Valent GROUP Compliance Check

Updating Health Plans for Coronavirus Changes

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

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

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

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

Action Steps

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

In addition, employers that offer special mid-year enrollment opportunities must consider the tax rules for premium payments.

Highlights

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

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

Important Dates

Jan. 1, 2020
Health FSAs and HRAs can reimburse OTC drugs and menstrual care products.

March 27, 2020
HDHPs can reimburse telehealth and other remote care services without a deductible.

Waiving Eligibility Requirements

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

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

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

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

Offering a Special Mid-year Enrollment Window

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

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

Section 125 Rules for Pretax Premiums

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

The IRS has identified some limited circumstances when employees can change their pre-tax elections during the plan year (called mid-year election change events). The IRS, however, has not issued any guidance that would allow employees to change their pre-tax elections due to the COVID-19 pandemic. Whether an

employee's COVID-19-related election change would satisfy any of the IRS' current rules for mid-year election change events is unclear and may depend on the specific facts involved.

For example, the IRS currently allows mid-year election changes when any of these events occurs:

- A change in employment status (such as an unpaid leave of absence or a change in worksite) if the change affects eligibility for coverage under the health plan;
- A significant change in health plan coverage; and
- A HIPAA special enrollment event (for example, marriage or birth of a child).

Many employees are experiencing employment changes due to the COVID-19 outbreak, but not all these changes impact eligibility for coverage. Also, it is not clear whether the health plan changes made by the Families First Coronavirus Response Act (FFCRA) (for example, mandatory coverage of COVID-19 testing without cost-sharing) would be a significant change for a health plan. Further, a special mid-year enrollment window for the COVID-19 pandemic is not covered under HIPAA's special enrollment rules.

Due to this uncertainty, employers should work with their tax and legal advisors to determine whether employees who enroll during the special enrollment window may pay their premiums on a pre-tax basis. Employers may allow employees to enroll in coverage during the special enrollment window and pay for coverage on an after-tax basis until the next plan year, but this tax treatment should be communicated to affected employees in advance because it may be unexpected.

Action Steps

Employers that want to implement this special enrollment opportunity should:

- ☑ **Determine whether newly enrolled employees' premiums will be paid on a pre-tax or after-tax basis**. Employers that allow employees to pay their premiums on pre-tax basis will need to consider whether newly enrolled employees can make pre-tax premium payments under the Section 125 rules (described above).
- ☑ **Review plan documents to determine if plan amendments are necessary**. Some plan documents may not require updating because they refer to the plan's enrollment opportunities in general terms. Plan documents that include more detail, such as describing the plan's initial enrollment period for newly eligible employees and annual open enrollment period, may need to be updated.
- ☑ **Communicate the special mid-year enrollment window to employees**. Employers should notify eligible employees as soon as possible about the special mid-year enrollment window and explain the relevant details, including the length of the window, the process for electing coverage, the effective date for coverage and the tax rules for premium payments (that is, pre-tax or after tax).

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

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

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

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

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

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

HDHPs – COVID-19 Treatment and Telehealth Services

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

- IRS Notice 2020-15 allows HDHPs to pay for **COVID-19 testing and treatment** before plan deductibles have been met, without jeopardizing their status. Also, according to the IRS, any COVID-19 vaccination costs count as preventive care and can be paid for by an HDHP without cost sharing.
- Effective March 27, 2020, the CARES Act allows HDHPs to provide benefits for **telehealth or other remote care services** before plan deductibles have been met, for plan years beginning before Jan. 1, 2022.

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

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

SMM Deadlines

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

Plan administrators must generally provide the SMM within **210 days** after the close of the plan year in which the change was adopted. However, if the change is a material reduction in group health plan benefits or services, the deadline for providing the SMM is **60 days after the change is adopted**.

In addition, the ACA requires plan administrators and issuers to provide participants with a summary of benefits and coverage (SBC). Plan administrators and issuers must provide **60 days' advance notice** of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the SBC. The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM. Frequently asked questions (FAQs) issued by federal agencies on health coverage changes required by the FFCRA and the CARES Act provide that the 60-day advance notice requirement does not apply to plan changes for COVID-19 testing coverage requirements and HDHP changes for coverage of telehealth and other remote care services. For these changes, the FAQs provide that health plans and issuers must notify participants as soon as reasonably practicable.