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Benefits Counselor – May 2020

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REGULATORY UPDATES

COVID-19 FAQs (April 11, 2020)

The U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (Departments) issued joint Frequently Asked Questions (FAQs) clarifying certain aspects of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Highlights include:

- The testing coverage requirements end when the COVID 19 related public health emergency ends. The FAQs clarify that the public health emergency ends the earlier of [1] the date the Secretary of HHS declares the emergency is over or 90 days following the date of the public health emergency declaration. As the current public health emergency declaration was issued on April 26, 2020, the testing requirements will end on July 25, 2020, unless the Secretary of HHS terminates the public health emergency earlier or otherwise extends it.
- Testing requirements apply to all group health plans (including grandfathered plans under the Affordable Care Act) except for plans that provide only excepted benefits (e.g., dental and vision plans) or plans that qualify as retiree-only plans. The FAQs also confirm that grandfathered plans will not jeopardize their status by complying with FFCRA's coverage requirements provided no other changes are made that would cause a loss of grandfathered status.
- "In-vitro diagnostic tests" include serological (antibody) tests. Additionally, items and services for "the evaluation of such individual for purposes of determining the need for diagnostic testing" include testing for other respiratory illnesses (e.g., flu tests, blood tests) to determine if COVID-19 testing is required.
- Plans must cover COVID-19 testing from an out-of-network provider at no-cost sharing. However, a plan may negotiate a rate with an out-of-network provider that is lower than the published cash price.
- The FAQs confirm the definition of a "visit" for COVID-19 testing purposes is truly regardless of setting—so long as there is a licensed health care provider administering the test. This includes drive-through screening, testing through an EAP, and other nontraditional settings, provided that a licensed health care provider is present and administers the testing. The FAQs also confirm that

offering testing through EAPs and on-site clinics will not cause these to cease being deemed an excepted benefit.

- The FAQs also provide non-enforcement policies for 60-day advance notice of plan changes related to COVID-19 that would otherwise be required for changes impacting the summary of benefits and coverage. This non-enforcement policy applies to FFCRA-related changes and to improvements to telehealth coverage (including telehealth coverage that exceeds FFCRA's requirements). The FAQs note that notice must be provided as soon as reasonably practical. These non-enforcement policies will continue while the FFCRA's testing requirement remains in effect or a national emergency declaration related to COVID-19 is in effect.

Note that the U.S. Food and Drug Administration has approved the first home-testing kit for COVID-19, obtainable by prescription, whereby the patient collects samples at home and mails them in to be tested. This would presumably fall under the "in-vitro" category and be covered at 100 percent as well.

COBRA FAQs (May 1, 2020)

The DOL issued FAQs concerning the coordination of COBRA and Medicare and corresponding updated model COBRA notices. The FAQs provide a reminder to plans that COBRA coverage can be terminated if a qualified beneficiary enrolls in Medicare *after* electing in COBRA. However, if a qualified beneficiary enrolls in Medicare *before* electing in COBRA, COBRA coverage may not be terminated due to Medicare enrollment. The FAQs clarify that Medicare will pay primary to COBRA for purposes of the Medicare Secondary Payer rules. They also clarify that if the qualified beneficiary is eligible for Medicare, but does not enroll in Medicare during the eight-month special Medicare enrollment period, the Medicare Part B late enrollment penalty may apply.

The updated model COBRA notices include a new section explaining these rules.

Joint Notice from IRS and EBSA (May 4, 2020) and EBSA Disaster Relief Notice

The Employee Benefits Security Administration (EBSA) and the IRS issued a joint notice announcing the extension of certain timeframes applicable to ERISA plans, and the participants and beneficiaries of such plans during the COVID-19 national emergency. EBSA also separately published Disaster Relief Notice 2020-01 to provide relief for employee benefit plans and service providers from certain ERISA deadlines. As described in more detail in our separate e-alert, the effect of this

guidance is to pause certain health and retirement plan deadlines from March 1, 2020 to 60 days after the end of the COVID-19 national emergency period (Outbreak Period). This includes:

- The 30-day deadline for an individual to request enrollment in a group health plan due to a HIPAA special enrollment event;
- The 60 day period for electing COBRA coverage following a qualifying event (as well as the 45-day initial and 30 day subsequent grace periods for a COBRA payment); and
- Participant obligations with respect to claims and appeals deadlines.

This change raises a concern with respect to health coverage. Presumably, participants who lose employer coverage could take a "wait-and-see" approach until after the Outbreak Period ends to both elect COBRA coverage and make back payments, if they required coverage in the interim. Also, participants who do this will not lose the opportunity to request a special enrollment period in new employer coverage. There are no restrictions on who can pay COBRA premiums—for example, a health provider may pay a COBRA premium on a patient's behalf.

Additionally, on the plan sponsor side, many notice and disclosure requirements are also tolled, provided that the plan administrator acts in good faith and furnishes the notices and documents as soon as administratively feasible.

The new guidance also provides relief for plan distributions and loans. If a retirement plan fails to follow procedural requirements for plan distributions or loans under the terms of the plan, the DOL will not treat it as an operational failure if:

- The failure is solely attributable to the COVID-19 outbreak;
- The plan administrator makes a good-faith diligent effort under the circumstances to comply with those requirements; and

The plan administrator makes a reasonable attempt to correct any procedural deficiencies, such as assembling any missing documentation, as soon as administratively practicable.

Additional FFCRA Clarifications

The DOL issued guidance regarding whether employers may require an employee to exhaust paid leave first or use paid leave concurrently with leave taken under the Expanded Family and Medical Leave Act and Emergency Paid Sick Leave Act:

- An employer may require an employee first exhaust existing paid leave or use existing paid leave concurrently with the 10 weeks of paid leave provided under the Expanded Family and Medical Leave Act.
- An employer may not require an employee to first exhaust existing paid leave or use existing paid leave concurrently with leave taken under the Emergency Paid Sick Leave Act.

The DOL also issued guidance regarding the calculation of FFCRA hours entitlement for employees with irregular schedules and/or irregular compensation.

IRS Disaster Relief Notices

IRS Notice 2020-23 automatically extends the deadlines for tax obligations due on or after April 1, 2020 and before July 15, 2020, including the filing deadlines for Form 5500s and Form 990s. Notably, this does not affect the Form 5500 July 31 deadline for calendar year plans. Notice 2020-23 also provides timing relief for plan loan repayments, indirect rollovers, required minimum distributions, and other time sensitive actions required under the Internal Revenue Code for plan sponsors.

NEW CASE LAW

Barnett v. Abbott Laboratories, et al., No. 2020 CV 2127 (N.D. Ill. filed April 3, 2020).

A participant filed a complaint against a 401(k) plan sponsor and third-party administrator alleging the plan fiduciaries failed to use the level of care, skill, prudence and diligence required of an ERISA fiduciary to protect plan assets after the participant's account was emptied in a cybersecurity breach. According to the complaint, the identity thief accessed the participant's account using her date of birth and the last four digits of her social security number. The identity thief then added a new bank account for direct deposit and contacted the third-party administrator's help-line for assistance regarding distributions. During the call, the help-line employee allegedly volunteered the participant's personal information to the identity thief, including her mailing address. Eight days later,

the identity thief successfully requested a distribution. The complaint also alleges the participant opted to receive e-notifications of changes in her account, however, because the plan notified her through U.S. mail, the identity thief was able to empty her account during the delay.

Although this is just a new filing (and not a decision), this case is one of the first in what could be a wave of litigation against plan fiduciaries, third party administrators and recordkeepers related to cybersecurity breaches. The coronavirus pandemic has also seen an increase in scams and cybersecurity attacks, as well as plan activity and distributions.

Divane v. Northwestern University, 953 F.3d 980 (7th Cir. 2020).

Divane v. Northwestern University, is the most recent decision in a series of cases following *Tibble v. Edison,* alleging that plan fiduciaries breached their duties with respect to investment options and excess fees. *Tibble* was a 2015 U.S. Supreme Court decision that was, on its surface, a statute of limitations case, but importantly held that a plan fiduciary has a continuing duty to "monitor. . . investments and remove imprudent ones."

In *Divane*, the plaintiffs alleged the plan fiduciaries improperly bundled services with one of the plan's recordkeepers that resulted in higher fees and the inclusion of expensive but sub-optimal investment options; improperly used multiple recordkeepers; and paid those recordkeepers excessive fees through an asset-based arrangement instead of a flat per-participant fee.

The U.S. Court of Appeals for the Seventh Circuit upheld the lower court's dismissal, holding that the facts alleged by the plaintiff failed to state a claim. The court reasoned that, while the plan contained some sub-optimal investment options, bundling services also allowed the plan sponsors to offer some investment options that were popular among the plan participants, but would not have been otherwise available. Further, nothing in ERISA requires a plan sponsor to be limited to one recordkeeper or prohibits an asset-based fee arrangement rather than fixed per-participant fee.

The court emphasized that the plaintiffs failed to allege that the plan "did not make their preferred [investment options] available to them. In fact [the plan] did. Plaintiffs simply object that numerous additional funds were offered as well." In comparison, in *Sweda v. University of Pennsylvania*, No. 17-3244 (3d Cir. 2019), the U.S. Court of Appeals for the Third Circuit, facing a similar fact pattern, overturned the lower court's dismissal, noting that "a meaningful mix and range of

investment options [does not insulate] plan fiduciaries from liability for breach of fiduciary duty," as "such a standard would allow a fiduciary to avoid liability by stocking a plan with hundreds of options, even if the majority were overpriced or underperforming."

Divane sheds additional light into *Tibble*'s holding with respect to a plan fiduciary's duty to remove imprudent investments, making it more difficult for plaintiffs (at least in the Seventh Circuit) to allege a breach of fiduciary duty claim based on the existence of expensive and underperforming investments when bundled with more favorable investments.

PROPOSED LEGISLATION FOR MULTI-EMPLOYER PENSION FUNDING CRISIS

The U.S. House of Representatives has proposed legislation, the Emergency Pension Plan Relief Act, which would repeal the Multiemployer Pension Reform Act of 2014 (MPRA). If passed and signed into law, plans will no longer have the ability to apply for benefit reduction under MPRA. In turn, the proposed legislation expands the Pension Benefit Guarantee Corporation's (PBGC) partition authority and increases the PBGC insured benefit. Plans that have already successfully applied to reduce benefits under MPRA would be eligible for partition. If they are partitioned, benefits reduced under MPRA would be reinstated and any unpaid benefits during the suspension period would be restored. The proposed legislation also includes measures to help struggling plans take advantage of existing laws. For example, it would allow plans to freeze their zone status for the current plan year. It also extends funding improvement and rehabilitation periods for plans in endangered and critical status.