

## **BENEFITS INSIDER**

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The **Benefits Insider** is a bimonthly member exclusive publication prepared for WorldatWork members by the American Benefits Council (“the Council”), a premiere benefits advocacy organization based in Washington, DC. This newsletter provides the latest news and analysis on the most important benefits-related policy matters in Congress, executive branch agencies and the federal judiciary.

*Please note: any views or opinions expressed in these stories represent the advocacy positions of the American Benefits Council and its membership. They do not necessarily reflect the views of WorldatWork or its membership. To inquire about membership with the American Benefits Council, contact Deanna Johnson at (202) 289-6700 or [djohnson@abcstaff.org](mailto:djohnson@abcstaff.org).*

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## RECENT LEGISLATIVE ACTIVITY

### Coronavirus Update: Summary of House-Passed COVID-19 Response Legislation Now Available; Senate to Vote March 18

The U.S. House of Representatives approved a revised version of the [Families First Coronavirus Response Act \(H.R. 6201\)](#) by a vote of 363-40 on March 14, and on March 16 passed [a number of changes to the bill](#) by unanimous consent. The U.S. Senate is the next to act on this legislation to provide relief from the impact of the novel coronavirus (COVID-19) pandemic. The White House has [given its blessing](#) to H.R. 6201 and a vote in the Senate is expected on March 18, although the next steps remain uncertain and Congress and the Administration are working on an additional economic stimulus package as well.

A [Benefits Blueprint summary](#) of the House-passed bill (as revised on March 16), prepared by Groom Law Group, Chartered, is now available. [Blueprints are normally accessible exclusively by Council members, but we are making this edition free to all.]

The Benefits Blueprint addresses many of the relevant elements of H.R. 6201, including provisions that would establish an emergency paid leave program, as well as an emergency paid sick leave mandate, for certain coronavirus related qualifying events, applicable to employers with fewer than 500 employees. The bill also requires group health plans and health insurance issuers to provide coverage of testing for COVID-19 (and the related office visit, including telehealth visits) without imposing cost-sharing or prior authorization or other medical management requirements.

Increasingly over the past couple years, Council members have expressed concern at the myriad different and often conflicting state and local laws related to paid leave. These concerns were an important reason the Council launched the [State Law Project](#). So prior to the COVID-19 pandemic, the Council has been advocating for legislation to preempt state and local paid leave requirements. The outbreak immediately brought this issue to the forefront and made paid leave a focus of congressional action. House Democrats originally proposed a requirement for all employers to provide at least 14 days of emergency paid sick leave and 12 weeks of emergency paid family and medical leave.

In response, the Council reached out to the White House, Senate and House of Representatives leadership of both parties, as well as appropriate congressional committees of jurisdiction. We also sent [a letter to all members of Congress](#) with a simple message: we appreciate the importance of paid leave as a component of the congressional response to address the crisis. So adherence to any federal requirement must deem employers to be in compliance with all state and local laws. This is important not simply to avoid administrative burdens to multi-state employers. It is also a matter of fundamental fairness to their employees who should receive the same paid leave benefits as co-workers living and working elsewhere - just as is the case for retirement and health benefits, pursuant to ERISA's federal preemption provisions.

We learned from House GOP sources that our message was very helpful as they worked with Democratic counterparts. The final measure that emerged from the House did not explicitly preempt state and local laws. However, we were gratified that the legislation was changed to apply solely to employers with fewer than 500 employees. These, of course, are companies less

likely to operate in multiple states or to have generous paid leave programs. This result is highly unusual inasmuch as so many laws typically exempt small, rather than large, companies.

To assist employers in paying for the cost of the new mandated paid leave requirements, the legislation provides a series of refundable tax credits. The credits are equal to the "qualifying" paid leave wages and certain "qualified" health care expenses paid by the employer. The large federal revenue loss that would have been associated with extending the tax credits (by virtue of extending the paid leave mandates) to employers also very likely factored into the decision to limit the mandate (and the tax credits), to smaller employers.

While the House-passed bill does not apply to larger employers, there will undoubtedly be an effort to do so in the next round of legislating. So, it is important that Council members continue to express to policymakers the importance of a uniform federal rule that both employees and employers may rely upon. The Council and its member companies are taking very important steps to assist working families during this period of extraordinary disruption. This collaborative effort will help mitigate anxiety and financial loss for millions of Americans. Collectively, we can help lawmakers develop practical policies that help families navigate the current crisis.

As noted above, a separate coronavirus response measure – designed to provide broader economic stimulus in response to ongoing financial market volatility – is also under development at this time. The Council is urging lawmakers to address sudden defined benefit pension funding shortfalls, arising from market declines and aggressively low interest rates, through both permanent and temporary funding stabilization.

## **RECENT REGULATORY ACTIVITY**

### **Treasury/IRS Issue Guidance Allowing HDHPs to Cover Screening, Treatment for COVID-19 Pre-Deductible**

As a key element of the federal government's response to the novel coronavirus (COVID-19) pandemic, the U.S. Treasury Department and Internal Revenue Service (IRS) issued [Notice 2020-15](#) on March 11 "to facilitate the nation's response to the 2019 novel coronavirus (COVID-19)." The Council had requested such guidance in numerous communications with policymakers over several weeks, culminating in [a March 10 letter](#) to Treasury and IRS.

The notice provides that until further guidance, a health plan that is otherwise a health savings account (HSA)-eligible high-deductible health plan (HDHP) will not fail to be an HDHP merely because it provides health benefits associated with testing for and treatment of COVID-19 without a deductible, or with a deductible below the minimum deductible for an HDHP.

In [a public statement](#) issued on March 11, the Council asserted that the guidance "gives companies the assurance they needed to ensure that screening can be provided at no cost to covered beneficiaries" and expressed appreciation for the rapid response from the agencies.

#### *Background*

This guidance follows formal and informal requests from the Council to confirm that screening of COVID-19 may be covered pre-deductible, without cost sharing, in HDHPs.

In its March 10 letter to the Treasury Department and the IRS, the Council explained that “[a]s employers work to contribute to the efforts to address the epidemic, and as the ability to screen for COVID-19 expands, many employers intend to provide COVID-19 screening through employer-provided health plans on a pre-deductible basis, and without cost sharing. This is to ensure that employees and their families seek screening when appropriate as one step to limit the spread of the outbreak. Further, some states have issued directives, or are considering doing so, to require insured plans to cover COVID-19 testing without cost sharing, including emergency room visits, and in-network urgent care and office visits.”

An issue arose, however, with respect to HDHPs. In order for a plan to qualify as an HDHP, it must satisfy certain requirements, including that it must have a minimum deductible and may not provide benefits for any year until the minimum deductible for that year is satisfied. However, Internal Revenue Code Section 223(c)(2)(C) provides a safe harbor for the absence of a deductible for preventive care. This means that an HDHP may provide preventive care benefits either without a deductible or with one that is below the otherwise required minimum annual level. Over the years, the Treasury Department and the IRS have provided guidance as to which benefits qualify as preventive care. In particular, [IRS Notice 2004-23](#) provides a safe harbor for preventive care benefits, including screening services, such as screening for certain infectious diseases.

While many employers view existing guidance as allowing pre-deductible coverage of COVID-19 screening (including when symptoms are present), other employers have raised questions as to whether a plan that provides screening for COVID-19 without cost sharing, if the individual has not yet met his/her deductible, qualifies as an HSA-compatible HDHP. As we stated in our March 10 letter “[t]his uncertainty among some employers has the potential to undermine employers’ ability to provide COVID-19 screening at no cost to employees and their family members; as well as to cause conflicts with state laws intended to mitigate the epidemic. Accordingly, we urge the Treasury Department and the IRS to confirm that a plan will retain its status as an HSA-compatible HDHP if it covers screening for COVID-19 (including the test itself, the administration of the test, and the related office visit), at no cost to the employee or a reduced cost to the employee, before the deductible is satisfied.”

This issue also garnered attention in Congress. In a March 10 [letter](#), Senator Steve Daines (R-MT) urged the Treasury Department “to take swift action to eliminate monetary barriers to testing for the Coronavirus disease” requesting that Treasury “issue guidance deeming COVID-19 testing a preventive care benefit permitted to be provided by an HSA-eligible HDHP without a deductible.”

#### *Notice 2020-15*

On March 11, Treasury and IRS issued Notice 2020-15, which provides that:

Due to the unprecedented public health emergency posed by COVID-19, and the need to eliminate potential administrative and financial barriers to testing for and treatment of COVID-19, a health plan that otherwise satisfies the requirements to be an HDHP under section 223(c)(2)(A) will not fail to be an HDHP merely because the health plan provides medical care services and items purchased related to testing for and treatment of COVID-19 prior to the satisfaction of the applicable minimum deductible. As a result, the individuals covered by such a plan will not fail to be eligible individuals under section 223(c)(1) merely because of the provision of those health benefits for testing and treatment of COVID-19.

That is, the notice not only addresses *screening* for COVID-19, but also *treatment* of COVID-19. The notice applies until further guidance is issued. Treasury and IRS note that the guidance does not modify previous guidance with respect to the requirements to be an HDHP in any manner other than with respect to the relief for testing for and treatment of COVID-19.

Further, Treasury and IRS note that vaccinations continue to be considered preventive care under Internal Revenue Code Section 223(c)(2)(C) for purposes of determining whether a health plan is an HDHP.

## **Council Comments on Drug Coupons and Cost-Sharing Limitations, Other HHS Rules**

On February 28, the American Benefits Council filed [written comments](#) on proposed modifications to rules regarding drug manufacturers' coupons and the annual limitation on cost sharing, as well as guidance regarding qualified small employer health reimbursement arrangements (QSEHRAs) and value-based insurance design.

The U.S. Department of Health and Human Services (HHS) recently released the [proposed Notice of Benefit and Payment Parameters \(NBPP\) for 2021](#), which is a set of regulations issued annually to implement select aspects of the Affordable Care Act (ACA). The 2021 NBPP addresses a number of issues relevant to plan sponsors, along with a number of issues outside that purview.

The Council's comment letter addresses the following topics:

### *Drug Manufacturers' Coupons and the Annual Limitation on Cost Sharing*

Most notably, the 2021 NBPP addresses the manner in which the value of drug manufacturers' coupons are treated for purposes of the annual limitation on cost sharing under the ACA, including for self-funded and large group market health plans. Specifically, HHS proposes to revise the regulations to provide that, to the extent consistent with applicable state law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers for specific prescription drugs may be, *but are not required to be*, counted toward the ACA's annual limitation on cost sharing.

This proposed guidance responds to an issue on which the Council has been [advocating](#) over the past year. The [2020 NBPP](#) had provided that group health plans and issuers would be prohibited from excluding the value of drug manufacturers' coupons when applying the annual limitation on cost sharing, unless a generic equivalent of the drug is available. This would have imposed material additional costs on some plans and issuers that had been excluding the value of coupons for drugs without a generic alternative from counting toward the annual limitation on cost sharing. Further, the rule could have raised a conflict with the Internal Revenue Services' (IRS) position that prior IRS guidance requires health savings account eligible high deductible health plans to disregard drug manufacturers' coupons when determining if the minimum deductible has been satisfied and to only count amounts actually paid by the individual. Owing to concerns raised by the Council and other stakeholders, the tri-departments released a [Frequently Asked Questions](#) document providing a non-enforcement safe harbor of the rule in the 2020 NBPP, pending the 2021 NBPP.

The Council's comment letter expresses support for the proposed changes to allow (but not require) group health plans and issuers to count the enrollee's cost-sharing portion associated with the value of drug manufacturers' coupons toward the annual limitation on cost sharing.

## QSEHRAs

The 2021 NBPP also provides a special enrollment period for certain individuals (those who are provided with a QSEHRA with a non-calendar year plan year) to enroll in or change their individual health insurance coverage through or outside of an exchange. Individuals provided with a calendar year QSEHRA can already enroll in the individual market during open enrollment. This issue was first raised in the June 2019 individual coverage HRA [final rules](#).

The Council's comment letter expresses support for this rule, noting that we support rules that facilitate the use of health reimbursement arrangements (HRAs) and other defined contribution health models, including QSEHRAs.

## *Value-Based Insurance Design*

In the 2021 NBPP, HHS also proposes to offer issuers of qualified health plans options to assist in the design of value-based insurance plans that would empower consumers to receive high-value services at lower cost. While this proposal would only impact individual and small group health insurance coverage offered on the exchange, the Council's comment letter notes that we are supportive of federal policies and rules that support and enhance value-based insurance design.

The comment letter also emphasizes that “employers are at the forefront of initiatives to lower health care costs and improve quality through various value-based design strategies and that increased plan sponsor access to pricing and claims data and meaningful and uniform quality measures are needed to facilitate the development and expansion of such programs.”

We expect HHS will issue final regulations this spring and the Council will report on any relevant updates.

## **Council Requests PEP Guidance from Treasury/IRS**

In a [February 27 letter](#) to the U.S. Department of Treasury and Internal Revenue Service (IRS), the American Benefits Council provided recommendations to ensure pooled employer plans (PEPs) can be effectively established for the 2021 plan year when PEP rules become effective.

Key provisions from the [Setting Every Community up for Retirement Enhancement \(SECURE\) Act \(H.R. 1994\)](#), enacted as a part of the 2019 funding package, allow small employers to pool their resources and achieve lower costs through PEPs and the ability to file a single consolidated Form 5500.

In the letter, the Council urged Treasury to publish the new consolidated Form 5500 so it can be used for the 2022 plan year (consistent with the SECURE Act effective date) and requested the following:

- Guidance on audit issues related to the new consolidated Form 5500 for PEPs
- Guidance on pooled plan providers (PPPs) related to administrative cost issues and the registration process and on mandatory Form 5500 changes for PEPs
- Model plan language to qualify for the one bad apple relief and to qualify for pooled employer plan status

The Council provided similar recommendations to the U.S. Department of Labor (DOL) in a [February 6 letter](#).

## **RECENT JUDICIAL ACTIVITY**

***No recent judicial activity to report.***