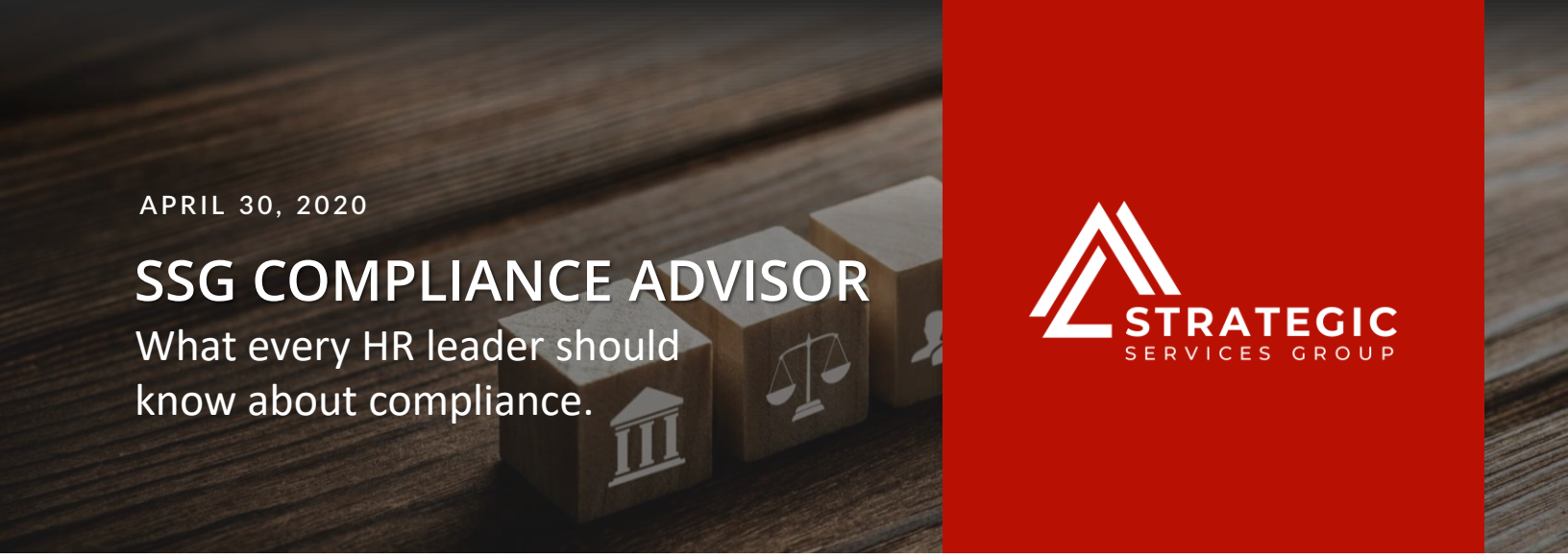

APRIL 30, 2020

SSG COMPLIANCE ADVISOR

What every HR leader should know about compliance.

STRATEGIC SERVICES GROUP

Final Rule on the Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Due to COVID-19

On March 13, 2020, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and by separate letter made a determination, under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, that a national emergency exists nationwide beginning March 1, 2020, as the result of the COVID-19 outbreak.

The Department of Labor (DOL) and the Department of the Treasury (Treasury) issued a final rule that extends certain timeframes under the Employee Retirement Income Security Act (ERISA) and Internal Revenue Code (IRC) for group health plans, disability, and other welfare plans, pension plans, and participants and beneficiaries of these plans during the COVID-19 national emergency. The timing extensions are issued to help alleviate problems faced by health plans to comply with strict ERISA and IRC timeframes and problems faced by participants and beneficiaries in exercising their rights under health plans during the COVID-19 national emergency. The final rule provides the timeframe extensions based on the end date of the "national emergency" (as of the date of this publication, the national emergency end date has not been announced) and the end date of the "outbreak period" which is the 60th day after the end of the national emergency. Under the final rule the outbreak period will be disregarded, meaning the timeframes for the group health plan requirements noted below will not begin to run until after the outbreak period has ended.

The following extensions will be effective on May 4, 2020.

HIPAA Special Enrollment Periods

Under HIPAA, group health plans must provide special enrollment periods in certain circumstances, including when an employee or dependent loses eligibility for any group health plan or other health insurance coverage in which the employee or the employee's dependents were previously enrolled (including coverage under Medicaid and the Children's Health Insurance Program), and when a person becomes a dependent of an eligible employee by birth, marriage, adoption, or placement for adoption. Generally, group health plans must allow such individuals to enroll in the group health plan if they are otherwise eligible and if enrollment is requested within 30 days of the occurrence of the event (or within 60 days, in the case of loss of Medicaid or state Children's Health Insurance Program (CHIP) coverage or eligibility for state premium assistance subsidy from Medicaid or CHIP).

Under the final rule, the outbreak period must be disregarded when determining if a participant timely requested HIPAA special enrollment (i.e., the 30-day or 60-day period will begin to run the day after the outbreak period). See the Appendix for examples.

COBRA

The COBRA continuation coverage provisions generally provide a qualified beneficiary a period of at least 60 days to elect COBRA continuation coverage under a group health plan. Plans are required to allow payment of premiums in monthly installments, and plans cannot require payment of premiums before 45 days after the day of the initial COBRA election. COBRA continuation coverage may be terminated for failure to pay premiums on time. Under the COBRA rules, a premium is considered paid on time if it is made no later than 30 days after the first day of the period for which payment is being made. Notice requirements prescribe time periods for employers to notify the plan of certain qualifying events and for individuals to notify the plan of certain qualifying events or a determination of disability. Notice requirements also prescribe a time period for plans to notify qualified beneficiaries of their rights to elect COBRA continuation coverage.

Under the final rule, the outbreak period must be disregarded when determining the 60-day COBRA election period, the date for making COBRA premium payments, and the date for qualified beneficiaries to notify the plan of a qualifying event or determination of disability. The outbreak period must also be disregarded when determining the date by which a COBRA election notice must be provided to a qualified beneficiary. See the Appendix for examples.

Claims Procedure

ERISA-covered employee benefit plans and non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage are required to establish and maintain a procedure governing the filing and initial disposition of benefit claims, and to provide participants with a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary. Plans may not have provisions that unduly inhibit or hamper the initiation or processing of claims for benefits. Further, group health plans and disability plans must provide participants at least 180 days following receipt of an adverse benefit determination to appeal (60 days in the case of pension plans and other welfare benefit plans).

Under the final rule, the outbreak period must be disregarded when determining the date for participants to file a benefit claim under the plan's claims procedures and the date by which a participant may file an appeal of an adverse benefit determination under the plan's claims procedure. See the Appendix for examples.

External Review Process

ERISA sets forth standards for external review that apply to non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage and provides for either a state external review process or a federal external review process. Standards for external review processes and timeframes for submitting claims to the independent reviewer for group health plans or health insurance issuers may vary depending on whether a plan uses a state or federal external review process. For plans or issuers that use the federal external review process, the process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed. The federal external review process also provides for a preliminary review of a request for external review.

(continued)

External Review Process (*continued)*

The regulation provides that if such request is not complete, the federal external review process must provide for a notification that describes the information or materials needed to make the request complete, and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Under the final rule issued by the DOL, the outbreak period must be disregarded when determining the date by which a participant may file a request for an external review after receiving an adverse benefit determination or final internal adverse benefit determination and the date by which a participant must file a corrected request for external review upon a finding that the request was not complete. See the Appendix for examples.

4/30/2020