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IRS Coronavirus Relief for Cafeteria Plan Elections and Carryovers

As part of its overall response to aid employers and employees in responding to the impact of the coronavirus pandemic, the Internal Revenue Service (IRS) has provided employers with a number of optional amendments that can be made to Section 125 cafeteria plans and related health plans and flexible spending arrangements (FSAs). The IRS guidance released on May 12, 2020, is a significant departure from current regulation of cafeteria plans as it allows employers the option of letting employees revoke, add, or change 2020 coverage elections mid-year without a qualifying status change.

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COVID-19 Tolling of Employee Benefit Plan Deadlines – Plan Sponsors Beware

A deadline is a deadline, except when it isn't. New COVID-19 relief for participants issued by the Department of Labor (DOL), in coordination with the Internal Revenue Service (IRS), extends key deadlines for health, retirement and welfare plans subject to ERISA and the Internal Revenue Code. In addition, the Department of Health and Human Services (HHS) indicated non-federal governmental plans are encouraged, but not required, to adopt the extensions.

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Agencies Issue Clarifying Guidance on COVID-19 Testing Coverage Provisions

A second round of FAQs recently issued by the Department of Labor (DOL), the Internal Revenue Service (IRS), and the Department of Health and Human Services (HHS) provides plan sponsors and insurers with additional implementation guidance relating to health coverage provisions under the Families First Coronavirus Response Act (FFCRA), as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The June 23 guidance in FAQs Part 43 is a follow-up to the Departments' April 11 guidance in FAQs Part 42 and provides specific clarifications on testing coverage and provider payments, summary of benefits coverage (SBC) notifications, temporary telehealth relief provisions, and various other compliance matters of significance to group health plans. The more significant provisions of the guidance are as follows.

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COVID-19 Employee Benefits Mandatory and Permissive Amendments Checklist

Among the many challenges for employers during the pandemic has been keeping track of the numerous legislative changes and updates from federal agencies relating to permissive and mandated benefit plan amendments. While many of these legal updates present welcome relief relating to the COVID-19 issues facing employers and employees, employers may be feeling overwhelmed by all of the guidance and new compliance obligations.

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IRS Coronavirus Relief for Cafeteria Plan Elections and Carryovers

The IRS has also given employers the option to extend grace periods to allow additional time to incur claims for reimbursement under health and dependent care FSAs. Other relief allows employers to expand telehealth coverage retroactively to January 1, 2020, without impacting health savings account (HSA) eligibility. What do employers need to know about these changes?

Key Parameters

If an employer elects to amend its cafeteria plan to provide for 2020 mid-year election changes, Notice 2020-29 provides the following key parameters.

Permitted Amendments

First, employers may, in their discretion, amend their cafeteria plan, group health plan(s), health flexible spending arrangements (HFSAs) and dependent care assistance programs (DCAPs) to make some or all of the following prospective changes:

- With respect to **employer-sponsored health coverage**, allow employees to:
  - Make a new election for employer sponsored coverage.
  - Revoke an existing election in order to enroll in another employer-sponsored coverage option.
  - Revoke an existing election in order to enroll in other "comprehensive" health coverage not sponsored by the employer (e.g., Medicare). This option requires employers to receive a written attestation from the employee certifying enrollment in the other coverage. Model language for the attestation is provided in the IRS guidance.
- With respect to an **HFSA or DCAP,** allow employees to:
  - Make a new election, revoke an election, or increase or decrease an existing election.
  - Allow an extension of time to incur expenses for reimbursement for HFSA or DCAP covered claims through December 31, 2020. To be eligible for this relief, the HFSA or DCAP must have a grace period or be a non-calendar year plan ending in 2020. Calendar year HFSAs or DCAPs without a grace period (i.e., an additional period for incurring claims ending no later than March 15 of the subsequent calendar year) are not eligible for this particular relief.

    If an HFSA has a plan year ending in 2020, but allows for a carryover, the IRS relief still allows employers to adopt the extended grace period for claims through December 31, 2020, even though offering simultaneous carryovers and grace periods are otherwise prohibited by Notice 2013-71. No similar relief is provided for HSA compatibility, and employees who are allowed extensions to incur HFSA expenses will **not** be eligible to contribute to an HSA during the extended period. Employers will need to evaluate the impact and consider if transitioning the HFSA to a more limited HSA-compatible HFSA as permitted by Notice 2005-86 would be helpful.

Employers Have Flexibility

Employers have flexibility to determine the extent to which any election changes are permitted and applied. While all election coverage changes must be prospective, employers are free to limit the number of election changes that can be made; specify the time period for which changes can be made; and in the case of HFSAs and DCAPs, limit elections to amounts not less than already reimbursed. Employers should consider the adverse selection risks in determining how expansively to amend their plans for mid-year changes.

Timing of Changes

Election changes must be made during calendar year 2020 and be prospective. Relief may be applied retroactively (pre-Notice) to a period on or after January 1, 2020, for cafeteria plans that already permitted mid-year election changes consistent with Notice 2020-29 requirements. In other words, the IRS will not enforce cafeteria plan violations for employers who previously allowed employees to make mid-year changes after January 1, 2020,

consistent with the notice as a result of the challenges faced by COVID-19.

Rules Still Apply

It is important to note that ERISA notice provisions still apply (likely requiring employers to inform all eligible employees of the change), as do cafeteria plan nondiscrimination rules (plans should ensure changes will not result in failures).

Miscellaneous Provisions

Plans must be amended to provide for the 2020 mid-year election flexibility or extended carryover periods, on or before December 31, 2021.

On a practical note, if employers wish to adopt mid-year election and carryover changes, employers often must consult with, and obtain advanced approval from, carriers and stop-loss providers. This is because the election restrictions limiting mid-year enrollment to qualifying changes in family status or HIPAA special enrollment are typically embedded into the terms of the group health plan or insurance policy, as well as the cafeteria plan.

High Deductible Health Plan Clarifications

In addition to providing parameters for mid-year election changes, Notice 2020-29 also clarifies a few COVID-19 issues related to HSA-eligible high deductible health plans (HDHPs).

First, the IRS guidance clarifies that relief provided in Notice 2020-15 (allowing coverage of COVID-19-related testing and treatment prior to satisfying the deductible) applies with respect to reimbursements of expenses incurred on or after January 1, 2020.

Next, it clarifies that "testing and treatment of COVID-19" under Notice 2020-15 includes the panel of diagnostic testing for influenza A and B, norovirus and other coronaviruses, respiratory syncytial virus (RSV), and another items or services required to be covered with no cost sharing under the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

Finally, it provides that treatment of telehealth and other remote care services pursuant to Section 3701 of the CARES Act applies to services provided on or after January 1, 2020, with respect to plan years beginning on or before December 31, 2021.

Additional Changes Announced by the IRS

Simultaneous to its release of Notice 2020-29, the IRS and Treasury released Notice 2020-33. The guidance in Notice 2020-33 is not COVID-19-specific, but does impact HFSA and Individual Coverage HRAs (ICHRAs) by providing several key changes.

- **HFSA**: The IRS now permits employers to increase the maximum HFSA carryover amount for plan years starting in 2020 from $500 to "20% of the maximum HFSA salary reduction contribution under §125(i) for that plan year." This means that the maximum carryover for a 2020 plan into a 2021 plan is $550 (20% of $2,750). Plans may adopt an amendment relating to this 2020 plan year change on or before December 31, 2021.
- **ICHRA**: The IRS also permits a plan to treat an expense for a premium for health insurance coverage as incurred on: (1) the first day of each month of coverage on a pro rata basis; 2) the first day of the period of coverage; or 3) the date the premium is paid. This allows an ICHRA to reimburse for health care coverage premiums paid prior to the first day of the plan year – relaxing the current rule that limits payment and reimbursements to current plan year expenses.

Conclusion

Employers wishing to adopt mid-year changes and other relief should consult with their benefit advisors. New guidance and clarifications are being issued frequently, so employers should check for the latest updates prior to acting. Stay tuned for future developments.

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COVID-19 Tolling of Employee Benefit Plan Deadlines – Plan Sponsors Beware

The deadline extensions are intended to provide relief to plan sponsors and participants impacted by COVID-19, but the significant flexibility provided to participants under these extensions give rise to administrative complexities that employers will likely consider burdensome, time consuming, and costly. Coordination with third party administrators (TPAs), benefit advisors, legal counsel and carriers is essential.

Generally, the guidance requires that certain deadlines falling on or after March 1, 2020, (even retroactively after the guidance was issued) through the "Outbreak Period" are tolled. The Outbreak Period is "the National Emergency Period plus 60 days following expiration after the National Emergency Period." Currently, the end of the National Emergency Period has not been declared.

Although the ruling primarily advantages employees, participants and COBRA beneficiaries, the ruling also extends certain employer deadlines.

Permitted Employer Extensions

- Extends time for plans to furnish ERISA-required notifications to "as soon as administratively practicable"
  - Summaries of material modification(s) (SMM) and summary plan description(s) (SPD)
  - Benefit/claims determinations
  - Blackout notices (30-day advanced notice as well as notices required after the blackout periods begins)
- Extends COBRA Election Notice provision timeline (the 44-day timeframe for provision of notice to a qualified beneficiary) by disregarding the Outbreak Period
- Extends notification and response deadlines under ERISA's claims procedures for plans covered by ERISA Section 503

In addition to formal extensions, the DOL will not take enforcement actions for temporary delays in forwarding participant contributions or loan repayments if the delays are attributable solely to the COVID-19 outbreak, and compliance is achieved as soon as administratively practicable under the circumstances. The Notice also encourages fiduciaries to make reasonable accommodations to prevent payment delays and benefit losses.

Permitted Employee Extensions

- Extends 30- and 60-day HIPAA Special Enrollment timeframes by disregarding the Outbreak Period
- Extends an ERISA plan's benefit claim filing deadlines (under the plan's claims procedures) by disregarding the Outbreak Period. This includes extending health flexible spending arrangement (health FSA) and health reimbursement account (HRA) run-out periods still in effect as of March 1, 2020, by disregarding the Outbreak Period.
- Extends an ERISA plan's deadline to file appeal of adverse benefit determination (180-day timeframe under a group health plan or disability plan) by disregarding the Outbreak Period
- Extends an ERISA plan's deadline to file an external review request (4 months for federal review; may be different for state), or provide additional information to perfect a request (4 months (or 48 hours following receipt of incomplete request notification, if later)) by disregarding the Outbreak Period
- Extends COBRA Qualifying Event Notice Deadlines (60-day employee notification for qualifying event) by disregarding the Outbreak Period
- Extends the COBRA Election Period (60-day timeframe/deadline for a qualified beneficiary to elect COBRA) by disregarding the Outbreak Period
- Extends COBRA Premium Payment Periods (45 days from COBRA election date to make initial premium deadline or 30-day grace period for

subsequent premium payment deadlines) by disregarding the Outbreak Period

Administrative and Procedural Challenges

Plan Sponsors, insurers, TPAs, COBRA administrators and stop-loss insurers are independently and collectively wrestling with the practical implications of these rules. For example, through the end of the Outbreak Period, which is yet to be determined, participants are not subject to deadlines to request HIPAA special enrollments, nor must they notify the plan of a special enrollment event – so employers may not know until third quarter 2020, or later, whether they have to extend group health coverage to employees and dependents retroactive to March 1. Similarly, COBRA qualified individuals do not have to notify the plan of COBRA qualifying events, elect COBRA, or pay COBRA premiums, providing participants extensive opportunity to take a "wait and see" approach while simultaneously obligating employers to reinstate coverage retroactively and/or advance premium payments for many months.

Next Steps

Unfortunately, the ruling creates more issues than answers, but following are next steps to address with your benefit advisors:

- Review plan communications and determine whether updates are needed to advise employees of their extended deadlines.
- Review options for retroactive cancellation of COBRA for nonpayment of premiums. The ruling allows retroactive cancellation of COBRA coverage if an employee fails to pay all premiums due at the end of the Outbreak Period, but some carriers and TPAs have network provider contracts limiting retroactive cancellations to 60 or 90 days.
- Consider whether plan amendments are required to reflect the tolling – or whether simply updating employee communications is sufficient. In this regard, the ruling does not change any of the applicable deadlines under the plans, it simply delays application of the deadlines. There is no indication that plan amendments generally are necessary for this temporary relief, but depending on the language in plan documents and policies, review and amendment may be needed
- Review employee communications to determine whether general or specific and targeted communications are necessary to address the tolling of benefit elections and COBRA premium payments.

Conclusion

There are many moving parts and questions associated with these rules and employers should consult their benefit advisor and legal counsel for guidance as further developments are likely.

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Agencies Issue Clarifying Guidance on COVID-19 Testing Coverage Provisions

Testing Coverage and Provider Payments

Insured and self-insured group health plans and insurers are generally required to cover certain items and services related to FDA-approved COVID-19 diagnostic testing, without cost-sharing, advanced authorization, or other medical management. The CARES Act also requires that test providers be reimbursed at the cash price published on their website, or if lower, a negotiated rate. The recent guidance clarifies the limitations on what must be covered.

Authorized and Non-Authorized Tests

Only the *in vitro* diagnostic tests that are FDA-approved for the detection of SARS-CoV-2 or the diagnosis of COVID-19, developed under a requested emergency use authorization, or state validated, must be covered, without cost sharing. If an employee takes a test that is *not* FDA-approved, the plan sponsor may verify that the test developer has requested, or intends to request, emergency use authorization from the FDA. It will not be considered an impermissible medical management activity for the plan sponsor to require verification of the test authorization prior to payment. If verification is not provided, coverage must be provided in accordance with plan terms which may include cost-sharing or a denial. A list of the authorized tests and providers is available on the FDA website.

"Attending Health Care Providers"

Only medically appropriate COVID tests are required to be provided without cost sharing and thus will require a referral from an "attending health care provider." An "attending health care provider" is defined to include the individual's primary physician but also any attending licensed/authorized provider that makes an individualized clinical assessment. If an attending health care provider orders a diagnostic test designed to be administered at home, it must be covered without cost-sharing. There are no limits on the number of no-cost COVID-19 diagnostic tests plans must provide, if an attending health care provider determines the tests are medically appropriate.

When Cost-Sharing Is Not Permitted

Plans must cover "facility fees" – provider office, telehealth, urgent care, emergency room – and "related items or services" associated with furnishing or determining the need to furnish a COVID-19 diagnostic test *without* cost-sharing. The FAQ includes an example where an individual is treated in an emergency room and the provider, in an effort to determine whether a COVID-19 test is appropriate, orders diagnostic test panels for influenza A and B and respiratory syncytial virus and a chest x-ray, and consequently a COVID-test. In this example, the plan is required to cover the related items and services without cost-sharing, prior authorization, or other medical management requirements, including any physician fees charged to read the x-ray and any facility fees associated in relation to the items and services.

Balance Billing

The CARES Act generally precludes balance billing for mandated diagnostic testing because the plan or issuer reimburses the provider for the full cost of the test with no cost sharing for the individual or other balance due.

When Cost-Sharing Is Permitted

General workplace health and safety screening tests not intended primarily for *individual* COVID-19 diagnosis or treatment are beyond the scope of the FFCRA and CARES Act mandates and are therefore *not* required to be covered without cost-sharing. Please note, however, that while cost-sharing is permitted, for a variety of reasons – including various return-to-work mandates, employee relations, and litigation risk reduction – many employers may be obligated to cover or choose to cover the cost of these screening tests.

Reimbursement

Out-of-network mandated COVID-19 testing must be reimbursed pursuant to the CARES Act (the cash price listed by the provider on the provider's website or a negotiated lower rate), and not at the ACA rate. Plans that do not have negotiated rates with out-of-network providers must either pay the cash price or negotiate lower rates, perhaps using available state reimbursement rate dispute resolution provisions. The HHS may impose civil penalties of up to $300 a day against providers that do not post their cash price for COVID-19 diagnostic testing.

Summary of Benefits and Coverage Notification

Looking ahead to the end of the COVID-19 emergency period, plan sponsors may want to undo the COVID-19 diagnosis or treatment coverage enhancements, which would be viewed as a plan modification that is material. To address concerns regarding the Summary of Benefits and Coverage 60-days advance notice obligation for material modifications, the guidance provides that plan sponsors will be deemed to have met this requirement if participants, beneficiaries, and enrollees (1) were previously notified of the general duration of the additional benefits coverage or reduced cost-sharing, or (2) were notified of the reversal reasonably in advance of the reversal.

Temporary Relief: Telehealth and Remote Care

Another provision of the new FAQs provides that large employers may offer solely telehealth and remote-care benefits for employees and dependents *who are not eligible under any employer sponsored plan* for the duration of any plan year beginning before the end of the COVID-19 emergency period. As noted in the guidance, a telehealth program offered independently is a group health plan subject to all federal requirements that apply to group health plans, which a telehealth program cannot satisfy as an independent program. However, the agencies are providing temporary relief from some of those provisions in ERISA part 7 and corresponding provisions in the Internal Revenue Code and Public

Health Service Act, including the annual and lifetime limit prohibitions and preventive services mandates.

Notwithstanding the relief from certain market reforms, the telehealth and remote care program would remain subject to other federal requirements such as COBRA, the prohibition of pre-existing condition exclusions; the prohibition of discrimination based on health status; the prohibition on rescissions; and the applicability of mental health parity requirements. While the recent guidance specifically discusses exempting the telehealth program from certain requirements in part 7 of ERISA, it does not address relief from ERISA generally or such other requirements as COBRA and HIPAA privacy and security requirements. Accordingly, employers wishing to adopt a broad application of telehealth or remote-care benefits for all employees should discuss the offering with their benefits advisor and legal counsel.

Compliance: Mental Health Parity, Wellness Standards, and Grandfathered Plans

The new guidance also confirms that no-cost items and services required under the FFCRA and CARES Act can be disregarded for purposes of MHPAEA compliance – specifically, the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations.

Further, plans are permitted to waive an applicable wellness standard (including a reasonable alternative standard) under a health-contingent wellness program if participants or beneficiaries are having difficulty meeting the standards due to COVID-19 circumstances. The waiver must be offered to all similarly situated individuals.

Finally, grandfathered health plans that add benefits or reduce or eliminate cost-sharing pursuant to the safe harbor outlined in FAQs Part 42 (Q9 and Q 14), and then subsequently reverse those benefits after the national COVID-19 emergency period is over, will not lose grandfathered status solely because of the reversal.

A Few Important Next Steps

In light of the new guidance, plan sponsors of group health plans should review their current practices as follows:

1. Ensure plan documents are amended to reflect mandatory and permissively adopted changes.
2. Ensure participant notices and disclosures are updated to reflect mandatory and permissively adopted changes. Communicate expected duration of COVID-19 related benefit changes.
3. Apply health-contingent wellness program standard waivers to all similarly situated individuals.
4. Consult TPA and/or insurers to ensure COVID-19 cost sharing has been properly eliminated (including deductibles, co-pays and co-insurance).
5. Consult TPA and/or insurers to ensure COVID-19 out-of-network billing complies with CARES Act requirements and balance billing restrictions.

For further guidance and new developments, employers should consult with their benefits advisor and legal counsel.

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COVID-19 Employee Benefits Mandatory and Permissive Amendments Checklist

Accordingly, below is a checklist of the most significant benefit plan changes that may be or are required to be adopted in the near future. This list is not exclusive and may not apply in all situations. Accordingly, it is essential that employers consult with legal counsel or their benefit plan advisors prior to making any plan changes to ensure their plans are properly updated to reflect all requirements. *(Last updated June 2020)*

Mandatory Group Health Plan	
FFCRA (insurer should update certificates and administer) WRAP plan not impacted	❑ GHPs (self-insured, insured, grandfathered) must cover COVID-19 related diagnostic testing and services to employees and covered dependents ❑ COVID-19 coverage must be provided without cost sharing from 3.18.20 through the end of the public emergency period ❑ Mandatory elimination of pre-authorizations and other medical management requirements as a precondition of COVID-19 testing or services
CARES Act §3201: expand definition §3203: rapid coverage of QCPV §3702: over the counter drugs and menstrual care products	❑ Expand definition of covered COVID-19 diagnostic testing to include some non-FDA approved, state developed tests, and HHS authorized tests ❑ Require rapid "15" day coverage of "qualifying coronavirus preventive services" or vaccines recommended by the USPSTF or CDC without cost sharing ❑ If necessary, amend definition(s) in plan or SPD: "qualified medical expenses" under §223(d)(2) to include non-prescribed medicine and drugs and/or menstrual care products; and "medical care" under IRC §106 to include menstrual care products
MANDATORY IN APPLICATION / MOST LIKELY, ARGUABLY, REQUIRES FORMAL AMENDMENT) DOL and Treasury – Notice 2020-01 and Final Rule 85 FR 26351, extending ERISA and IRC Timeframes Outbreak Period (National Emergency Period (end TBD) through 60 days after end of National Emergency Period)	❑ Extend 30 and 60-day HIPAA Special Enrollment timeframes by disregarding the Outbreak Period ❑ Extend an ERISA plan's benefit claim filing deadlines (under the plan's claims procedures) by disregarding the Outbreak Period (including HFSA and Health Reimbursement Account (HRA) run out periods still in effect as of 3.1.20) ❑ Extend an ERISA plans deadline to file appeal of adverse benefit determination (180-day timeframe under a GHP or disability plan) by disregarding Outbreak Period ❑ Extend an ERISA plan's deadline to file an external review request, or provide additional information to perfect a request (generally 4 months for federal review, may be different for state) or provide additional information to perfect a request (4 months (or 48 hours following receipt of incomplete request notifications, if later)) by disregarding the Outbreak Period ❑ Extend COBRA Election Notice provision timeline (44-day timeframe for provision of notice to qualified beneficiary) by disregarding the Outbreak Period ❑ Extend COBRA Election Period (60-day timeframe/deadline for a qualified beneficiary to elect COBRA) by disregarding the Outbreak Period ❑ Extend COBRA Premium Payment Periods (45 days from COBRA election date to make initial premium deadline (or 30-day grace for subsequent premium payment deadlines, starting at beginning of coverage month)) by disregarding the Outbreak Period

Mandatory Group Health Plan	
DOL and Treasury – Notice 2020-01 and Final Rule 85 FR 26351, extending ERISA and IRC Timeframes (continued)	❑ Extend ERISA plan's deadlines to furnish ERISA-required notifications to "as soon as administratively practicable. ERISA-required notifications include summaries of material modifications, summary plan descriptions, benefit/claims determinations, blackout notices (30-day advanced notice and notices required after blackout period begins)
Any employer/insurer coverage extensions or changes provided for furloughed or terminated employees that are not currently reflected in plan documents	

Permissive Group Health Plan	
CARES Act §3701	❑ Permitted expansion of telehealth services and other remote care services. Temporary safe harbor allowing HDHP participants to remain HSA-eligible even if cover telehealth services before satisfying the plan's statutory minimum deductible. Safe harbor for COVID-19 related and non-COVID-19 related telehealth between 3.27.20 – 12.31.21 (Notice 2020-29 confirms application to services provided between 1.1.20 and 12.31.21)
CARES Act §3702 (for HSAs (including ERISA exempt) and account based plans (HRAs (including ICHRAs), Archer Medical Savings and HFSAs)	❑ Permits over the counter drugs to be treated as "qualified medical expenses" without a prescription (*not-COVID-19 related*) for account plan coverage/reimbursement ❑ Permits menstrual care products to be treated as "qualified medical expenses" for account plan coverage/reimbursement
Notice 2020-15	❑ Allow HDHP coverage of "COVID-19 testing and treatment" prior to satisfying deductible without jeopardizing HSA (Notice 2020-29 clarifies effective 1.1.20 and includes panel of diagnostic testing for influenza A&B, norovirus, RSV and items/services required without cost sharing under FFCRA and CARES)

Mandatory Cafeteria/HSFA/DCAP (and impacted health plan(s))	
DOL and Treasury – Notice 2020-01 and Final Rule 85 CFR 26351	❑ Extend health flexible spending arrangement (HFSA) and Health Reimbursement Account (HRA) run out periods still in effect as of 3.1.20, by disregarding the Outbreak Period

Permissive Cafeteria/HFSA/DCAP (and impacted health plan(s))	
Notice 2020-29 Amendment for 2020 PY change due by 12.31.21	❑ Allow 2020 mid-year election changes (add, revoke, change) CP, HFSA, DCAP and underlying employer GHP coverage. With revocations, employee making changes must provide an attestation ❑ Extend time to incur expenses for 2020 HFSA and DCAP reimbursements
Notice 2020-33 (not COVID-19 related and also applies to ICHRAs)	❑ Permit increase in maximum HFSA carryover amount for plan years starting in 2020 from $500 to "20% of the maximum HFSA salary reduction contribution under §125(i) for that plan year. 20-21 = $550 (20% of $2,750)
CARES Act §3702	❑ Permitted to use HFSA dollars on over-the-counter drugs without a prescription and menstrual care products

Mandatory Group Retirement Plans (not IRAs)	
CARES Act §2202: Loans §2203: Temp suspension RMD	❑ Delay repayment for existing loans per participant request (delay repayments between 3.27.20 - 12.31.20 for up to 1 yr/extend loan period). ❑ Amend plan to reflect chosen option - Temporary Suspension of Required Minimum Distribution Rules. See Notice 2009-82 providing two sample amendments for plan sponsors (continue 2020 RMDs but provide individuals opportunity to opt-out or default to discontinue 2020 RMDs.)
SECURE Act	❑ Amend plan to allow certain long-term part-time employees to participate – those who worked at least 500 hours in 3 consecutive 12-month periods and have reached age 21 by end of the consecutive 12-month period. Track PTE service hours in 2021 PY – so in 2024 PY, PTE makes elective deferrals (no match or profit-sharing contribution required) ❑ (may be purely administrative) plans with lifetime income investment options must provide an annual benefit statement that includes the lifetime income disclosure. DOL to issue model statements (disclosure and assumptions) before 12/20/20 ❑ Prohibits plan loans made via credit cards and similar arrangements (effective for loans made after 12/20/19) ❑ Increase required beginning date age for mandatory distributions to age 72 (effective for distributions after 12/31/19 for individuals turning 70 ½ after 12/31/19). Note, if account owner dies before RBD and spouse is the beneficiary, spouse can delay distributions until 12/31 of year in which decedent would have attained age 72 ❑ Accelerates post-death minimum distribution rules (new general rule-must distribute by end of 10th year following the year of death, exceptions apply)

Mandatory Group Retirement Plans (not IRAs)	
SECURE Act (continued)	❑ For plans that provide hardship distributions (decision to provide is permissive), waives early withdrawal penalties for qualified disaster distributions up to $100K for participants who live in presidentially declared disaster areas. Can spread income tax payment on distribution over 3-year period and permitted to repay the distribution back into a retirement plan. NOTE – the SECURE Act disaster relief provisions must be adopted by last day of PY 2020 (or 2022 for governmental plans) – 12.31.20 for calendar year plans. Note. Pursuant to Rev. Proc. 2020-9 (and Rev. Proc. 2019-39 for nongovernmental 403(b) plans) final hardship regulations amendments not due until 12.31.21 but operational compliance due earlier (1.1.20)

Permissive Group Retirement Plans (not IRAs)	
CARES Act §2202: In-service distributions and loans §3608: Minimum Required funding contribution delay	❑ Allow plan to provide Qualified Individuals a COVID-19 related in-service distribution right between 1.1.20 – 12.31.20 (numerous requirements including certification and **mandatory** waiver of 10% excise tax) ❑ Allow Qualified Individuals to recontribute up to the full amount of any COVID-19 related distribution as a timely rollover during ensuing 3-year period ❑ Allow increased COVID-19 related plan loans limits for Qualified Individuals between 3.27.20 – 9.22.20 (numerous requirements including certification) ❑ *(No indication plan amendment is necessary*) – delay payment of Code §430(j) annual minimum funding contribution(s) due in 2020 to 1.1.2021
SECURE Act	❑ Allows 401(k) safe harbor changes (e.g., increase maximum automatic deferral rate for QACA to 15%; eliminate annual safe harbor notice for 401(k) non-elective safe harbor plans and delayed adoption of non-elective safe harbor plans) ❑ Allows greater portability for lifetime income investment option (plan may allow qualified distributions of the lifetime income investment or distribution in the form of a qualified plan distribution annuity contract) ❑ Allows penalty-free in-service distributions for qualified births or adoptions (withdrawals up to $5,000 within one year following qualified birth or adoption" are not subject to 10% early withdrawal tax) ❑ Allows defined benefit and 457(b) plans to reduce the minimum age for in-service distributions to 59 ½

Mandatory Miscellaenous Adoptions	
SECURE Act	❑ Must treat "difficulty of care" payments to home healthcare workers as eligible Code §415 compensation ❑ Provides tax-free distributions from 529 plans for certain apprenticeship program expenses and up to $10K per individual for qualified student loan repayments (principal or interest) (special rules for distributions to siblings of designated beneficiaries) ❑ Repeals unrelated business taxable income tax for qualified parking and transportation fringe benefits provided by tax-exempt employers to employees ❑ ADMINISTRATIVE PROVISIONS ASSOCIATED WITH VARIOUS SECURE ACT CHANGES (MANDATORY): extends PCORI fees through PYs ending in 9/30/29; tenfold increase in IRS civil penalties relating to failure to file retirement plan returns & notices (Form 5500, 3405 withholding notices; Form 8955-SSA for terminated vested participants (including failure to update status changes); failure to notify IRS of registration changes; failure to file income tax return)

Permissive Miscellaneous Adoptions	
Notice 2020-33 (not COVID-19 related)	❑ Allows individual coverage HRAs (ICHRAs) to treat premium expenses for health insurance paid in the prior year, as a current year expense
CARES Act §3702 – Impacts HSAs not considered GHPs	❑ Permits over the counter drugs to be treated as "qualified medical expenses" without a prescription (not-COVID-19 related) permanent impact ❑ Menstrual care products now qualify as "medical care" for tax-free distributions
CARES Act §2206	❑ Permits employers with qualified educational assistance programs to pay for employee student loans on a tax-free basis between 3.27.20 – 12.31.20
SECURE Act	❑ Extends family and medical leave tax credit for 2020 wages meeting IRC §45S parameters ❑ Allows relief for multiple employer DC plans (MEPs) ❑ Permits expansion of 403(b) eligibility – employees of nonqualified church-controlled organizations may be covered in a 403(b) plan that consists of a retirement income account. Mandates future IRS guidance on custodial account treatment related to 403(b) plan terminations ❑ ADMINISTRATIVE PROVISIONS ASSOCIATED WITH VARIOUS SECURE ACT CHANGES (PERMISSIVE): Provides nondiscrimination testing relief for frozen/closed plans; modifies PBGC premiums for cooperative and small employer charity (CSEC) plans; provides (currently permissive) consolidated Form 5500 reporting requirements for DC plans with the same trustee, ERISA fiduciary (ies) and investments; allows qualified retirement plans to be adopted after the close of a taxable year

COVID-19 Amendment Due Dates:

CARES Act Special Amendment Period. Generally, plans may be amended retroactively for the distribution and loan provisions as late as the last day of the plan year beginning on or after January 1, 2022, which for calendar year plans is 12.31.22 (12.31.24 for governmental plans).

SECURE Act provides a remedial amendment period. Generally, qualification requirement compliance and anti-cutback rule relief provided for amendments made pursuant to the SECURE Act or any Treasury or Labor regulations issued under the SECURE Act, for amendments made on or before the last day of the first plan year beginning on or after 1.1.22 (1.1.24 for multiemployer plans) which for calendar year plans is 12.31.22 (12.31.24 for multiemployer plans).

Generally, amendments to health and welfare plans that are material, note, FFCRA and CARES amendments are considered material changes, must be communicated in a Summary of Material Modifications (or an updated SPD) within 210 days of close of the plan year (or 60 days after date of adoption of a material reduction of covered services/benefits). However, best practice is to provide SMMs ASAP so participants do not rely to their detriment on outdated materials. Generally best to rely on carrier and TPA materials to ensure no inconsistencies with plan terms. Note also EBSA Disaster Relief Notice 2020-01 which extends the time for plans to furnish ERISA required notifications such as benefit determines, SPDs and SMMs, pursuant to good faith efforts "as soon as administratively practicable."

Discretionary retirement plan amendments must generally be made by the last day of the plan year in which the change is effective.

Notice 2020-29 Amendments: 2020 mid-year election and extended carryover amendments due by 12.31.2021.

Notice 2020-33 Amendments: HFSA carryover amendment for 2020 plan year due by 12.31.2021.

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