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Your workplace, our insight

Employee Benefits Update March 2020

The Impact of the COVID-19 Pandemic on Your Medical and Retirement Plans

As many of us are working remotely during the COVID-19 pandemic, we wanted to share some thoughts and observations about how the pandemic could impact the medical and retirement plans that you offer to your employees.

I. *Medical Plans*

- The costs of COVID-19 diagnostic testing: In the last 7-10 days, many states (including Maryland) have taken measures to require fully-insured medical plans that are registered in those states to waive co-pays, deductibles, co-insurance and other out-of-pocket expenses associated with COVID-19 testing.
  - ➢ If you have a fully-insured medical plan, you should check with your carrier and broker to identify which state law governs your particular policy, in order to understand whether one of these new mandates applies to you.
  - ➢ If you have a self-insured medical plan, your plan is exempt from these state laws, but you will want to contact your third-party claims administrator and your stop loss carrier, because many of them are working with their self-funded plans to also waive and fully cover these costs.
  - ➢ If you sponsor a high-deductible health plan ("HDHP") for your employees, you should know that last week the IRS issued Notice 2020-15, which advised that HDHPs may fully cover all costs of COVID-19 diagnostic testing for a participant, even if the participant has not yet satisfied his or her annual deductible under that HDHP. This is re-assuring news to employers sponsoring HDHPs, as well as to employees who have health savings accounts ("HSAs"), whose ability to contribute to those accounts depends on the HDHP meeting all IRS requirements.
  - ➢ Under the "Families First Coronavirus Response Act" bipartisan legislation that was passed by the House in the early hours of Saturday, March 14th, all COVID-19 testing would be fully covered under group health plans, regardless of whether they are self-funded or fully-

Important Dates

March 31:

- Confirm recordkeepers have filed Forms 1099-R, if filing electronically
- File ACA information reporting returns (Forms 1094-C and 1095-C) for 2019, if filing electronically
- File Form 5330 to report excise taxes and payment for excess 2018 plan year ADP/ACP contributions (or Form 5558 for up to 6 month extension)

April 1:

- Confirm recordkeepers paid initial RMDs to participants who turned 70½ in 2019

April 15:

- File Form 8928 to report excise taxes for noncompliance with obligation to make comparable HSA contributions unless Form 7004 filed to extend filing to October 15
- Complete electronic filing with PBGC under ERISA 4010 if AFTAP is less than 80% for 2019, if not previously filed
- Process distributions of excess 402(g) deferrals under 401(k)/403(b) plan for 2019

April 30:

- Pay final 2019 comprehensive PBGC premium due to the PBGC for plans that filed an earlier estimated variable rate premium in the October 15, 2019 comprehensive filing

insured. This means that no deductibles, co-payments or co-insurance could be required, and that any pre-authorization requirements would be waived. As of March 17, 2020, the Senate has not yet passed this bill, so it has not yet been enacted.

  - If you do make changes to your medical plan terms about the costs of COVID-19 diagnostic testing—whether those changes are mandated by state or Federal law, or whether you are making them voluntary—remember that any changes should be memorialized in a written plan amendment, Summary of Material Modifications, or updated Summary Plan Description.

- The costs of COVID-19 treatment:

  - At this time, there are no special rules about how medical plans should process the costs of treatment for COVID-19. Consequently, medical benefits and services for treatment of the COVID-19 virus (whether that treatment consists of prescription drugs, outpatient visits, hospitalization or otherwise) would be subject to the same terms and conditions that apply to similar types of services under your plan.

- The cost of personal protective equipment:

  - At this time, it does not appear that costs for personal protective equipment, such as gloves, masks or disinfecting supplies, would be considered medical expenses that are eligible to be reimbursed from an HSA or a health flexible spending account.

- HIPAA privacy concerns:

  - HIPAA privacy rules require covered entities (such as group health plans) and their business associates to protect the privacy and security of protected health information. In the context of the COVID-19 pandemic, HIPAA concerns in the workplace primarily will arise only if information about an individual's COVID-19 infection status is disclosed from the health plan to you, as the employer. HIPAA is NOT implicated when an individual employee voluntary discloses his or her COVID-19 status to the employer in connection with sick leave or other employment policies. Nevertheless, as with any personal information, HR and benefits professionals should be discreet and keep any such information confidential, limiting discussion to the minimum necessary to accomplish the intended purpose of any such disclosure.

- COBRA coverage:

  - If, as a result of the COVID-19 pandemic, an employee who is covered under your group medical plan loses that coverage, because he or she is laid off from employment or experiences a reduction in hours such that he or she is no longer eligible for your group health plan, then your employee, and all of the employee's enrolled dependents, will have experienced a qualifying loss of coverage under COBRA and will be eligible to elect continuation coverage, in accordance with standard COBRA rules and procedures.

- Benefit plan election changes:

  - If an employee who is covered under a spouse's medical plan loses that coverage, either because the spouse is laid off from employment or experiences a reduction in hours such that he or she is no longer eligible for their group health plan, then your employee may have experienced a qualifying change in status that would permit him to change his benefit elections under your plan, as long as those election changes are consistent with the change in status.

II. *Retirement Plans*

- Hardship distributions:

  - Hardship distributions from tax-qualified retirement plans, such as 401(k) plans and 403(b) plans, typically can only be made if they are for expenses for certain limited purposes (*e.g.*, medical

expenses, funeral expenses, amounts needed to prevent foreclosure or eviction, funeral expenses, and certain tuition payments), which cannot be satisfied from any other sources. At this time, the IRS has not issued any guidance relaxing these rules to the extent that a participant experiences some financial strain as a result of the COVID-19 pandemic, but does not otherwise qualify for a hardship distribution.

- Company contributions to retirement plans:
  - Employers looking to ease the cash flow crunch of continuing to pay employees who are on extended leaves of absence for quarantine or other COVID-19 related reasons may wish to consider adjusting the level of company contributions, such as matching or nonelective profit sharing contributions, to their retirement plans. This typically requires a formal, written plan amendment and a Summary of Material Modifications, unless your plan terms already provide that your contribution level is fully discretionary.
  - However, if you sponsor a "safe harbor" plan, be aware that there are specific compliance considerations—and advance notice obligations—that are likely to apply if you are interested in implementing a reduction to your safe harbor contributions in the middle of your plan's fiscal year.
- Participant investment education:
  - Given the extreme market volatility in the last few weeks, your retirement plan participants may be anxious about the security and investment of their retirement funds. Consider reaching out to your plan's recordkeeper for educational material about investment education on topics such as the importance of diversification, asset allocation, and long-term investment strategies.

We will continue to monitor the fast-moving developments and government guidance relating to the COVID-19 pandemic on your employee benefit plans. If you have any questions, please feel free to contact any member of our Employee Benefits and Executive Compensation Group below.

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Employee Benefits Update

March 2020

The Impact of the COVID-19 Pandemic on Your Employee Benefit Plans: Part 2

Has it really only been a week?

Since our first COVID-19 Employee Benefits Update, President Trump has signed into law the Families First Coronavirus Response Act (the "FFCRA"); Congress is deliberating an economic stimulus and aid bill that will impact employee benefit plans; and many of you have called with questions about how the COVID-19 pandemic is affecting your workforce and your benefit plans.

Our Firm has published a terrific "User's Guide" to the FFCRA, but we thought it would be helpful for our clients to also address some benefits-related issues in this Employee Benefits Update.

MEDICAL PLAN ISSUES

Q1. Does my group health plan have to cover the cost of COVID-19 diagnostic testing?

- Yes. Under the FFCRA, all group health plans—regardless of employer size, whether they are fully-insured or self-funded, or whether they are high-deductible plans or traditional plans—must cover the full cost of COVID-19 diagnostic testing. The testing cannot be subject to copays, coinsurance, deductibles, or pre-authorization requirements. In addition, group health plans must cover the full cost of items and services provided to a participant during a health care visit *(i.e.*, office visit, telehealth visit, urgent care center visit, or emergency room visit) that results in covered COVID-19 testing, but only to the extent that the items or services relate to an evaluation to determine whether the test is needed, or to furnishing or administering the test.
- This requirement does not apply to retiree-only plans and HIPAA-excepted benefit plans.
- This change will need to be reflected in a written amendment to your group health plan document, and in a Summary of Material Modifications or updated Summary Plan Description.

Q2. If I am an employer with fewer than 500 employees, and one of my employees qualifies for Paid Sick Time ("PST") under the new Emergency Paid Sick Leave Act ("EPSLA") that was part of the FFCRA, do I need to continue to provide the employee with coverage under our group medical plan?

Yes. This is authorized paid sick leave, so you should continue to provide them with coverage under your group medical plan, and deduct their share of premiums (if any) from their pay, consistent with how you handle any other paid sick leave or paid time off.

Q3. If I am an employer with fewer than 500 employees, and one of my employees qualifies for paid emergency family medical leave under the new Emergency Family Medical Leave Act ("EFMLA") that was part of the FFCRA, do I need to provide the employee with coverage under our group medical plan?

Yes. As with the regular FMLA, an EFMLA-covered employee is entitled to remain an active participant in your group health plan for the duration of their EFMLA leave. In addition, the employee's payment of their share of any premiums for continued group health plan coverage during EFMLA leave should be treated the same way you handle any other type of FMLA leave (*i.e.*, prepayment; pay-as-you-go, with the employee directly sending in the premiums from home; or recouping the premiums from the employee when they return to work).

Q4. If I furlough employees or put them on a temporary leave of absence (not covered by FMLA or EFMLA), do I need to issue COBRA notices, or can I elect to continue their health insurance coverage during the leave of absence or furlough?

There is both a technical answer and a practical answer to this question.

From a *technical* perspective, you need to check the eligibility and coverage terms of your medical plan documents. Some (but not all) medical plan documents already provide for continued coverage during temporary, approved leaves of absence, in which case your furloughed employees can continue to be covered without any issues. However, in many other situations, even if you are not formally terminating the employee's employment, they may still be experiencing a reduction in hours such that they no longer meet the stated eligibility requirements for coverage under the terms of your group health insurance policy or plan document.

- If an employee loses eligibility under the terms of your policy or plan document because of a reduction in hours, COBRA would normally apply, meaning that the employee and all of the employee's enrolled dependents will be able to elect continuation coverage, in accordance with standard COBRA rules and procedures.
- ***However,*** if you wanted to provide the employee with continued coverage under your group health plan during the period of leave or furlough, and your plan documents do not already provide for this, you can do so by amending your health plan documents.
  - If you have a fully-insured plan, you will need to work with the insurance company that issued your health insurance policy, in order to amend the eligibility terms to allow for continued coverage for an employee who has a temporary cessation of employment or reduction in hours.

- If you have a self-funded plan, you have the ability to control the terms of your plan, so amending your plan to clarify the continued eligibility of employees on leave or furlough should not be too difficult. You will need to work with your third-party administrator/claims administrator to amend the eligibility terms of your health plan documents, and you should also confirm any changes with your stop-loss insurance carrier.
- In developing this amendment, consider whether you want to limit the scope of the amendment just to leaves or furloughs due to the COVID-19 emergency, rather than having the reason for the leave or furlough be open-ended.
- You will also need to consider how you will collect the employee's share of premiums for this continued coverage. For instance, you could have the employee prepay their premiums; pay their share of premiums from home as they go along through their leave or furlough (which can present logistical challenges); or have the employer pay the full amount of premium and then recover the employee share once the employee returns to work (which exposes the employer to some economic risk if the employee does not return to employment).
- If you decide to pay the full cost of premiums for some of the employees on leave or furlough, but you do not do that for other active employees, you should discuss with your third-party administrator the impact that this might have (if any) on the IRS nondiscrimination testing that applies to premium payments and medical plans, especially given the reality that many of the employees on leave or furlough will be non-highly compensated employees and those tests are designed to flush out special benefits provided in favor of highly compensated individuals, not the other way around.

- Lastly, in determining whether the employees you furlough or place on leave will be eligible for COBRA coverage, or whether you will amend your plans to permit continued coverage during the furlough or leave, you should take into consideration how these employees will be counted for purposes of your ACA compliance. For example, if you use a one-year look-back measurement period and your plan year serves as your stability period, an employee who is furloughed or put on a leave of absence during this plan year, but whose health plan coverage is terminated because of a reduction in hours, may still be considered as a "full-time employee" who was not offered affordable coverage under your group health plan during the period of leave or furlough, which could have implications for your ACA reporting and potential employer shared responsibility penalties.[1]

From a *practical* perspective, if you have a fully-insured plan, you should know that in recent days, several insurance companies have pre-emptively announced that they intend to waive eligibility and hours conditions for employees on leave or furlough, at least for a period of time. If you are with a carrier that has made such an announcement, you do

[1] A full discussion of the employer shared responsibility requirements under the ACA, how employers establish look-back measurement periods and stability periods, and how employers fulfill their reporting obligations and assess potential penalties, is beyond the scope of this Employee Benefits Update. For more information about these requirements, please refer to several of our prior Employee Benefits Updates (March 2014 and February 2015).

not need to amend your plan documents, but you should keep copies of all of their communications in your records. If your carrier has not taken this approach, but if you anticipate that the leave or furlough is going to last only a few weeks or a couple of months (and recognizing that none of us can discern how long all of this is going to last), you could make the business decision to just continue covering the furloughed workers on your fully-insured medical plans, without making any adjustment to your plan document. While there is some modest risk that your insurer could come back at some point and assert that these employees should not have been on the plan during the period of leave or furlough (except through COBRA), assuming that the employees resume active employment with the company in the near future, it would seem that this risk would be quite low.

Q5. Should I continue making employer contributions to employees' Health Savings Accounts ("HSAs") while they are on a leave of absence or furlough?

If you are continuing an employee's coverage under your high deductible group health plan during a furlough or a leave of absence (whether due to FMLA, EFMLA or otherwise)—rather than having them go on COBRA—and your policies and open enrollment materials communicated that you would make HSA contributions as long as your employee met the conditions you established in your policies, then we recommend that you continue to make those employer contributions to your employees' HSAs while they are on a leave of absence or furlough, even though the IRS has not squarely addressed this question.

Q6. Can I expand the terms of my group health plan to cover telemedicine, without cost sharing, since that has become a popular alternative during this pandemic?

If you decide that you want to change the terms of your group health plan to cover telemedicine without cost sharing, such as deductibles, copayments, or coinsurance, you first need to check with your insurance carrier (if you sponsor a fully-insured plan), or with your claims administrator and stop loss carrier (if you sponsor a self-insured plan).

If you sponsor a traditional medical plan that is not a high deductible health plan, and you decide to implement this benefit change, you will need to work with your insurance carrier or claims administrator, as the case may be, to prepare a formal written plan amendment, along with a Summary of Material Modifications or an updated Summary Plan Description.

However, if you sponsor a high-deductible health plan, we do <u>not</u> recommend making this change at this time. Unless the IRS issues guidance permitting waivers of cost sharing requirements for telemedicine services, such a change could cause your plan to cease to be a qualifying high deductible health plan, which in turn could jeopardize the ability of you, and your employees, to contribute to any HSAs.

CAFETERIA PLAN ISSUES

Q7. If I sponsor a dependent care assistance plan, can employees change their benefit elections since schools and childcare centers are closed?

Yes. If an employee no longer has childcare expenses because their children are home due to the widespread closure of schools and childcare centers, they have experienced a "significant reduction in coverage", which would permit them to reduce, or discontinue, elections under your dependent care assistance plan, as long as your plan documents permit this.

DISABILITY AND LIFE INSURANCE PLAN ISSUES

Q8. During the COVID-19 pandemic, which employees can qualify for benefits under my short-term disability plan?

Regardless of whether your short-term disability plan is an ERISA-covered plan or a salary continuation payroll practice that is exempt from ERISA, your employees will need to have experienced an illness or disability to qualify for benefits. This likely means they will need to have received a diagnosis of COVID-19 personally; merely staying at home to self-isolate is not likely to be sufficient to qualify for short-term disability (or long-term disability) benefits.

Q9. If I put any employees on a temporary leave of absence or furlough, will their group life, accidental death and dismemberment ("AD&D"), and disability insurance benefits be terminated automatically, or can I continue their coverage, without interruption, during the period of leave or furlough?

As with medical coverage, addressed in Q4. above, this will depend on the terms of your insurance policies and plan documents.

With the exception of some short-term disability benefits that are self-insured, virtually all life, AD&D and long-term disability benefits are fully-insured with a third-party insurance company. Therefore, you will need to check the terms of your plan documents to determine if an employee on a temporary leave of absence or furlough will lose their eligibility for coverage because they will no longer be actively working, and if there are any conversion or portability rights for an employee to continue the coverage on their own. However, as with fully-insured medical plans (described above in Q4.), you should know that in recent days, several insurance companies have pre-emptively announced that they intend to waive eligibility and hours conditions for employees on leave or furlough, for at least a period of time. If you are with a carrier that has made such an announcement, you do not need to amend your plan documents, but you should keep copies of all of their communications in your records.

If your employees on leave or furlough will lose coverage under your life, AD&D and/or disability benefit plans, without an amending changing your policy's eligibility conditions, then we recommend that you work with the carriers to make sure they provide written notice to the employees of any right that they might have to convert or port their

policy to individual coverage in a timely way, since many insurance policies provide only a limited window of time (typically 30 days) to do this.

On the other hand, if you want to continue coverage under your life, AD&D, and/or disability insurance programs for employees on leave or furlough, and your insurance carrier has not already informed you that they are going to waive any eligibility conditions during the pandemic, you will need to work with your insurance carrier to adopt a formal written amendment to your plan documents, along with a Summary of Material Modifications or updated Summary Plan Description.

RETIREMENT PLAN ISSUES

Q9. If finances are tight, may our company, in order to save money, reduce or eliminate company contributions to our 401(k) or 403(b) retirement plan?

The answer to this question depends on the type of plan you have, the written terms of that plan, and IRS regulations.

- If your retirement plan has a fully discretionary contribution—where the amount and timing of company contributions (if any) depends each year on company action—then you should be able to reduce or eliminate company contributions to that plan. Depending on your plan governance structure, and prior communications made to employees about the contributions that they might expect for the year, you may need updated resolutions by your Board of Directors or Compensation Committee, and updated employee communications, but you may not need a formal amendment to your plan document.
- If your retirement plan specifies a fixed matching or nonelective contribution (but is not a "safe harbor" plan, as described below), you should review the plan's terms about the eligibility conditions for receiving those company contributions, to make sure any changes to your contributions do not impermissibly reduce the right to those benefits for employees who have already satisfied those eligibility conditions. However, you could consider making changes to your plan's contribution levels going forward, provided that you make a formal written amendment to your plan documents and also issue a Summary of Material Modifications or updated Summary Plan Description to your employees.
- If your retirement plan is a "safe harbor" plan, there are specific compliance considerations—and advance notice obligations—that apply if you are interested in implementing a reduction to your safe harbor contributions in the middle of your plan's fiscal year. For example, if you can demonstrate that your company is operating at an economic loss, or if your annual safe harbor notice for 2020 reserved your right to modify or suspend the safe harbor contributions, then you can amend your plan to change your contributions, provided that you (i) amend your plan document; (ii) give your employees at least 30 days' advance notice of the change so they can modify their own contribution elections; (iii) fully fund the safe harbor contributions that were due before the amendment was adopted; and (iv) perform ADP/ACP testing for the entire 2020 plan year.

Q10. Has the IRS changed its rules about retirement plan hardship withdrawals for employees who may be facing financial strain during the COVID-19 pandemic?

Not at this time. Currently, if a 401(k) plan or 403(b) plan permits hardship distributions, such distributions can typically only be made if they are for certain qualifying medical expenses, funeral expenses, amounts needed to prevent foreclosure or eviction, funeral expenses, etc., which cannot be satisfied from any other sources.

The IRS has not issued any guidance relaxing these rules to the extent that a participant experiences some financial strain as a result of the COVID-19 pandemic, but does not otherwise qualify for a hardship distributions. It is possible, however, that in the near future, the IRS or Congress may relax the conditions for hardship withdrawals, or consider the COVID-19 pandemic to be a "disaster", permitting withdrawals without being subjected to the 10% early distribution tax that would normally apply if the employee were under age 59-1/2.

Q11. Can my employees borrow from their accounts in our company's qualified retirement plan?

Yes, if your retirement plan has this feature. However, any plan loan made from your company's qualified retirement plan has to meet certain IRS conditions, as well as the terms of your plan and any stand-alone loan policy that you may have adopted. For example, many loan policies restrict loans to actively-working employees who are being paid, because the loans are repaid through payroll deduction. Therefore, if you are putting an employee on an unpaid leave of absence or temporary furlough, they may not be able to obtain a loan, unless you modify the terms of your plan documents or loan policies, and develop special strategies to suspend loan repayments during the leave of absence or furlough, or support the employee's repayment of the borrowed funds while they are on leave or furlough.

Q12. If I am laying off a lot of my employees, do I have to worry about a partial plan termination?

Yes, this is something of which you should be aware. The IRS presumes that your qualified plan has undergone a "partial termination" if the turnover rate of your plan participants is at least 20%. Therefore, if you are laying off a significant number of your employees who participate in your plan, your plan may be experiencing a "partial termination", which would require you to fully vest the benefits of the affected individuals and report the partial termination on the plan's Form 5500. It is also important to keep in mind that a "partial termination" is not limited to a one-time event, but can also occur as a result of a series of layoffs spread out over time.

PAYROLL TAX CREDIT ISSUES

Q13. Can you explain how the payroll tax credit for PST and EMFLA leave works?

Our Firm's User Guide to the FFCRA details how the payroll tax credit will work for amounts that you pay for PST and EFMLA leave, subject to the dollar caps imposed by the FFCRA.

In addition to these amounts, the payroll tax credit is increased by the amount of "qualified health expenses", which appears to mean the employer's share of health premiums associated with the PST or EFMLA paid to affected employees, for the period of their PST or EFMLA leave. Future guidance, which should be issued in the next several weeks, will likely clarify which expenses constitute "qualified health expenses".

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We will continue to monitor the fast-moving developments and government guidance relating to the COVID-19 pandemic that impacts your employee benefit plans. Please stay healthy, and contact any member of our Employee Benefits and Executive Compensation Group, below, should you have any questions.

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Employee Benefits Update

March 2020

The Impact of the COVID-19 Pandemic on Your Employee Benefit Plans: Part 3

Since our first two COVID-19 newsletters, summarizing the impact of the pandemic on your employee benefit plans (Part 1 and Part 2), President Trump is expected to sign into law as early as today the massive economic stimulus and financial relief act, known as the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"). The CARES Act makes several significant, albeit temporary, changes affecting retirement plans and other employee benefit plans, as summarized below.

CHANGES IMPACTING RETIREMENT PLANS

Q1. Does the CARES Act change the retirement plan hardship withdrawals rules for employees who may be facing financial strain during the COVID-19 pandemic?

Yes. The CARES Act creates a new type of distribution from qualified retirement plans, known as a "coronavirus-related distribution".

- Individuals who can receive a coronavirus-related distribution:

  A coronavirus-related distribution must be made to a qualifying individual who meets the following requirements:

  - Who is themselves diagnosed with COVID-19;
  - Who has a spouse or dependent diagnosed with COVID-19; or
  - Who experiences adverse financial consequences because of being quarantined; being furloughed or laid off, or having work hours reduced due to COVID-19; being unable to work due to lack of child care due to COVID-19; the closing or reducing hours of a business owned or operated by the individual due to COVID-19; or other factors as determined by the Treasury Secretary.

  For this purpose, the CARES Act specifies that employers will be able to rely on an employee's self-certification that they meet these requirements.

- Amount of a coronavirus-related distribution:

  Up to $100,000 in a coronavirus-related distribution can be paid from tax-qualified retirement plans, such as 401(k) plans, 403(b) plans and 457(b) plans, per person, no later than December 31, 2020, although all plans maintained by an employer and

members of its controlled group will be aggregated for purposes of calculating this limit.

- Favorable tax treatment of coronavirus-related distributions:

  These special distributions have more favorable tax treatment than regular hardship or disaster-related distributions from 401(k) and 403(b) plans, because the CARES Act provides that these amounts qualify for the following tax relief:

  - No 10% penalty tax (which is normally imposed on recipients under the age of 59 ½) will apply;
  - The regular income tax on the distribution can be spread, ratably, over three years; and
  - The distribution can be recontributed to the plan within three years—effectively being treated as a rollover—and the amounts recontributed in any given year will not "count" against that year's IRS or plan limits on the amount that the employee can contribute to the plan.

- How to implement a coronavirus-related distribution:

  This new distribution right is optional (not mandatory) for employers, and will eventually require a formal written amendment to your plan terms by the end of the 2022 plan year (similar to the extended deadline for amending plans for the SECURE Act changes).

  We expect this distribution feature will be a very popular option for employers to implement; in fact, at least one large recordkeeper (Fidelity) has announced that it will automatically implement coronavirus-related distributions for all of the plans using its pre-approved documents, unless an employer affirmatively opts out by March 31, 2020. Therefore, we recommend that you check with your recordkeeper about how it will support early adoption of this new distribution right.

Q2. Are there any special provisions in the CARES Act for participant loans from retirement plans during the COVID-19 pandemic?

Yes; the CARES Act makes changes that impact both new and existing plan loans.

- New plan loans:

  For new plan loans to qualifying individuals impacted by COVID-19 (as defined in Q1. above), which are made within 180 days after the CARES Act becomes law, the maximum amount of a plan loan has increased to the lesser of 100% of the present value of the participant's account, or $100,000 (reduced by the outstanding balance of other plan loans during the preceding one year period).

- Existing plan loans:

  Existing plan loans held by qualifying individuals impacted by COVID-19 (as defined in Q1. above) that have a due date between the date of enactment and the end of 2020 receive a one-year extension from the original due date, which means that plans will need to re-amortize the remaining loan payments accordingly.

Q3. Have the required minimum distribution rules changed for 2020?

Yes, but only for defined contribution plans, 457(b) plans and IRAs.

Because of the economic downturn and volatile markets due to the COVID-19 pandemic, required minimum distributions (RMDs) from defined contribution plans such as 401(a), 401(k) and 403(b) plans, as well as 457(b) plans and IRAs (but not defined benefit pension plans) do not need to be made for the 2020 calendar year. This includes 2020 RMDs for individuals receiving them, because they had reached age 70 ½before 2019, and for individuals who would receive an RMD for the first time in 2020.

Q4. Do the same funding rules apply to defined benefit pension plans in 2020?

No; the CARES Act provides some financial relief to sponsors of defined benefit plans, as follows:

- Any ERISA-required minimum contributions to a single-employer defined benefit pension plan during 2020, including quarterly contributions, are delayed to January 1, 2021, at which time the delayed amounts will be due, plus interest.
- An employer may also elect use the 2019 plan year adjusted funding target attainment percentage (AFTAP) for the 2020 plan year. This may be helpful for plans with fiscal years that started after January 2020 and might have reported unusually low AFTAPs for 2020 otherwise, because of the dramatic decline in financial markets since the start of the year. By using the 2019 AFTAP, the plan may be able to avoid triggering funding-related benefit restrictions, such as limiting lump sum payments or restricting future benefit accruals.

TAX-FREE STUDENT LOAN REPAYMENTS

Q5. Can we offer any new student loan repayment benefits to employees?

Yes, but only for this year.

Between now and January 1, 2021, employers can provide a tax-free student loan repayment benefit, directly to their employees or their employees' lenders, for up to $5,250, and this repayment will be excluded from the employee's income.

- Important note: If you already sponsor an educational assistance program for your employees, providing up to $5,250 in tax-free benefits for tuition, fees and books, please note that the $5,250 cap per individual includes both the new student loan repayment benefit as well as current educational assistance that you may otherwise already be providing.

CHANGES AFFECTING HEALTH PLANS

Q6. Does the CARES Act expand coverage of COVID-19 diagnostic testing and address pricing of these tests?

Yes. In our prior newsletters [Part 1 and Part 2], we described how the Families First Coronavirus Relief Act ("FFCRA") requires group health plans to provide COVID-19 diagnostic testing, without any cost to the plan participant.

In light of the much-publicized shortage of tests for the coronavirus, and the interest in using tests that are being developed by organizations other than the CDC, the CARES Act makes two changes related to COVID-19 testing:

- It expands the definition of covered diagnostic tests to include tests for which the developer has sought emergency approval from the FDA, that are developed or authorized by a State, or that are otherwise deemed appropriate by HHS.
- It dictates how much group health plans will need to pay medical providers for these tests, requiring the providers to publicly post their costs on their websites, and suggesting that the same level of coverage will apply both to in-network and out-of-network services.

Q7. Does my group health plan have to cover COVID-19 preventive services and vaccines?

Yes. Anticipating the fast pace at which vaccines and other preventive items are being developed to combat COVID-19, the CARES Act requires group health plans to provide, without any cost-sharing, qualifying coronavirus preventive services, including certain evidence-based items or services that have "A" or "B" recommendations from the U.S. Preventive Services Task Force, as well as vaccines that are approved by the CDC, within 15 days of when these items are approved. This is significantly faster than under current law, which requires group health plans to cover new preventive services under the Affordable Care Act during the first plan year that begins on or after one year from the approval's or recommendation's issue date.

Q8. Can my high deductible health plan cover telehealth and remote care services without cost sharing?

Yes. The CARES Act remedies a problem we identified in our second newsletter, and now provides that for plan years beginning on or before December 31, 2021, high deductible health plans can provide telemedicine or other remote care services before the deductible has been met, without impacting the qualifying status of those plans or jeopardizing the ability of employers (or employees) to contribute to employees' health savings accounts (HSAs).

Q9. Have the rules for reimbursement of over-the-counter drugs and products from HSAs and medical flexible spending accounts changed?

Yes. Amounts paid after December 31, 2019 for over-the-counter drugs and menstrual products can be reimbursed as qualifying medical expenses, from both health savings and medical flexible spending accounts, even if the employee did not receive a prescription for such items.

EXECUTIVE COMPENSATION CHANGES

Q10. Does the CARES Act impose compensation limits on businesses receiving financial aid?

Yes. Businesses that qualify for loans, loan guarantees, and other investments to obtain liquidity, pursuant to some of the stimulus and financial aid measures provided under the CARES Act, will face caps on the compensation provided to their highly-compensated executives, for a restricted time period beginning on the date that they receive the loan, guarantee or investment until one year after that aid is no longer outstanding.

The limits are imposed on two tiers:

- For executives whose total compensation in 2019 exceeded $425,000, their total compensation in any 12-month period during the restricted time period cannot exceed their 2019 pay; if they are terminated, their severance cannot exceed twice their total 2019 compensation.
- For executives whose total compensation in 2019 exceeded $3,000,000, the total compensation paid in any 12-month period during the restricted time period cannot exceed the sum of (i) $3,000,000, plus (ii) 50% of the excess over $3,000,000 that the individual received in 2019.

PAYROLL TAX CHANGES

Q11. Does the CARES Act make additional changes to the payroll tax credits?

Yes. These changes are as follows.

- Advance funding of FFCRA payroll tax credits
  - The payroll tax credits for the new paid sick time and emergency family medical leave, provided under the FFCRA (and described in our earlier newsletter, found here) can be advanced to employers, but the government will need to develop forms and instructions first, in order to permit employers to utilize this.
  - In addition, the CARES Act waives any penalties that an employer might face if it fails to file payroll taxes on time, because it is anticipating the FFCRA credit.
- Additional payroll tax credit for employers financially impacted by COVID-19 shutdowns
  - Employers whose operations were fully or partially suspended due to a COVID-19 related shutdown order, or whose gross receipts declined by more than 50% when compared to the same quarter in the prior year, will be able to get a refundable payroll tax credit for 50% of wages paid by employers to employees during the COVID-19 crisis.
  - The credit is based on "qualified wages" paid to employees.

- For employers with greater than 100 full-time employees, "qualified wages" are wages paid to employees when they are not providing services due to the COVID-19 related circumstances described above.
- For eligible employers with 100 or fewer full-time employees, all employee wages qualify for the credit, whether the employer is open for business or subject to a shut-down order.

- The credit is provided for the first $10,000 of compensation, including health benefits paid to an eligible employee, for wages paid or incurred from March 13, 2020 through December 31, 2020.
- This credit must also take into account the FFCRA credit.

Q12. Does the CARES Act change the deadline for payment of the employer share of FICA taxes?

Yes. Employers can defer payment of the employer share of Social Security taxes (6.2%) that they would otherwise pay, for the period between the date of enactment and December 31, 2020. The deferred taxes can be paid over the next two years, paying half by December 31, 2021 and the other half by December 31, 2022.

We will continue to monitor the fast-moving developments and government guidance relating to the COVID-19 pandemic that impact your employee benefit plans. Please stay healthy, and contact any member of our Employee Benefits and Executive Compensation Group, below, should you have any questions.

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Employee Benefits Update

April 2020

The Impact of the COVID-19 Pandemic on Your Employee Benefit Plans: Part 4

Since our first three COVID-19 newsletters (Part 1, Part 2 and Part 3), the government has been issuing informal guidance about how to interpret, and implement, some of the new law changes, as summarized below. In addition, this newsletter addresses frequently asked questions about benefit programs, including dependent care assistance plans, leave-sharing programs, and qualified disaster relief payments that many employers have implemented to help their employees deal with the COVID-19 pandemic and related economic recession.

COVID-19 TESTING UNDER HEALTH PLANS

Q1. What type of coverage does our group health plan have to provide for COVID-19 diagnostic testing, without any cost-sharing (such as deductibles, co-payments or co-insurance), or any prior authorization or other medical management requirements?

- Covered diagnostic tests must include tests that have already been approved by the U.S. Food and Drug Administration (the "FDA"); for which the developer has sought emergency approval from the FDA; that are developed or authorized by a State; or that are otherwise deemed appropriate by the Department of Health and Human Services ("HHS").

- Recent FAQs issued by the government extend the scope of the required testing to include serological tests that will be used to detect antibodies that result after exposure to the virus that causes COVID-19. These tests are widely viewed as a critical element to the public health safety concerns associated with the "re-opening" of the economy.

Q2. What kind of coverage is required for clinical visits where COVID-19 testing is provided?

- Government guidance clarifies that health plans must cover items and services furnished to an individual during a healthcare provider visit that results in the order for, or administration of, a COVID-19 diagnostic test.

- These healthcare provider "visits" include office, virtual, urgent care or emergency room visits, as well as non-traditional settings such as drive-through screening and testing sites.

- In addition, because clinicians are encouraged to test for other causes of respiratory illness, the FAQs recognize that other items and services such as influenza tests and blood tests may be performed during the visit, and require health plans to fully cover those services and items as well, without any cost-sharing, pre-authorization requirements or other medical management techniques.

Q3. Does my plan have to cover COVID-19 diagnostic testing provided by out-of-network providers?

Yes. Health plans must cover COVID-19 testing, without any cost-sharing, prior authorization or medical management requirements, regardless of whether the clinician providing the testing is an in-network or out-of-network provider.

For an out-of-network provider, the plan must reimburse the provider based on the price listed on a public internet site, unless the plan and provider negotiate a lower rate.

Q4. For what period of time is this coverage required?

Coverage for COVID-19 testing must be provided by a group health plan as of March 18, 2020 and through the declared COVID-19 public health emergency. This is currently set to end on June 16, 2020 but could be extended, or terminated earlier, by the federal government.

Q5. What health plans are subject to these requirements?

- All employer-sponsored group health plans will need to comply with these requirements, whether fully-insured or self-insured, and regardless of whether the group health plan is considered subject to ERISA.

- Retiree-only plans, on-site medical clinics, short-term and limited duration insurance, limited scope dental and vision plans, and most employee assistance programs ("EAPs") are exempt. However, if an on-site clinic or EAP offers benefits for COVID-19 diagnostic testing, they will not lose their exempt status.

Q6. What type of notice do I have to provide my employees about these changes?

Recent FAQs issued by the government confirm that you do not need to issue a new Summary of Benefits and Coverage ("SBC") describing these changes. Although a notice is not required, you should work with your insurance carriers, brokers and third-party administrators to notify your plan participants of these changes as soon as reasonably practicable.

GUIDANCE ON CALCULATING THE NEW PAYROLL TAX CREDITS

As described in our Employee Benefits Update Part 2, under the Families First Coronavirus Response Act ("FFCRA"), employers with fewer than 500 employees who provide employees with qualifying paid sick leave or qualifying paid emergency family medical leave (together, "Qualified Leave Wages") are eligible for payroll tax credits for the cost of the Qualified Leave Wages (up to certain caps), plus the employer's share of Medicare taxes on the Qualified Leave Wages and the cost of "Qualified Health Plan Expenses" associated with the leave. The IRS recently issued informal guidance, through FAQs, addressing a number of practical questions about how these credits will be implemented.

Q7. When can employers claim the credits?

The credits are available for Qualified Leave Wages paid to employees for FFCRA qualifying leave taken between April 1, 2020 and December 31, 2020.

Q8. What are Qualified Health Plan Expenses that can be included in the payroll tax credits?

Qualified Health Plan Expenses include the cost of the employer's premiums or premium-equivalents for the group health plan coverage provided by the employer to the employee receiving the Qualified Leave Wages, as well as the employee's share of any premiums or premium-equivalent amounts that are paid on a pre-tax basis. Qualified Health Plan Expenses do not include amounts that the employee paid with after-tax contributions.

Q9. How are Qualified Health Plan Expenses determined?

The determination of Qualified Health Plan Expenses involves several steps:

1. If you offer more than one plan option, determine the Qualified Health Plan Expenses separately for each plan, and then allocate those expenses among all employees who participate in that plan.

2. For each group health plan that is fully-insured, you have several choices:

    - You can use the COBRA premium that would be charged to the employee receiving the Qualified Leave Wages for the period of the FFCRA qualifying leave—which may, as a practical matter, be the easiest solution; or

    - You can determine the average premium rate for all employees covered by the plan, by first determining the *average annual premium* per employee; then determining the *average daily premium* per employee by dividing the average annual premium by the average number of working days during the year; and then allocating the average daily premium to each day for which the employee is paid Qualified Leave Wages (with appropriate and reasonable adjustments for part-time employees); or

- You can use a substantially similar method that takes into account the average premium rate determined separately for employees with employee-only coverage and employees with other than employee-only coverage.

3. For each group health plan that is self-funded:

    - You can use the COBRA premium that would be charged to the employee receiving the Qualified Leave Wages for the period of the FFCRA qualifying leave; or

    - You can use any reasonable actuarial method, which should include determining the average premium-equivalent rate per employee.

4. Qualified Health Plan Expenses can also be increased by both employer contributions and pre-tax employee contributions to a medical flexible spending account and/or a health savings account.

The FAQs provide the following example of how to calculate Qualified Health Plan Expenses, if the COBRA rate is not used:

- An employer sponsors an insured group health plan covering 400 employees, each of whom is expected to work 260 days per year (5 days per week x 52 weeks = 260 days).

- The *total annual premium* for the 400 employees is $5.2 million, which includes both the employer payments and pre-tax payments by employees.

- Using one average premium rate for all employees (regardless of whether someone has self-only coverage or family coverage), the *average annual premium* is $13,000 ($5.2M/400 = $13,000).

- For each employee expected to have 260 work days per year, the *average daily premium* is $50 ($13,000/260 = $50).

- $50 is the amount of Qualified Health Plan Expenses allocated to each day of FFCRA qualifying leave.

IMPACT OF COVID-19 ON DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Q10. Can employees change their elections under a dependent care flexible spending account if their children are home due to the closure of day care facilities, or if their dependent care expenses are lower than expected?

Yes. Employees who are participating in a dependent care flexible spending account program (a "DCAP") are legally permitted to change, or discontinue, their pre-tax contributions mid-year, but whether they are permitted to do so depends on the terms of the DCAP plan document and the administrative procedures you and your DCAP administrator (if any) have established.

Q11. Can an employee newly-enroll in a DCAP because their child is now at home due to school closures and the employee now has dependent care expenses not anticipated when the child was in school full-time?

Under IRS regulations, it is not clear this scenario would be considered a valid status change, permitting a new election. However, we are hopeful that the IRS will issue informal guidance on this point in the future.

Q12. Can my employees have access to their unused DCAP balances, if they have difficulty spending the contributions already made?

Maybe, depending on whether your DCAP plan document includes an optional grace period and/or "spend down" feature.

- A grace period is an exception to the typical "use it or lose it" rule, because it allows participants to use their prior year DCAP contributions for dependent care expenses incurred during the 2-1/2 months following the end of the plan year (i.e., by March 15th, if a calendar plan year is being used).

- A spend-down feature allows a former employee to seek reimbursement of qualifying dependent care expenses incurred through the end of the current plan year (and any grace period), even though their employment has been interrupted or ended.

If your DCAP plan document does not have either or both of these optional features, you could consider amending your plan to add them.

LEAVE-SHARING PROGRAMS
AND DISASTER RELIEF PAYMENT FUNDS

Q13. If I establish a paid time off (PTO)-sharing program for my employees, which employee includes the value of the donated PTO in their W-2 income – the employee donating the paid leave or the employee using the donated paid leave?

There are two types of PTO-sharing programs that can be implemented so that the donor employee is not taxed on the value of the donated leave:

- major disaster leave-sharing programs; and
- medical emergency leave-sharing programs.

Under both types of leave-sharing programs, the employee donating the paid leave is not taxed on the value of the leave donated to the leave bank (but is not entitled to claim the donated leave as a charitable contribution for income tax purposes), and recipients of the leave are subject to federal income and employment taxes on the pay they receive upon use of the donated leave.

A leave-sharing program must meet different requirements to qualify as a major disaster leave-sharing program or a medical emergency leave-sharing program eligible for this tax treatment. If the program does not qualify, then donor employees are treated as having W-2 wages for the leave, as if the donor employees themselves used the leave. In this case, however, the employee is entitled to claim the donated leave as a charitable contribution for income tax purposes.

Q14. What requirements does a leave-sharing program have to meet to qualify as a major disaster leave-sharing program?

A major disaster leave-sharing program permits employees to deposit leave in an employer-sponsored leave bank, for use by other employees who have been adversely affected by an event that has been declared a "major disaster" by the President under Section 401(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (the "Stafford Act") or for which the President directs the Office of Personnel Management to establish an emergency leave donation program. As of April 8, 2020, the COVID-19 pandemic had been declared a major disaster under the Stafford Act in all 50 states, which permits employers to establish COVID-19 disaster leave-sharing programs, with the understanding that the leave deposited can only be used for this particular disaster.

To qualify as a major disaster leave-sharing program, the program should be memorialized in a written plan document that includes these features:

- allowing employee-donors to deposit accrued leave in the employer-sponsored leave bank for employees who have been adversely affected by a "major disaster"—in this case, the COVID-19 pandemic;

- limiting the amount of donated leave to the amount of the donor's normal leave accrual, and providing that the donor cannot direct which recipient uses their donated leave;

- identifying eligible leave recipients to be those employees for whom the COVID-19 pandemic has caused severe hardship to the employee, or family member of the employee, that requires the employee to be away from work;

- requiring the employer to make a reasonable determination (based on need) of the amount of leave a recipient may utilize from the leave bank;

- providing that the leave recipient, who receives the paid leave from the leave bank, is paid at his or her normal rate of pay and does not receive cash instead of using the donated leave;

- requiring that the leave recipient use the donated leave for purposes related to the COVID-19 major disaster;

- adopting a reasonable limit on the timing of donations and use of the donated leave by recipients, since this type of leave-sharing program is, by definition, limited to the specific "major disaster", and because leave deposited on account of one major disaster cannot be used for employees affected by other disasters; and

- providing for the proportionate return of unused, donated leave back to the donors after the end of the COVID-19 pandemic, so the donor can use the leave.

Q15. What requirements does a leave-sharing program have to meet to qualify as a medical emergency leave-sharing program?

A medical emergency leave-sharing program permits employees to donate leave to a leave bank for use by other employees affected by a medical emergency. It should be memorialized in a written plan document that includes these key features:

- identifying qualified leave recipients, so only employees with a medical condition (or a family member with a medical condition) that requires a prolonged absence from work and results in a substantial loss of income can qualify to use donated leave;

- requiring leave recipients to submit a written application to the employer, describing the medical emergency;

- requiring the recipient to first exhaust all other available paid leave; and

- providing that the leave recipient, who receives the paid leave from the leave bank, is paid at his or her normal rate of compensation.

In contrast to the major disaster leave-sharing program, a medical emergency leave-sharing program does not end automatically; there is no limit on the amount of leave that an employee may donate; a donating employee can designate the recipient of the donated leave; and the employer does not have to return unused leave to donor-employees.

Q16. What type of special financial assistance program can an employer provide to employees facing health and financial hardship because of the COVID-19 outbreak?

When President Trump issued a statement declaring the COVID-19 pandemic to be a "federally declared disaster", that set the stage for employers to be able to create a fund for "qualified disaster relief payments" under Section 139 of the Internal Revenue Code ("Section 139"). While these programs have not been widely adopted, when they are implemented, they create a unique opportunity for employers to provide tax-free cash payments to their workers.

To qualify for tax-free treatment under Section 139, employer-provided payments can cover reasonable and necessary personal, family, living or funeral expenses incurred as a result of the COVID-19 pandemic. However, amounts designed as wage replacement, that are reimbursed by insurance or otherwise compensated, and that are not incurred because of the declared disaster do not qualify. Although not required, employers interested in providing tax-free cash payments under Section 139 should consider implementing a written policy or plan that sets out the parameters for receipt of such payments, including eligibility requirements and the types of covered expenses.

We will continue to monitor the fast-moving developments and government guidance relating to the COVID-19 pandemic that impact your employee benefit plans. Please continue to stay healthy, and contact any member of our Employee Benefits and Executive Compensation Group, below, if you have any questions.

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Employee Benefits Update May 2020

The Impact of the COVID-19 Pandemic on Your Employee Benefit Plans: Part 5

The Government Issues Initial Regulatory Relief and Guidance

Executive Summary

Following the enactment of the CARES Act, and given the ongoing COVID-19 pandemic, the Department of Labor ("DOL"), the Department of Treasury ("Treasury"), the Internal Revenue Service (the "IRS"), and the Department of Health and Human Services provided welcome regulatory relief to benefit plans and participants in the following guidance that was issued recently:

- EBSA Disaster Relief Notice 2020-01, issued on April 28, 2020 (the "EBSA Notice 2020-01");
- A final rule and joint notice issued by the DOL, the Treasury, and the IRS on April 28, 2020 (the "Joint Notice");
- A list of FAQs on COVID-19 for Participants and Benefits Coverage issued by the DOL on April 28, 2020 (the "DOL FAQs"); and
- A series of FAQs on the special CARES Act distribution and loan provisions for eligible retirement plans issued by the IRS on May 4, 2020 (the "IRS FAQs").

This guidance provides participants and plan sponsors with additional flexibility during the COVID-19 pandemic to comply with otherwise applicable deadlines and procedures, and answers some key questions about health plan coverage, retirement plan loans, and retirement plan distributions. Plan sponsors should work closely with the third-party administrators of their benefit plans to ensure their good faith compliance with these new standards.

I. *EBSA Notice 2020-01*

EBSA Notice 2020-01 provides good faith relief from certain deadlines that would otherwise affect the operations of retirement, health and welfare benefit plans during the COVID-19 "Outbreak Period", which is defined to be the period that started March 1, 2020 and that ends 60 days following the announcement of the end of the COVID-19 national emergency. Specifically, EBSA Notice 2020-01 provides good faith relief for deadlines during the Outbreak Period in four critical areas that affect benefit plan administration and operations:

Participant Disclosures and Notices

During the Outbreak Period, plan sponsors and fiduciaries are relieved from complying with strict deadlines for furnishing certain required notices or disclosures to plan participants, beneficiaries and other persons, as long as they act in good faith to furnish any required notice or disclosure as soon as administratively practicable. The notices for which the relief may apply include, but are not limited to:

- Annual funding notices;
- Summary annual reports;
- Summary plan descriptions and summaries of material modifications;
- Investment mapping notices;
- Qualified domestic relations order notices;
- Notices of adverse benefit determinations and appeals; and
- Blackout notices. Furthermore, advance blackout notices for individual account plans, like 401(k) and 403(b) plans, will not be required during the Outbreak Period, and the DOL will not enforce the otherwise applicable requirement to make a written determination that the COVID-19 emergency qualifies as a circumstance beyond the plan's reasonable control that prevents the plan from issuing a blackout notice.

In addition to acting in good faith to provide these notices and disclosures as soon as administratively practicable, plan sponsors may also use electronic means of communication for individuals that are reasonably believed to have effective access to electronic media (*e.g.,* emails, text messages, continuous access websites). This permissive approach to electronic disclosures appears to signal that the DOL is finalizing its much-awaited regulations permitting the electronic disclosure of all retirement plan information.

Retirement Plan Loans, Distributions and Related Retroactive Amendments

EBSA Notice 2020-01 also provides plan fiduciaries with relief in connection with authorizing retirement plan loans and distributions and adopting related retroactive amendments. If a retirement plan does not follow verification requirements under the terms of its plan document for plan loans or distributions, the DOL will not treat it as a failure if (i) it is solely attributable to the COVID-19 outbreak; (ii) the plan administrator makes a good faith, diligent effort to comply with those requirements; and (iii) the plan administrator makes a reasonable attempt to correct any procedural deficiencies, such as assembling documentation, as soon as practicable. It is important to note that this relief is only provided by the DOL and does not govern any issues that may fall under the jurisdiction of the IRS.

In addition, as noted in our prior COVID-19 newsletters, the CARES Act permits retirement plans to extend loan repayments for outstanding participant loans to a "qualified individual" for up to one year, with subsequent reamortization, and to increase the permissible limits for new retirement plan loans that are made before September 22, 2020.

In connection with these changes, the DOL will not treat any person as having violated plan loan requirements and limitations under Title I of ERISA solely because: (1) such person made a plan loan to a qualified individual under the CARES Act and applicable IRS guidance; or (2) a qualified individual delayed making a plan loan repayment in compliance with the CARES Act and applicable IRS guidance. Furthermore, the Notice confirms that EBSA will treat a plan that offers participant loans authorized under the CARES Act as having complied with the terms of an amendment to implement such loans, provided that the amendment is adopted by the last day of the first plan year beginning on or after January 1, 2022 (or such later date as permitted by the Treasury), and the terms of the amendment comply with the CARES Act.

Timing of when Participant Contributions Must be Remitted to Benefit Plan

EBSA Notice 2020-01 states that the DOL will not take enforcement action against plan sponsors and fiduciaries who experience delays in depositing participant contributions and loan repayments as a result of the COVID-19 pandemic, provided that any delay is temporary and the plan administrator continues to satisfy its ERISA fiduciary obligation to act reasonably, prudently, and in the best interest of plan participants to deposit such payments as soon as is reasonably practicable.

Despite this non-enforcement policy, we urge caution here, for several reasons. First, the DOL historically has taken the position that given the wide use of payroll-related technology by employers of all sizes, most employers should be able to remit participant contributions within a few business days; consequently, we anticipate that the employer will face a high burden in order to provide that delays were due to the COVID-19 pandemic. Secondly, the relief provided in the EBSA Notice extends only to participant contributions, which means that employers must continue to make any required employer contributions on a timely basis, in accordance with the terms of their plans (which may require contributions every payroll period) and consistent with their past administrative practices.

Form 5500 and M-1 Filing Deadlines

The due date to file a Form 5500 otherwise due between April 1, 2020 and July 14, 2020, has been extended to July 15, 2020.

To date, however, the DOL has not extended the due date for 2019 Form 5500 filings for calendar year plans. That means that for calendar year plans, the normal Form 5500 due date remains July 31, 2020 with an option to extend the Form 5500 deadline until October 15th by filing an IRS Form 5558 before the plan's normal deadline.

Form M-1 filings required for multiple employer welfare arrangements (MEWAs) are provided relief for the same period of time as the Form 5500 relief.

II. *Joint Notice*

The Joint Notice extends key deadlines in three primary areas involving benefit plan operations:

Claims Procedures

All ERISA-covered benefit plans, whether retirement plans, health plans or welfare plans, are required to maintain reasonable claims procedures that provide participants with a reasonable opportunity for a full and fair review of denied claims. These requirements include certain timeframes during which certain actions must take place. To provide additional flexibility and protection to plan participants, the Joint Notice provides that all ERISA-covered plans must disregard the Outbreak Period for all plan participants, beneficiaries and claimants in determining (1) the date within which an individual must file a claim for benefits under the plan's claims procedures; (2) the date within which a claimant must file an appeal of an adverse benefit determination, including a request for an external review, under the plan's claims procedures; and (3) the date by which claimants may provide additional information upon a finding that the request for an external review was not complete. This relief will require plan sponsors to work with their third-party claims administrators to ensure that they are complying with the additional relief provided to participants and not denying benefit claims prematurely.

HIPAA Special Enrollment Periods

The Joint Notice also extends the HIPAA special enrollment window under group health plans for employees who gain a dependent by birth, marriage, adoption, or placement for adoption, and for employees, spouses, and dependents who lose coverage under another group health plan. Normally, individuals have 30 days (in some cases 60 days) after the occurrence of the HIPAA special enrollment event to request enrollment in a health plan outside of the regular open enrollment period. Those deadlines are now tolled during the Outbreak Period.

COBRA Continuation Coverage

Lastly, the Joint Notice extends certain time frames regarding continuation of group health plan coverage under COBRA, to provide participants with additional time to elect and pay for such coverage. A summary of those changes and other recent developments affecting COBRA rights and obligations is available in our Employee Benefits Update available here.

III. *The DOL FAQs*

The DOL issued FAQs that provide additional helpful information for participants to better understand how their rights are affected by the COVID-19 pandemic, which are available here.

Highlights of the DOL's FAQs include the following:

- How health plan coverage, and premium payments, during the COVID-19 pandemic may be handled for individuals whose place of employment has temporarily closed;
- The ability of employers to change or terminate health benefits or retirement plan benefits in certain circumstances, provided that they have adequately reserved their rights to do so and provide any required notices;
- How plan participants, including pension plan retirees, should obtain information about their plan benefits;
- An explanation of the relaxed participant loan and retirement plan distribution rules under the CARES Act; and
- Information that certain plan disclosures may be delayed by the COVID-19 pandemic.

IV. *The IRS FAQs*

The IRS FAQs provide clarifying information on the special coronavirus-related distributions and expanded loan options for retirement plans permitted under the CARES Act. Highlights of the IRS FAQs, which are available here, include the following:

- Explaining the definition of "qualified individuals" under the CARES Act for purposes of receiving the coronavirus-related distributions and expanded loan options. Of particular note is that, at this time, the IRS FAQs do not expand the definition of a "qualified individual" to include a participant's spouse who may have experienced adverse financial consequences because they have been laid off, furloughed, or experienced a reduction in hours, nor does the definition of a "qualified individual" include a person whose pay has been reduced as a cost-cutting strategy but whose hours remain the same. However, the IRS and Treasury do reserve the right to further expand the list of factors taken into account in order to determine whether a person is a "qualified individual" for purposes of these distribution and loan rights;
- Clarifying how the tax treatment, tax reporting and repayment options of coronavirus-related distributions will be implemented;
- Providing that an individual can characterize a distribution that they receive as a "coronavirus-related distribution", even if their employer does not add this feature to their retirement plan;
- Affirming that a plan administrator can rely on an individual's certification that they are eligible to receive a coronavirus-related distribution unless they have "actual knowledge" to the contrary; and
- Clarifying that it is optional for employers to adopt some, none, or all of the CARES Act distribution and expanded loan provisions.

To discuss the impact of the recent regulatory guidance on your employee benefit plans, please contact any member of our Employee Benefits and Executive Compensation Group below.

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Employee Benefits Update May 20, 2020

The Impact of the COVID-19 Pandemic on Your Employee Benefit Plans: Part 6

Changes to Cafeteria Plan Mid-Year Election Rules, Increase of Health FSA Carryover Limit, Extension of Health & Dependent Care FSA Claims Periods, and Clarifications about Prior Changes

Executive Summary

The Internal Revenue Service (the "IRS") and the Treasury Department recently issued Notice 2020-29 and Notice 2020-33 (the "Notices"). This client alert addresses how these Notices provide guidance to employers who wish to provide additional flexibility to their employees during the COVID-19 pandemic with respect to their benefit elections under cafeteria plans, health flexible spending arrangements (health FSAs), and dependent care flexible spending arrangements (dependent care FSAs). The Notices also modestly increase the carryover limit for health FSAs, extend the health FSA and dependent care FSA claims period, and clarify the ability of individual coverage health reimbursement arrangements (HRAs) to reimburse premiums incurred prior to the beginning of a plan year.

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Mid-Year Election Changes Permitted Under Cafeteria Plans for 2020 Only

A cafeteria plan—often referred to as a "Section 125 plan" or a "flexible benefits plan"—is a plan maintained by an employer that allows employees to choose between receiving taxable income or receiving "qualified benefits", such as health insurance coverage, health FSAs, and dependent care FSAs, which are not included in gross income. Under the cafeteria plan rules, participant elections generally must be made prior to the first day of the plan year and must be irrevocable for that plan year, except in certain limited circumstances, such as if the employee experiences a change in status or there are significant changes in the cost of coverage.

IRS Notice 2020-29 temporarily loosens the cafeteria plan rules to permit employees to prospectively change their elections, mid-year, for health coverage, health FSAs (including limited purpose health FSAs compatible with high deductible health plans and health savings accounts), and dependent care FSAs, for the 2020 calendar year. Specifically, an employer, in its discretion, may (but is not required to) amend its cafeteria plan to allow eligible employees to:

- make a new election to enroll in health coverage, if the employee initially declined to elect such coverage;

- revoke an existing health coverage election and make a new election to enroll in different health coverage (including changing enrollment from self-only coverage to family coverage);

- revoke an existing election for health coverage, provided the employee attests in writing that the employee is enrolled, or will immediately enroll, in other comprehensive health coverage not sponsored by the employer. (Notice 2020-29 provides template language for the written employee statement.) The employer can rely on this statement, unless the employer has actual knowledge that the employee is not or will not be enrolled in other comprehensive health care coverage;

- revoke an election, make a new election, or decrease/increase an existing health FSA election; and

- revoke an election, make a new election, or decrease/increase an existing election regarding a dependent care FSA.

Employers taking advantage of the Notice 2020-29 relief may determine the extent to which election changes are permitted and applied, provided that any permitted election changes are provided on a ***prospective basis only*** and the changes to the election requirements do not result in failure to comply with the nondiscrimination rules applicable to cafeteria plans. For example, an employer may choose to:

√ limit the period during the 2020 calendar year in which the election changes can be made;

√ limit the number of election changes;

√ for health FSAs and dependent care FSAs, limit mid-year election changes to amounts no less than amounts already reimbursed, in order to limit the employer's financial exposure; or

√ limit election changes to those that increase or improve an employee's coverage.

Employers must inform all employees eligible to participate in their cafeteria plans about changes made to the election requirements for the 2020 calendar year. A formal amendment to the cafeteria plan must be adopted on or before December 31, 2021.

Increase in Carryover Limit for Health FSAs

Under current regulations, any unused amounts remaining in a health FSA at the end of a plan year are forfeited under the "use it or lose it" rule, unless the cafeteria plan allows a carryover of unused amounts up to $500, or a grace period during which an employee can apply unused amounts to pay qualifying expenses incurred during the grace period.

Recognizing that the carryover limit has not kept pace with increases in the maximum amount an employee can contribute to a health FSA—which is $2,750 for 2020—IRS Notice 2020-33 increases the carryover limit to 20 percent of the maximum salary reduction contribution for the plan year, rounded to the next lowest multiple of $10. This means that the maximum carryover amount from the 2020 plan year, into the 2021 plan year, will be $550 (20% of $2,750).

If an employer decides to allow this increased carryover amount, plan participants should be notified, and the cafeteria plan must be formally amended. If the carryover limit is changed for the 2020 plan year, the amendment must be adopted by December 31, 2021. The amendment can include language that references the indexed amount so that the cafeteria plan does not need to be amended each year to reflect increased carryover amounts.

Extended Claims Period through December 31, 2020 for Health and Dependent Care FSAs

IRS Notice 2020-29 permits (but does not require) an employer to provide an extended period to apply unused amounts remaining in health and dependent care FSAs. If an employer adopts this extension, participants will be able to apply unused amounts remaining in a health FSA (whether a general purpose or limited purpose health FSA) or a dependent care FSA at the end of a grace period ending in calendar year 2020 or a plan year ending in 2020 to pay or reimburse expenses incurred through December 31, 2020. The Notice reminds employers that health FSA amounts may be used only for medical care expenses, and dependent care FSA amounts may be used only for dependent care expenses; notably, however, it does not provide for a cash out of unused FSA balances.

This extension of time to apply unused amounts is available both to cafeteria plans that have a grace period and to cafeteria plans that permit carryovers. In addition, an employee with unused amounts in a health FSA remaining at the end of the 2020 plan year or grace period ending in calendar year 2020, and who is allowed an extended period to incur expenses, will not be eligible to contribute to a health spending account (HSA) during the extended period unless the health FSA is a limited purpose health FSA that is HSA-compatible.

If an employer chooses to adopt these optional changes, the employer must inform all employees eligible to participate in the cafeteria plan about the changes, although a formal amendment to the cafeteria plan for the 2020 plan year does not need to be adopted until December 31, 2021.

Clarification Regarding Scope of COVID-19 Diagnostic Testing to Be Covered Without Cost-Sharing

IRS Notice 2020-29 clarifies that COVID-19 diagnostic testing, which is required to be covered without any cost-sharing, includes the panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV), as well as any items or services required to be covered with zero cost-sharing under the Families First Coronavirus Response Act and the CARES Act. This coverage applies to expenses incurred on or after January 1, 2020.

Clarification Regarding Telehealth and Remote Care Services

IRS Notice 2020-29 also clarifies that individuals retain eligibility to contribute to an HSA if they also receive coverage for telehealth and other remote care services provided outside a high deductible health plan and before satisfying the minimum deductible. This treatment of telehealth and other remote care services applies with respect to services provided on or after January 1, 2020 for plan years beginning on or before December 31, 2021.

Clarification of Individual Coverage HRA Reimbursement

While the general rule is that individual coverage HRAs cannot reimburse medical care expenses incurred prior to the beginning of the plan year, IRS Notice 2020-33 addresses some of the administrative complexities that can arise in applying that rule when reimbursing individual health insurance premiums. The Notice clarifies that an individual coverage HRA is permitted to treat expenses for health insurance coverage premiums 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. This means, for example, that an individual coverage HRA with a calendar year plan year may immediately reimburse a substantiated premium for health insurance coverage that begins on January 1 of that plan year, even if the covered individual paid the premium for coverage prior to the first day of the plan year.

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To discuss the impact of this recent guidance on your employee benefit plans, please contact any member of our Employee Benefits and Executive Compensation Group below. Please click here to access Isler Dare's COVID-19 information webpage.

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