BENEFITS BULLETIN

March 23, 2020 (*updated)

FREQUENTLY ASKED QUESTIONS:

Benefits Considerations in Response to Novel Coronavirus (COVID-19)

Q1. Is an employer restricted by the Health Insurance Portability and Accountability Act (HIPAA) from disclosing that an employee tested positive for COVID-19?*

A1. *HIPAA imposes strict rules on covered entities, including group health plans, with respect to the handling of identifiable health information – or PHI. Covered entities are prohibited from disclosing PHI for reasons other than treatment, payment, or health care operations. However, there are some exceptions to these rules that are particularly relevant to COVID-19.*

First, a disclosure may be made to public health authorities for the purpose of preventing or controlling a disease. Second, disclosure may be made to individuals who are at risk of contracting or spreading the disease so long as another law permits the disclosure. And third, disclosure may be made when necessary to prevent or lessen a serious or imminent threat to the health and safety of another person or the public. In all instances, though, covered entities must ensure that only the minimum necessary information is shared.

Importantly, employers are likely to obtain information on the health status of an employee in their role as employer, such as where an employee calls in sick or requests to work remotely in order to self-quarantine. Information obtained in this manner is not subject to HIPAA's disclosure rules, but the information may nevertheless be subject to other state and federal regulations like the ADA.

Q2. How can an employer provide no-cost coverage for COVID-19 testing and treatment?*

A2. *Under the Families First Coronavirus Response Act, all health plans must cover no-cost coverage for COVID-19 testing. This includes insured and self-funded plans*

regardless of size. Additionally, insurance commissioners in several states have directed health insurance carriers to waive cost-sharing for the treatment of COVID-19, and many major carriers have announced that these costs will be waived irrespective of a state mandate. Thus, employer-sponsors of fully-insured health plans will likely need to take no action in order to provide employees with no-cost coverage for these services. Conversely, employer-sponsors of self-insured plans will need to consult with claims administrators and stop-loss carriers to accommodate no-cost coverage for COVID-19 testing and treatment, and will likely need to make plan amendments.

Employers should be aware of the impact these no-cost or reduced-cost services may have on the HSA eligibility of employees. While the IRS announced that the waiver of cost-sharing requirements for services related to COVID-19 will not jeopardize HSA eligibility, the waiver of costs for other non-preventive services, such as blanket waivers for telemedicine benefits, may have an adverse effect.

Q3. Can an employer require employees to undergo temperature screenings or other health examinations as a condition of reporting to work?*

A3. *The Americans with Disabilities Act (ADA) prohibits medical inquiries unless the inquiry is job-related and consistent with business necessity; e.g., healthcare workers working with vulnerable populations in a hospital or assisted living facility may be required to have their temperature taken before reporting to work. The ADA, then, would normally not permit such a health inquiry absent a legitimate business necessity.*

However, on March 18, the EEOC issued guidance allowing employers to take the temperatures of employees absent business necessity in an effort to limit the spread of COVID-19. Thus, employers may now require employees to undergo temperature screenings as a condition of reporting to work. But the guidance does not permit employers to implement any other type of screening or physical beyond temperature reading.

Q4. What impact do reduced work hours have on employee eligibility for coverage under the group health plan?*

A4. *Group health plans often determine eligibility for coverage based on the hours worked by the employee or the employee's status as full-time. A reduction in hours may result in loss of eligibility under the terms of the plan, but the specific terms of the plan will control. Where the terms of the plan are vague with respect to evaluating eligibility, employers should take a reasonable approach to making such determinations and should apply the criteria consistently to all employees. Employers should also ensure that any carrier-imposed limitations are followed.*

For employees whose eligibility is determined by the use of a look-back measurement period, eligibility will remain locked in place for the full duration of any stability period regardless of a reduction in hours, though these employees may have the opportunity to voluntarily drop coverage (see Q/A 5).

Q5. Are employees permitted to make mid-year election changes under benefit programs due to a reduction in hours?

A5. *A Section 125 plan, or a cafeteria plan, allows employees to pay for certain benefits on a pre-tax basis by complying with the rules of the Internal Revenue Code. Participant elections generally must be irrevocable until the beginning of the next plan year. However, regulations permit employers to design their cafeteria plans to allow employees to change their elections during the plan year if certain conditions are met.*

For changes in employment status that involve a reduction of hours, a "reduction of hours" event may allow certain election changes even if benefit eligibility is not affected (e.g., because the employee is locked into full-time status during a stability period and remains eligible for health coverage). Here, the employee would be allowed to make a mid-year election change to drop medical coverage.

Similarly, if the employee must pay a greater portion of the premium as a result of the reduction in hours (e.g., a change from full-time to part-time status requires the employee to contribute a greater amount towards the cost of coverage), then the cost-change rules should permit the employee to make an election change to a lower-cost medical option. In lieu of selecting a lower-cost option, the employee may choose to revoke coverage.

While a reduction in hours will provide for some election change opportunities for medical coverage, such opportunities for Health FSA coverage are rarer. In general, a reduction in hours that does not affect the employee's eligibility will not provide an opportunity for a mid-year election change under the Health FSA. Conversely, participants should be permitted to make election changes to DCAP coverage where the cost of dependent care increases or decreases mid-year, or where the need for dependent care increases or decreases, which may be the natural result of a reduction in hours.

Q6. What impact does a furlough (i.e., an extended leave) have on employee eligibility for coverage under the group health plan?

A6. *Typically, an employee placed on furlough is treated similarly to an employee on an unprotected leave of absence. If the employer has an existing policy or practice that dictates how long an employee may remain eligible for coverage during furlough or an*

unprotected leave of absence, that policy should be followed. In the absence of such a policy, the employer should implement a policy that is reasonable and that is applied consistently. Note that many insurance carriers impose a limit on the length of this period, so employers should ensure that their chosen policy complies with carrier requirements.

Employers often provide for up to one month of continued eligibility while on an unprotected leave, though some may provide for more and others less. If the leave extends beyond this period of time, the employee's coverage will terminate and COBRA will be offered (if applicable). If the employee later returns to active employment, he/she will have an opportunity re-elect coverage as an active employee.

During the leave, the employee and employer should continue to make their normal premium contributions.

Q7. How should employee contributions be handled when the amount of the paycheck is too little to cover the normal deduction, or when there is a period without pay?*

A7. *When the full amount of the employee contribution cannot be withheld from pay, the employer has two options. First, the employer can require that the employee make up the difference or shortfall by making a direct payment to the employer. A direct payment like this means the employee will lose the tax advantage of a pre-tax payroll deduction taken through a Sec. 125 Plan, and such a direct payment may be difficult for the employee during a period of reduced or no pay, but it ensures that premium contributions continue as normal.*

The second option is for the employer to cover the full cost of coverage during the period of reduced or no pay. Then, the employer can later recoup these contributions from the employee via accelerated payroll deductions when the employee's pay resumes. This option is convenient for employees and may be a reasonable choice when the period of reduced or no pay is short. But this option does present some risk to the employer in the event the employee does not later return to active employment as expected.

Regardless of the chosen method, the employer should provide the same option to employees on a consistent basis and should ensure employees clearly understand their responsibilities.

Q8. What impact does a layoff (i.e., a termination of employment) have on employee eligibility for coverage under the group health plan?*

A8. *When an employee is laid off (or terminated) from employment, he/she is no longer*

eligible for coverage under the group health plan as an active employee. Coverage will generally terminate no later than the last day of the month in which the termination of employment occurs. Unless the terms of the plan allow for continued coverage of employees post-employment termination, employers should not allow terminated employees to continue participating in the plan beyond this date.

An employer who wishes to provide some form of continued financial contribution towards the cost of coverage may do so by subsidizing or reimbursing a portion of the COBRA premium (if COBRA is available and elected). However, employers should specify the period of time during which a subsidy or reimbursement will be provided and note that the cessation of the subsidy or reimbursement will not be considered a loss of coverage that will trigger a special enrollment opportunity for Marketplace coverage or other employer-sponsored coverage.

In lieu of a subsidy or reimbursement of COBRA premiums, an employer may instead provide a severance payment that is intended to cover a portion of the cost of insurance premiums. The severance payment will be treated as taxable income.

Q9. What coverage options do employees have following a layoff (i.e., a termination of employment)?

A9. *In general, coverage under the group health plan will terminate no later than the last day of the month in which the layoff occurs. Former employee-participants who wish to obtain other coverage, and those in states where the maintenance of health coverage is required, will have options.*

If the employer-sponsored plan is subject to COBRA or a similar state continuation of coverage law, the former employee (and any dependents who were enrolled in the group health plan) can elect to continue the same coverage for a period of up to 18-36 months. The cost of coverage under COBRA is 102% of the monthly premium, though the cost for coverage provided under state continuation laws may be higher.

As an alternative to continuation coverage under the group plan, the loss of coverage experienced by former employee-participants will trigger a special enrollment period for mid-year enrollment in an individual plan on the Marketplace. The deadline for enrollment is 60 days following the date that coverage was lost.

Finally, the loss of coverage experienced by former employee-participants may create an opportunity for mid-year enrollment on another employer-sponsored health plan, such as through a spouse or a parent. The deadline for enrollment is typically 30 days following the date that coverage was lost. The plan's documents should be consulted for further details.

ADDITIONAL RESOURCES

Health and Human Services (HHS) Bulletin

https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf

IRS Notice 2020-15

https://www.irs.gov/pub/irs-drop/n-20-15.pdf

EEOC Guidance issued March 18, 2020*

https://www.eeoc.gov/eeoc/newsroom/wysk/wysk_ada_rehabilitaion_act_coronavirus.cfm

Kaiser Family Foundation – Private Health Insurance Key Facts & Issues

https://www.kff.org/private-insurance/issue-brief/private-health-coverage-of-covid-19-key-facts-and-issues/

Department of Labor – COVID-19 and Family & Medical Leave Act (FMLA)

https://www.dol.gov/agencies/whd/fmla/pandemic

Center for Disease Control (CDC)

https://www.cdc.gov/coronavirus/2019-ncov/index.html

Occupation Safety and Health Administration (OSHA)

https://www.osha.gov/SLTC/covid-19/

Centers for Medicare & Medicaid Services (CMS)

https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus