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INSIGHT

IN THIS ISSUE

Pension Plans Legislative and Agency Update

COVID-19 Legislative Developments

On May 15, 2020, the House of Representatives passed the *Health and Economic Recovery Omnibus Emergency Solutions Act* (HEROES Act, H.R. 6800). The extensive legislation, which covers hundreds of pages and topics, is House Speaker Nancy Pelosi's (D-CA) opening salvo in negotiations with Senate Republicans on a fourth COVID relief and stimulus package.

While the HEROES Act covers an array of benefits-related topics – among them, single employer pension funding relief, relief for failing multiemployer pension plans, rollovers and limit increases for Flexible Spending Accounts (FSAs), and COBRA subsidies – Senate Republicans have not acted on the bill and do not plan to do so. Recent discussions indicate that Republicans are eyeing a narrowly crafted bill focusing on business liability protections, funding to healthcare providers, and increased testing and tracing capacity.

Democrats have mentioned providing federal funding directly to state and local governments hard-hit by lost tax revenues. A recent report by the Congressional Budget Office indicates that such a direct infusion would be more beneficial to the overall economy than business or individual tax cuts and credits. Republicans have not been receptive to the idea and have been publicly adamant that any federal funds, if appropriated, would not be used to shore up ailing state and local pensions.

So far, negotiations on a fourth package have been informal and at the staff level. Negotiations at higher levels began in earnest the week of July 20th. Lawmakers in both chambers of Congress are hopeful that they can pass a relief bill before lawmakers adjourn for summer recess on August 7th.

Ohio Legislation Introduced to Create State-Facilitated Retirement Plan for Private Sector Workers

On May 19, 2020, two junior Democratic members of the Ohio House of Representatives introduced H.B. 645 to create a defined benefit savings plan for private sector workers. If passed, this would be the first state facilitated retirement savings program for private sector workers administered by a public pension fund, though several states have previously discussed the concept. The program would be administered by, but separate from, the Ohio Public Employees Retirement System (OPERS). All private sector funds would be

held in a separate trust, segregated from public pension funds. OPERS would develop the program's investment policy and ensure that the program qualifies for tax exempt status under the Internal Revenue Code (IRC).

The legislation requires employers that do not offer a tax-exempt retirement plan to provide employees access to the state facilitated program via automatic enrollment. This requirement would apply to all private sector and non-profit employers in the state, regardless of size. It does not apply to state, local, or federal employers. Employee contributions would range from 3% to 5%, but employees can opt-out of the plan.

Action on this legislation can occur throughout the remainder of the year as the legislature meets year-round. However, given the bill's lack of endorsement by leadership and the fact that Republicans hold a super-majority in both legislative chambers, the bill has slim chances of advancement.

Several states across the nation have passed legislation to establish state facilitated automatic IRA programs for private sector workers. Oregon, Illinois, and California have programs up and running and have facilitated $81 million in savings over the last two years. There are roughly 141,000 funded accounts and 21,000 active employers across all three states.

There is active litigation challenging California's program, which was brought by the Howard Jarvis Taxpayers Association ("HJTA") against CalSavers. Under California law, certain employers that do not offer a retirement plan must automatically enroll their employees in a state-run payroll deduction IRA, known as CalSavers. The law was originally passed in 2012, and the state is currently in the process of implementing the CalSavers program.

California's law mandates that employers with five or more employees must participate in CalSavers if they do not offer an employer sponsored retirement plan. HJTA argues that this arrangement is preempted by ERISA, as ERISA preempts state laws that "relate to" employee benefit plans.

In 2019, a state court held that CalSavers is not an employee benefit plan and that "finding that ERISA preempts CalSavers would be out-of-step with the underlying purposes of" ERISA because CalSavers does not govern a central matter of an ERISA plan's administration or interfere with nationally uniform plan administration. HJTA appealed the ruling to the Ninth Circuit Court of Appeals, and the Department of Labor (DOL) recently filed an amicus brief in support of HJTA's position.

Agency Guidance

- On April 28, 2020, the Employee Benefits Security Administration (EBSA) of the Department of Labor (DOL) issued guidance for retirement plans that extends certain deadlines and provides other relief in light of the national coronavirus outbreak. The notice, jointly issued with the Department of the Treasury and Internal Revenue Service (IRS), extends certain time frames: 1) affecting participants' rights to healthcare coverage, portability, and continuation of group health plan coverage under COBRA; 2) allowing plan participants to file or perfect benefit claims or appeals of denied claims; and 3) allowing plan officials to furnish benefit statements, annual funding notices, and other notices and disclosures required by ERISA so long as they make a good faith effort to furnish the documents as soon as administratively practicable.

- On May 27, 2020, the DOL published its final electronic disclosure rule. Effective July 27, 2020, the rule allows retirement plan sponsors to post retirement plan disclosures online as long as certain requirements are satisfied. It also allows plans to use mobile applications to deliver notices and disclosures. On June 3, 2020, the DOL issued an information letter that makes clear that 401(k) fiduciaries can prudently include private equity as a component of an ERISA plan's diversified investment option, such as a target date fund.

- On June 12, 2020, the IRS issued Notice 2020-35 that delayed certain filings for employee benefit plans until July 15, 2020. Notably, this notice extends relief to certain non-ERISA plans, including 403(b) plans, for which the remedial amendment period and plan amendment rules were postponed.

- On June 17, 2020, the EEOC issued guidance that provides that employers may not require antibody testing before permitting employees to re-enter the workplace under the Americans with Disabilities Act.

- On June 19, 2020, the IRS issued Notice 2020-50, which

provides clarity to plan administrators and participants on coronavirus-related loans and distributions following the passage of the CARES Act. Importantly, this Notice expands access to COVID-19 relief for households—not just individuals—impacted by the virus.

- On June 23, 2020, the DOL issued a proposed regulation defining plan fiduciaries' duties under ERISA when considering economically targeted investments or those that incorporate environmental, social, and governance (ESG) factors.
- On June 23, 2020, the IRS issued Notice 2020-51, which provides guidance on how defined contribution plans (including 403(b) and governmental 457(b) plans) and IRAs may implement the waiver of 2020 required minimum distributions (RMDs) under the CARES Act. The notice extends the 60-day indirect rollover period through August 31, 2020; explains which 2020 waived RMDs can be rolled over; provides relief from certain IRA indirect rollover limitations; offers relief for certain SECURE Act errors; and provides sample plan amendments for the 2020 waived RMDs.
- On June 29, 2020, the DOL issued a proposed prohibited transaction class exemption for investment advice fiduciaries.

Recent IRS Impermissible CODA Rulings Related to Governmental Plans

Governmental plans under section 401(a) are prohibited from offering cash or deferred arrangements (CODAs) that operate akin to a 401(k) plan, unless adopted prior to 1986. Generally, a CODA provides participants a choice between cash or a taxable benefit and a deferral. Importantly, the IRS provides that CODAs can nullify governmental "pick-ups"—the mechanism by which employee contributions are treated as pre-tax. However, IRS Revenue Ruling (Rev. Rul.) 2006-43 provides an exception that participants can make a one-time irrevocable election regarding participation in the plan without violating the CODA prohibition, but the election must occur when the employee is first eligible to participate in the plan.

Historically, the IRS has interpreted the pick-up exemption to CODA rules very narrowly. This has resulted in difficulty for governmental plans that want to allow participants a choice between benefit structures after the date of initial hire. Of particular concern is when participants are offered a choice between two governmental 401(a) plans that result in different pick-up contribution rates. The IRS recently released two instructive private letter rulings (PLRs) on the topic, which will be especially illustrative for plans considering new benefit tiers.

In May 2020, the IRS issued PLRs 202020019 and 202020006, both dealing with the establishment of a new hybrid benefit tier to governmental plans. In both cases, employees were given a one-time, irrevocable election between their current benefit structure and the new hybrid plan. Statutes in both cases provided that most employees would receive the same picked-up contribution rate in both plans. However, some employers would be required to make an additional contribution to retiree medical accounts under the new hybrid plan.

The IRS ruled that pick-up contributions were valid under 414(h)(2) and in line with Rev. Rul. 2006-43 where mandatory contributions were the same between the new and old plan; where employers were required to make added contributions to the hybrid plan and total contributions between the two plans were not the same, there was an impermissible cash or deferred arrangement.

These recent IRS rulings make clear that when providing participants with a post-hire choice between benefit structures, the simplest formula for avoiding CODA prohibitions is to keep mandatory, pre-tax employee contributions between the two plans identical. Alternatively, contributions can be made post-tax, subject to Section 415 limits.

IRS Signals Focus on 403(b) and 457(b) Catch-Ups

The IRS recently signaled its intent to focus on Section 403(b) and 457(b) plan catch-up contributions this year. In May 2020, the IRS published issue snap shots and indicated a potential increase in audits of 403(b) and 457(b) plans around catch-up contributions in its 2020 Program Letter for Tax Exempt & Government Entities division. Of

particular importance to the IRS is the interaction between special catch-up contributions and age 50 catch-up contributions.

The 403(b) Plan Issue Snapshot reiterates the general rules for catch up contributions in this type of plan, as well as for special catch-up contribution rules under IRC 402(g)(7) and age 50 catch-up contributions under 414(v). Notably, this Snapshot provides a roadmap for IRS audits, which includes:

- Review the Forms W-2 to determine if any employee has exceeded the basic IRC Section 402(g) limit regarding elective deferrals. This indicates that the employee made catch-up contributions.
- Determine if the plan document permits the age 50 catch-up or the special 403(b) catch-up contributions. For plans that permit both types, make sure the contributions are applied to the limits in the proper order.
- Verify that the qualified organization keeps the records necessary to calculate the special 403(b) catch-up and that the calculations are accurate.

Similar to the aforementioned IRS publication, the 457(b) Issue Snapshot outlines the rules for special 457 catch-up contributions, plan administrator requirements, and age 50 catch-ups in 457(b) plans. It also provides the following audit tips:

- Determine if the employer is a governmental or a tax-exempt entity.
- Verify that the plan document has the language for special 457(b) catch-up contributions.
- Note the normal retirement age and verify that it can be no greater than age 70½, and no less than age 65 or the age the participant may retire and receive full benefits from the pension plan sponsored by the employer.
- Verify a participant-elected normal retirement age is within the above parameters, if the plan permits a participant to elect his normal retirement age.
- Verify the underutilized amounts: Determine the first date the participant was eligible to participate in the 457(b) plan; the original effective date of the plan; the participant's annual deferrals for all prior years; and the basic annual limitation in effect for those years. (See the examples in Treasury Regulation (Treas. Reg.) 1.457-4(c)(3)(iv)(D)).
- Verify that the plan document has the language for age 50 catch-up contributions and that the plan sponsor is a governmental entity.
- Verify that no participant in a governmental Section 457(b) plan used both the special 457 catch-up and the age 50 catch-up in the same year.
- Include a participant's vested salary reduction and non-elective employer contributions in determining whether annual deferrals comply with the basic annual limitation and the increased limit under the catch-up provisions.
- If any participant's deferrals exceed the maximum amount allowed, the participant has excess deferrals and the plan is non-qualified. Governmental sponsored plans may correct this error using the 180-day rule in Treas. Reg. 1.457-9(a). For an eligible IRC 457(b) plan of a tax- exempt entity, a plan that is operated in a manner inconsistent with IRC Section 457(b) and Treas. Reg. Sections 1.457(b)-3 through 1.457(b)-8 and Section 1.457-10 becomes an ineligible plan subject to IRC 457(f). Per Section 4.09 of the Employee Plans Compliance Resolution System (Rev. Proc. 2019-19), for failures associated with an eligible Section 457(b) plan of a tax-exempt entity, the IRS generally will not enter into an agreement to address those failures. Correction through a closing agreement under the authority in Delegation Order 8-3 may be permitted in very limited circumstances.[1]

Given that the IRS will focus on catch-up contribution issues in 2020, plans may want to consider taking the proactive step of reviewing plan documents regarding eligibility for and calculation of catch-up contributions, as well as comparing plan operations to documents.

[1]Delegation Order 8-3 (formerly DO-97, Rev. 34; updated 10-02-2000) provides delegated authority within the IRS for certain agreements concerning internal revenue tax liability.

Pension Litigation Update – *Torres v. American Airlines*

Litigation is brewing across the country on defined benefit plan assumptions relating to actuarial equivalence. In short, plaintiffs are challenging plan sponsor assumptions for converting a single life annuity to an optional benefit form, such as a joint and survivor annuity. Plan participants argue that actuarial assumptions used by plans are resulting in lower benefits for optional benefit forms. Plaintiffs claim this runs counter to ERISA's requirement that optional forms of benefits be "actuarially equivalent" to the participant's accrued benefit normally paid as a single life annuity. Of particular concern to plaintiffs are older mortality tables from the 1970s and 1980s. Thus far, nearly a dozen cases have been filed addressing actuarial equivalence. Among the most closely watched has been *Torres v. American Airlines* (*Torres*), where the fight for class certification recently stalled. *Torres* was the first case of its type in which the court provided insight into its reasoning on denying class certification.

Plaintiffs in *Torres* brought claims under ERISA Section 502 for declaratory relief, reformation of the plan, payment of benefits, and fiduciary breach. They contended that the plan's use of the weighted UP-1984 mortality table violated the actuarial equivalency requirement. Plaintiffs sought certification of a class that included participants and beneficiaries who receive a joint and survivor annuity, a preretirement survivor benefit, or a certain life annuity. The named plaintiffs each received one of these types of benefits.

The U.S. District Court for the Northern District of Texas denied class status in early June 2020. It found that the named plaintiffs and absent class members receiving late retirement benefits had a conflict of interest and, therefore, the named plaintiffs could not adequately represent the entire class. The court reasoned that if the plaintiffs were successful at proving their claim and relief was granted, it would not be able to apply class-wide.

At the end of June 2020, the plaintiffs in *Torres* filed a brief in support of their request to file a second-class certification motion. In their brief, the plaintiffs argued that any conflicts that existed could be addressed by narrowing the proposed class to exclude any participant who chose a certain and life annuity or retired after turning 65. It is unclear as to whether or not this would have satisfied the court's concerns when it originally denied class certification, as the parties filed a stipulation in federal court requesting that the suit be dismissed on July 20th.

Although challenges to actuarial equivalence are currently impacting the private sector, governmental plans would be wise to keep an eye on this activity. If class actions challenging these assumptions are successful, it is possible that public plan actuarial standards could be similarly challenged in the future.

Health Legislative Update: Provisions in the House-Passed HEROES Act

In response to COVID-19, the House of Representatives passed additional legislation, H.R. 6800, entitled the *Health and Economic Recovery Omnibus Emergency Solutions Act* (the HEROES Act, or the Act). Despite passage, the Act is likely to end in the House, with the White House already threatening to veto the bill. However, some of the provisions may be included in a bipartisan package, and are indicative of the Democratic majority's priorities in the House. Below are the key provisions in the HEROES Act that impact health and welfare plans, including various notice requirements, relief and flexibility for cafeteria plans, and changes to paid leave. The Senate is currently considering its own version of new COVID-19 legislation. Although the House and Senate do not appear to be close to an agreement, the stated goal is to pass new COVID-19 legislation before the August recess.

Advance Prescription Drug Refills

The Act requires group health plans and health insurance issuers that offer group or individual coverage to notify participants within five business days of the enactment of the Act, or five business days of the beginning of the emergency period, as to whether the plan will permit advance prescription drug refills during the emergency period. An emergency period is the period during which there exists an emergency or disaster declared by the President pursuant to the *National Emergencies Act* or the *Robert T. Stafford Disaster Relief and Emergency Assistance Act* and a public health emergency declared by the Secretary pursuant to Section 319 of the *Public Health Service Act*. If the plan or insurer permits advance refills, consumers must be notified within five business days on how to obtain those refills.

Mandated COVID-19 Treatment without Cost-Share

The Act also requires group health plans and health insurers to cover all medically necessary COVID-19 treatment without cost sharing during the public health emergency. What is deemed medically necessary would be determined by the Tri-Agencies within one week of enactment of the Act. This would include items or services "regardless of whether such items or services are ordinarily covered under the terms of a group health plan or group or individual health insurance coverage offered by a health insurance issuer." Individuals are additionally provided a private right of action to sue plans and issuers that fail to provide such coverage. Coverage would be effective upon enactment of the Act.

Premium Subsidies

The Act also would require: 1) premium subsidies for certain individuals who elect COBRA or for individuals who are furloughed; and 2) notice to eligible individuals about the subsidies that are available through the Act. Eligible individuals who elect COBRA (except individuals who voluntarily terminate employment) and furloughed individuals who are still eligible for their employer-sponsored plan would be able to collect approximately nine months of full premium subsidies under the Act. This premium assistance would run from March 1, 2020 to January 31, 2021. Plan administrators would be required to notify individuals of the premium assistance and the option to enroll in different coverage, where permitted, in the COBRA election notice. Plan administrators would also be required to provide a similar election notice to furloughed workers. At the end of the premium assistance, at least 15 days prior to expiration, employers must notify eligible individuals of the pending expiration, the date of expiration, their eligibility for coverage without assistance, and information regarding the ACA Exchange for which they are eligible.

Cafeteria Plans and Flexible Spending Arrangements (FSAs)

The Act's provisions provide a number of relief and flexibility options for cafeteria plans. As detailed below, any of the available changes that are adopted into law must be amended in the cafeteria plan, health FSA plan, or dependent care FSA plan no later than the last day of the plan year in which the amendment is effective. The plan must be operated consistent with the amendment from the effective date. The available options include:

- ***Dependent care assistance*** provided from an employer may be excluded up to $10,500, from the previous $5,000 (or up to $5,250, from $2,500, in the case of a married taxpayer filing separately), for taxable years beginning during 2020;
- ***Health FSA*** carryovers increased to $2,750, up from $550, from 2020 to 2021 plan year;
- ***Dependent care FSAs*** may carryover up to $10,500 (or up to $5,250 for married filed separately), from 2020 to 2021 plan year;
- ***Cafeteria plans*** may carryover paid time off benefits from the 2020 to 2021 plan year with no cap in carryover amount;
- ***FSA or paid time off elections*** may be modified one time by plan participants, in addition to the eligible election period, for any reason between the date of the Act's enactment and December 31, 2020; and
- ***Health FSAs, dependent care FSAs and cafeteria plans*** may extend their unused benefit grace period for the 2020 plan year for up to 12 months.

Paid Leave

The Act builds upon the already expanded *Family and Medical Leave Act* (FMLA) provisions that were approved in the *Families First Coronavirus Response Act* and the *Coronavirus Aid, Relief, and Economic Security Act*. Further expansions in this Act include:

- Expansion of availability of leave from December 31, 2020 to December 31, 2021;
- Expansion of applicability of provisions to employers with 500 or more employees;
- Additional covered reasons for leave, including to obtain medical diagnosis, complying with self-isolation orders, caring for family members who must self-isolate, or caring for individual with disability or senior citizen for whom care is unavailable;
- Expansion of covered family members to include next of kin, domestic partners, grandparents or grandchildren, or individuals related by blood or affinity whose association is equivalent to family relationship;

- Increase in maximum paid FMLA leave to $12,000, up from $10,000; and
- Requirement to allow for intermittent and reduced schedule leave.

The Act additionally expanded emergency paid sick leave, to coexist with the FMLA expansions. These expansions include applying the extended availability, provisions to all employers, same covered reasons, allowing employees to take leave intermittently or a reduced schedule, and making leave available to employees as soon as they begin employment.

CMS Permits Non-Federal Governmental Plans to Extend Certain Timeframes

In April 2020, the Departments of Labor (DOL) and Treasury (together, the Departments) issued a Final Rule (or Joint Federal Register Notice) extending certain deadlines related to health and welfare plans in response to the current COVID-19 pandemic. The extensions do not apply to non-Federal governmental plans and health insurance issuers. The Centers for Medicare & Medicaid Services (CMS) subsequently announced that it concurred with the Final Rule and will adopt a temporary, relaxed enforcement policy to extend similar timeframes otherwise applicable under the Public Health Service Act (PHSA) to non-Federal governmental group health plans and health insurance issuers offering coverage in connection with a group health plan. In the CMS Insurance Standards Bulletin, CMS notes that "[w]hile the extension of time frames is not mandatory for non-Federal governmental plans, CMS encourages plan sponsors of non-Federal governmental plans to provide relief to participants and beneficiaries similar to that specified in the Joint Federal Register Notice."

The Final Rule suspends certain deadlines until the end of the "Outbreak Period," which applies retroactively beginning March 1, 2020 and ending 60 days after the end of the COVID- 19 national emergency (or such other date announced by the Departments in future guidance), but no longer than one year. Thus, these deadlines do not apply during the Outbreak Period and begin to run again when the Outbreak Period is over. Any portion of the deadline that started before March 1 will count toward the deadline when the Outbreak Period ends (*e.g.,* if 15 days of a 30-day deadline had already ran before March 1, the deadline that applies when the Outbreak Period ends is 15 days).

If elected by the plan sponsor, the suspended deadlines applicable to non-Federal governmental plans include:

- **COBRA Election Notice -** The 14-day deadline (44 days where the employer is the plan administrator) for a plan administrator to provide a COBRA election notice to qualified beneficiaries.
- **HIPAA Special Enrollment Period** - The 30-day (in some cases, 60-day) deadline for individuals to enroll in a group health plan following a HIPAA special enrollment event (*i.e.*, birth, adoption or placement for adoption of a child, marriage, loss of other health coverage, or eligibility for a state premium assistance subsidy).
- **COBRA Qualifying Event and Disability Extension Notices** - The 60-day deadline by which qualified beneficiaries must notify the plan of certain qualifying events (*e.g.*, divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the plan) or a disability determination.
- **COBRA Election** - The 60-day deadline to elect COBRA continuation coverage.
- **COBRA Premium Payments** - The 45-day (for the initial payment) and 30-day (for subsequent payments) deadlines to pay COBRA premiums. Note that the Departments have stated that a plan is permitted to cancel coverage during the non-payment period and retroactively reinstate coverage if the individual later pays the premium. It is assumed that CMS would take the same position.
- **Benefit Claims and Appeals** - The deadline by which participants may file a benefit claim (under the terms of the plan) and the 180-day (for group health plans) and 60-day (for other welfare benefit plans) deadlines for appealing an adverse benefit determination.
- **External Review -** The 4-month period for a claimant to file a request for federal external review.
- **Perfecting a Request for External Review** - The 4-month (or 48-hour following receipt of an incomplete request notification, if later) period for a claimant to perfect an incomplete request for external review.

IRS Releases Notices 2020-29 and 2020-33 Affecting Cafeteria Plans

In May 2020, the IRS released two Notices affecting cafeteria plans and FSAs. Notice 2020-29 provides COVID-19-related relief for cafeteria plans, and FSAs and high deductible health plans (HDHPs), and Notice 2020-33 establishes a permanent increase to the carryover limit for health FSAs and provides clarification regarding health reimbursement arrangements (HRAs).

Notice 2020-29

- ***Election Changes and Extended Claims Period*.** The COVID-19 pandemic significantly altered the expectations that many employees had when they made their coverage elections for the 2020 plan year. As a result, these employees may need additional flexibility to make mid-year election changes or to continue to use FSA balances that they would otherwise not be able to use. Notice 2020-29 provides that, for the remainder of the 2020 calendar year, employers may (but are not required to) amend their cafeteria plans to provide the following:

    - ***Election changes*.** Allow employees to make prospective election changes to: 1) add medical, dental, and vision coverage; 2) change medical, dental, and vision plan options; 3) drop medical, dental, and vision coverage (if he/she attests in writing that he/she will enroll in other medical, dental, or vision coverage); or 4) add, increase, or decrease health FSA and dependent care FSA election. Employees may make these election changes irrespective of whether the reason for the change meets the current change in election criteria in the cafeteria plan regulations (in Treas. Reg. § 1.125-4), and individuals do not need to be affected by COVID-19. Notice 2020-29 also allows employers to designate a particular period during which employees may make these mid-year election changes.

    - ***Extended claims period*.** Allow employees to use health and dependent care FSA amounts remaining at the end of a grace period or plan year that ends in 2020 to pay or reimburse expenses incurred for the same type of FSA through December 31, 2020. This extension is available for both cafeteria plans with a grace period, cafeteria plans with a carryover, and cafeteria plans with neither. The extension does not apply in 2021. Note that individuals do not need to be affected by COVID-19 to take advantage of the extended claims period. The employers that want to adopt an extended general-purpose health FSA should consider the impact on employees' ability to contribute to HSAs.

To adopt these changes, employers must currently notify employees of the changes and must amend the cafeteria plan by December 31, 2020.

- ***Clarification of Relief for HDHPs*.** The Notice also clarifies prior COVID-19-related relief for HDHPs. When the IRS issued earlier COVID-19-related relief in March (Notice 2020-15), the IRS provided that a health plan will not fail to be a health savings account (HSA)-eligible HDHP merely because the plan provides medical care services and items purchased related to COVID-19 testing and treatment prior to the satisfaction of the applicable minimum deductible. Notice 2020-29 clarifies that this relief applies with respect to reimbursements of expenses incurred on or after January 1, 2020. Notice 2020-29 also clarifies what counts as COVID-19 testing and treatment. Specifically, the panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV) and any items or services required to be covered with zero cost-sharing under the *Families First Coronavirus Response Act* (FFCRA) and the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) constitute COVID-19 testing and treatment for purposes of Notice 2020-15.

- ***HDHPs and Telehealth Safe Harbor***. The Notice clarifies the effective date of the telehealth safe harbor for HDHPs in the CARES Act. Under the CARES Act, an HSA-compatible HDHP can provide coverage for telehealth and other remote care services without a deductible or with a deductible below the minimum annual deductible required under the HSA rules. This provision was effective beginning March 27, 2020. Notice 2020-29 applies this safe harbor retroactively to services provided on or after January 1, 2020.

Notice 2020-33

Unrelated to COVID-19, Notice 2020-33 provides the following additional relief:

- ***Health FSA Carryovers.*** Notice 2020-33 permanently increases the maximum carryover for health FSAs from $500 to an amount equal to 20% of the maximum salary reduction contribution under Code section 125(i) for the applicable plan year (currently $2,750). Thus, for carryovers from the 2020 plan year, the maximum carryover amount will be $550 (20% of $2,750). Just like the maximum health FSA elective contribution amount, these carryover amounts will be increased each year. Note that individuals do not need to be affected by COVID-19 to take advantage of the increased carryover; this is a permanent change.
- ***Premium Incurrence Date for HRAs.*** Currently, individual coverage HRAs may reimburse individual health insurance coverage and Medicare premiums, but only to the extent those premiums were incurred while the individual was a participant in the HRA plan. However, many individuals pay January premiums in December of the prior year (when the individual was not yet a participant in the HRA plan). Notice 2020-33 addresses this issue by providing that an HRA may treat an expense for a premium for health insurance or Medicare coverage as incurred on: 1) the first day of each month of coverage on a pro rata basis; 2) the first day of the period of coverage; or 3) the date the premium is paid. Thus, an individual coverage HRA on a calendar year plan year may reimburse a substantiated premium for health insurance coverage for January, even if the individual paid the premium prior to January (*e.g.,* in December). This rule does not have an expiration date, so it applies beyond 2020 as well.

Tri-Agency FAQs on FFCRA and CARES Act

In response to the COVID-19 pandemic, Congress passed two pieces of legislation, the *Families First Coronavirus Response Act* (FFCRA) and the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act). The Departments of Labor, the Treasury, and Health and Human Services (collectively, the Tri-Agencies) issued guidance regarding the new COVID-19 provisions. On April 11, 2020, the first set of COVID-19 FAQs were posted (part 42 of the ACA Implementation FAQs), and on June 23, a second set of COVID-19 FAQs were posted (part 43 of the series). Notably, in issuing the FAQs part 42, the Tri-Agencies state that their priority is "assisting (rather than imposing penalties on)" regulated entities.

The FFCRA and CARES Act generally require group health plans and health insurance issuers to provide benefits for certain items and services related to testing for the detection of SARS-CoV-2, the virus that causes COVID-19, or the diagnosis of COVID-19 (collectively, COVID-19), without any cost sharing requirements, prior authorization, or other medical management requirements. Some highlights of the guidance include:

Covered Plans

The FAQs clarify that the FFCRA and CARES Act requirements apply to group health plans (including self-insured) and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans). This includes non-Federal governmental plans and church plans. The requirements do not apply to excepted benefits and short-term limited duration coverage.

Effective Date

The requirements apply as of March 18, 2020, the date the FFCRA was enacted, and are effective through the duration of the COVID-19 public health emergency.

COVID-19 Tests

During a COVID-19 testing-related doctor's visit, items and services also must be covered without cost-sharing, to the extent they relate to either evaluating the need for, furnishing, or administering a COVID-19 test. This prohibition on cost sharing applies during visits that "result in an order for, or administration of, a COVID-19 diagnostic test." Of note, the Tri-Agencies clarify that "visit" includes traditional settings (such as office visits, which include in-person and telehealth, as well as visits to urgent care centers and emergency rooms), as well as non-traditional settings such as "drive-through screening and testing sites[.]" Items and services are covered where they are "medically appropriate for the individual, as determined by

an individual's attending health care provider." The health care provider need not be "directly" responsible for providing care, as long as an individualized clinical assessment is made.

FAQs part 43 clarify that testing must be covered if the test is approved, cleared, or authorized under the *Federal Food, Drug and Cosmetic Act*. The list of tests that have received emergency use authorization is available on the Food and Drug Administration (FDA) website at: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd.

Moreover, the CARES Act requires coverage of tests for which the "the developer has requested, or intends to request, emergency use authorization" from the FDA. FAQs part 43 provide that tests are covered until the emergency use authorization request is denied, or the developer does not submit a request within a reasonable timeframe. The Tri-Agencies refer to the FDA website for laboratories and manufacturers that have validated their own tests and are offering them as outlined in FDA guidance. In addition, a plan or issuer may take reasonable steps to verify that a test offered by a developer meets the statutory criteria.

The FAQs also state that plans and issuers are required to cover at-home testing, where ordered by an attending health care provider, and the test otherwise meets the statutory criteria. However, testing for work-place screening or return-to-work programs, or otherwise not for the purpose of individualized diagnosis or treatment, is not covered. Additionally, the FFCRA is not limited with respect to the number of COVID-19 diagnostic tests for an individual, so long as the other guidelines are met (medically appropriate, determined by health care provider, etc.).

Serological Antibody Tests

The FAQs clarify that the prohibition on cost-sharing (and preauthorization and medical management) also applies to serological tests for coronavirus antibodies, indicating an individual had an earlier infection.

Out of Network

The CARES Act specifies that group health plans and issuers must reimburse out-of-network providers of COVID-19 diagnostic testing at a price negotiated with the provider, or a publicly posted cash price. FAQs part 43 state that the reimbursement provisions relate to the COVID-19 test, but do not address the rate for any other items and services. Further, the statute precludes balance billing for COVID-19 testing; however, it does not preclude balance billing for other items and services.

Plan Changes and Notice

Both sets of FAQs make explicit that the Tri-Agencies will not take enforcement actions against plans and issuers that immediately provide enhanced benefits, and provide notice to enrollees "as soon as reasonably practicable." FAQs part 43 state that, if a plan or issuer reverses the changes for COVID-19 at the end of the public health emergency, the Tri-Agencies will consider the notice requirements satisfied if the plan or issuer previously notified participants and beneficiaries of the general duration of changes in coverage, or notifies participants and beneficiaries within a reasonable time frame before the reversal of the changes.

About GRS

Founded in 1938, Gabriel, Roeder, Smith & Company (GRS) is a national actuarial and benefits consulting firm. GRS is dedicated to bringing clients innovative, sustainable solutions that the firm helps put into action. The firm supports the long-term success of pension, OPEB, and health and welfare benefit plans. Associates deliver high-quality services that reflect GRS' core values, which include professionalism and ethics in all aspects of business. The firm attracts the best talent in the industry by providing a collaborative work environment that respects the diversity and professional aspirations of our associates.

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