Health Compliance Issues Triggered by COVID-19

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Segal

Today's Presenters

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Agenda

Legislation Update

Health Plan Provisions

Telehealth

Deadline Extensions

Cafeteria Plan Changes

Resources

Q&A

Important Legislation affecting Health Plans

The Families First Coronavirus Responses Act (Families First Act)

The Families First Act (PL 116-127) passed on March 18, 2020 and provides paid leave, tax credits, expanded unemployment and nutrition assistance, and free testing

The Coronavirus Aid, Relief, and Economic Security (CARES) Act

The Cares Act (PL 116-136) passed on March 27, 2020 and enacted mandates for coverage for group health plans

Health Provisions

Families First Act and CARES Act

COVID-19 Testing and Visits

Effective March 18, 2020 through the end of the Public Health Emergency

- Group health plans and insurers must cover:
  - FDA-approved diagnostic tests and tests for which approval has been requested or tests developed by States;
  - Test administration; and
  - Items and services given during office / urgent care / telehealth / emergency room visits to the extent they relate to the evaluation or furnishing the test
- No deductibles, copays or coinsurance permitted
- No prior authorization or medical management requirements permitted
- No requirements to cover treatment under Federal law
  - Some state insurance laws are broader, but would not apply to self-insured plans

Families First Act and CARES Act

COVID-19 Tests

- If plan (or insurer) has a negotiated rate with a diagnostic test provider that rate would apply
- If plan (or insurer) does not have a negotiated rate with the provider
  - The plan (or insurer) must reimburse the provider the cash price for such service as listed by the provider on a public website

Families First Act and CARES Act

FAQs Released 4/11/20

- Serological tests (to detect antibodies) must also be covered without cost sharing
- Related tests furnished during visit (e.g., blood test, flu test) must also be covered without cost sharing if visit results in the ordering of, or administration of, COVID-19 test
  - Attending health care provider determines what care is medically appropriate in accordance with accepted standards of medical care
- "Visits" include non-traditional settings e.g., drive-through sites where health care professionals administer the tests

Families First Act and CARES Act

FAQs Released 4/11/20

- Plan sponsors are encouraged to promote use of telehealth, including for mental health and substance use disorders
- When telehealth is available, no cost sharing can be applied to telehealth visits that result in the ordering of a COVID-19 test
- Requirements do not apply to retiree-only plans

Families First Act and CARES Act

FAQs Released 4/11/20

- No requirement to provide 60 days' advance notice of benefit enhancements related to COVID-19
- EAPs that meet the requirements to be considered "excepted benefits" will not fail to meet those requirements if EAP provides COVID-19 diagnostic and testing services during the emergency
- On-site clinics are "excepted benefits" and can provide testing

Telehealth

HHS Guidance
Telemedicine Coverage

- HHS will not penalize healthcare providers that use telecommunication methods that may not fully comply with HIPAA
  - https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
  - Guidance makes it easier for individuals to seek virtual care from their current provider
  - Plans can also use a telehealth network – either stand alone or through their TPA – to provide network telehealth services

HDHP/HSAs and Telehealth

CARES Act

High-Deductible Health Plans (HDHP) may cover telehealth or other remote care services before deductible is met

- Effective January 1, 2020 (see Notice 2020-29), and applicable to plan years beginning on or before December 31, 2021

If the plan offers telehealth, what is required?

- Telehealth related to COVID-19 *testing* must be paid without cost sharing during the public health emergency (Families First)
- Regular cost sharing may be applied to telehealth related to COVID-19 *treatment* and treatment for other conditions

Significant change in how health care is delivered

COVID-Related Deadlines

Health and Disability Plan Deadlines Extended

- In determining certain deadlines, group health and disability plans must disregard the “Outbreak Period” — starting on March 1, 2020, and ending 60 days after end of the emergency
- 85 Fed. Reg. 26351 (May 4, 2020)
- The extended deadlines relate to:
  - HIPAA special enrollment
  - COBRA
  - Claims and appeals

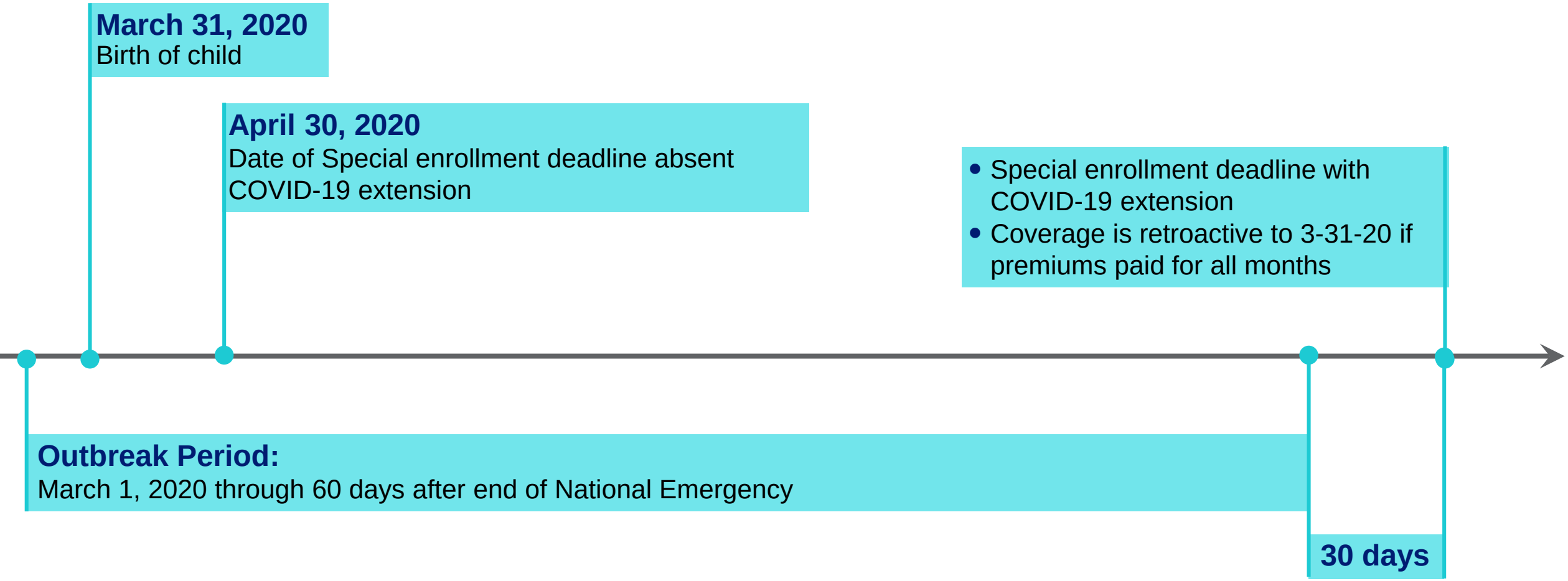
Covered Group Health Plans

- ERISA-governed plans and plans subject to Internal Revenue Code are covered by the delays
- Non-federal governmental health plans are not governed by the delay regulation, but HHS encourages them to follow it
  - https://www.cms.gov/files/document/Temporary-Relaxed-Enforcement-Of-Group-Market-Timeframes.pdf
  - https://www.cms.gov/files/document/COVID-19-Letter-to-Non-Federal-Governmental-Plans.pdf

Special Enrollment

- Group health plans must allow individuals to enroll in the plan based on loss of eligibility for other coverage or acquisition of a new dependent for at least 30 days after the event
  - Special enrollment period is 60 days in event of loss of coverage under Medicaid or CHIP
- Under the delay regulation, the Outbreak Period must be disregarded in determining these deadlines
- Plans will have to allow additional time to request special enrollment, up to 30 days (or 60 days) after end of the Outbreak Period - participants must pay any applicable premiums for coverage

Special Enrollment Deadline



Claims and Appeals Extensions

- Group health plans, including those with disability benefits, must extend deadlines for filing claims and appeals without regard to the Outbreak Period, including:
  - Deadline for filing a benefit claim
  - Deadline for filing an appeal of an adverse benefit determination
  - For non-grandfathered health plans, a request for external review or information to complete the request for external review

Claims and Appeals Examples

- On March 1, 2020, a participant received covered medical treatment, but a claim was not submitted until April 1, 2021
  - Under the plan, claims must be submitted within 365 days
  - Since Outbreak Period is disregarded in determining this deadline, this claim would be considered timely
- Participant received a notification of an adverse benefit determination from their disability plan on January 28, 2020, with a 180-day appeal period
  - When determining the 180-day period, the Outbreak Period is disregarded

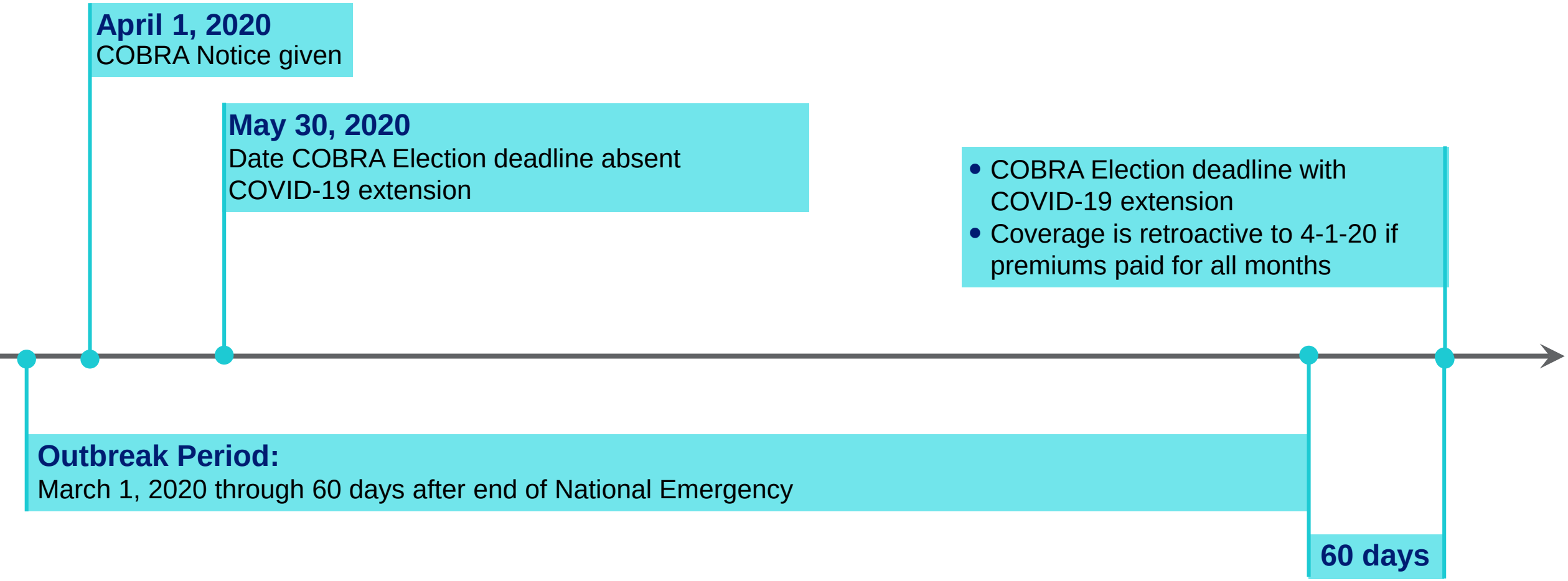
COBRA Extensions

- Plans must determine deadlines under COBRA without regard to the Outbreak Period, including:
  - The deadline to elect COBRA
  - The deadline to pay the first premium
  - The 30-day grace period for premium payment
  - Notice of a COBRA qualifying event by the participant (e.g., divorce, loss of dependent status or receipt of a Social Security Disability determination)

COBRA Extensions

- The Outbreak Period is also disregarded when calculating the deadline for plan sponsors and administrators to provide COBRA election notices
- If possible, plan administrators should continue to provide COBRA notices to qualified beneficiaries so they are aware of their right to continuation of coverage

COBRA Election Deadline



New COBRA Model Notices

- On May 1, 2020, DOL's Employee Benefits Security Administration (EBSA) released new model general and election notices for continued health coverage under COBRA
- New language encourages individuals to consider their Medicare options prior to electing COBRA continuation coverage
  - Especially because individuals may incur a Medicare Part B late enrollment penalty if they do not enroll in Medicare within eight months of losing employer-sponsored coverage, regardless of whether they elect COBRA.
- Notices also explain that plans may terminate COBRA continuation coverage for individuals who elect COBRA and later enroll in Medicare.
  - If the individual is already enrolled in Medicare Parts A or B prior to electing COBRA, COBRA continuation coverage cannot be terminated because of enrollment in any part of Medicare.
- EBSA also issued answers to frequently asked questions on COBRA and Medicare.

DOL Disaster Relief Notice 2020-01

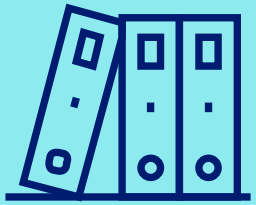
- DOL has extended deadlines for certain notices, disclosures and other documents under Title I of ERISA.
- Plan and its fiduciaries will not violate ERISA for failing to provide a covered document due during the period that began on March 1, 2020, and ends on the 60th day after the end of the emergency, if they make a good-faith effort to provide document as soon as possible under the circumstances.
- Good-faith effort includes use of electronic alternative means of communicating with plan participants and beneficiaries whom the plan fiduciary reasonably believes have effective access to electronic means of communication (including email, text messages and continuous access websites).

Implementing the Outbreak Period Delay

- Plan sponsors may need to consider the following:
  - Revise COBRA notices
  - Prepare “insert” for existing notices explaining the Outbreak Period delay
  - Prepare administrative procedures to assist plan administrator to implement the delay period
- If COBRA subsidy passes Congress, clear documents and administrative procedures will be important tools

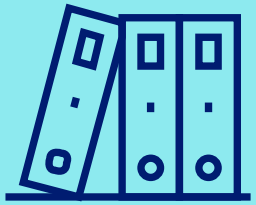
Cafeteria Plan Guidance

Temporary Guidance on Election Changes



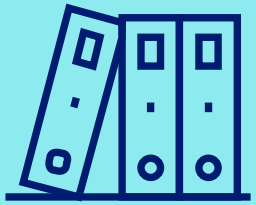
- Under guidance issued on May 12, 2020 by the Treasury Department and the IRS in Notice 2020-29, through December 2020, employers may choose to:
  - Permit various mid-year election changes to be made prospectively (on a going forward basis only)
  - Give employees an extension until end of the year to spend unused funds in their health FSAs and dependent care assistance programs (DCAPs)

Permanent Guidance on Carryover Amounts



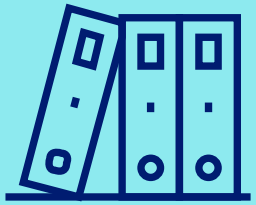
- Notice 2020-33 provides a new formula for determining the maximum unused health FSA amount employers may permit employees to carry over from a plan year for 2020 and beyond (currently $500)

Employer Choices and Documents



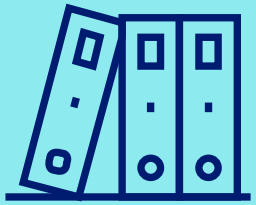
- Employers may permit some, all or none of these options, and are not required to provide unlimited election changes
- Employers should review these changes with their flex plan administrators and insurers to determine what changes can be implemented
- Plans would have to be amended no later than December 31, 2021, to take advantage of this new flexibility or increase the carryover amount

Permissible mid-year election changes



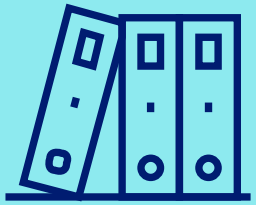
- Employers may prospectively allow employees to:
  1. Make a new health coverage election, if they previously declined employer-sponsored health coverage,
  2. Revoke their current election and enroll in different employer-sponsored coverage (e.g., move from an HMO to a PPO), including changing from self-only to family coverage, or
  3. Revoke their current election *without* electing different employer-sponsored coverage provided
     - They make a written attestation that they have other health coverage (sample attestation is included in the guidance)

Health FSAs and DCAPs



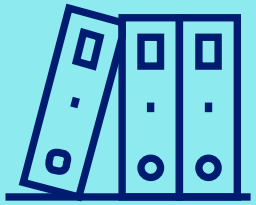
- Employers may prospectively allow employees who have health FSAs or DCAPs to:
  - revoke an election
  - make a new election
  - decrease an existing election, or
  - increase an existing election.
- Also applies to limited-purpose health FSAs that are designed to be compatible with HSAs

Extra Time to Spend Funds



- If employees have unused amounts in health FSAs or DCAPs as of end of a plan year (or grace period) ending in 2020, employer may permit those funds to be used to pay or reimburse medical care or dependent care (as applicable) through December 31, 2020
- Extension of time also applies to plans that provide for a carryover

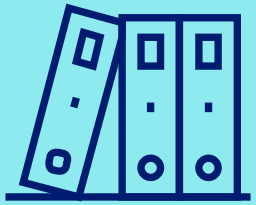
Permanent Guidance on Carryover Amounts



- Notice 2020-33, provides a new formula for determining maximum unused health FSA amount that employers may permit employees to carry over from a plan year for 2020 and beyond (currently $500)
- New formula will be equal to 20% of the maximum salary reduction to a health FSA allowable for that year
- Employee can be permitted to carry over a maximum of $550 from a plan year starting in 2020 to a plan year starting in 2021 (20% of $2,750, this year's maximum salary deferral)

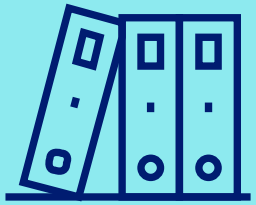
Other Benefit Rules

CARES Act



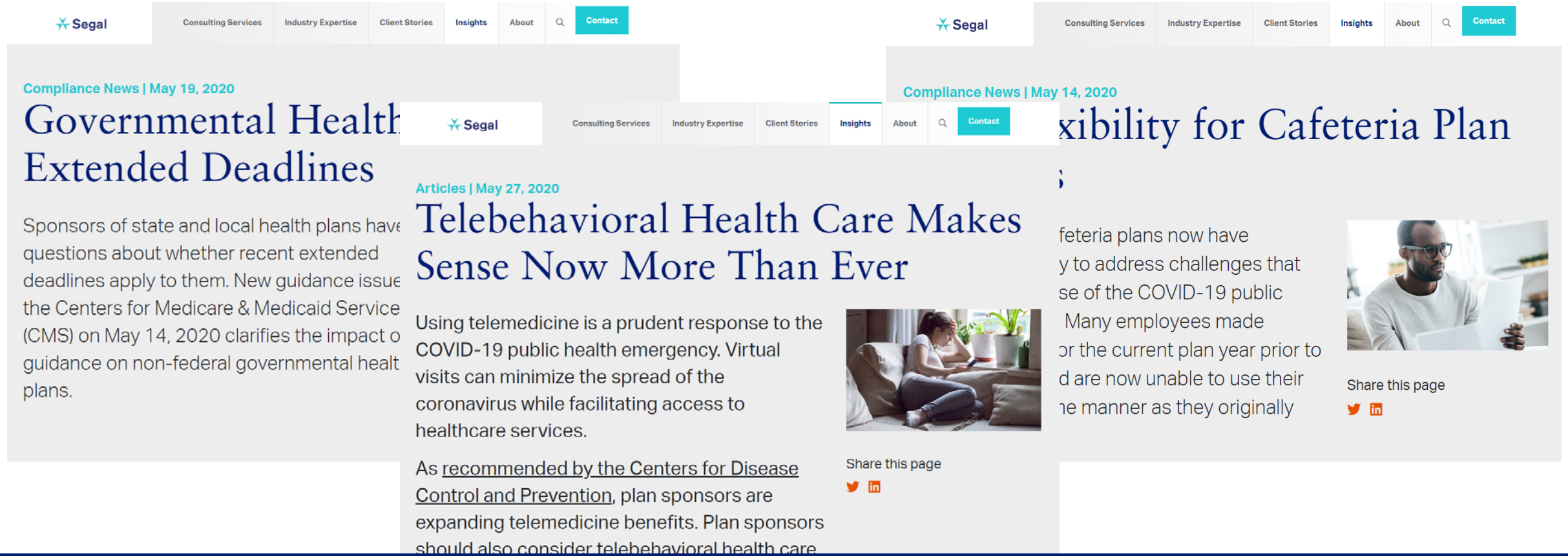
- ACA rule that required a prescription before plan could pay for over-the-counter drugs and medications repealed
- Permits menstrual care products may be treated as medical expenses eligible for reimbursement from HSAs, HRAs, and FSAs (for expenses after December 31, 2019)

Implementing the Flex Changes



- Employers with non-calendar year plan years may see higher demand to access accounts than those with calendar year plans
- Employers may have already allowed changes based on existing IRS rules, which may have addressed most issues
- Needs may be more critical in some industries than others
- Most employers with carryovers of $500 will want to increase the amount by amending 125 plans

For More Information



www.segalco.com/COVID-19

Questions?