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Developments & Key Issues for Health and Welfare Plans in 2020

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Outline

- Cafeteria and Flexible Spending Account Changes
- High Deductible Health Plan Changes
- Telehealth/Telemedicine Coverage
- Affordable Care Act in the News
- COBRA Update
- Odds & Ends

Cafeteria Plan Rules
Overview

- Cafeteria plans are plans that allow employers to offer their employees the ability to make elections between cash on the one hand and certain non-taxable benefits on the other hand
  - The most common non-taxable benefits offered through a cafeteria plan are elections of health coverage and payments of premiums for health coverage on a pre-tax basis, reimbursements from health flexible spending accounts (FSA), and reimbursements from dependent care FSAs
- If elections between cash or non-taxable benefits are not made pursuant to a cafeteria plan, the non-taxable benefits offered to employees are taxable to the employees as though they had elected the cash, even if they actually elect the non-taxable benefits
  - In exchange for the special tax treatment offered by cafeteria plans, the IRS has imposed many restrictions on such plans, including the ability of employees to change their elections during the course of a plan year, limitations on the amounts that can be reimbursed during a plan year, and the ability to carry over amounts from one plan year to the next

Notices 2020-29 and 2020-33; CARES Act

- Recognizing the impact of COVID-19 on both employers and employees, Congress enacted various pieces of legislation, executive orders were issued, and various governmental agencies issued special guidance in a variety of areas, all to assist employers and employees in dealing with the daily changing circumstances caused by the pandemic
- In the context of cafeteria plans, the IRS issued two notices that are aimed at providing employees greater flexibility with respect to health coverage elections, the period during which claims can be submitted under cafeteria plans, and the limits that apply under cafeteria plans
- In addition, the Coronavirus Aid, Relief and Economic Security Act (CARES Act) made changes with respect to the types of expenses that can be reimbursed from a health FSA under a cafeteria plan

General Rule
Changes to Elections

- One of the restrictions imposed on cafeteria plans is that cafeteria plan elections generally must be made prior to a plan year and cannot be changed after the beginning of the plan year to which they relate except in very limited circumstances—most notably in the case of the plan participant's "change in status"
- Permitted changes in status are set forth in IRS regulations and are very circumscribed
  - Permitted status changes include events such as marriage, birth of a child, changes in employment status, and, in certain cases, changes in the cost of the coverage under an employer's health plan
- An election change must be both on account of a change in status and consistent with the change in status
  - IRS regulations set forth the rules that apply for determining whether a particular election change is on account or and consistent with a particular change in status
  - For example, the regulations provide that a change in coverage can be made on account of the birth of a child but a drop in coverage would not be consistent with that change in status event

COVID Guidance
Changes to Elections

- The guidance issued by the IRS in connection with the COVID-19 pandemic modifies and broadens the cafeteria plan change in election rules with respect to health coverage, health FSAs and dependent care FSAs (Notice 2020-29)
- The guidance provides that an employer may amend its cafeteria plan to permit all employees who are eligible to make contributions under the plan (regardless of whether they are *actually* making contributions at the relevant time) to make prospective changes to their elections regarding employer-sponsored health coverage and FSAs for calendar year 2020
  - With respect to health coverage, employees can be given the ability to prospectively (a) make a new election if the employee initially declined coverage, (b) revoke an existing election and make a new election to enroll in a different health coverage option, and (c) revoke an existing coverage election
  - If an employee seeks to revoke an election for employer-sponsored health coverage, that employee must provide a written attestation that he or she is enrolled in or will immediately enroll in other comprehensive health coverage
  - With respect to health and/or dependent care FSAs, employees can be given the ability to prospectively (a) revoke an existing election, (b) make a new election, or (c) increase or decrease an existing election

COVID Guidance
Changes to Elections (con't)

- The election changes permitted under the guidance are available to eligible employees, whether or not they are affected by the COVID-19 pandemic
- The election changes permitted under the guidance apply regardless of whether or not the "normal" change in status rules are satisfied
  - This means that election changes do not need to be on account of or consistent with a change in status
- An employer is not required to modify its plans to provide for any or all of the changes or to provide for unlimited changes
  - If an employer does decide to permit some or all of the changes, it will need to amend its plans to reflect the changes that apply

COVID Guidance
Changes to Elections (con't)

- A plan amendment reflecting the changes to the election rules must be adopted no later than December 31, 2021, and can be retroactive to January 1, 2020
  - If the amendment is made retroactively, the employer must inform all individuals who are eligible to participate in the plan of the changes and the plan must be operated in accordance with the notice to the employees

General Rule
Use It or Lose It; Run-out Period

- A cafeteria plan does not include a plan that defers compensation or provides benefits that defer compensation
  - If a plan permits an employee to carry over amounts allocated for benefits in one plan year to provide benefits in a subsequent plan year, the plan provides for the deferral of compensation and violates the cafeteria plan rules
- The "use it or lose it" rule—a hallmark of cafeteria plans—is shorthand for the required plan provisions and administrative rules relating to cafeteria plans that prevent the plan from violating the prohibition on the provision of deferred compensation
  - Generally, this rule requires that the amounts allocated under the cafeteria plan for claims incurred in one year cannot be used to reimburse claims incurred in a later year—the participant must either "use" the amounts allocated for one year or "lose" (forfeit) those amounts

General Rule
Use It or Lose It; Run-out Period (con't)

- A plan does not violate the use it or lose it rule by providing a "run-out" period
- A run-out period is a period (usually relatively brief) following the end of a plan year during which a plan participant can submit and be reimbursed for expenses incurred in the prior plan year
  - A run-out period, which is included in almost all cafeteria plans, is a rule of administrative convenience for both employees and employers; it does not alter the general principles of the use it or lose it rule
  - Amounts reimbursed during a run-out period are counted against the amounts allocated for the plan year to which the run-out period relates and are subject to any limits applicable under the plan for that plan year

General Rule
Grace Period; Carryover

- Beginning in 2005, the IRS issued guidance that permits employers to include a "grace period" in their plans as an exception from the use it or lose it rule
  - A grace period cannot exceed 2-1/2 months following the end of the plan year to which the grace period applies
  - If a plan provides for a grace period, unused amounts from the prior plan year can be used to reimburse expenses incurred during the grace period
  - Any amounts from the prior plan year that are not used to reimburse claims incurred either in that plan year or the grace period are forfeited
- A plan can provide a run-out period with respect to claims incurred in the grace period

General Rule
Grace Period; Carryover (con't)

- In 2013, the IRS further whittled away at the use it or lose it rule by permitting employers to add a "carryover" provision to their plans
- In connection with the implementation of limits on the maximum contributions that can be contributed to a health FSA under cafeteria plans, the IRS issued guidance that permits employers to include a "carryover" provision in their plans as an exception from the use it or lose it rule
  - If a plan provides for a carryover provision, an amount of up to $500 or, if less, unused amounts in the employee's health FSA from the prior plan year (or, in any case, a lower amount provided under the plan) can be added to the employee's health FSA for the subsequent plan year and used to reimburse eligible expenses incurred in the subsequent plan year
  - The carryover will not count against the health FSA limits for the applicable carryover plan year ($2,750 for health FSAs in 2020)
  - A plan cannot have **BOTH** a grace period and a carryover provision in the same plan year
- Carryover provisions relating to dependent care FSAs are not permitted

COVID Guidance

Use It Lose It, Run-out Periods, Grace Periods and Carryovers

- The guidance issued by the IRS in connection with the COVID-19 pandemic modifies the rules relating to run-out periods, grace periods and carryovers (Notice 2020-29)
- The guidance provides that an FSA account with a grace period ending in 2020 or a plan year ending in 2020 may permit employees with unused amounts as of the end of the grace period or plan year to use such amounts for reimbursements for medical care expenses (with respect to a health FSA) or dependent care expenses (for a dependent care FSA) incurred through December 31, 2020—thus significantly extending the normal grace period that would have otherwise ended as of March 15, 2020 (in the case of a calendar year plan)
  - Consistent with the rules in effect prior to the COVID-19 guidance, however, employees may not use amounts under one type of FSA for another type of expense (for example, a health FSA balance cannot be used to reimburse dependent care expenses or vice versa) and a plan cannot have a grace period **AND** a carryover provision

COVID Guidance

Use It Lose It, Run-out Periods, Grace Periods and Carryovers (con't)

- The COVID-19 guidance also modifies the rules relating to the determination of the maximum carryover amount (Notice 2020-33)
- Under the guidance, the carryover limit for health FSAs beginning in 2021 will be increased from $500 to $550
  - For future years, the maximum carryover amount will be increased based on the maximum permitted FSA contribution limit for the applicable plan year (future year maximum will be 20% of the maximum salary reduction contribution permitted to health FSAs)
- The guidance does not extend the carryover provisions to dependent care FSAs
- A plan amendment reflecting the changes to the carryover limit for 2020 must be adopted no later than December 31, 2021, and can be retroactive to January 1, 2020
  - If the amendment is made retroactively, the employer must inform all individuals who are eligible to participate in the plan of the changes and the plan must be operated in accordance with the notice to the employees
  - For future years, the amendment would need to be adopted on or before the last day of the plan year from which amounts can be carried over

General Rule
Eligible Reimbursements from Health FSAs

- In general, health FSAs can only reimburse expenses for items constituting medical care, including medications
  - The determination of whether an expense constitutes medical care that is reimbursable from a health FSA is determined under IRS rules
  - The IRS has limited the types of expenses that could be reimbursed from a health FSA
- The Affordable Care Act of 2020 (ACA) provided that, beginning as of January 1, 2011, a health FSA was not permitted to reimburse expenses for an over-the-counter (OTC) medication unless the employee had a prescription for the medication
  - No prescription was required for insulin

COVID Guidance
New Items for Reimbursement Under Health FSAs

- The CARES Act provides that OTC medications purchased after December 31, 2019, are reimbursable from a health FSA
  - The types of OTC medications covered by the CARES Act changes include non-prescription pain relievers, cold/allergy medications, and antacids
  - The CARES Act also provides that expenses for menstrual care products are treated as incurred for medical care (and so are reimbursable from health FSAs)
  - Items that are not medications but merely beneficial to general health, such as vitamins, are not reimbursable under the CARES Act changes
- In order to offer reimbursement for the expanded items, the cafeteria plan (health FSA) must be amended
  - The CARES Act does not provide for an expanded amendment period for these items and so it may be prudent to ensure that the plan is amended prior to the time the expanded reimbursements are permitted under the plan

COVID Guidance
Employer Considerations

- Employers should carefully consider available design decisions before implementing the changes permitted under the new guidance relating to cafeteria plans
  - Although employers may wish to take advantage of the new flexibility, they may also want to limit the changes
  - For example, employers may determine that they do not want to extend election changes for the entire period permitted by the guidance but may want to provide some ability for employees to make changes during particularly hard-hit periods of the pandemic
  - The IRS suggests, and we agree, that employers may want to consider limiting election changes to prevent "adverse selection" and limiting changes to no less than the amounts already reimbursed
    - For example, without such a limitation, an employee who had already received full reimbursement under a health FSA for the year could revoke his or her election prospectively and stop making contributions to the health FSA for the remainder of the year – leaving the employer responsible for making up the shortfall
  - In any event, employers must ensure that changes do not result in nondiscrimination failures

Health Plan and High Deductible Health Plan (HDHP) Changes

- Health plans (including HDHPs) must cover, without deductible or cost-sharing
  - Diagnostic COVID testing when determined medically appropriate by the individual's attending health care provider
  - Services administered in connection with a provider's determination of whether a COVID-19 test is necessary
  - COVID-19 vaccines
- Extensive provisions related to reimbursement rates

High Deductible Health Plan (HDHP) Changes

- HDHPs may cover, without (or with limited) deductible or cost-sharing
  - COVID-19 treatment
  - For plan years beginning on or before December 31, 2021, telehealth and other remote care services

Guidance: IRS Notice 2020-29, IRS Notice 2020-15, FAQs About FFCRA and CARES Act Part 43

Telehealth Coverage

- Standalone telehealth benefits provided to non-benefits eligible employees often do not comply with Affordable Care Act requirements for group health plans, including preventive care and no annual or lifetime limit mandates
- Joint FAQs prepared by the DOL, HHS and Department of Treasury provide some latitude for employers wishing to offer broad-based telehealth coverage
- For any plan year beginning before the end of the COVID-19 emergency, any plan that solely provides benefits for telehealth or remote care services is exempt from group market reforms

Telehealth Coverage

- Relief limited to arrangements
  - Sponsored by a large employer
  - Offered to employees (or dependents) not eligible under any other group health plan
- Other provisions continue to apply, including
  - Prohibitions against pre-existing condition exclusions, rescissions, discrimination re: health status
  - Mental health/substance use disorder parity

Telehealth Coverage

- While the agencies didn't clarify, it seems other requirements should apply, such as
  - COBRA obligations
  - Form 5500 filing requirement
  - Plan document/SPD obligations

Guidance: FAQs About FFCRA and CARES Act Part 43

Update on the ACA
California v. Texas

- December 2018: US District Court in Texas invalidates Affordable Care Act
- December 2019: Fifth Circuit holds that requirement to maintain health insurance without penalty is unconstitutional; asks District Court whether individual mandate can be severed from remainder of ACA
- March 2020: Supreme Court agrees to hear the case
- November 10, 2020: *California v. Texas* scheduled for oral argument

Update on the ACA
Statute of Limitations

- How long does the IRS have to collect employer shared responsibility payments?
  - Typically, the IRS applies a 3-year statute of limitations from the later of the date a return is filed or due
  - Forms 1094-C and 1095-C are the forms employers file to assist with calculating liability for employer shared responsibility payments
  - Notwithstanding, the IRS released a Chief Counsel Memorandum in late February 2020, concluding that an employer's filing Forms 1094-C and 1095-C does *not* start the running of the statute of limitations on employer shared responsibility payments under the ACA

Update on the ACA
Statute of Limitations

- **Why?** The return doesn't provide sufficient data to calculate an employer's tax liability
  - Neither the IRS nor the employer knows whether someone will seek coverage on an exchange
  - The forms don't include eligibility for a premium tax credit

Guidance: Gen. Couns. Mem. 20200801F (Dec. 26, 2019, released Feb. 21, 2020), at https://www.irs.gov/pub/irs-lafa/20200801f.pdf

Recent COBRA Developments

- COBRA basics
- COBRA Notices
- COVID-19 extended COBRA deadlines
- COBRA: are premium subsidies coming?
- Trends in COBRA litigation
- New DOL model COBRA Notices
- Best practices
- COBRA: issues in M&A transactions

COBRA Basics
Background

- Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272, 100 Stat. 82): Federal statute that requires continuation of private employer group health coverage for eligible individuals
- COBRA has been with us for 35 years, has been amended from time to time to make the law more robust and clear up ambiguities, and rules have been relaxed in times of crisis to provide extended time frames for notice, election and payment periods (e.g., in the wake of Hurricanes Katrina and Maria) and to provide premium relief (e.g., The American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (ARRA))

COBRA Basics
Key Features

- Group health plan of an employer that employs 20 or more employees on more than 50 percent of its typical business days in the previous calendar year is subject to COBRA (determined on a controlled group basis; takes into account foreign companies; part-time employees are counted, but as a fraction of full-time employees)
- Up to 18, 29 or 36 months of post-event coverage, depending on nature of qualifying event
- Mere *eligibility* for new coverage during COBRA period does not end liability
- Controlled group liability for COBRA coverage (excise taxes and penalties)

COBRA Basics
Qualified Beneficiaries

- Qualified beneficiaries
  - Covered employees who lose group health plan coverage due to voluntary or involuntary employment termination (other than by reason of gross misconduct) or due to reduction in hours
  - Retirees who lose retiree coverage due to employer's Chapter 11 bankruptcy
  - Spouses and dependent children who lose coverage and on the day before the qualifying event were covered under the group health plan

COBRA Basics
Qualifying Events

- Qualifying events and applicable maximum COBRA periods
  - Termination of employment, other than by reason of gross misconduct, or reduction in hours (up to 18 months of COBRA coverage)
  - Former employer's Chapter 11 bankruptcy (retiree's COBRA coverage may continue until death; for spouse and dependent children, up to 36 months of COBRA coverage after retiree's death)
  - Death of the covered employee (for spouse and dependent children, up to 36 months of COBRA coverage)
  - Divorce or legal separation from the covered employee (for spouse and dependent children, up to 36 months of COBRA coverage)
  - Employee becomes entitled to Medicare (for spouse and dependent children, up to 36 months of COBRA coverage)
  - Loss of dependent child status (up to 36 months of COBRA coverage)

COBRA Notices
Notice Types

- COBRA Notices
  - Initial / General Notice
  - Election Notice
  - Notice of Unavailability
  - Notice of Termination

COBRA Notices
Initial General Notice

- **Initial General Notice: 29 C.F.R. § 2590.606-1**
  - Plan Administrator: Plan administrator must provide initial written COBRA notice to employee and spouse when employee first becomes covered under employer's group health plan
- **Initial General Notice Timing**
  - Notice must be furnished to each employee and each employee's spouse, not later than the earlier of (i) 90 days after the date on which such individual's coverage under the plan commences (or, if later, 90 days after the date on which the plan first becomes subject to the continuation coverage requirements) or (ii) the first date on which the administrator is required to furnish the covered employee, spouse, or dependent child of such employee, a COBRA election notice (i.e., notice of the right to elect continuation coverage)
  - A notice so furnished is deemed to be provided at the time coverage under the plan commences
- **Initial General Notice Content**
  - Name of plan and name, address and telephone number of party/parties from whom additional information about the plan and continuation coverage can be obtained

COBRA Notices
Initial General Notice

- **Initial General Notice Content** (cont'd)
  - General description of the continuation coverage under the plan (including identification of classes of individuals who may become qualified beneficiaries, types of qualifying events that may give rise continuation coverage right, employer's obligation to notify plan administrator of the occurrence of certain qualifying events, maximum period for which continuation coverage may be available, when and under what circumstances continuation coverage may be extended beyond applicable maximum period, and plan's premium payment requirements); Explanation of plan's requirements regarding qualified beneficiary's responsibility to notify administrator of certain qualifying events (divorce, legal separation, or a child's ceasing to be a dependent under the terms of the plan); and description of plan's procedures for providing such notice
  - Explanation of plan's requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to administrator of a determination by the Social Security Administration that a qualified beneficiary is disabled, and description of plan's procedures for providing such notice
  - Explanation of importance of keeping administrator informed of current addresses of all participants or beneficiaries under plan who are or may become qualified beneficiaries
  - Statement that notice does not fully describe continuation coverage or other rights under plan and that more complete information regarding such rights is available from plan administrator and in the plan's SPD

COBRA Basics
Notice of Qualifying Event

- **Notice of Qualifying Event**
  - Employer: Employer must notify plan administrator within 30 days of employee's death, employment termination, reduction in hours, entitlement to Medicare, or start of bankruptcy proceedings **29 C.F.R. § 2590.606-2**
  - Employee or Other Qualified Beneficiary: Employee, former employee, or qualified spouse or dependent must notify the plan administrator within 60 days of divorce or legal separation of the employee, loss of dependent child status, or occurrence of a second qualifying event within an initial 18- or 29-month COBRA period **29 C.F.R. § 2590.606-3**
  - Employee or Other Qualified Beneficiary: A COBRA-qualified beneficiary who receives a determination by SSA of having been disabled during the first 60 days of a COBRA period must provide notice to the plan administrator of such disability determination within 60 days of the determination in order to be eligible for an additional 11 months of COBRA coverage (if SSA subsequently determines that the individual is no longer disabled, the qualified beneficiary must provide notice to the plan administrator within 30 says of such determination) **29 C.F.R. § 2590.606-3**

COBRA Basics
Election Notice

Election Notice: 29 C.F.R. § 2590.606-4

- **Election Notice Timing**
  - Plan Administrator: Subject to some exceptions, within 14 days of receiving notice of a qualifying event, the plan administrator must provide each qualified beneficiary with notice of the qualified beneficiary's right to elect COBRA coverage
- **Election Notice Content**
  - Election notice must be written in a manner calculated to be understood by the average plan participant and shall contain the following information:
    - Name of plan and name, address and telephone number of party responsible under ***plan for administration of continuation coverage benefits***
    - Identification of qualifying event

COBRA Basics
Election Notice

- **Election Notice Content** (cont'd)
- Identification, by status or name, of qualified beneficiaries who are recognized by plan as being entitled to elect continuation coverage with respect to the qualifying event, and date on which coverage under plan will terminate (or has terminated) unless continuation coverage is elected
- Statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that covered employee or qualified beneficiary who is covered employee's spouse (or was covered employee's spouse on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event, and that a parent or legal guardian may elect continuation coverage on behalf of a minor child
- Explanation of plan's procedures for electing continuation coverage, including explanation of the time period during which election must be made, and date by which election must be made

COBRA Basics
Election Notice

- **Election Notice Content** (cont'd)
- Explanation of the consequences of failing to elect or waiving continuation coverage, including explanation that a qualified beneficiary's decision whether to elect continuation coverage will affect future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the ERISA with reference to where a qualified beneficiary may obtain additional information about such rights, and description of plan's procedures for revoking a waiver of the right to continuation coverage before the date by which election must be made
- Description of plan's continuation coverage that will be made available, if elected, including date on which such coverage will commence (either by providing description of coverage or by referring to plan's SPD)
- Explanation of maximum continuation coverage period that will be available, if elected; explanation of continuation coverage termination date, and explanation of any events that might cause continuation coverage to be terminated early
- Description of circumstances (if any) under which maximum continuation coverage period may be extended due either to occurrence of a second qualifying event or a determination by SSA that the qualified beneficiary is disabled, and the length of any such extension

COBRA Basics
Election Notice

- **Election Notice Content** (cont'd)
- In the case of notice that offers continuation coverage with maximum duration of less than 36 months, a description of plan's requirements regarding qualified beneficiaries' responsibility to provide notice of a second qualifying event and notice of a disability determination by SSA, along with description of plan's procedures for providing such notices (including times within which such notices must be provided and the consequences of failing to provide such notices). Notice must also explain qualified beneficiaries' responsibility to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled
- Description of amount, if any, that each qualified beneficiary will be required to pay for continuation coverage
- Description of payment due dates, qualified beneficiaries' right to pay on a monthly basis, grace periods for payment, address to which payments should be sent, and the consequences of delayed payment and non-payment
- Explanation of importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries
- Statement that notice does not fully describe continuation coverage or other rights under plan, and that more complete information regarding such rights is available in plan's SPD or from plan administrator

COBRA Basics
Electing & Paying for COBRA

- Qualified beneficiary has an election period of at least 60 days' duration that runs from the later of (i) the date the loss of coverage would occur due to the qualifying event or (ii) the date the qualified beneficiary is provided with notice of the right to elect COBRA coverage (i.e., the postmark date)
- After electing COBRA coverage, the qualified beneficiary has 45 days in which to make the initial COBRA premium payment (retroactive to the first day of COBRA coverage)
- Thereafter, the qualified beneficiary pays premiums on a monthly basis and has a 30-day grace period for payment before coverage may be terminated for non-payment

COBRA Basics
Penalties for COBRA Failures

- Excise Tax
  - $100 per day per affected qualified beneficiary (up to $200 per family per day), with a maximum of $500K for unintentional, non-willful failures
- ERISA
  - $110/day ERISA penalty
- Controlled Group Liability
  - Penalties are joint and several liabilities of the controlled group

COVID-19 Extended COBRA Deadlines

- The Departments of Labor & Treasury issued rules in May 2020 extending certain employee benefits-related timeframes during the COVID-19 "outbreak period," including the COBRA deadlines below 85 Fed. Reg. No. 86 26351 et seq. (May 4, 2020)
- "Outbreak Period": period that began March 1, 2020, and ends on the date that is 60 days after the announced end of the COVID-19 national emergency. The Outbreak Period must be disregarded for purposes of determining the following COBRA deadlines*
  - The pandemic national emergency has been extended three times, most recently on October 2, when the US Health and Human Services Secretary announced that the national emergency period (which had been extended to October 23, 2020) will be extended until January 20, 2021 (it is possible that the extension could be lifted earlier or that the end date could be further extended)

*Deadlines are also extended for special health plan enrollments and claims/appeals procedures

COVID-19 Extended COBRA Deadlines

- The Outbreak Period is disregarded for purposes of determining the following periods and dates
  - Group health plans and their sponsors and administrators
    - Date for providing COBRA election notice
  - Qualified beneficiaries
    - Date for individuals to notify the plan of a qualifying event or a disability determination
    - 60-day COBRA election period
    - Date for making COBRA premium payments (45-day initial payment & each 30-day grace period)

COVID-19 Extended COBRA Deadlines

Periods before the Outbreak Period may still be counted

- **Example 1:** Assume qualified beneficiary received a COBRA election notice before the Outbreak Period began and as of March 1, 2020 (first day of Outbreak Period), 25 days of the 60-day election period had elapsed. Qualified beneficiary has until 35 days after the end of the Outbreak Period to make a COBRA election.
- **Example 2:** Assume qualified beneficiary elected COBRA coverage on February 1, 2020, effective as of January 1, 2020, and that premiums for coverage are due on the first day of each calendar month, subject to the statutory 30-day grace period. Absent a COVID-19 extension, full initial payment for COBRA coverage (e.g., for January and February) would have been due by March 17, 2020, and the premium for March coverage would have been due by March 31, 2020 (taking into account the 30-day grace period). With the COVID-19 extended deadlines, assuming qualified beneficiary remains eligible for COBRA coverage, the initial premium for January and February would be due on the 17th day after the end of the Outbreak Period and premiums for all other months ending within the Outbreak Period would be due by the 30th day after the end of the Outbreak Period.

COBRA: Are premium subsidies coming?

- Four ARRA-like bills have been introduced in Congress that would provide for COBRA premium subsidies
  - All of these bills propose premium subsidies that are different from ARRA (which provided a 65% premium subsidy)
  - Three bills propose a 100% premium subsidy (Section 70307 of H.R. 6379; H.R. 6514; and Division B, Title III of H.R. 6800)
  - One bill would permit qualified beneficiaries to pay the active employee rate had the individual not experienced the COBRA qualifying event (Section 4 of H.R. 6810)
  - Some of the bills would allow individuals who experienced a reduction in hours without loss of health plan coverage to receive the same premium assistance
  - All of the bills would permit employers to take payroll tax credits to recoup the portion of COBRA premiums not paid by the COBRA qualified beneficiaries

Trends in COBRA Litigation

- History of COBRA litigation: early cases involved individual issues such as failure to provide timely notice or denial of COBRA for alleged gross misconduct. While such cases have not disappeared, the past two years have seen a proliferation of COBRA-related *class action* lawsuits of a different type in which claims are focused on notice deficiencies.
- Over the years, waves of class action lawsuits have arisen over (i) defined benefit pension plan calculations and (ii) defined contribution plan fees. Specific firms find an ERISA niche, developing a reputation through which they may garner more cases.
- These class actions can net enormous fees for the firms that are filing them. Over the past year, there have been at least 18 class action lawsuits challenging the sufficiency of COBRA notices. The cases are likely to keep rising in the time of COVID-19, given the large numbers of furloughs, reductions in hours, and terminations.
- See article: "A New Target of ERISA Class Action Lawsuits: COBRA Election Notices," *Bloomberg Law*, Nancy G. Ross and Richard E. Nowak, May 2020

Trends in COBRA Litigation

- Most of the recent cases have been filed in Florida, where there are two law firms leading the charge against large companies that have business operations throughout the country
  - These defendants include Walmart, Lowes, Home Depot, Lockheed Martin, US Foods, Best Buy, JP Morgan Chase, Starbuck's and Amazon, to name a few
- Firms in other states have been boarding the COBRA class action bandwagon
- Class Certification: That's the key to significant damages
  - The idea is that there are common deficiencies and common harms (rules of civil procedure require satisfaction of commonality requirements)

Trends in COBRA Litigation

- Examples of alleged COBRA notice deficiencies
  - Notice is not written in a manner calculated to be understood by the average plan participant
  - Notice fails to identify and provide contact information for the party responsible for administering COBRA coverage
  - Notice fails to explain how to enroll in COBRA coverage and/or fails to provide an enrollment form
  - Notice does not explain COBRA coverage termination date
  - Notice does not explain the consequences of late or non-payment of premiums and/or fails to provide address to which payments must be sent
  - Failure to include all of the required language in a single notice (i.e., information was provided but in multiple notices)
  - Notice included additional language about potential criminal and civil penalties for making false statements on a COBRA election form, allegedly as a scare tactic

Trends in COBRA Litigation

- How technical are some of the alleged COBRA notice deficiencies?
- One of the alleged deficiencies is that the COBRA notice at issue included the name and contact information for the third party administering COBRA under the employer's health plan and not all of the plan's administrators
- On June 29, 2020, the ERISA Industry Committee (ERIC) filed an amicus brief in *Bryant v Walmart Stores, Inc.* (USDC S.D. Fla.) in support of Walmart, arguing that COBRA regulations recognize the practical necessity of large employer health plans to use third-party administrators by requiring the name of the party responsible for COBRA administration (plaintiffs dropped the case the following month after federal magistrate judge recommended against certifying the class)
- In *Carter v Southwest Airlines Co. Board of Trustees*, the DOL recently filed a motion to submit an amicus brief in support of the employer on the same issue

Trends in COBRA Litigation

- Typical defenses
  - Lack of standing
  - Class certification
  - Substantial compliance
  - Use of DOL Model Notice not mandatory
- Third-party administration – are employers off the hook?
  - No (but depending on terms of contract with TPA, employer may have claim under contract)

Trends in COBRA Litigation

- Settlements
  - Lockheed Martin: $1.25 million
  - Target: $1.6 million
  - Marriott $250K
  - Bank of America, Lowes & Best Buy

Model COBRA Notices

- May 1, 2020, DOL issued updated versions of its model general notice and model election notice to ensure that qualified beneficiaries better understand the interaction between Medicare and COBRA
- How Medicare and COBRA interact depends on whether an individual's Medicare entitlement occurs before or after the COBRA qualifying event
- ERISA regulations provide that use of the model notices is not required, but DOL will consider their use, appropriately completed,* to constitute compliance with the notice content requirements of COBRA

* **29 C.F.R. § 2590.606-1(g)**: "In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements..."

- Medicare Q&A in updated Model Notices: Next Slide

Model COBRA Notices

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

- In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the initial enrollment period for Medicare Part A or B, you have an 8-month special enrollment period to sign up, beginning on the earlier of
  - The month after your employment ends; or
  - The month after group health plan coverage based on current employment ends.
- If you don't enroll in Medicare Part B and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
- If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain COBRA continuation coverage plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
- For more information visit https://www.medicare.gov/medicare-and-you
- https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

COBRA: Best Practices

- Best Practices
  - Ensure that COBRA inquiries are addressed promptly – determine when an inquiry rises to the level of a claim and ensure that claim is handled in accordance with ERISA claims/appeals rules & plan governance procedures
  - Review COBRA notices against the new DOL models
  - If a third-party COBRA administrator is engaged, review the administrator's notices, as well as the service contract
    - Does service contract have a standard of performance?
    - Is there indemnification in the event of a loss?
    - If there is litigation, who controls it and what are each party's obligations?

COBRA: Best Practices

- Best Practices (cont'd)
  - Consider using DOL model notice, if not already doing so
  - Is a significant portion of your workforce non-English speaking and, if so, are you providing COBRA notices in the respective language(s)?
  - Are you or your third-party COBRA administrator supplementing the election notice with COVID-19 deadline extension information?

COBRA: Best Practices

- Best Practices (cont'd)
  - Review fiduciary liability insurance
    - Who is covered?
    - What is covered/not covered? (Typically benefits, taxes & penalties are not covered, but litigation costs may be.)
    - If there is litigation, who controls it and what are each party's obligations?

COBRA: Issues in M&A Transactions

- Although not a recent development, sellers and buyers in business transactions often fail to consider the COBRA M&A rules
- Treasury regulations only address application of COBRA to business transactions involving corporations, but the preamble to the regulations indicates that similar rules are to be applied in the context of the transfer of non-corporate interests such as partnerships or LLC interests
- Liability for COBRA is apportioned between the **Selling Group** and the **Buying Group**
- The **Selling Group** is the controlled group (generally determined based on **common ownership interests of at least 80%**) of which an Acquired Organization ceases to be a member (in the case of a stock sale) or the controlled group that includes the seller (in an asset sale)
- The **Buying Group** is the controlled group of which an Acquired Organization becomes a member (in the case of a stock sale) or the controlled group that includes the entity that is buying assets (in an asset sale)

COBRA: Issues in M&A Transactions

- An **Acquired Organization** is a corporation that ceases to be a member of one controlled group as the result of a stock sale; if the Acquired Organization does not become a member of another controlled group (such as in the case of a spin-off), the Acquired Organization is considered the Buying Group
- M&A Qualified Beneficiary
  - Asset Sale - an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose **qualifying event occurred prior to or in connection with the sale** and who is, or whose qualifying event occurred in connection with, a covered employee **whose last employment prior to the qualifying event was associated with the assets being sold**
  - Stock Sale - an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose **qualifying event occurred prior to or in connection with the sale** and who is, or whose qualifying event occurred in connection with, a covered employee **whose last employment prior to the qualifying event was with the acquired organization**

COBRA: Issues in M&A Transactions

- In a stock sale, a covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children.
- By contrast, an asset sale generally triggers a qualifying event for a covered employee and the employee's spouse and dependent children who are covered under a group health plan of the selling group immediately before the sale unless (i) the buying group is a successor employer and employs the covered employee immediately after the sale; or (ii) the covered employee (or the spouse or any dependent child) does not lose coverage (within the meaning of COBRA) under a group health plan of the selling group after the sale
- Successor Employer – The buying group is a successor employer to the selling group if the buying group continues the business operations associated with the assets purchased from the selling group **without interruption or substantial change**. A buying group does not fail to be a successor employer in connection with an asset sale merely because the asset sale takes place in connection with a Chapter 11 bankruptcy proceeding.

COBRA: Issues in M&A Transactions

- Buyer and seller may negotiate contract terms that allocate COBRA responsibility differently from the allocation in the COBRA M&A rules, but the party with the obligation under the COBRA rules remains liable if the party that has the contractual obligation fails to satisfy it
- Considerations
  - Transaction structure (stock or asset sale)
  - Whether there are any M&A Qualified Beneficiaries
  - If an asset sale, whether Buying Group is a "successor employer"
  - Whether Selling Group will (or will be able to) maintain its group health plan after closing and, if so, for how long
  - Keep in mind that the maximum COBRA period is 36 months

Other Delayed Deadlines

- Benefit claim filing
- Adverse benefit determination appeal
- External review request
- Submit request for additional information

M. v. Premera Blue Cross – 10th Circuit

- *Firestone:*
  - Benefit denials reviewed *de novo* unless plan gives administrator or fiduciary discretionary authority
  - Lower courts typically apply "arbitrary and capricious" or "abuse of discretion" standard if plan grants discretionary authority to administrator or fiduciary

M. v. Premera Blue Cross – 10th Circuit

- Plan document clearly conveyed discretionary authority on plan administrator
- Summary plan description stated that participants could request "all pertinent plan documents"
- However:
  - Summary plan description did not describe discretionary authority
  - Participants were not automatically provided a copy of the plan document
  - Language did not suggest another document existed affecting judicial review

M. v. Premera Blue Cross – 10th Circuit

- Divided court held that plan administrator was not entitled to deference because the participants lacked notice of the plan administrator's discretionary authority
- Dissent: decision is not supported by ERISA or case law
- Action items (particularly in 10th Circuit)
  - Review/revise SPD so that it includes that the plan administrator or fiduciary has discretionary authority to determine benefits eligibility and review plan terms, or
  - Provide participants plan documents

HIPAA and COVID

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