National Compliance Update

USI EMPLOYEE BENEFITS

September 24, 2020

Renewal Considerations: Potential Liability Exposures Due to COVID-19-Related Extensions

As reported earlier,[1] employees have an extended timeframe to, in part, elect COBRA, make COBRA payments, add dependents, and appeal denials of benefits. As the timeframe may extend beyond the current plan year, in some cases with coverage going into effect retroactively for many months, there are concerns about what gaps in insurance coverage there could be. This may particularly be an issue with stop loss insurance.

SUMMARY OF THE ISSUES

Employers must disregard the Outbreak Period, March 1, 2020 until 60 days after the announced end of the National Emergency,[2] for each of the following topics below. At this point, an end to the National Emergency has not been announced. For purposes of the following examples, February 28, 2021 is used as the end of the Outbreak Period. This is purely illustrative. The Outbreak Period may end earlier than this date, in which case the following examples are subject to the change.

1. COBRA (applies to all health plans of employers with 20 or more employees):

- The 60-day election period for a qualified beneficiary to elect COBRA continuation of coverage.
- The date for making monthly COBRA premium payments.
- The date for individuals to notify the plan of a qualifying event or disability determination.

[1] See USI's May 5, 2020 Compliance Update, "New Guidance Offers Relief and Extends Deadlines for Benefit Plans"

[2] For purposes of the Outbreak Period, the National Emergency is determined based on a March 13, 2020 letter from President Trump to Secretaries of the Departments of Homeland Security, the Treasury, and Health and Human Services and the Administrator of the Federal Emergency Management Agency. The announced end date of the National Emergency may not be the same date as the end of the Public Health Emergency period announced by HHS (currently October 23, 2020). For purposes of this illustration we use the same date but note National Emergency end date for purposes of the Outbreak Period may be different.

Example of a potential problem:

- An employee fails to make a COBRA premium payment for the month of July 2020 by the end of July (missing the July 1 deadline and grace period under traditional rules). Under new rules, as long as he makes the payment by March 30, 2021, his July 2020 coverage must be reinstated.
- COBRA is an employer law, not a carrier law. If a participant is seeking coverage retroactively this far in the past, there could likely be a large claim. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

2. Special Enrollment Rights (applies to major medical plans):

- The date for a participant to request a special enrollment right for group health plan coverage which is otherwise 30 days from the loss of other coverage or acquisition of a dependent (60 days for loss of Medicaid or SCHIP or for a gain of premium assistance).

Example of the potential problem:

- An employee has a baby on April 15, 2020. She could request enrollment to the medical plan in March 2021 for an April 15, 2020 effective date. Her employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.
- Carriers of insured plans are directly subject to the HIPAA Special Enrollment Rule. However, stop loss carriers are not. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

3. Claims for Benefits (applies to all ERISA-covered plans):

- The date within which individuals may file a benefit claim as described under the plan's terms.

Example of the potential problem:

- An employee did not make a timely claim under traditional rules for a medical service provided in June 2020. She could make a claim in April 2021 for reimbursement of the June 2020 expense. Her employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.
- Carriers of insured plans and some third-party administrators ("TPAs") are claims fiduciaries. Who will adjudicate the claim? Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

4. Appeals of Denied Claims (applies to all ERISA-covered plans):

- The date within which claimants may file an appeal for an adverse benefit determination. For health and disability claims, a claimant has 180 days, for all other claims 60 days.

Example of the potential problem:

- An employee's claim for benefits is denied in April 2020. He misses his opportunity to appeal, resulting in his lack of exhausting administrative remedies and, thus, his inability to pursue the matter further under traditional rules. He appeals in April 2021.
- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

5. External Review (applies to all non-grandfathered major medical plans):

- The date the claimant may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination.

- The date within which a claimant may file information to perfect a request for external review.

Example of the potential problem:

- An employee's claim for benefits is denied in April 2020. He misses his opportunity to request for an external review. He appeals in January 2021.
- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

Please see *Appendix A* for a breakdown of how these rules apply to each line of coverage.

EMPLOYER ACTION STEPS

The following are recommendations for employers to consider:

For a currently self-funded medical plan remaining self-funded and with the same stop loss carrier and/or TPA at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules (sample in *Appendix B*).

For a currently self-funded medical plan remaining self-funded but switching stop loss carriers and/or TPAs at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules (sample in *Appendix B*);
- Establish which administrator (current or new) will adjudicate the claims.

For a currently insured medical plan going self-funded (or vice versa):

- Current carrier should adjudicate and pay claims, but best practice would be to so confirm.

Appendix A

Medical stop loss carriers/self-funded medical plans:	
All issues may apply: ▪ COBRA ▪ Special Enrollment Rights ▪ Claims for Benefits ▪ Appeals of Denied Claims ▪ External Review *(only non-grandfathered major medical plans).*	*If the TPA has been appointed a claims fiduciary, which one will adjudicate claims should there be a change in carrier? Review stop loss coverage to determine coverage protections.*
Medical carriers (fully insured):	
▪ COBRA ▪ Claims for Benefits* ▪ Appeals of Denied Claims* ▪ External Review (*only non-grandfathered major medical plans*)*	*Carriers are directly subject to the HIPAA Special Enrollment Rule.*
Disability (advice to pay):	
▪ Claims for Benefits ▪ Appeals of Denied Claims	*Not as worrisome, as the employer pays the claims regardless.*
Life insurance, disability (insured):	
▪ Claim for Benefits* ▪ Appeals of Denied Claims*	
Dental, vision (self-funded):	
▪ COBRA ▪ Claims for Benefits ▪ Appeals of Denied Claims	*Not as worrisome due to limited liability.*
Dental, vision (insured):	
▪ COBRA ▪ Claims for Benefits* ▪ Appeals of Denied Claims*	*Not as worrisome due to limited liability.*

* *Carriers are claims fiduciaries, but which one will adjudicate claims, should there be a change in carrier?* Informal responses USI received from the major medical carriers suggest that, in a fully insured arrangement, the medical carrier at the date of service is responsible for the claims, assuming the extended emergency period timeline is met, premiums were paid, affected claims were for a covered service, and plan requirements are otherwise met.

Appendix B

Sample Amendment No. [___] to the [_____] Plan

WHEREAS, the [_____] Plan (the "Plan") reflects the generally applicable ERISA, COBRA, and HIPAA special enrollment right timeframes.

WHEREAS, recent law requires the extension of time due to the COVID-19 pandemic.

WHEREAS, [_____] (the "Company") hereby amends the Plan to reflect these changes in the law.

NOW, THEREFORE, the Plan is amended as described below.

Notwithstanding any other provision of the Plan to the contrary, the period of March 1, 2020 through the end of the "Outbreak Period" is disregarded with respect to the date an employee may:

- request a HIPAA special enrollment;[3]
- elect COBRA;
- pay a COBRA premium;
- notify the Plan of a qualifying event or disability determination;
- file a benefit claim;
- file an appeal for an adverse benefit determination;
- file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination [*non-grandfathered plans*]; and
- file information to perfect a request for external review [*non-grandfathered plans*].

The Outbreak Period ends on the 60th day after the end of the National Emergency. The National Emergency begins March 1, 2020 and ends on a date as announced by the federal government.

[3] 30 days from the loss of other coverage or acquisition of a dependent (60 days for loss of Medicaid or SCHIP or for a gain of premium assistance).