provided in Field Assistance Bulletin (FAB) 2006-03 (the "continuous access" website approach for benefit statements), FAB 2008-03 (electronic distribution of QDIA notice made in accordance with either IRS or DOL safe harbors), and Technical Release 2011-03R (interim enforcement policy regarding the use of electronic media for distributing participant-level fee disclosures under ERISA).

Also, to aid in the transition, a plan administrator may treat an electronic address in its possession as of July 27, 2020, as having been provided by the participant, beneficiary or other individual entitled to covered documents for purposes of treating such person as a covered individual under the safe harbor, even if the plan administrator does not have documentation on how the email address was obtained, provided that the plan administrator acts reasonably, in good faith, and otherwise complies with the safe harbor requirements.

Going forward

Many plan administrators will find the new electronic disclosure options to be far more useful than the prior safe harbor standard adopted in 2002, at least for certain participant groups. "Mixing and matching" methods of delivery is permissible, so plan administrators should determine the best approach for each cohort given his or her particular situation (e.g., a plan could use the 2002 safe harbor for participants who are "wired at work" and use the new safe harbors for some or all of the remaining participants).

The final rule eliminates the ability to provide pension benefit statement information using a "continuous access website" allowed under FAB 2006-03, after an 18-month transition period. Sponsors relying on this guidance will need to transition to a new approach for distributing the pension benefit statement.

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IRS proposes rule on tax treatment of certain health care arrangements

By Maureen Gammon, Anu Gogna, Ben Lupin and Kathleen Rosenow

On June 8, 2020, the IRS released **proposed regulations** addressing the treatment of certain medical care arrangements under section 213 of the Internal Revenue Code. Section 213 allows taxpayers to take an itemized deduction for medical care expenses, including health insurance, that exceed a specified percentage of the taxpayer's adjusted gross income (currently 7.5% but increasing to 10% for the 2021 tax year). Section 213 is also used to determine what medical expenses may be reimbursed from certain account-based plans, including health reimbursement arrangements (HRAs), health flexible spending accounts (FSAs), and health savings accounts (HSAs), on a tax-preferred basis.

The proposed regulations provide that payments for direct primary care (DPC) arrangements and health care sharing ministry (HCSM) memberships are medical care expenses under section 213, and, as such, may be reimbursed by an HRA. However, coverage under these arrangements could cause an individual to be ineligible to contribute to an HSA.

As proposed, the regulations will apply for taxable years that begin on or after the date final regulations are published. Comments on the proposed regulations are due by August 10, 2020.

Background

On June 24, 2019, President Trump issued **Executive Order 13877**, Improving Price and Quality Transparency in American Healthcare to Put Patients First. It directs the secretary of the Treasury to propose regulations to treat expenses related to certain types of arrangements, including DPC arrangements and HCSM membership, as eligible medical expenses under section 213.

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Proposed regulations

The proposed regulations provide that amounts paid for a DPC arrangement will qualify as medical expenses under section 213 regardless of whether they are for medical care or medical insurance (which depends on how the DPC arrangement is structured). The rule defines a DPC arrangement as a contract between an individual and one or more primary care physicians who agree to provide medical care for a fixed annual or periodic fee without billing a third party.

Payments for membership in an HCSM are considered payments for medical insurance under the proposed regulations. The definition of HCSM in the proposed regulations comes from the tax code, which provides that the individual shared responsibility payment (which is reduced to zero after December 31, 2018) does not apply to an individual who is a member of an HCSM. Generally, an HCSM is a tax-exempt organization (or a predecessor of which) that has

been continuously in existence since December 31, 1999, and whose members share a common set of ethical or religious beliefs and share medical expenses in accordance with those beliefs, without regard to the state in which a member lives or works. While HCSMs themselves do not provide any medical care, members may receive payments from other members to help with their medical bills.

The proposed regulations also adopt the long-standing IRS position that amounts paid for membership in a health maintenance organization and amounts paid for coverage under certain government-sponsored health care programs (Medicare Parts A, B, C and D; Medicaid; Children's Health Insurance Program; TRICARE; and certain veterans' health care programs) are treated as amounts paid for medical insurance for section 213 purposes.

The proposed regulations do not address whether any particular arrangement or payment constitutes, or is part of, an employee welfare benefit plan for ERISA compliance purposes. They do note that the Department of Labor advised the Treasury Department and the IRS that an employer's funding of a health benefit arrangement for employees, in most circumstances, qualifies it as an ERISA-covered plan.

HRA reimbursement

The proposed regulations provide that an HRA — including a qualified small employer HRA, an HRA integrated with a traditional group health plan, an HRA integrated with individual health insurance coverage or Medicare (individual coverage HRA or ICHRA), or an excepted benefit HRA — may reimburse DPC arrangement fees and payments for an HCSM membership, as they are considered section 213 medical expenses.

HSA eligibility

An HSA-eligible individual is someone who is covered under an HSA-qualified high-deductible health plan (HDHP) and, at the same time, not covered under a non-HDHP that provides coverage for any benefit covered under the HDHP. If an individual has medical coverage that provides benefits before the HDHP minimum annual deductible is met, the individual will not be eligible to contribute to an HSA.

According to the proposed regulations, an individual covered under the type of DPC arrangement that provides for a wide array of primary care services and items — such as physical examinations, vaccinations, urgent care, laboratory testing, and the diagnosis and treatment of sickness or injuries — generally would not be eligible to contribute to an HSA

The proposed regulations do not address whether a health FSA or HSA can reimburse DPC arrangement expenses or HCSM membership fees.

because 1) the arrangement constitutes a health plan or insurance that provides coverage before the HDHP minimum annual deductible is met, and 2) it provides a type of coverage that is not preventive care or disregarded for HSA eligibility purposes by IRS HSA guidance.

An individual participating in a DPC arrangement may contribute to an HSA if 1) the arrangement does not provide coverage under a health plan or insurance (for example, the arrangement solely provides for an anticipated course of specified treatments of an identified condition), or 2) it solely provides for disregarded coverage or preventive care (for example, it solely provides for an annual physical examination). However, if the DPC arrangement fee is paid by an employer, then that arrangement would be a group health plan and the individual would be disqualified from contributing to an HSA.

Health FSA and HSA reimbursements

The proposed regulations do not address whether a health FSA or HSA can reimburse DPC arrangement expenses or HCSM membership fees. While health FSAs may generally reimburse medical care expenses as defined under section 213, they are specifically prohibited from reimbursing health care coverage premium expenses. It appears that the health FSA would not be permitted to reimburse the expenses or fees for a DPC arrangement or HCSM membership that constitutes a health plan or insurance (as discussed above).

While a DPC arrangement or HCSM membership can affect an account holder's eligibility to make HSA contributions, those eligibility rules do not apply for reimbursement purposes. However, insurance premiums are only qualified medical expenses for HSA purposes in certain limited situations, such as for COBRA premiums, premiums for health coverage maintained while the individual is receiving unemployment compensation, or premiums for any deductible health insurance (other than a Medicare supplemental policy) when the HSA holder is age 65 or older. As a result, it appears that expenses for DPC arrangements and HCSM membership fees would only be reimbursable if one of the exceptions applies. Additional guidance from the IRS is needed to clarify this issue.

Going forward

When the regulations are finalized, employers should:

- Determine if they wish to allow the HRA to reimburse DPC arrangement fees and payments for an HCSM membership. The tax code would allow these expenses to be reimbursed on a tax-preferred basis, but the employer-sponsored HRA is not required to do so.
- Avoid offering DPC arrangements to employees contributing to an HSA. An employee covered by such an arrangement should be aware that it may affect HSA eligibility and avoid establishing an HSA or making HSA contributions.
- Be aware that DPC arrangement expenses or HCSM membership fees would only be reimbursable from an HSA on a tax-favored basis in limited circumstances; employers may want to communicate this to their employees and encourage them to consult an independent tax advisor. Unless the IRS issues additional guidance, employers should not allow their health FSA to reimburse DPC arrangement expenses or HCSM membership fees.

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DOL proposes update to MHPAEA self-compliance tool

By Maureen Gammon and Kathleen Rosenow

The Department of Labor (DOL) has released a **proposed 2020 MHPAEA Self-Compliance Tool**, updating the one published in 2018.[1] The tool is intended to help group health plans evaluate compliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). While the update does not add any new compliance obligations, it incorporates new DOL guidance, adds compliance examples, provides best practices for internal compliance strategies for group health plans and offers more "warning signs" that may require additional review to ensure MHPAEA compliance.

Usage of the Self-Compliance Tool is not required; a group health plan may choose to implement the tool at any time or not at all. Note that the Self-Compliance Tool is not intended to be a substitute for full MHPAEA compliance testing.

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Background

Under the MHPAEA, the financial requirements and treatment limitations imposed by a group health plan or health insurance issuer on mental health and substance use disorder (MH/SUD) benefits generally cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical (M/S) benefits. In addition, nonquantitative treatment limitations (NQTL) may not be imposed on MH/SUD benefits unless comparable processes, strategies, evidentiary standards or other factors are applied no more stringently to M/S benefits in the same classification.

Under the 21st Century Cures Act, the DOL, the Department of Health and Human Services, and the Department of the Treasury are required to provide a publicly available document with guidance on program compliance and update it every two years. The proposed 2020 MHPAEA Self-Compliance Tool is an update to the tool issued in April 2018.

Proposed revisions

The proposed Self-Compliance Tool incorporates changes in several areas:

Integration of recent guidance. The update incorporates MHPAEA guidance included in the departments' Final FAQs Part 39.[2] These FAQs covered such issues as experimental treatment exclusions, evidentiary standards, prescription drug limits, exclusions for particular conditions, step therapy,

[1] See "**Agencies propose FAQs on nonquantitative treatment limits under MHPAEA**," *Insider*, May 2018.
[2] See "**Final FAQs issued on nonquantitative treatment limits under MHPAEA**," *Insider*, September 2019.

reimbursement rates, network adequacy standards, coverage restrictions based on facility type, emergency room care and disclosure requirements for network listings.

Revised compliance examples. The proposed 2020 Self-Compliance Tool revises the 2018 version's noncompliance examples, adding an explanation of how plans and issuers could correct these violations. An added appendix also includes more examples.

Best practices for establishing an internal compliance plan. Although not required by MHPAEA, the departments encourage group health plans to establish an internal compliance strategy to prevent, detect and resolve potential MHPAEA violations. Compliance plans should:

- Conduct effective training and education.
- Ensure retention of records and information systems.
- Conduct regular internal monitoring and compliance reviews.
- Respond promptly to detected offenses and develop corrective action.

The Self-Compliance Tool also contains a listing of some of the items that the DOL may request in an MHPAEA audit.

Warning signs of noncompliance. The DOL previously issued guidance on "warning signs" that may serve as red flags to possible impermissible treatment limitations that warrant further review. The 2020 proposed update adds examples from recent federal and state enforcement efforts, including:

- A plan applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain M/S benefits within a classification.
- A plan or issuer generally pays at or around Medicare reimbursement rates for MH/SUD benefits while paying much more than Medicare reimbursement rates for M/S benefits.
- A plan reimburses MH/SUD physicians (e.g., psychiatrists), on average, less than M/S physicians for the same evaluation and management codes.

Medicare reimbursement rate tool. A second new appendix in the Self-Compliance Tool can be used to compare plan reimbursement rates to Medicare.

The Self-Compliance Tool also contains a listing of some of the items that the DOL may request in an MHPAEA audit.

Compliance examples

The proposal contains several interesting MHPAEA compliance examples:

Prescription drug coverage. If a plan or coverage excludes all other benefits for a particular MH condition or SUD but nevertheless covers formulary prescription drugs for that condition or disorder, it would be covering MH/SUD benefits in one classification (prescription drugs). As a result, the plan would be required to provide MH/SUD benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides M/S benefits.

Residential treatment. If a plan covers room and board for inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care (both of which the plan classifies as inpatient care), but restricts room and board for MH/SUD residential care, the plan would be imposing an impermissible restriction based on facility type – a treatment limitation – only on MH/SUD benefits and therefore violating MHPAEA. The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with M/S inpatient treatment.

Reimbursement rates. To comply with MHPAEA, a plan must determine reimbursement rates for in-network providers in a comparable manner for both M/S and MH/SUD benefits. For example, if the Medicare Physician Fee Schedule is used to determine reimbursement rates for M/S benefits, it must also be used to determine reimbursement rates for MH/SUD benefits. Any variance in rates applied by the plan to account for factors such as the nature of the service, provider type, market dynamics, and market need or availability (demand) must be applied comparably to both MH/SUD and M/S benefits.

Network adequacy. To address shortages in M/S specialist providers and unreasonable appointment wait times, plans may adjust provider admission standards by increasing reimbursement rates and develop a process for accelerating enrollment in their networks; however, plans must take

comparable, and no more stringently applied, measures to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and M/S providers in the plan's network.

NQTL factors. Plans have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards), as long as they are applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In an example scenario, a plan utilizes a panel of medical experts, with equivalent expertise in both M/S and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and has legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices due to high cost and legitimate safety concerns to impose preauthorization requirements on M/S benefits in the same classification, then requirements would be met.

In addition, the proposal notes a few new examples of how a plan can show that its standards and processes are used comparably for both MH/SUD benefits and M/S benefits in the same classification: 1) internal quality control reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and M/S benefits are comparable; and (2) summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and M/S demonstrate that the research was similarly used for both MH/SUD and M/S benefits.

Going forward

The DOL is requesting comments by July 24, 2020, on the proposed Self-Compliance Tool, updated sections only (which are marked in yellow throughout the document).

Plan sponsors should review the proposed tool to ensure they are in compliance as well as consider full MHPAEA compliance testing if they have not tested in the past or have changed their plan design since they last tested.

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