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Employee Benefits Update

April 2020

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

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

COVID-19 TESTING UNDER HEALTH PLANS

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

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

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

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

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

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

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

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

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

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

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

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

Q5. What health plans are subject to these requirements?

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

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

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

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

GUIDANCE ON CALCULATING THE NEW PAYROLL TAX CREDITS

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

Q7. When can employers claim the credits?

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

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

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

Q9. How are Qualified Health Plan Expenses determined?

The determination of Qualified Health Plan Expenses involves several steps:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPACT OF COVID-19 ON DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

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

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

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

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

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

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

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

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

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

LEAVE-SHARING PROGRAMS
AND DISASTER RELIEF PAYMENT FUNDS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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