



Executive Series | What You Need To Know
COVID-19 | Employee Benefits Compliance Webinar
Frequently Asked Questions (FAQs)

Group Health Plan Coverage Considerations



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April 20, 2020

On March 31, 2020, USI's national Employee Benefits Compliance team hosted a COVID-19 Employee Benefits Compliance Update Webinar. During the call, many questions were submitted by participants. These questions have been collected and answered here, split into three topics: group health plan coverage considerations, FFCRA leave provision considerations, and FFCRA payroll tax credit considerations.

The following questions and answers address group health plan coverage considerations.

This information is up to date as of April 20, 2020. Due to the rapidly changing nature of this material, there may be new or updated information that is not included in this summary. The IRS regularly updates their website with FAQs related to group health plan coverage considerations – for more information, visit <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf>.

General Group Health Plan Questions

Q1: If an employer is sponsoring a qualified High Deductible Health Plan (“HDHP”) with a Health Savings Account (“HSA”), will providing coverage for testing for, or treatment of, COVID-19 disqualify covered individuals from HSA eligibility?

No. Under IRS Notice 2020-15, it is clear that providing coverage for testing for, or treatment of, COVID-19 with no cost sharing and prior to satisfaction of the minimum required statutory deductible, will not disqualify an individual from eligibility to open and contribute to an HSA.

Q2: Under the CARES Act, telehealth and other remote services can be provided by an HDHP prior to satisfaction of the deductible without jeopardizing HSA eligibility of covered individuals. However, the relief is temporary. When does the relief expire?

The relief expires for plan years that begin on or after December 31, 2021.

For example, for a calendar year HDHP, this relief applies as follows:

- January 1, 2020 – December 31, 2020 plan year, and
- January 1, 2021 – December 31, 2021 plan year.

In this example, the relief would no longer be available effective with the January 1, 2022 plan year.



Q3: Is the change allowing reimbursement of over-the-counter (“OTC”) medications and drugs without a prescription through tax favored accounts (e.g., health FSA, HSA, HRA) permanent?

Yes. This change is permanent as the CARES Act removed the prohibition that was instituted as part of the Affordable Care Act.

Q4: Is reimbursement for OTC medicines and drugs without a prescription limited to OTC products used to treat a COVID-19 diagnosis?

No. Any OTC medicine or drug can be reimbursed on a tax favored basis through a health FSA, HRA or HSA without a prescription. A diagnosis of COVID-19 is not required to qualify for this relief.

Q5: Will I need to amend my health FSA or HRA plan document to include OTC medicines and drugs as a qualified expense?

Whether a plan amendment is necessary will depend on your existing plan terms and the definition of qualified medical expenses. A plan may have broad language that will capture this change without need for a plan amendment.

Alternatively, the existing terms of your plan may exclude OTC medicines and drugs from reimbursement unless prescribed. If this is the case, your plan will need amending.

Work with your flexible benefit administrator to determine whether a plan amendment is needed, and they should be able to provide you with the required plan language to reflect this change.

Q6: Under the CARES Act, the change in treatment of OTC medicines and drugs is effective as of January 1, 2020. If I must amend my plan to allow for this change, can it be retroactive?

In general, plan amendments must be made on a prospective basis. So, if a plan amendment was made April 1, 2020 to provide reimbursement for OTC medicines and drugs on a tax-favored basis, such expense incurred on or after April 1, 2020 would be eligible. Retroactive amendments generally are not allowed.

However, it is possible future IRS guidance could permit tax favored reimbursement for any OTC medicine or drug without a prescription as of January 1, 2020, even if the plan terms do not align, so long as an amendment is in place by the end of the year. While this seems to be the intent of the CARES Act, further guidance from the IRS is needed.

Q7: What menstrual products are now considered “qualified medical expenses” for tax favored accounts?

Effective January 1, 2020, the CARES Act expands the definition of “qualified medical expenses” to include menstrual products. The term “menstrual care product” means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.



Q8: Is there a list of OTC medicines and drugs that can be provided on a tax favored basis through health FSAs, HRAs, and HSAs?

Generally, ibuprofen, acetaminophen, naproxen, aspirin, cold and allergy medications are examples of medicines and drugs that may be reimbursed on a tax favored basis without a prescription.

While the IRS does not have a formal list, most flexible benefit administrators maintain a list and can provide as needed.

Q9: Is an employer now required to cover OTC medicines and drugs in their tax-favored program?

With respect to a health FSA or HRA, the employer will decide what expenses are eligible for reimbursement through these tax favored programs. This is established by employers through the plan terms. While federal law permits reimbursement of any qualified medical expense as defined under Code Section 213(d), the employer's plan terms may narrow expenses that are eligible for reimbursement through the plan.

For example, an employer has a PPO plan offered alongside a self-funded HRA. The HRA is designed to reimburse the employee for co-pays and co-insurance for expenses under the PPO plan. Nothing in the CARES Act requires the employer to allow HRA reimbursement for OTC medicines and drugs.

On the other hand, since an HSA is an employee-owned account, the employer cannot place limitations on how the employee uses the HSA funds.

Q10: As many elective procedures are being cancelled in response to the COVID-19 pandemic, is there any relief for individuals who set aside health FSA funds for a procedure that has now been cancelled?

Specific IRS-relief is not available for this scenario at this time.

In the meantime, we must rely on choices already permitted under the rules (with vendor approval):

- Plans can change the run-out period
- Plans can implement a grace period
- The Plan could consider a \$500 carryover provision

However, an individual cannot "cash out" the health FSA as a result.

Employers that sponsor HDHP/HSA plans should be careful if implementing changes to the FSA that may impact HSA eligibility in the future.

Further guidance from the IRS may be forthcoming in this area.



Q11: Can an employee who previously declined the health FSA add that benefit mid-year due to COVID-19?

No. An employee who previously declined a health FSA would need a qualified life event under the Section 125 rules in order to enroll in the health FSA mid-year. The IRS has not expanded the qualified life event rules for Health FSAs as it relates to COVID-19.

Dependent Care Flexible Spending Account Questions

Q12: As a result of COVID-19, many day care providers have had to close. Can an employee make a change to reduce (or drop) his Dependent Care Assistance Program (DCAP)¹ election as a result of a provider closure?

Yes. When there is a change in the cost of a dependent care provider (including the elimination of cost), a DCAP can permit a mid-year change in election as long as the cost change is imposed by a dependent care provider who is not a relative of the employee. Employees should be directed to the DCAP vendor to make election changes.

Q13: If an employee is furloughed, can the employee make changes to his/her DCAP elections?

Yes, under two circumstances.

1. When the childcare provider's cost has changed, similar to Q12 above.
2. Where the employee no longer requires DCAP because he/she is no longer working (or is teleworking from home), therefore childcare does not require care outside of the home (or it is not available).

In both scenarios, the employee is able to make changes to his/her DCAP/Dependent FSA elections.

Q14: If employees are teleworking (due to office closure), should the employer inquire whether they are still eligible for the DCAP?

Compliance with the DCAP is ultimately the employee's responsibility as an individual taxpayer. However, as best practice, it could be helpful to provide employees with information on how to make changes to the DCAP elections in the event your offices are closed.

¹ Also referred to as a dependent care FSA.



Eligibility Questions

Q15: Are employees allowed to remove dependents from the group health plan mid-year if the cost is too expensive or if they can secure cheaper coverage?

A change in the ability to pay for coverage is not a reason to be able to make a mid-year election change. Mid-year election changes should be outlined in the cafeteria plan documents. Typically, under the cafeteria plan permitted mid-year election changes, an employee must experience a qualified life event to make a change to elections made at the outset of coverage/open enrollment. Unless the dependents have experienced some other qualified life event, an employee is not permitted to make changes to a pre-taxed benefit for the duration of the plan year.

Q16: If an employer decides to relax eligibility rules, should this be documented in the SPD?

Yes. Any change in eligibility (even if only for a limited time), should be incorporated into the SPD through an SMM.

Q17: An employee has a reduction in hours but, under the terms of the medical plan, that does not result in a loss of coverage. Would the reduction in hours affect eligibility for other benefits?

Continued eligibility for non-medical benefits is determined separately from continued eligibility for the medical plan. Continued eligibility provisions in all applicable plan documents should be consulted to determine how a reduction in hours impacts such eligibility for other lines of coverage.

Q18: If we have furloughed employees (still our active employees but working no hours), and we are extending group health plan coverage for the duration of the furlough, how is this reflected when we report on Form 1095-C for CY 2020?

- Covered Employees: There will be no reporting change for employees that remain covered.
- Employees who waived coverage:
 - There may be a reporting change depending on whether the employee is considered an ACA full-time employee during the furlough and whether there is an available safe harbor code to use in line 16. This will depend on specific facts and circumstances that should be reviewed with USI, payroll and/or your legal counsel.



Q19: Our carrier is allowing a mid-year enrollment opportunity related to COVID-19 for individuals who previously declined the group health plan coverage. What compliance issues should be considered before adopting this change?

If the employer is going to adopt this one-time mid-year enrollment opportunity, it should be outlined in an amendment to the plan documents.

Unless these employees are experiencing a cafeteria plan qualifying event permitting a mid-year election change to pay for coverage, then any individuals enrolling (which may include a spouse and dependents) in the plan through this carrier-provided mid-year enrollment opportunity should pay for such coverage on a post-tax basis for the remainder of the plan year.

Special considerations for self-funded plans. Employers with self-funded plans should seek approval from stop loss carriers before adding new enrollees to the group health plan outside of traditional enrollment or special enrollment opportunities. Employers with self-funded plans should also evaluate the cost and risks associated with these enhanced benefits.

Q20: If we lay off a group of employees who are offered COBRA, and then hire them back at some point later, can they be reinstated on the benefits (just as before they left)?

It appears it is up to the employer and contingent upon the terms of the various benefit programs. An example in the cafeteria plan regulations indicates that when more than 30 days have elapsed between an employee's termination and rehire, the plan (by design) can either allow a new election, require that the old election be reinstated, or keep the participant out of the plan until the next plan year. Any rules your cafeteria plan may already have in place would be found in the plan document.

Generally, under the ACA, if an employee is rehired within 13 weeks (26 weeks for certain educational institutions), the employee maintains his/her status as a full-time employee (or not a full-time employee) for purposes of the employer mandate. Eligibility rules may be written to mirror this treatment.

Q21: If an employee just takes a voluntary leave (i.e., not COVID-19 related or subject to FMLA), are they eligible for continuation of coverage?

General plan terms are applicable. Employers will need to review the terms of the various benefit programs to understand how coverage is treated during a voluntary leave of absence. Typically, an employee will only remain eligible if they maintain a certain number of hours of service or are on a protected leave (e.g. FMLA, USERRA or other state protected leave). To the extent group health plan coverage is lost as a result of a reduction in hours, COBRA applies.



Q22: We are hiring many temporary employees at this time to support our “essential business.” Are we required to offer them health care benefits?

The rules under the Affordable Care Act’s employer mandate have not changed due to COVID-19 or the resulting legislation passed to help employers and citizens during the pandemic. Therefore, an employer is not required to offer coverage, but could be subject to an employer mandate penalty for not offering affordable, minimum value coverage to employees who are deemed to be full-time (generally those who have 30 hours of service in a week or 130 hours of service in a month as determined under the monthly or look-back measurement method).

The employer should also look to their plan documents. If these temporary employees fit into the eligibility parameters established by their plan documents (usually established by an hours-of-service threshold) and are not otherwise excluded, then health care benefits should be offered. This may extend to other component benefit programs as well.

Helpful Resources

To help clients navigate these challenging times USI has implemented a **STEER (Steer Through Epidemic & Economic Recovery) Task Force**. This cross-functional team is working to provide timely COVID-19 information, understand cross-industry and geography impact and evolving responses, and to develop and deliver tailored solutions to help clients **steer** through this epidemic challenge and economic recovery.

For additional resources, tools, information, and links, please visit our COVID-19 resource page: www.usi.com/public-health-emergencies

