

SUMMARY TABLE AND IN-DEPTH ANALYSES OF COVID-19 LEGISLATION FOR EMPLOYER-BASED RETIREMENT AND WELFARE PLANS

Employers and public retirement systems have faced a number of new and difficult challenges as the first weeks and months of the coronavirus pandemic have quickly worked to change our businesses, our communities, and the way we live. In an effort to provide Americans with financial assistance and security and additional health coverage during these unprecedented times, Congress and the President moved rapidly to enact significant legislation to assist employers and their employees. The Families First Coronavirus Response Act ("FFCRA") was enacted on March 18, 2020, followed soon after by the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), enacted on March 27, 2020. These two laws contain several mandatory and optional provisions applicable to employer-based retirement plans and welfare plans.

In the weeks since, the Internal Revenue Service and the Departments of the Treasury, Labor, and Health and Human Services have worked seemingly nonstop to produce regulatory and sub-regulatory guidance to assist plan sponsors with implementing the requirements and optional provisions under the FFCRA and the CARES Act. They have also granted relief from several plan-related deadlines during the period of the national emergency in an effort to minimize the possibility of individuals losing benefits.

To assist employers and public retirement systems with the myriad of changes, we have catalogued the provisions of the FFCRA and CARES Act that impact employer-sponsored retirement plans, health plans, and other benefits in a table format. We have summarized the statutory provisions as well as related regulatory guidance that has been issued as of the date of this publication. The table includes a high level discussion of the law and practical considerations. For a more in-depth analysis, we have provided a comprehensive discussion of each provision at the end of the table. Readers can skip directly to these sections by clicking the "closer look" links found in the left-hand column of each row.

For more information about the employee benefit implications of the COVID-19 pandemic and how they might affect your employee benefit plans, please contact any one of Ice Miller's employee benefits attorneys. You may find contact information and more information about Ice Miller's Coronavirus Task Force and Resource Center at icemiller.com.

This publication is intended for general information purposes only and does not and is not intended to constitute legal advice. The reader should consult with legal counsel to determine how laws or decisions discussed herein apply to the reader's specific circumstances.

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The table beginning on the following page summarizes key provisions under the Families First Coronavirus Response Act ("**FFCRA**") (enacted 3/18/20) and the Coronavirus Aid, Relief, and Economic Security Act ("**CARES Act**") (enacted 3/27/20), as well as related regulatory guidance issued to date, that impact employer-sponsored retirement plans, health plans, and other benefits. Additional information can be found after the table and by clicking the "closer look" links shown in the left column.

Common acronyms used throughout this table include:

- ACA – Patient Protection and Affordable Care Act of 2010
- CRD – coronavirus-related distribution
- DOL – Department of Labor
- EAP – employee assistance program
- ERISA – Employee Retirement Income Security Act of 1974
- FAQ – frequently asked question
- FDA – Food and Drug Administration
- FSA – flexible spending account
- IRC – Internal Revenue Code of 1986
- IRS – Internal Revenue Service
- HDHP – high deductible health plan
- HHS – Health and Human Services
- HIPAA – Health Insurance Portability and Accountability Act.
- HRA – health reimbursement arrangement
- HSA – health savings account
- RMD – required minimum distribution

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I. RETIREMENT RELIEF PROVISIONS			
<p>Coronavirus-related distributions (CRDs) CARES Act § 2202 <i>Effective January 1, 2020 through December 30, 2020</i> Take a closer look.</p>	<ul style="list-style-type: none"> • A CRD is a new category of distribution made from an eligible retirement plan or IRA to a qualified individual on or after January 1, 2020, and before December 31, 2020, up to an aggregate limit of \$100,000. • An individual is a "qualified individual" if: <ul style="list-style-type: none"> ○ Either the individual or his or her spouse or dependent has a confirmed diagnosis of COVID-19; or ○ The individual has experienced adverse financial consequences as a result of being quarantined, furloughed, laid off, having work hours reduced, the inability to work due to a lack of childcare, the close or reduction of a business, or other factors determined by the 	<p>This provision is optional.</p> <p>This provision applies to:</p> <ul style="list-style-type: none"> • 401(a) plans (including 401(k) plans) • 403(b) plans • Governmental 457(b) plans • IRAs <p>This provision creates a new in-service distribution right for 401(k), 403(b), and governmental 457(b) plans. It does not create a new in-service distribution right for defined benefit plans and money purchase pension plans (MPPs) which are otherwise prohibited from allowing in-service distributions before age 59 ½. However, CRDs can be made in-service from a defined benefit plan or MPP for participants who have attained age 59 ½.</p> <p>Regardless of whether an eligible retirement plan offers CRDs, distributions that are</p>	<ul style="list-style-type: none"> • Many retirement plan vendors took immediate action following enactment of the CARES Act to prepare their systems for administration of CRDs across all eligible retirement plans. Some vendors implemented an "opt-out" approach for the plans they administer, while others implemented a more conservative "opt-in" approach. Accordingly, it is possible that CRDs were permitted in operation from a retirement plan before a plan sponsor had time to consider whether to adopt this optional provision. • The vendors' expedited implementation was in response to the anticipated demand by participants for access to retirement funds. However, in determining whether to "flip the switch" on CRDs, plan sponsors should consider the needs and

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	<p style="text-align: center;">Secretary of the Treasury.</p> <ul style="list-style-type: none"> An individual who receives a CRD may repay the CRD within three years of the distribution in one or more payments to an eligible retirement plan to which the individual may make rollover contributions. Unless the individual elects otherwise, the amount of a CRD is taxed ratably over a three-year period. CRDs are not subject to the 10% early distribution penalty tax. CRDs made from a retirement plan are not subject to mandatory 20% withholding, nor is a 402(f) special tax notice required. Accordingly, 10% withholding will apply, unless the participant elects out of withholding. 	<p>otherwise permitted from the plan that meet the criteria of a CRD will receive the tax treatment afforded by this provision.</p> <p>A plan sponsor could choose to permit CRDs under its retirement plan, but adopt a lower dollar limit than \$100,000 or allow CRDs only from specific money sources, such as a participant's elective deferral account. However, some retirement plan vendors have indicated that they do not have the capacity to administer deviations from the general CRD rules.</p>	<p>concerns of their specific employee population.</p> <ul style="list-style-type: none"> Employers should consider the risk of retirement leakage and a potentially severe impact on "retirement readiness" if CRDs are heavily utilized by their employees. Although employees have the option to repay CRDs over a three-year period, few employees may be in a financial position to do so. Even so, taking a distribution when account balances have taken significant market losses means that repayment later (when the market is presumably higher) will never fully make the employee whole. Plan sponsors may wish to consider including education on these issues with employee communications. Plan sponsors that initially chose to "out-out" can reevaluate and opt-in at any time during 2020.

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			<ul style="list-style-type: none"> It is important that plan sponsors follow their regular procedures for plan amendments in choosing whether to add CRDs to their plans.
<p>Increased limits on plan loans CARES Act § 2202(b)(1) <i>Effective March 27, 2020 through September 22, 2020</i> Take a closer look.</p>	<ul style="list-style-type: none"> The CARES Act amends IRC § 72(p) to temporarily increase the maximum loan amount that a plan may permit with respect to qualified individuals ("qualified individuals" has the same meaning as with respect to CRDs, above). The provision increases the maximum loan amount to \$100,000 (from \$50,000) and permits loans up to 100% (from 50%) of the present value of the participant's account. The increased maximum applies to loans initiated from March 27, 2020 to September 22, 2020. 	<p>This provision is optional. This provision applies to:</p> <ul style="list-style-type: none"> 401(a) plans (including 401(k) plans) 403(b) plans Governmental 457(b) plans <p>A plan sponsor could choose to adopt a lower maximum loan limit, such as \$75,000 rather than \$100,000. However, some retirement plan vendors have indicated that they do not have the capacity to administer deviations from the general increased loan limit rules.</p>	<ul style="list-style-type: none"> A plan must offer loans, or the plan sponsor must amend the plan to allow loans, for this provision to apply. If a plan sponsor adopts this provision, it does not operate to override the plan's loan terms apart from the maximum limit. For example, if a plan limits participants to one outstanding loan at a time and restricts loans to employee contributions only, applying this provision to increase the maximum amount of a loan does not allow for additional loans or expanded contribution sources, unless the plan is amended. A plan sponsor can choose to permit CRDs and not choose to increase the loan

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<p>Delayed repayment of plan loans</p> <p>CARES Act § 2202(b)(2)</p> <p><i>Effective March 27, 2020 through December 31, 2020</i></p> <p>Take a closer look.</p>	<ul style="list-style-type: none"> The CARES Act extends the due date for loan repayments scheduled to be made from March 27, 2020 to December 31, 2020, with respect to qualified individuals ("qualified individuals" has the same meaning as with respect to CRDs, above). The due date for any payment scheduled for the relief period is delayed for up to one year. Payments after the suspension period are required to be adjusted to reflect the delayed due date plus any interest accruing during such delay. The delay is disregarded in determining compliance with the five-year term limit and amortization rules. 	<p>This provision is optional.</p> <p>This provision applies to:</p> <ul style="list-style-type: none"> 401(a) plans (including 401(k) plans) 403(b) plans Governmental 457(b) plans <p>Although the CARES Act reads as if this provision is mandatory, the IRS issued FAQs on May 4, 2020, which state that this provision is optional.</p>	<p style="text-align: center;">limits, or vice versa.</p> <ul style="list-style-type: none"> A participant with an existing loan will need to self-certify that he or she is a qualified individual before loan payments are suspended. Because an employee must take affirmative action to request suspension of loan repayments, a qualified individual who does not request this relief could choose to default on a loan in order to claim the deemed distribution as a CRD on his or her personal income tax return. As a CRD, the distribution would be exempt from the 10% early withdrawal penalty and can be repaid to the plan within three years. If this is a viable option, some participants may prefer to default on their loan this year, rather than have loan payments suspended. Regardless of whether or not a plan permits relief under this provision, Notice 2020-

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			<p>23 automatically extends plan loan repayments that are due on or after April 1, 2020 and before July 15, 2020. Such extended loan repayments are due on July 15, 2020. Accordingly, all participants with outstanding plan loans – not only qualified individuals – have loan repayment relief through July 15, 2020. More information on Notice 2020-23 is provided below.</p>
<p>Suspension of required minimum distributions (RMDs) paid in 2020 CARES Act § 2203 <i>Effective January 1, 2020 through December 31, 2020</i> Take a closer look.</p>	<ul style="list-style-type: none"> • The CARES Act waives RMDs for calendar year 2020. • The waiver applies to: <ul style="list-style-type: none"> ○ RMDs required to be paid in 2020 by December 31, 2020; and ○ RMDs required to be paid for 2019 by April 1, 2020, which were not paid by December 31, 2019. • The five-year distribution period that applies to certain beneficiaries will be determined without regard to 	<p>Plan sponsors have options regarding implementation of this provision.</p> <p>This provision applies to:</p> <ul style="list-style-type: none"> • Defined contribution 401(a) plans (including 401(k) plans) • 403(b) plans • Governmental 457(b) plans • IRAs <p>Plan sponsors that are subject to the RMD waiver may choose to:</p> <ol style="list-style-type: none"> 1. Suspend payment of 	<ul style="list-style-type: none"> • Not all retirement plan vendors are giving plan sponsors a choice as to how to implement the RMD waiver. Rather, some vendors have made decisions as to when they will suspend and when they will continue RMD payments, and plan sponsors cannot deviate from those decisions. Accordingly, plans with multiple vendors may in actual operation be implementing the RMD waiver in different ways.

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	<p>calendar year 2020.</p> <ul style="list-style-type: none"> If an eligible rollover distribution paid in 2020 would have been a RMD for 2020 but for the waiver, the distribution is not subject to the direct rollover rules, 20% mandatory withholding does not apply, and the 402(f) special tax notice is not required. Accordingly, 10% withholding will apply, unless the participant elects out of withholding. 	<p>2020 RMDs unless the participant elects to receive payment;</p> <ol style="list-style-type: none"> 2. Continue payment of 2020 RMDs unless the participant elects to suspend payment; or 3. Take approach #1 with respect to all participants except those who are receiving their RMD as part of scheduled installment payments, in which case take approach #2. 	<ul style="list-style-type: none"> If a participant receives a withdrawal in 2020 that would otherwise be a RMD, he or she may be able to roll over the amount to an eligible retirement plan.
II. HEALTH PLAN PROVISIONS			
<p>Mandatory Coverage of COVID-19 Diagnostic Testing</p> <p>FFCRA § 6001; CARES Act §§ 3201, 3202</p> <p><i>Effective March 18, 2020, for the duration of the public health emergency, as declared by the Secretary of HHS. The Secretary of HHS</i></p>	<ul style="list-style-type: none"> The FFCRA, as amended by the CARES Act, requires coverage for the following items and services without any cost-sharing, prior authorization, or other medical management requirements: <ul style="list-style-type: none"> ○ <i>In vitro</i> diagnostic tests for the detection of SARS-CoV-2 or the diagnosis of 	<p>This provision is <u>mandatory</u>.</p> <p>Except as specifically excluded below, the provision applies to:</p> <ul style="list-style-type: none"> All group health plans (including grandfathered health plans) All health insurers of individual or group health insurance policies 	<ul style="list-style-type: none"> Most health plans and insurers likely already cover the services needed for testing COVID-19, but now they must do so without any cost-sharing or medical management requirements. Prohibited cost-sharing includes deductibles, copayments, and coinsurance. A plan amendment may be required

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<p><i>declared a public health emergency for the entire United States regarding the coronavirus. The declaration is retroactive to January 27, 2020.</i></p> <p>Take a closer look.</p>	<p>the virus that causes COVID-19, and the administration of such a test, that:</p> <ul style="list-style-type: none"> ▪ Is FDA approved, cleared, or authorized; ▪ The test developer has requested, or intends to request, emergency use authorization under the Food, Drug, and Cosmetic Act; ▪ Is developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or ▪ HHS otherwise has approved in guidance. <p>Serological tests for COVID-19 are included in this mandate. These tests are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the</p>	<p>This includes:</p> <ul style="list-style-type: none"> • Both <u>self-funded</u> and <u>fully-insured</u> group health plans • Group health plans sponsored by private companies (ERISA plans) • Group health plans sponsored by non-federal governmental entities • Group health plans sponsored by religious employers (church plans) • Coverage offered in the individual market through or outside of an Exchange • Student health insurance coverage <p>The provision <u>does not apply</u> to:</p> <ul style="list-style-type: none"> • Short-term limited duration insurance • Excepted benefits (these include benefits such as on-site medical clinics, limited scope vision or 	<p>and self-insured plans should consult with stop-loss carriers to ensure coverage.</p> <ul style="list-style-type: none"> • Covering these mandatory benefits will not cause a plan to lose its grandfathered status under the ACA. • These mandated benefits must be provided both in-network and out-of-network. • All items and services provided during a visit that results in an order for or administration of an <i>in vitro</i> diagnostic test must be covered without cost-sharing, prior authorization, or medical management requirements if the item or service relates to: (1) the furnishing or administration of the diagnostic test or (2) the evaluation of the individual to determine need for the diagnostic test. This might include influenza tests or blood tests to rule out other illnesses before ordering a COVID-19 test. • HDHPs may provide health

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	<p>diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19.</p> <ul style="list-style-type: none"> ○ Items and services furnished during a visit to a provider's office (including via telehealth), urgent care, an emergency room, drive-up testing site, or other (even nontraditional) provider visit that results in an order for or administration of an <i>in vitro</i> diagnostic test described above, but only to the extent the item or service relates to: (1) the furnishing or administration of the diagnostic test or (2) the evaluation of the individual to determine need for the diagnostic test. ● In addition, the CARES Act generally requires plans and issuers providing coverage for 	<p>dental benefits, and benefits for long-term care, nursing home care, home healthcare, community-based care, and many EAPs)</p> <ul style="list-style-type: none"> ● Retiree-only group health plans 	<p>benefits associated with testing for and treatment of COVID-19 without a deductible which will allow individuals covered under such an HDHP to remain eligible to make HSA contributions.</p> <ul style="list-style-type: none"> ● Guidance issued on April 11, 2020, by the Departments of Labor, Treasury and HHS in the form of FAQs provided several helpful explanations related to this coverage requirement, which are discussed in more detail in our closer look. ● The FAQs clarify that states may impose additional standards and requirements that are not incompatible with the federal requirements. ● It is unclear whether the addition of this mandated testing, or any other plan enhancements made in connection with COVID-19, constitutes a significant change in coverage that would allow employees to

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	<p>these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website.</p> <ul style="list-style-type: none"> ○ Under the CARES Act, all testing providers must post the cash price for a COVID-19 diagnostic test on their website. The penalty for failing to do so is up to \$300 per day. There is not a similar provision requiring posting of the cash price for related items and services. ○ Employers should encourage plan participants to use in-network providers, when possible, to reduce out-of-pocket expenses to participants and costs to the plan. 		<p>make mid-year election changes to add coverage under the cafeteria plan rules. Employers should consult with legal counsel to determine whether to allow employees to make mid-year election changes.</p>

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<p>Rapid Coverage of Preventive Services and Vaccines for Coronavirus</p> <p>CARES Act § 3203</p> <p><i>Effective with respect to each qualifying coronavirus preventive service within 15 business days after the date on which a recommendation is made relating to the service.</i></p> <p>Take a closer look.</p>	<ul style="list-style-type: none"> • Group health plans and issuers of group and individual policies must cover any "qualifying coronavirus preventive service" without cost-sharing. • A "qualifying coronavirus preventive service" includes an item, service, or immunization intended to prevent or mitigate the coronavirus disease and that is: <ul style="list-style-type: none"> ○ An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force; or ○ An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. 	<p>This provision is <u>mandatory</u>.</p> <p>Except as specifically excluded below, the provision applies to:</p> <ul style="list-style-type: none"> • All non-grandfathered group health plans • All health insurers of individual or group health insurance policies <p>This includes:</p> <ul style="list-style-type: none"> • Both <u>self-funded</u> and <u>fully-insured</u> group health plans • Group health plans sponsored by private companies (ERISA plans) • Group health plans sponsored by non-federal governmental entities • Group health plans sponsored by religious employers (church plans) • Coverage offered in the individual market through or outside of an Exchange • Student health insurance 	<ul style="list-style-type: none"> • Under the ACA, non-grandfathered group health plans are already obligated to cover without cost-sharing both evidence-based items and services with ratings of "A" or "B" and immunizations with recommendations from the Advisory Committee on Immunization Practices. However, under the ACA, plans normally have a year or more to implement newly recommended preventive services. The effect of the new provision is to require health plans to cover these services within 15 business days after the date a recommendation is made if the services are intended to prevent or mitigate the coronavirus. This means that health plans must stay alert and informed throughout the COVID-19 public health emergency, as preventive services can be expected to receive approval on a rolling basis as new evidence emerges.

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	<ul style="list-style-type: none"> The coverage requirement applies 15 business days after the date on which a preventive coverage recommendation is made. 	<p>coverage</p> <p>The provision <u>does not apply</u> to:</p> <ul style="list-style-type: none"> Grandfathered group health plans Short-term limited duration insurance Excepted benefits (these include benefits such as on-site medical clinics, limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home healthcare, community-based care, and many EAPs) Retiree-only group health plans 	<ul style="list-style-type: none"> The ACA regulations permit a plan that has a network of providers to limit first dollar coverage of preventive services to in-network coverage only. This rule should apply to coverage of qualifying coronavirus preventive services as well, unless the circumstances are such that obtaining coverage for these services is so difficult that limiting the coverage to in-network providers creates access issues. We believe that guidance would be necessary to specifically extend this coverage out-of-network.
<p>Temporary Safe Harbor for HDHP Coverage of Telehealth and Remote Services</p> <p>CARES Act § 3701</p> <p><i>Effective March 27, 2020 through the last day of the plan year that begins on or</i></p>	<ul style="list-style-type: none"> The CARES Act provides a temporary safe harbor for HDHPs to cover "telehealth and other remote care services" without a deductible. Telehealth visits do not have to be connected with COVID- 	<p>This provision is optional.</p> <p>This provision applies to group health plans and health insurance issuers that offer HDHPs.</p>	<ul style="list-style-type: none"> This change is statutory and follows sub-regulatory guidance from the IRS in Notice 2020-15 that allowed testing and treatment for COVID-19 to be covered under HDHPs without a deductible. In Tri-Agency Guidance

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<p><i>before December 31, 2021 (through December 31, 2012 for calendar-year plans)</i></p> <p>Take a closer look.</p>	<p>19 to be eligible for this relief.</p>		<p>issued in the form of FAQs on April 11, 2020, the Departments of Labor, Treasury, and HHS strongly encouraged all plans and issuers to promote the use of telehealth and other remote care services.</p> <ul style="list-style-type: none"> A plan amendment may be required and self-insured plans should consult with stop-loss carriers to ensure coverage. Employers should use caution if they consider implementing a full-scale telehealth program for all employees outside of their group health plan. Such a program could be subject to the full range of requirements under ERISA, the ACA, and other employee benefit laws.
<p>Expansion of Qualified Medical Expenses Under Account-Based Health Plans</p> <p>CARES Act § 3702</p>	<ul style="list-style-type: none"> The CARES Act expands the types of medical care for which individuals may be reimbursed from HSAs, FSAs, HRAs, and Archer medical savings accounts (MSAs) ("Account-Based 	<p>This provision is optional with respect to health FSAs and HRAs, although in practice, many employers allow these accounts to reimburse for all qualified medical care allowed</p>	<ul style="list-style-type: none"> Prior to the CARES Act, qualified medical expenses for purposes of Account-Based Health Plans excluded medicines or drugs unless they were prescribed or were insulin. This was an ACA

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<p><i>Effective January 1, 2020</i></p> <p>Take a closer look.</p>	<p>Health Plans") to include:</p> <ul style="list-style-type: none"> ○ over-the-counter medicines and drugs; and ○ menstrual care products. 	<p>under the law.</p> <p>This provision is <u>automatic</u> with respect to HSAs and Archer MSAs. Employers cannot design limitations on qualified medical expenses for purposes of these accounts.</p>	<p>change. The CARES Act effectively reverses the ACA restriction to once again allow over-the-counter medicines and drugs to be reimbursed from Account-Based Health Plans.</p> <ul style="list-style-type: none"> • Most employers will need to amend their FSA and HRA plan documents to allow for the reimbursement of these expenses. • Although the effective date of this provision is January 1, 2020, FSAs may only be amended prospectively, thus it appears that over-the-counter medicines and drugs and menstrual products may not be eligible for reimbursement from FSAs until plan documents are amended to include them in eligible medical expenses. • The expansion of qualified medical expenses under this provision does not qualify as a change in status that would permit an employee to make a mid-year election change to

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			<p>his or her health FSA contributions.</p> <ul style="list-style-type: none"> An employee may make prospective changes to his or her HSA contributions at any point in the plan year, even with respect to HSA contributions made by salary reduction on a pre-tax basis. As a result, HSA participants may wish to increase HSA contributions in response to this expanded coverage. Debit card vendors, pharmacies, and retail stores may take some time to update software so that these expenses can be paid with a debit card. Until then, participants may have to submit manual claims.

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III. OTHER EMPLOYEE BENEFIT RELATED PROVISIONS			
<p>Employer-Provided Student Loan Repayments CARES Act § 2206 <i>Effective March 27, 2020 through December 31, 2020</i> Take a closer look.</p>	<ul style="list-style-type: none"> The CARES Act expands tax-free education assistance programs to include student loan repayments, on a temporary basis for the remainder of 2020. The provision expands the education assistance that may currently be provided tax-free to employees under an education assistance program pursuant to IRC § 127 to include qualified student loan debt incurred by the employee for the education of the employee. The maximum amount of tax-free education assistance an employer may provide under an education assistance program is capped at \$5,250 annually. 	<p>This provision is optional.</p> <p>This provision applies to employers that offer education assistance benefits under IRC § 127.</p>	<ul style="list-style-type: none"> This change gives employers an additional avenue of relief to employees who are working to pay off student loans related to their own education (it does not apply to student debt incurred by the employee for education of the employee's spouse or dependent). Separately, Section 3513 of the CARES Act temporarily suspends payments on federal student loans through September 30, 2020. These two provisions together provide significant short-term relief options to employees with student debt.
<p>IRS Extends Time-Sensitive Deadlines to July 15, 2020 Due to COVID-19 IRS Notice 2020-23</p>	<ul style="list-style-type: none"> IRS Notice 2020-23 provides a broad range of relief to extend numerous deadlines that fall between April 1, 2020 and July 15, 2020. The 	<p>The relief is automatic, and applies to any person with a specified time-sensitive action due to be performed during the applicable time period.</p>	<ul style="list-style-type: none"> Plan sponsors should be aware that several significant IRS deadlines for retirement plans that fall between April 1, 2020 and

COVID-19 AND EMPLOYER-BASED RETIREMENT & WELFARE PLANS

<u>PROVISION</u>	<u>SUMMARY</u>	<u>APPLICATION</u>	<u>ICE MILLER INSIGHTS</u>
<p><i>Extensions apply to a number of deadlines that fall between April 1, 2020 and July 15, 2020</i></p> <p>Take a closer look.</p>	<p>extended deadline applies to (among other items):</p> <ul style="list-style-type: none"> ○ Making 2019 contributions to qualified retirement plans ○ Correcting 2019 excess contributions ○ The 60-day timeframe for completing an indirect rollover ○ Timeframes for correcting errors under the IRS's correction procedures (EPCRS) ○ Making plan loan payments 	<p>A "person" includes any individual, trust, estate, partnership, association, company, and corporation.</p>	<p>July 15, 2020 have been extended until July 15, 2020.</p> <ul style="list-style-type: none"> • The loan payment relief under Notice 2020-23 applies regardless of whether the individual is a "qualified individual" for purposes of CARES Act loan relief, and regardless of whether the plan has adopted the CARES Act loan relief provisions. Individuals who request suspension of their loan payments pursuant to this relief should not be placed in default. Moreover, interest should not accrue on the missed loan payments during such period.
<p>Relief for Retirement and Health Plans and Participants Due to COVID-19</p> <p>Joint Notice, IRS and Employee Benefit Security Administration (EBSA)</p> <p>EBSA Disaster Relief Notice 2020-21</p>	<ul style="list-style-type: none"> • The Joint Notice requires plans to disregard the period beginning March 1, 2020 and ending 60 days after the COVID-19 national emergency terminates (the "Outbreak Period") in determining deadlines for: <ul style="list-style-type: none"> ○ Special enrollment; 	<p>The relief is automatic to applicable plans and participants. The plans include:</p> <ul style="list-style-type: none"> • Group health plans • Disability plans • Other employee welfare benefit plans • Employee pension benefit plans (both 	<ul style="list-style-type: none"> • The Joint Notice requires plan sponsors to disregard the Outbreak Period when applying deadlines for HIPAA special enrollment and COBRA elections and payments. Because the Outbreak Period begins March 1, plan sponsors will need to consider whether

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<p><i>Extensions apply to a number of deadlines that fall between March 1, 2020 and 60 days after the national emergency is lifted</i></p> <p>Take a closer look.</p>	<ul style="list-style-type: none"> ○ COBRA 60-day election periods; ○ COBRA premium payments; ○ COBRA election notices; ○ Making claims pursuant to the plan's claim procedures; ○ Appealing adverse benefit determinations; and ○ Requesting external review. ● During the same Outbreak Period defined above, EBSA Notice 2020-21 granted delays and other relief related to: <ul style="list-style-type: none"> ○ Notices, disclosures, and documents due under ERISA Title I; ○ Failures to follow verification procedures for plan loans and distributions; ○ Loans provided pursuant to the CARES Act; 	<p>defined contribution plans and defined benefit plans)</p> <p>The Joint Notice technically applies only to plans subject to ERISA and the IRC, and Notice 2020-21 technically applies only to plans subject to ERISA. However, HHS, which has jurisdiction over non-federal governmental plans, intends to adopt a policy of measured enforcement to extend the same timeframes to non-federal governmental plans.</p>	<p>some participants whose enrollment windows closed or deadlines expired are entitled to more time to complete an election.</p> <ul style="list-style-type: none"> ● Because many participants will likely be unaware that they have an extended timeframe to take certain actions, we believe that plan sponsors have a fiduciary obligation to communicate this extension to employees and COBRA participants. ● The Joint Notice operates to extend the run-out period for FSAs, which for many calendar year plans occurs in the first 90 days of the following plan year. Run-out periods that ended after March 1, 2020 should be tolled – and FSA administrators should continue to accept 2019 FSA claims – through the end of the Outbreak Period, plus any additional days left in the run-out period after the Outbreak Period began.

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<u>PROVISION</u>	<u>SUMMARY</u>	<u>APPLICATION</u>	<u>ICE MILLER INSIGHTS</u>
	<ul style="list-style-type: none">○ Forwarding loan repayments to a plan;○ Blackout notices; and○ Form 5500 and Form M-1 filings.		

A CLOSER LOOK: CORONAVIRUS-RELATED DISTRIBUTIONS

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Section 2202(a) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020, adds a new category of distribution, referred to as a "coronavirus-related distribution" or "CRD", made from an eligible retirement plan or IRA to a qualified individual on or after January 1, 2020, and before December 31, 2020, up to an aggregate limit of \$100,000. The IRS issued [frequently asked questions](#) (FAQs) addressing CRDs on May 4, 2020, which stated that the Treasury Department and IRS anticipate releasing guidance on these provisions in the near future. In the interim, the FAQs advise employers to refer to IRS guidance issued in Notice 2005-92 which addressed similar distribution provisions under the Katrina Emergency Tax Relief Act of 2005 (KETRA), for guidance on the CRD provisions.

Types of Plans

CRDs are permitted from the following types of plans:

- 401(a) plans (including 401(k) plans);
- 403(b) plans;
- Governmental 457(b) plans; and
- IRAs

Distributions from a 401(k) plan, 403(b) plan, and governmental 457(b) plan generally cannot be made in-service until age 59 ½. The CARES Act creates a new in-service distribution right for these plans. For example, a participant in a 401(k) plan who is age 40 can request a CRD in-service if the participant is a qualified individual, even though the distribution would not otherwise be permitted under applicable law.

While CRDs can be made from defined benefit plans and money purchase pension plans (MPPs), the IRS stated in FAQs issued on May 4, 2020 that the CARES Act does not create a new in-service distribution right for these types of plans. Accordingly, CRDs from a defined benefit plan or MPP cannot be made in-service prior to age 59 ½. This restriction would apply to any MPP assets held in profit sharing plan, so it is important to identify whether a 401(a) plan holds MPP assets before implementing CRDs.

CRDs are not permitted from 457(b) plans sponsored by tax-exempt employers.

Qualified Individuals

A "qualified individual" is an individual who:

1. is diagnosed with the virus SARS-CoV-2 or with COVID-19 by a test approved by the Centers for Disease Control and Prevention; or
2. has a spouse or dependent diagnosed with the virus SARS-CoV-2 or with COVID-19 by a test approved by the Centers for Disease Control and Prevention; or
3. experiences adverse financial consequences as a result of being quarantined, furloughed or laid off or having work hours reduced due to the virus SARS-CoV-2 or COVID-19; or
4. experiences adverse financial consequences as a result of being unable to work due to lack of child care due to the virus SARS-CoV-2 or COVID-19; or
5. experiences adverse financial consequences as a result of closing or reducing hours of a business owned or operated by the individual due to the virus SARS-CoV-2 or COVID-19.

The IRS is also authorized to issue guidance that expands the list of factors taken into account in determining whether an individual is a qualified individual. The IRS indicated in FAQs issued on May 4, 2020, that it is currently reviewing comments from the public requesting that this list of factors be expanded.

Categories 3, 4 and 5 above relate to the financial impact to the employee directly and do not include the financial impact related to a spouse's or dependent's employment. For example, an employee is not a "qualified individual" by reason of his or her spouse being furloughed by the spouse's employer. Category 5 also does not include the circumstance where an employer has reduced employee pay but not reduced employee work hours. For employers that have not furloughed or laid off employees, or reduced work hours for employees, their employees will likely only be qualified individuals to the extent that either they or their spouse or dependent has been diagnosed with the virus SARS-CoV-2 or with COVID-19. This is an important consideration when determining whether to add this type of distribution to an employer's retirement plan.

The plan administrator can rely on employee self-certification that he or she is a qualified individual, unless the administrator has actual knowledge to the contrary. However, IRS FAQs issued on May 4, 2020, reiterate that the individual can only treat the distribution as a CRD on his or her tax return if the individual actually meets the eligibility requirements.

Employer Considerations

Many retirement plan vendors took immediate action following enactment of the CARES Act legislation to prepare their systems for administration of CRDs across all eligible retirement plans. Some vendors implemented an "opt-out" approach for the plans they administer, while others implemented a more conservative "opt-in" approach. Accordingly, it is possible that CRDs were permitted in operation from a retirement plan before a plan sponsor had time to consider whether to adopt this optional provision. The vendors' expedited implementation was in response to the anticipated demand by participants for access to retirement funds. However, while employers are not required to actually amend their retirement plans until the end of the plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans) to provide for CRDs, it is still important that an employer go through the plan's normal plan amendment processes in determining whether or not to permit CRDs under the plan. An employer that initially chooses to "opt-out" of CRDs can reevaluate and opt-in at any time during 2020.

Many retirement plan vendors have established administrative processes to expedite CRD requests through their call centers and/or online, and have waived the normal fees for processing distributions. Since they can rely on participant self-certification that a participant is a qualified individual, vendors can process a CRD without any required paperwork (except in the case of ERISA plans that require spousal consent for distributions, in which case additional paperwork will be needed). Accordingly, in many cases there will be very little effective oversight as to whether the employee truly meets the criteria of a qualified individual, making this an in-service distribution option that could be exercised by potentially any employee.

In determining whether to permit CRDs, plan sponsors should consider the needs and concerns of their specific employee population. In addition, employers should evaluate the risk of retirement leakage and the potentially severe impact on "retirement readiness" if CRDs are heavily utilized by their employees. CRDs are being made easily accessible by vendors, the definition of qualified individual is fairly broad, and the amount of the distribution does not have to correspond to the actual economic loss suffered by a qualified individual. Although employees have the option to repay CRDs over a three-year period, few employees may be in a financial position to do so. Even so, taking a distribution when account balances have taken significant market losses means that repayment later (when the market is presumably higher) will never fully make the employee whole. Plan sponsors may wish to consider including education on these issues with employee communications.

Employer Compliance

The \$100,000 limit on CRDs is an individual limit across all retirement plans and IRAs. An employer is responsible for ensuring compliance with the \$100,000 limit only with respect to the retirement plans it and any employer in its controlled group maintains. An employer with multiple vendors and/or multiple plans should discuss with its vendors how this limit will be monitored in the aggregate. Employers that sponsor a retirement plan or plans and also participate in a state retirement plan should discuss with the state plan how this limit will be monitored in aggregate. Many vendors are requiring participant certifications that this limit has not been (and will not be) exceeded as part of the distribution request, which should help to demonstrate good faith in attempting to comply with this rule.

Taxation of CRDs

CRDs are exempt from the 10% early distribution tax under IRC § 72.

If a retirement plan permits CRDs, the distribution is not treated as an eligible rollover distribution, mandatory withholding does not apply, and a 402(f) special tax notice is not required. Accordingly, 10% withholding will apply, unless the participant elects out of withholding. The CRD will be reported on a Form 1099-R, even if the CRD is repaid in 2020. IRS guidance issued under KETRA provides that the Form 1099-R can reflect either distribution code 2 (early distribution, exception applies) or distribution code 1 (early distribution, no known exception) in box 7.

If a retirement plan does not permit CRDs, a qualified individual may treat a distribution as a CRD on his or her federal tax return if the distribution otherwise satisfies the requirements for a CRD. For example, a terminated employee who could elect a distribution at any time may request a distribution that qualifies as a CRD. The same is true for an employee who is permitted to take in-service distributions upon reaching age 59 ½. In these situations, although the individual may take advantage of favorable tax treatment for the distribution, the plan would report the distribution based on the type of withdrawal permitted. In most cases, this would mean the distribution would be reported as an eligible rollover distribution that is subject to 20% mandatory withholding. In addition, if the participant receives the distribution before age 59 ½, it would be reported on Form 1099-R as a distribution that is subject to the early distribution penalty. If the distribution qualifies as a CRD, the individual would be able to receive a waiver of this penalty when completing his or her income tax return.

Unless a participant elects otherwise, a CRD will be included in his or her gross income ratably over three tax years beginning with the year of distribution. Note that the retirement plan or IRA will report the entire distribution as taxable (subject to any investment in the contract) in the year of distribution. The participant is responsible for reporting the distribution in gross income on his or her income tax return using Form 8915-E.

Repayment

A participant who receives a CRD may repay all or part of the distribution in one or more contributions to any eligible retirement plan to which a rollover contribution can be made within three years of the distribution. The repayment will be treated for tax purposes as a direct rollover (or, if made to an IRA, as a trustee-to-trustee transfer) made within 60 days of distribution, such that the participant is not subject to federal income tax on the CRD. A participant who repays a CRD may need to file an amended tax return to claim a refund of any taxes attributable to the amount of the CRD included in income for that year.

The IRS stated in FAQs issued on May 4, 2020, that "it is anticipated that eligible retirement plans will accept repayments" of CRDs, but noted that plans that do not accept rollover contributions are not required to be amended to accept repayments. The FAQs do not provide a definitive answer as to whether an eligible retirement plan that permits rollovers could refuse to accept CRD repayments. We expect this question to be answered in guidance that the IRS has stated will be issued in the near future.

IRS Notice 2005-92 issued under KETRA states that a plan administrator accepting a repayment of a CRD must reasonably conclude that the repayment is eligible for rollover treatment, made within the three year repayment period, and is not in excess of the amount of the distribution. The plan administrator may rely on the reasonable representations of the individual in accepting a repayment. Qualified individuals will use Form 8915-E to report repayments made during a taxable year.

A CLOSER LOOK: LOAN INCREASES AND REPAYMENT RELIEF [\[return to the chart\]](#)

The IRS issued [frequently asked questions](#) (FAQs) addressing plan loan changes on May 4, 2020, which stated that the Treasury Department and IRS anticipate releasing guidance on these provisions in the near future. In the interim, the FAQs advise employers to refer to IRS guidance issued in Notice 2005-92 which addressed similar loan provisions under the Katrina Emergency Tax Relief Act of 2005 (KETRA), for guidance on the loan provisions.

Plan Loan Increases

Section 2202(b) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020, increases the loan limits for any loan made from a 401(a), 403(b), or governmental 457(b) plan to a qualified individual during the 180-day period beginning on the date of enactment of the Act (March 27, 2020 through September 22, 2020). The CARES Act increases the maximum loan amount to \$100,000 (currently \$50,000) and permits loans up to 100% (currently 50%) of the present value of the participant's account. For this purpose, a "qualified individual" is defined using the same criteria applicable to coronavirus-related distributions (CRDs) (see the prior Closer Look on Coronavirus-Related Distributions).

As a starting point, a plan does not have to permit loans, and there is nothing in the CARES Act that requires a plan to permit loans. Accordingly, a plan that does not already offer loans would need to be amended to permit them if it wanted to take advantage of these increased loan limits. A plan that is adding the increased loan limit under the CARES Act must be amended to reflect that decision by the last day of the plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans). However, if a plan is being amended to add loans generally, that amendment must be adopted by the end of the plan year in which loans are first permitted. In either case, it is important that an employer go through the plan's normal plan amendment processes in determining whether to permit loans (or loan increases) under the plan.

Even if a plan already permits loans, it does not have to permit loans in the maximum amount permitted by law, nor with respect to all money sources under the plan. Again, there is nothing in the CARES Act that requires a plan sponsor to expand its current loan limits or the money sources from which loans can be made. Accordingly, if a plan sponsor adopts the temporary loan increase under the CARES Act, the increase does not alter any of the loan restrictions that may otherwise be in effect under the plan's loan policy. For example, if a plan limits participants to one outstanding loan at a time, then a participant with an outstanding loan may not apply for a new loan with a higher maximum until the outstanding loan is fully repaid. Similarly, if a plan restricts loans to employee contribution sources only, the increased loan maximum will not change the sources from which the loan may be funded (although it may increase the amount that may be taken from permitted money sources). An employer would need to revise its loan policy if it wanted to make these types of changes.

Note also that if a participant has previously defaulted on a plan loan and has not repaid that defaulted loan to the plan, the participant is not eligible for another loan in any event, unless the plan sponsor permits loan repayment through payroll reduction. Additionally, ERISA plans may require spousal consent before a loan can be granted.

A participant must be a "qualified individual" to take advantage of the increased loan maximum. Unlike the statutory language establishing CRDs, the CARES Act does not contain a provision allowing the plan administrator to rely on an employee's certification that he or she is a qualified individual. In practice, however, vendors are administering this provision based on individual self-certification. This approach is consistent with IRS Notice 2005-92 which provided guidance on similar loan provisions under KETRA. In this guidance, the IRS provided that a plan administrator is permitted to rely on a participant's reasonable representations that such participant is a qualified individual, unless the administrator has actual knowledge to the contrary.

Delayed Loan Repayments

The CARES Act also extends the repayment dates for a qualified individual with an outstanding loan on or after the date of enactment of the Act under a retirement plan. If the due date for any loan repayment occurs during the period from March 27, 2020 through December 31, 2020, the due date for the repayment is delayed by one year. Any subsequent repayments of the loan are required to be adjusted to reflect the delayed due date and any interest accruing during such delay, and the period of the delay is disregarded for purposes of determining compliance with the five-year term limit and the amortization rules.

Only "qualified individuals" are eligible for this loan relief. The term "qualified individual" is defined using the same criteria applicable to CRDs and for the increase in loan maximums.

On its face, this provision appears to be mandatory. However, the IRS stated in its May 4, 2020 FAQs that this provision is optional, consistent with its interpretation of similar provisions under KETRA. A plan that is permitting loan suspensions under the CARES Act must be amended to reflect that decision by the last day of the plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans). If adopted, suspension will not apply automatically. Since the suspension is only available to qualified individuals, participants with an existing loan cannot have their loan repayments suspended unless they first self-certify that they are a qualified individual.

Resumption of Loan Repayments

We do not yet have guidance on how a loan should be re-amortized and when repayments must resume once the one-year delay of payments due between March 27, 2020 and December 31, 2020 ends. However, IRS FAQs issued on May 4, 2020, refer to Notice 2005-92 for guidance on this question. Notice 2005-92 set forth a safe harbor for satisfying similar loan suspension provisions that was part of KETRA, under which a participant was required to resume loan payments upon the end of the suspension period, and the term of the loan was extended by the term of the suspension period. The payments were adjusted to reflect accrued interest and were required to be paid in substantially level installments over the remaining period of the loan, determined by adding the suspension period to the original loan period.

Automatic Loan Relief to All Taxpayers Under Notice 2020-23

Separately, and unrelated to the CARES Act provisions that provide loan relief to qualified individuals, the IRS extended deadlines of "time-sensitive actions" under Notice 2020-23 to all taxpayers. This includes any loan repayment to a plan that is due on or after April 1, 2020 and before July 15, 2020. The delayed due date is July 15, 2020. This applies regardless of whether the taxpayer is a qualified individual and regardless of whether the plan has adopted the loan relief otherwise available under the CARES Act.

If a participant delays his or her loan payment during this period (including by asking the employer to suspend payroll deduction of a loan being paid by payroll deduction), the plan may not treat a loan as in default due to the missed payment. Pursuant to Notice 2020-23, the period from the actual due date until July 15, 2020 must be disregarded in the calculation of interest, so interest should not accrue as a result of suspension of these payments. Note that the waiver of interest should also apply to any employee who suspends loan repayments under the CARES Act provision, for the period of the extension under Notice 2020-23 (*i.e.*, through July 15, 2020), notwithstanding the CARES Act language that otherwise requires interest to accrue during the suspension period.

Given current projections regarding the pandemic, it is possible that the IRS may issue subsequent guidance to extend this deadline further.

A CLOSER LOOK: SUSPENSION OF REQUIRED MINIMUM DISTRIBUTIONS

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Section 2203 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020, waives required minimum distributions (RMDs) for defined contribution plans and IRAs for calendar year 2020. This provision recognizes that current participant account balances are generally significantly lower than the December 31, 2019 balances used in the RMD calculations. As a result, the 2020 RMDs are likely to be overstated, and require participants to take taxable distributions that lock in losses at a time when the value of their investments are low.

The waiver applies to:

- any RMD required to be paid in 2020; and
- 2019 RMDs that are required to be made by April 1, 2020 (if not already made in 2019).

For purposes of determining RMDs after 2020, an individual's required beginning date is determined without regard to this 2020 waiver.

Types of Plans

This provision applies to:

- Defined contribution 401(a) plans (including 401(k) plans);
- 403(b) plans;
- Governmental 457(b) plans; and
- IRAs.

It does not apply to qualified defined benefit plans or to 457(b) plans sponsored by tax-exempt employers.

Implementation Options

Plan sponsors that are subject to the RMD waiver may choose to:

- Suspend payment of 2020 RMDs unless the participant elects to receive payment;
- Continue payment of 2020 RMDs unless the participant elects to suspend payment; or
- Take the first approach with respect to all participants except those who are receiving their RMD as part of scheduled installment payments, in which case take the second approach.

However, not all retirement plan vendors are giving plan sponsors a choice as to how to implement the RMD waiver. Rather, some vendors have made decisions as to when they will suspend and when they will continue RMD payments, and plan sponsors cannot deviate from those decisions. Accordingly, plans with multiple vendors may in actual operation be implementing the RMD waiver in different ways. Plans must be amended to reflect the RMD waiver rules that applied under the plan by the last day of the plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans).

If a participant receives a withdrawal in 2020 that would otherwise be a RMD, he or she may be able to roll over the amount to an eligible retirement plan. The IRS permitted such rollovers and extended the 60 day rollover period in addressing a similar RMD suspension in 2009 under the Worker, Retiree, and Employer Recovery Act of 2008 (WRERA) in Notice 2009-82. The IRS may issue similar guidance under the CARES Act.

Taxation

If an eligible rollover distribution paid in 2020 would have been a RMD for 2020 but for the waiver, the distribution is not subject to the direct rollover rules, 20% mandatory withholding requirement, or the 402(f) notice. Accordingly, 10% withholding will apply, unless the participant elects out of withholding.

Death Beneficiaries

The CARES Act suspends the requirement to pay all RMDs that would otherwise be required to be paid in 2020 with respect to defined contribution plans. For beneficiaries, this means that no beneficiary who is receiving annual RMD payments from an eligible retirement plan is required to receive a 2020 RMD by December 31, 2020. Employers may choose to address 2020 RMD payments to beneficiaries in the same manner they have chosen to handle payments to participants, which may differ based on their withdrawal type.

Some beneficiaries are governed by the five-year rule and are not required to receive annual RMD payments under the life expectancy rule. This would apply to non-individual beneficiaries (such as a trust or charity) when the participant dies before his or her required beginning date. In this situation, the entire account balance is required to be paid out by December 31 of the fifth calendar year following the year of the participant's death (and no amount of the account is required to be paid before that time). The CARES Act provides that calendar year 2020 is disregarded for purposes of applying the five-year rule. Therefore, these beneficiaries have the option to not take a distribution of their account in 2020 if their five-year period would otherwise end in 2020, and/or to disregard calendar year 2020 when determining their five-year period.

Note that in all cases, a beneficiary is not required to receive a RMD in the year of death. So for plan participants who die in calendar year 2020, RMD requirements will not apply to their beneficiaries in 2020, and the earliest payment date would be 2021. The beneficiary RMDs due in 2021 that relate to 2020 deaths are not impacted by the CARES Act.

Any RMD payments made to beneficiaries in 2020 are subject to 10% tax withholding, unless the beneficiary elects out of withholding.

A CLOSER LOOK: MANDATORY COVERAGE OF COVID-19 TESTING

[\[return to the chart\]](#)

Background

The Families First Coronavirus Response Act (FFCRA) became law on March 18, 2020, and requires health plans to provide coverage—*without any cost-sharing, prior authorization, or other medical management requirements*—for *in vitro* diagnostic products and services related to diagnosing COVID-19.

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) became law on March 27, 2020, and made a number of changes for health plans in relation to the COVID-19 pandemic, including expanding the requirement to cover COVID-19 diagnostic testing, clarifying the prices plans are required to pay for COVID-19 diagnostic testing, requiring coverage of COVID-19 preventive treatment within 15 days of an administrative recommendation, and adding a temporary safe harbor for HDHPs to cover telehealth services.

On April 11, 2020, the U.S. Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") jointly released [frequently asked questions](#) (FAQs) regarding the implementation of the health coverage provisions of the FFCRA and the CARES Act.

We expect the Departments to issue additional guidance implementing the FFCRA and CARES Act in the future.

Coverage Mandate Applies Broadly to Almost All Plans

The requirement under the FFCRA and the CARES Act to provide coverage—*without any cost-sharing, prior authorization, or other medical management requirements*—for *in vitro* diagnostic products and services related to diagnosing COVID-19 ("Coverage Mandate") applies to a wide variety of group health plans and health insurance issuers. Except as specifically excluded below, the Coverage Mandate applies to:

- All group health plans (including grandfathered health plans); and
- All health insurers of individual or group health insurance policies.

This includes:

- Both self-funded and fully-insured group health plans;
- Group health plans sponsored by private companies (ERISA plans);
- Group health plans sponsored by non-federal governmental entities;
- Group health plans sponsored by religious employers (church plans);
- Coverage offered in the individual market through or outside of an Exchange; and
- Student health insurance coverage.

The provision does not apply to:

- Short-term limited duration insurance;
- Excepted benefits (these include benefits such as on-site medical clinics, limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home healthcare, community-based care, and many EAPs); and
- Retiree-only group health plans.

Compliance with the Coverage Mandate will not cause a grandfathered plan to lose its grandfathered status.

So-called "excepted benefits" are exempt from a number of laws that normally apply to health plans, including

many provisions of the ACA and HIPAA portability standards. EAPs are excepted benefits as long as they, among other things, do not provide significant benefits in the nature of medical care. The FAQs clarify that EAPs will not be considered to provide such benefits solely because they offer benefits for the diagnosis and testing for COVID-19 during the public health emergency. In addition, on-site medical clinics are also considered to be excepted benefits, and the FAQs confirm they will not lose that status simply by providing benefits for the diagnosis and testing for COVID-19. This means that employers may, but are not required to, provide these services through an EAP or an on-site clinic for employees who are not covered under the employer's group health plan.

Coverage Mandate Requires Coverage for Items Furnished On and After March 18

The Coverage Mandate requires coverage for items and services that were furnished on or after March 18, 2020. The Coverage Mandate continues to apply for the duration of the COVID-19 public health emergency. Unless it is extended or terminated early, the current COVID-19 public health emergency is set to expire on July 25, 2020.

Items and Services that Must Be Covered

The Coverage Mandate requires coverage (*without any cost-sharing, prior authorization, or other medical management requirements*) for FDA-approved *in vitro* diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of these products. This includes diagnostic tests that:

- The test developer has requested, or intends to request, emergency use authorization for under the Food, Drug, and Cosmetic Act;
- Are developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or
- HHS otherwise has approved in guidance.

The FAQs made clear that a required "*in vitro* diagnostic test" includes a serological test for COVID-19. Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19. The Food and Drug Administration does not currently believe they should be the sole basis for diagnosis.

In addition to coverage for COVID-19 testing as just described, the Coverage Mandate also requires coverage (*without any cost-sharing, prior authorization, or other medical management requirements*) for items and services furnished during a visit to a provider's office (including via telehealth), urgent care, or an emergency room that results in an order for or administration of an *in vitro* diagnostic product described above, but only to the extent the item or service relates to: (1) the furnishing or administration of the diagnostic product, or (2) the evaluation of the individual to determine need for the diagnostic product. This requirement can include a test (such as an influenza test or a blood test) that is not an *in vitro* diagnostic test if the provider determines that it should be performed to determine whether COVID-19 diagnostic testing is necessary, and if the visit results in an order for, or administration of, COVID-19 diagnostic testing. The FAQs provide the following example:

Therefore, for example, if the individual's attending provider determines that other tests (*e.g.*, influenza tests, blood tests, etc.) should be performed during a visit (which term here includes in-person visits and telehealth visits) to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage for the related tests under Section 6001(a) of the FFCRA. This coverage must be provided without cost-sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

While it remains unclear, it appears that a plan would not have to cover these additional items or services if a plan participant is given a presumptive COVID-19 diagnosis and an actual COVID-19 test is not ordered. Future guidance may clarify this point. Employers may wish to automatically provide these services upon a presumptive

COVID-19 diagnosis without cost-sharing or other requirements.

Most health plans and insurers likely already cover the services needed for testing COVID-19, but now they must do so without any cost-sharing or medical management requirements. Prohibited cost-sharing includes deductibles, copayments, and coinsurance. Although most plans and insurers cover the treatment of COVID-19 (through coverage of hospitalizations and other services), neither the FFCRA nor the CARES Act require that plans cover the treatment of COVID-19 without cost-sharing, prior authorization, or medical management.

Effects on HDHPs and HSA Eligibility

Pursuant to Notice 2020-15, released March 11, 2020, the IRS has ruled that HDHPs may provide health benefits associated with testing for and treatment of COVID-19 without a deductible. As a result, individuals who are covered under HDHPs that are required to cover COVID-19 testing under the FFCRA without cost-sharing will remain eligible to make contributions to an HSA. Notice 2020-15 did not provide for a specific expiration date for this relief.

Pricing of Coverage of Testing for COVID-19

The CARES Act clarified the prices that group health plans and issuers are required to pay for diagnostic tests for which coverage has been mandated. Plans that had applicable negotiated rates in effect before the COVID-19 public health emergency (*i.e.*, prior to January 27, 2020) will pay that negotiated rate. Otherwise, plans will pay the cash price for the service listed by the provider on a public website, unless the plan or issuer can negotiate a lower rate.

The CARES Act requires that providers of diagnostic tests for COVID-19 publicize, during the COVID-19 public health emergency, the cash price for their diagnostic test on a public website. The CARES Act imposes penalties of up to \$300 per day on any provider of a diagnostic test for COVID-19 that fails to publicize its price as required.

The FAQs clarify that the Coverage Mandate applies to tests and services provided by out-of-network providers. Thus, plans must reimburse out-of-network providers any negotiated rate in effect before the COVID-19 public health emergency, or otherwise the cash price for the service listed on the provider's public website.

A "Visit" Includes Both Traditional and Non-Traditional Care Settings

The Coverage Mandate requires coverage of "items and services furnished during a visit to a provider's office (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits." According to the FAQs, the Departments construe the term "visit" broadly to include both traditional and non-traditional care settings. This means the Coverage Mandate applies to drive-through screening and testing sites, among others.

Non-Enforcement Policy for SBC Advanced Notice Requirement

Section 2715 of the Public Health Service Act (PHSA), as added by the Affordable Care Act, requires plans to provide a Summary of Benefits and Coverage (SBC), including an updated SBC or notice if the plan makes a material modification in any of the terms that would affect the content of the SBC. Notice is required within 60 days prior to the date the modification becomes effective.

The FAQs clarify that the Departments "will not take enforcement action against any plan or issuer" that makes a coverage modification "to provide greater coverage related to the diagnosis and/or treatment of COVID-19," even if the plan/issuer does so without providing at least 60 days' advance notice. This non-enforcement policy also applies to plans and issuers that change coverage to provide telehealth and other remote care services.

Both non-enforcement policies apply to changes made during the public health emergency or national emergency declaration related to COVID-19. They cease to apply once the emergency declarations expire.

Importantly, plans and issuers must still provide notice of their coverage changes "as soon as reasonably practicable." In addition, the Departments will continue to take enforcement action against any attempts to limit or

eliminate benefits or increase cost-sharing to offset the expense of the Coverage Mandate.

States May Impose Additional Requirements

State laws may go further and require more expansive coverage of COVID-19 testing and treatment as long as the state requirements do not prevent the application of a federal requirement, and as long as the requirements are not preempted by ERISA, which is generally applicable to self-funded group health plans not affiliated with a governmental or a religious entity.

A CLOSER LOOK: OTHER CARES ACT PROVISIONS AFFECTING HEALTH PLANS

[\[return to the chart\]](#)

Background

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) became law on March 27, 2020, and made a number of changes for health plans in relation to the COVID-19 pandemic, including expanding the requirement to cover COVID-19 diagnostic testing (discussed separately), requiring coverage of COVID-19 preventive treatment within 15 days of an administrative recommendation, and adding a temporary safe harbor for high deductible health plans (HDHPs) to cover telehealth services. The CARES Act also expands the categories of medical expenses that are eligible for reimbursement for account-based medical plans.

On April 11, 2020, the U.S. Departments of Labor, Health and Human Services, and the Treasury (together, Departments) jointly released [frequently asked questions](#) (FAQs) regarding the implementation of the health coverage provisions of the Families First Coronavirus Response Act (FFCRA) and the CARES Act.

15-Business-Day Coverage Window for New Preventive Services

Group health plans that are not grandfathered under the Patient Protection and Affordable Care Act (ACA) are obligated to cover both evidence-based items and services with ratings of "A" or "B" and immunizations with recommendations from the Advisory Committee on Immunization Practices. The ACA added this requirement to Section 2713 of the Public Health Service Act. Under the ACA, plans normally have a year or more to implement newly recommended preventive services.

The CARES Act directs the Departments to require group health plans and issuers of group and individual policies to cover any "qualifying coronavirus preventive service" without cost-sharing. A "qualifying coronavirus preventive service" includes an item, service, or immunization intended to prevent or mitigate the coronavirus disease and that is:

- An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force; or
- An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

The effect of the new requirement is to clarify that health plans must cover these services within 15 business days (not one year or longer as with other preventive services under the ACA) after the date a recommendation is made if the services are intended to prevent or mitigate coronavirus. This means that health plans must stay alert and informed throughout the COVID-19 public health emergency, as preventive services can be expected to receive approval on a rolling basis as new evidence emerges.

The ACA regulations permit a plan that has a network of providers to limit first dollar coverage of preventive services to in-network coverage only. This rule should apply to coverage of qualifying coronavirus preventive services as well, unless the circumstances are such that obtaining coverage for these services is so difficult that limiting the coverage to in-network providers creates access issues. We believe that specific guidance would be necessary to specifically extend this coverage out-of-network.

Promotion of Telehealth

The FAQs include a strong emphasis on telehealth. The Departments noted that, by using telehealth, "patients are able to seek treatment from a healthcare professional in their home, without having to go to a medical office or hospital, helping minimize the risk of exposure to and community spread of COVID-19." The Departments strongly

urge plans to promote the use of telehealth and other remote care services by "ensuring access to a robust suite of telehealth and other remote care services, including mental health and substance abuse disorder services, and by covering telehealth and other remote care services without cost-sharing or other medical management requirements."

Employers should use caution if they consider implementing a full-scale telehealth program for all employees outside of their group health plan. Such a program could be subject to the full range of requirements under ERISA, the ACA, and other employee benefit laws.

Temporary Safe Harbor for HDHP Coverage of Telehealth and Remote Services

Individuals who contribute to health savings accounts (HSAs) must be covered by an HDHP and cannot be covered by any plan that is not an HDHP and that also covers any benefit covered by the HDHP. A plan is not an HDHP if it provides coverage for services without a high deductible, with specified exceptions including preventive care. This would normally prevent an HDHP from paying for telehealth services prior to the time an individual satisfies the plan's deductible.

The CARES Act provides a temporary safe harbor for HDHPs to cover "telehealth and other remote care services" without a deductible. The relief applies March 27, 2020, and extends through plan years that begin on or before December 31, 2021. Telehealth visits do not have to be connected with COVID-19 to be eligible for this relief. This change is statutory and follows sub-regulatory guidance from the Internal Revenue Service in Notice 2020-15 that allowed testing and treatment for COVID-19 to be covered under HDHPs without a deductible.

Accordingly, beginning March 27, 2020, participants covered by an HDHP that provides first-dollar coverage for telehealth and remote care services will not lose their eligibility to contribute to HSAs through plan years beginning on or before December 31, 2021.

Expansion of Qualified Medical Care for HSAs, FSAs, HRAs, and Archer MSAs

The CARES Act expands the types of medical care individuals may purchase with funds from HSAs, FSAs, HRAs, and Archer medical savings accounts to include (1) menstrual care products and (2) over-the-counter medicines and drugs. These changes are effective for expenses incurred and for amounts paid after 2019. The CARES Act does not contain an expiration date for this change, so it appears to be permanent.

Funds in these account-based plans may be used only for "qualified medical expenses," which include amounts paid for medical care under IRC § 213(d). Prior to the CARES Act, "qualified medical expenses" included amounts paid for medicines or drugs only if the medicine or drug was prescribed or was insulin. The CARES Act eliminates the requirement that the medicine or drug be prescribed. This reverses a restriction imposed by the ACA and once again allows over-the-counter medicines and drugs to be reimbursed from these account-based plans.

The CARES Act also clarifies that "qualified medical expenses" include "menstrual care products," which include tampons, pads, liners, cups, sponges, and similar products used for similar purposes.

Most employers will need to amend their FSA and HRA plan documents to allow for the reimbursement of these expenses. Many plan documents specifically excluded over-the-counter drugs (and never included menstrual products) from the definition of medical expenses eligible to be reimbursed under FSAs and HRAs. Those specific exclusions will need to be removed.

Although the effective date of this provision is January 1, 2020, FSAs may only be amended prospectively, thus it appears that over-the-counter medicines and drugs and menstrual products may not be eligible for reimbursement from FSAs until plan documents are amended to include them in eligible medical expenses.

This expansion allowing coverage of over-the-counter medicine and drugs and menstrual products does not trigger an election change under an FSA allowing an individual to increase an elected contribution to an FSA. The rules under IRC § 125 allowing election changes when coverage is increased under a qualified benefit do not

apply to FSAs. On the other hand, those rules do allow prospective election changes to HSAs at any point in the plan year. As a result, HSA participants may wish to increase HSA contributions in response to this expanded coverage.

A CLOSER LOOK: EMPLOYER-PROVIDED STUDENT LOAN REPAYMENTS

[\[return to the chart\]](#)

Section 2206 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020, expands tax-free education assistance programs that employers may offer their employees to include student loan repayments. This allows employers to provide a tax-free student loan repayment benefit of up to \$5,250 in 2020. This provision is only effective from March 27, 2020 through December 31, 2020.

Education Assistance Programs

Education assistance programs are permitted under IRC § 127. They allow employers to provide tax-free education assistance to their employees in amounts of up to \$5,250 per year. To meet the requirements of IRC § 127, the program must be set forth in writing, communicated to all eligible employees, and offered to employees on a basis that does not discriminate in favor of highly compensated employees. Employees eligible for the program cannot be given a choice between receiving the educational assistance benefits or taxable compensation.

Prior to the CARES Act, “educational assistance” was defined to include payment of expenses incurred by the employee for education of the employee, such as tuition, fees, books, and supplies. The CARES Act temporarily expands the definition of educational assistance to include payments on the principal or interest of any qualified student loan debt incurred by the employee for the education of the employee. This includes student loan debt incurred by the employee for his or her own higher education expenses, but does not include any student debt incurred by the employee related to the education of a spouse or dependent.

An employer that offers an education assistance program may make student loan repayments to the employee or directly to the lender. These payments are excluded from the gross income of the employee, provided all educational assistance benefits do not exceed \$5,250. Student loan repayments after 2020 are not eligible to be covered.

Federal Student Debt Payment Relief

Apart from the benefits provided under education assistance programs, Section 3513 of the CARES Act temporarily suspends payments on federal student loans through September 30, 2020. The provision also suspends accrual of interest on such loans during this period. Federal student loan borrowers may continue to make payments on principal during the suspension, but it is not required. Importantly, borrowers do not need to make payments during this period to continue to qualify under existing loan forgiveness programs or loan rehabilitation programs. For purposes of these programs, the loan payments will be treated as if they are made each month. Additionally, loan payments will be treated as if they are made each month for purposes of reporting loan information to a consumer reporting agency. Lastly, all collection efforts related to federal student loan debts are suspended through September 30, 2020. This means that wage garnishments and reductions to tax refunds and Social Security benefits on account of defaulted loans will be suspended for this period.

Employer Considerations

Employers may adopt education assistance programs to provide this benefit to employees. Employers that already offer education assistance programs may revise them to include student loan repayments through December 31, 2020. While payments on federal student loans will not be required through September 30, 2020, the federal relief does not apply to private student loans and does not result in loan forgiveness (for those not enrolled in loan forgiveness programs). Therefore, assistance with continued payments may help employees who are financially impacted by COVID-19 stay on track with their loan repayment schedule.

A CLOSER LOOK: EXTENDED DEADLINES

[\[return to the chart\]](#)

This Closer Look includes a summary of guidance we have received as of the date of publication that allows for deadline extensions applicable to employee benefit plans, or otherwise requires employee benefit plans to disregard periods related to the COVID-19 national emergency when determining applicable timeframes.

BACKGROUND

On March 13, 2020, President Trump declared a national emergency related to COVID-19 and separately determined that, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a national emergency existed beginning March 1, 2020.

IRC § 7508A and ERISA § 518 authorize the Secretaries of the Treasury and Labor, respectively, to postpone by up to one year the application of any deadline under the Internal Revenue Code or ERISA in the case of a federally declared disaster or a terroristic or military action. The relief granted by the regulatory agencies to employee benefit plans and participants as described below is pursuant to this authority.

IRS NOTICE 2020-23

On April 9, 2020, the Internal Revenue Service (IRS) issued [Notice 2020-23](#) to extend deadlines for numerous "time-sensitive actions" due to be performed on or after April 1, 2020 and before July 15, 2020. Under authority pursuant to IRC § 7508A, the Secretary of the Treasury determined that any person (defined to include any individual, trust, estate, partnership, association, company, and corporation) with a specified time-sensitive action due to be performed during the time period of April 1, 2020 to July 15, 2020 is affected by the COVID-19 emergency, and is therefore eligible for the relief described in Notice 2020-23.

The relief automatically postpones until July 15 the deadline for any of the time-sensitive actions outlined below that were due to be performed on or after April 1, 2020 and before July 15, 2020.

Time-Sensitive Actions

Notice 2020-23 extends relief to two classes of "time-sensitive actions" described in other IRS guidance. The first class relates to certain court deadlines related to tax claims. The second class incorporates the time-sensitive actions listed in Revenue Procedure 2018-58, an extensive document that lists the acts that the IRS may postpone in the event of a federally declared disaster.

Revenue Procedure 2018-58 specifically identifies 44 different employee benefits time-sensitive actions the IRS may postpone in the event of a federally declared disaster. Listed here are several (but not all) of the time-sensitive actions postponed until July 15, 2020 under Notice 2020-23 for employee benefit plans:

- Loan repayments to qualified employer plans;
- Contributions to IRAs to be considered contributed in the prior taxable year;
- Furnishing IRA contribution information to the owner and filing Form 5498 with the IRS;
- Furnishing HSA contribution information to the beneficiary and filing Form 5498-SA with the IRS;
- Year-end forfeiture of unused amounts elected under a cafeteria plan;
- Elections by a qualified participant in an ESOP to direct the plan's investment of at least 25% of his or her account;
- Distribution of excess deferrals and related income and excess aggregate contributions and related income;
- 60-day rollovers of eligible rollover distributions to eligible retirement plans, including IRAs;
- Rollovers of qualified plan loan offsets to eligible retirement plans;

- An ESOP's distribution of dividends on stock of a C corporation to participants and beneficiaries;
- Elections of permissible withdrawals from an eligible automatic contribution arrangement;
- Distribution of nondeductible contributions to a qualified employer plan to avoid a 10% tax;
- Distribution of excess contributions to an IRA or certain other tax-favored accounts to avoid a 6% tax;
- Filing Form 5500, Form 5500-SF, Form 5500-EZ, and Form 8955-SSA; and
- Correction periods for self-correction of operational failures under the Employee Plans Compliance Resolution System (EPCRS).

Interest and Penalties Suspended

As a result of the postponement of the deadline for time-sensitive actions, the period beginning on April 1, 2020, and ending on July 15, 2020, will be disregarded in the calculation of any interest, penalty, or addition to tax for failure to file the specified forms or to pay the specified payments postponed by Notice 2020-23.

Relief for Participants

Several of the time-sensitive actions outlined above provide relief to plan sponsors and administrators of retirement plans and welfare benefit plans. Plan sponsors and administrators should be aware of this relief to understand when they have additional time to complete certain plan actions and related tax filings.

Notice 2020-23 also provides specific relief to participants. Plan administrators should be prepared to respond to participant requests for eligible relief and to process otherwise "late" actions that are permitted by this guidance. This includes:

- Requests to suspend loan payments until July 15, 2020. This is an optional decision for the participant that applies regardless of whether the participant qualifies for the loan relief provided under the CARES Act, and regardless of whether the plan has adopted the CARES Act loan provisions. If a participant chooses to delay his or her payment during this period, the plan must suspend payments by payroll deduction (if applicable) and may not treat the loan as in default due to the missed payments. In addition, interest should not accrue during the suspension of payments. The suspension of interest accrual would appear to apply equally to qualified individuals who elect to suspend their loan payments under the CARES Act relief, through July 15, 2020.
- Requests to complete rollover contributions after the 60-day deadline. Individuals whose 60-day deadline to complete a rollover contribution expires on or after April 1, 2020 and before July 15, 2020 will have until July 15, 2020 to complete the rollover.
- Cafeteria plan extensions for non-calendar year plans. A cafeteria plan with a plan year beginning on April 1, May 1, June 1, or July 1 can allow employees to make new elections until July 15, 2020, even in the absence of a change in status event. In addition, FSA participants should be permitted until July 15, 2020 to incur qualified medical expenses without forfeiture if the plan year ends during this period. New hires during this period may have until July 15, 2020 to make elections.
- IRA contributions. Employers that sponsor deemed IRA programs in their plans can accept IRA contributions designated for the 2019 plan year through July 15, 2020.

IRS AND EBSA JOINT NOTICE

On May 4, 2020, the Employee Benefits Security Administration (EBSA) in the Department of Labor (DOL) and the IRS filed a [Joint Notice](#) to extend numerous deadlines applicable to retirement and health plans subject to ERISA and the Internal Revenue Code. The Department of Health and Human Services (HHS), which has jurisdiction over non-federal governmental health plans and insurance issuers, concurred in the relief provided by the Joint Notice. HHS intends to offer similar relief for governmental plans and encourages governmental plans, states, and issuers to act in a manner consistent with the Joint Notice.

Applicable Plans

The Joint Notice encompasses all of the following plans:

- Group health plans;
- Disability plans;
- Other employee welfare benefit plans; and
- Employee pension benefit plans (both defined contribution and defined benefit plans).

Overview of Relief Provided

The Joint Notice requires applicable plans to disregard the period beginning March 1, 2020 and ending 60 days after the COVID-19 national emergency terminates (referred to as the "Outbreak Period") in determining deadlines for:

- Enrolling in the plan upon a special enrollment event;
- Electing COBRA continuation coverage;
- Making COBRA premium payments;
- Notifying the plan of a COBRA qualifying event or determination of disability;
- Filing an initial benefit claim;
- Filing an appeal of an adverse benefit determination; and
- Requesting an external review after receipt of a final adverse benefit determination (and perfecting such request).

In addition, with respect to group health plans and their sponsors and administrators, the Outbreak Period is disregarded when determining the date for providing a COBRA election notice.

To the extent there are different Outbreak Period end dates for different parts of the country, EBSA and the IRS will issue additional guidance regarding the application of this relief.

Special Enrollment Periods

General Rule. ERISA § 701(f) and IRC § 9801(f) specify various events that qualify an individual for a mid-year special enrollment period under a health plan, including loss of other coverage, termination of Medicaid or CHIP coverage, and having or becoming a new dependent. Qualifying individuals may request enrollment within 30 days or 60 days, as applicable, of the qualifying event.

Example. Employee does not participate in Employer's group health plan. Employee gives birth on March 31, 2020 and would like to enroll herself and the child in Employer's plan. Assume the Outbreak Period ends on July 28, 2020. Employee may exercise her special enrollment rights until 30 days after July 28, 2020, or by August 27, 2020.

Implications. In the example above, the plan must permit the employee to elect coverage for herself and her child retroactively to the date of birth, provided that all required premiums are paid by August 27, 2020. For special enrollment events that are not related to the birth or adoption of a child, such as special enrollment due to a loss of other coverage, an employee is entitled to elect coverage that is effective no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment. In that case, the employee's extended enrollment right would not provide the employee with retroactive coverage.

Individuals whose special enrollment event occurred as early as February 2020 (or January 2020 in the case of a Medicaid or CHIP special enrollment event) may still have additional time to enroll in coverage, after disregarding the Outbreak Period. If an employee was previously denied enrollment due to missing a deadline that has been extended by the Joint Notice, the employee must be notified of his or her additional time to enroll and when such coverage will be effective. In addition, all employees should be notified of this extension since some employees may have failed to come forward because they assumed that they missed their opportunity to enroll under the

plan's existing terms.

COBRA Election Periods

General Rule. ERISA § 605 and IRC § 4980B(f)(5) require that group health plans allow qualified beneficiaries to elect continuation coverage within an "election period," which begins by the date coverage terminates due to the qualifying event, is at least 60 days long, and ends, generally, at least 60 days after the date coverage terminates.

Example. Employee's hours are reduced due to COVID-19. Employee becomes ineligible for Employer's group health plan as of April 1, 2020. Employer provides Employee a COBRA election notice on April 1, 2020. Assume the Outbreak Period ends on July 28, 2020. Employee may elect COBRA coverage within 60 days of July 28, 2020, or by September 26, 2020. If COBRA coverage is elected and premiums are timely paid by the qualified beneficiary, the COBRA coverage will be retroactive to April 1, 2020.

Considerations. Individuals who received a COBRA election notice as early as January 2020 may still have additional time to elect COBRA coverage, after disregarding the Outbreak Period. If an employee (including a former employee) was previously denied COBRA coverage due to missing a deadline that has been extended by the Joint Notice, the employee must be notified of his or her additional time to elect COBRA.

COBRA Premium Payment Deadlines

General Rule. ERISA § 606(2)(C) and (3) and IRC § 4980B(f)(2)(B)(iii) and (C) require, generally, that premiums for COBRA coverage be paid within 30 days of the date due.

Example. Former Employee elected COBRA coverage on January 1, 2020. Premiums are due by the first of the month, and no later than the statutory 30-day grace period. Beginning in March, Former Employee fails to pay the premium every month during the Outbreak Period. Assume the Outbreak Period ends on July 28, 2020. As of August 1, 2020, Former Employee has made no premium payments during the Outbreak Period.

Premiums for March through July that are paid within 30 days after July 28, 2020, or by August 27, 2020, are timely. Former Employee is entitled to COBRA coverage for all of these months if he makes payment. The premium for August is due by August 31, 2020 (the 30-day grace period applicable to August's payment).

If Former Employee pays only two months' premiums by August 27, 2020, he is entitled to COBRA for March and April only and the plan is entitled to cancel his COBRA coverage as of May 1, 2020.

Considerations. Individuals whose COBRA continuation coverage was previously terminated due to a failure to timely pay premiums may need to have their coverage reinstated to the extent that payments are not treated late after disregarding the Outbreak Period. Plan sponsors should confirm with their COBRA administrators that COBRA terminations are not occurring due to a failure to receive timely payment during the Outbreak Period and that processes are in place to process and pay claims if payment is received at the end of the Outbreak Period.

COBRA Notice of Qualifying Event

General Rule. ERISA § 606(a)(3) and IRC § 4980B(f)(6)(C) require that each covered employee or qualified beneficiary notify the plan administrator of certain qualifying events (divorce, loss of dependent status, and being determined to be disabled by Social Security) generally within 60 days of the date of the qualifying event.

Example. Employee and Spouse divorce on April 1, 2020. Normally, Spouse has 60 days to notify the plan administrator of the divorce in order to claim a right to COBRA continuation coverage. Assume the Outbreak Period ends on July 28, 2020. Spouse must notify the plan administrator of the divorce within 60 days of July 28, 2020, or by September 26, 2020.

Considerations. Individuals who experienced a COBRA qualifying event as early as January 2020 may have additional time to notify the plan administrator of the qualifying event in order to elect COBRA continuation coverage. Because the plan administrator may not be aware of the potential employees impacted, all employees

should be notified of this extension.

COBRA Election Notice Deadlines (Plan Administrator Relief)

General Rule. ERISA § 606(c) and IRC § 4980B(f)(6)(D) require plan administrators to notify qualified beneficiaries of their rights in the case of a qualifying event. Notification is generally required within 14 days of the date on which the plan administrator is notified.

Example. Employee's spouse notifies plan administrator of a divorce and seeks COBRA coverage on April 1, 2020. Assume the divorce is final on April 1, 2020. Normally, the plan administrator has 14 days to provide the spouse with a COBRA election notice. Assume the Outbreak Period ends on July 28, 2020. The plan administrator must provide the spouse with a COBRA election notice by August 11, 2020. If COBRA coverage is elected and premiums are timely paid by the spouse, the COBRA coverage will be retroactive to April 1.

Considerations. The other COBRA relief provided under the Joint Notice applies to participants and qualified beneficiaries. By contrast, this provision extends the time by which the plan administrator must provide a required notice to a qualified beneficiary. While this relief is certainly helpful for employers (or their COBRA administrators) that have experienced significant disruption in their business operations, employers and administrators should work in good faith to provide an election notice as soon as possible in an effort to minimize a loss of benefits to qualified beneficiaries.

Benefit Claims Deadlines

General Rule. A plan's claims procedure, subject to ERISA regulations, specifies the period in which an individual may file a benefit claim. This relief applies to all plans covered by the ERISA claims regulations, including, but not limited to, group health plans, disability plans, and retirement plans.

Example. Participant receives covered medical treatment on March 1, 2020, but does not submit her claim to the plan until April 1, 2021. The plan requires claims to be submitted within 365 days of treatment. Assume the Outbreak Period ends on July 28, 2020. Participant's claim is timely and may be submitted within 365 days of July 28, 2020, or by July 28, 2021.

Considerations. Beyond application of this claim filing extension to traditional group health plans and retirement plans, plan sponsors should be aware of the application of this relief to health and dependent care FSAs. Calendar year plans very often require FSA claims to be submitted within the first 90 days of the following calendar year in which the claim was incurred. For those plans, the deadline falls within the Outbreak Period, so the deadline to submit FSA claims in this circumstance is automatically extended until the Outbreak Period ends, plus any additional days left in the run-out period after the Outbreak Period began.

Appeals Deadlines

General Rule. A plan's claims procedure, subject to ERISA regulations, specifies the period in which an individual may appeal an adverse benefit determination. The minimum period is 60 days (or 180 days for group health plans) following receipt of a notification of the adverse determination. This relief applies to all plans covered by the ERISA claims regulations, including, but not limited to, group health plans, disability plans, and retirement plans.

Example. Participant received notice of an adverse benefit determination from his disability plan on January 28, 2020. The notice provides a 180-day period for appeal. Assume the Outbreak Period ends on July 28, 2020. Participant may file an appeal within 148 days (180 days – 32 days between January 28 and March 1) of July 28, 2020, or by December 23, 2020.

Considerations. Plan administrators and appeals committees must remember to disregard the Outbreak Period in reviewing plan appeals to determine if the procedural timing requirements have been met. If the plan administrator fails to strictly adhere to the plan's internal claims and appeals procedures (as modified by this relief), it may jeopardize the deferential standard of review afforded to plans under ERISA if the claim is ultimately

challenged in court.

Deadlines for Requesting (and Perfecting Requests) for External Review

General Rule. ERISA and IRS regulations require non-grandfathered group health plans and insurers to allow claimants four months to request external review of an adverse benefit determination or final internal adverse benefit determination that is eligible for external review. Claimants who have filed an incomplete request for external review are permitted to perfect their claim within the later of the four-month period for requesting review or the 48-hour period following notification of the missing materials.

Considerations. The external review process is generally overseen by the plan's claims administrator and contracted independent review organizations (IROs). The plan administrator should confirm that the claims administrator and IROs will disregard the Outbreak Period in determining the timeframes applicable to external reviews.

Key Takeaways

We believe that plan administrators have a fiduciary duty to notify all employees of the extensions required by the Joint Notice. These extensions can have a significant impact on the ability of participants, beneficiaries, and claimants to effectively exercise their health coverage portability and continuation coverage rights and to file or perfect their benefit claims.

The Joint Notice does not address whether plans must be amended to reflect the temporary extension, which end date is not yet known (and which may be different in different regions of the country). Notwithstanding, we believe that, consistent with the aims of the Joint Notice and the good faith requirements outlined below with respect to EBSA guidance, plan sponsors should use their best efforts to communicate this relief to all employees in order to minimize the possibility of individuals losing benefits because of a failure to comply with certain pre-established timeframes.

EBSA DISASTER RELIEF NOTICE 2020-01

On April 28, 2020, the DOL issued EBSA Disaster Relief Notice 2020-01 to provide delays and other relief to health and retirement plans governed by ERISA. The Department of HHS, which has jurisdiction over non-federal governmental plans and insurance issuers, concurred in the relief provided by Notice 2020-01. HHS intends to adopt a policy of measured enforcement to extend similar timeframes to non-federal governmental group health plans and insurers. HHS encourages governmental group health plans and issuers to operate in a manner consistent with Notice 2020-01.

Overview of Relief Provided

Notice 2020-01 grants delays and other relief to health and retirement plans related to:

- Notices, disclosures, and documents due under ERISA Title I during the national emergency;
- Failures to follow verification procedures for plan loans and distributions;
- Loans provided pursuant to the CARES Act;
- Deadline for adopting loans and distributions permitted by the CARES Act;
- Forwarding repayments of participant loans to a plan;
- Blackout notices; and
- Form 5500 and Form M-1 filings.

Deadlines for All Required Notices and Disclosures

Pursuant to Notice 2020-01, the DOL will not consider a plan or fiduciary in violation of ERISA for failing to furnish a notice, disclosure, or document that is required to be furnished by Title I of ERISA during the Outbreak Period if the plan and fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively

practicable under the circumstances.

The "Outbreak Period" is defined in the same way as it is defined for purposes of the Joint Notice discussed above, *i.e.*, March 1, 2020 through 60 days after the national emergency is lifted. Acting in "good faith" includes using electronic alternative means of communication with plan participants and beneficiaries that the fiduciary reasonably believes have effective access to electronic means of communication. This includes electronic communication by means of email, text messages, and continuous access websites.

This relief applies to all notices, disclosures, and documents—other than those specifically encompassed by the Joint Notice—required to be furnished during the Outbreak Period under Title I of ERISA, including:

- Blackout notice
- Summary Plan Description
- Summary of Material Modification
- Summary Annual Report
- Notification of Benefit Determination (Claims Notices and Explanation of Benefits)
- Plan Document
- Summary of Material Reduction in Covered Services or Benefit
- Medical Child Support Order Notice
- National Medical Support Notice
- CHIPRA Notice
- Wellness Program Disclosure
- Newborns' Act Description of Rights
- Michelle's Law Enrollment Notice
- Women's Health and Cancer Rights Act Notice
- MHPAEA Criteria for Medically Necessary Determination Notice
- Summary of Benefits and Coverage
- Summary of Benefits and Coverage Notice of Modification
- Periodic Pension Benefit Statement
- Statement of Accrued and Nonforfeitable Benefits
- Suspension of Benefits Notice
- DRO and QDRO Notices
- Notice of Significant Reduction in Future Benefit Accruals
- Section 404(c) Plan Disclosures
- Qualified Default Investment Alternative Notice
- Automatic Contribution Arrangement Notice
- Annual Funding Notice
- Plan and Investment Fee Disclosure
- Plan Service Provider Disclosure

Verification Procedures for Plan Loans and Distributions

The DOL advises that it will not treat failures to follow a plan's verification procedures for loans or distributions during the Outbreak Period as failures if:

- The failure is solely attributable to the COVID-19 outbreak;
- The plan administrator makes a good-faith diligent effort to comply with the requirements; and
- The plan administrator makes a reasonable attempt to correct procedural deficiencies as soon as practicable.

This relief does not extend to verification procedures related to spousal consent, if applicable, or other statutory or

regulatory requirements under the jurisdiction of the Department of Treasury and IRS.

Plan Loans under the CARES Act

The DOL will not treat any person as having violated the provisions of Title I of ERISA solely for providing loans, or delaying repayment of loans, in accordance with Section 2202(b) of the CARES Act.

Deadline for Adopting Loans and Distributions Permitted by the CARES Act

ERISA plans may operate in accordance with the loan and distribution provisions of Section 2202 of the CARES Act prior to adopting an amendment, provided the amendment is adopted by the last day of the first plan year beginning on or after January 1, 2022. This deadline is consistent with the deadline imposed by the CARES Act and the IRS for amending plans for these provisions.

Deadline for Forwarding Participant Contributions and Loan Repayments to Plan

Under existing guidance, participant contributions and loan repayments are considered plan assets and must be forwarded to the plan on the earliest date that they can be reasonably segregated from general assets, and no later than the 15th business day of the month in which paid to or withheld by the employer.

During the Outbreak Period, the DOL will not take enforcement action against a temporary delay in forwarding participant payments or contributions due solely to a failure attributable to COVID-19. Employers are advised to act reasonably, prudently, and in the interest of employees to forward the amounts as soon as administratively practicable.

Blackout Notices

Plan administrators of individual account plans generally must provide 30 days' advance notice to participants and beneficiaries whose rights under the plan will be temporarily suspended, limited, or restricted by a blackout period. The regulations provide an exception to the advance notice requirement when the inability to provide the notice is beyond the reasonable control of the plan administrator and a fiduciary so determines in writing. The DOL will not require the written documentation by a fiduciary pursuant to the regulation for blackout notices covered by Notice 2020-01, as pandemics are by definition beyond a plan administrator's control.

Form 5500 and Form M-1

The DOL is providing relief with regard to the Form 5500 and Form M-1 that is identical to the relief provided by the IRS with regard to the Form 5500 under IRS Notice 2020-23. With respect to Forms 5500 due prior to July 15, 2020, the IRS delayed the deadline for those Forms 5500 to July 15, 2020.

Key Takeaways

The DOL made clear in Notice 2020-01 that, during the COVID-19 national emergency, the guiding principle of plans must be to act reasonably, prudently, and in the interest of the covered workers and their families who rely on their health, retirement, and other employee benefit plans for their physical and economic wellbeing. Plan fiduciaries are expected to make "reasonable accommodations" to prevent the loss of benefits by participants and to attempt to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes. The DOL's approach to enforcement during this time will be to emphasize compliance assistance while providing for grace periods and other appropriate relief.