COVID-19 Employer Compliance Handbook

Employer Handbook on Employee Benefits
Compliance Concerns Associated with COVID-19

April 17, 2020

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Now more than ever, employers need customized support as they try to navigate the multitude of issues arising from the COVID-19 pandemic. Employers are faced with important decisions related to their employees and the benefits that they are able to offer. Some of the material issues you may have already considered, others you may not, given the fast changing landscape. To help you get through this challenging time, the Gallagher Compliance Consulting team has put together this handbook. If you have questions, please reach out to your Gallagher Consultant for assistance.

About Gallagher Compliance Consulting

Gallagher's Compliance Consulting practice, which consists of more than 30 attorneys and consultants, averaging over 20 years of experience, partners with employers to deliver the strategy, deep expertise and holistic approach that allows our clients to differentiate their organization and build a workplace culture centered on organizational wellbeing at sustainable cost structures. Gallagher understands that employers are faced with numerous challenges when they are crafting benefits programs that meet their operational goals while still complying with all relevant mandates. Those same employers are now faced with additional unique challenges as a result of the COVID-19 pandemic. However, during this tumultuous time, Gallagher's compliance experts have continued to help employers stay on top of the many challenges they are confronting. Our team is immersed in the details and legal issues surrounding all aspects of employer-provided benefits during the COVID-19 pandemic, and together with our clients we work on crafting proactive plans that protect workforce and organizational wellbeing, reduce risk, take into consideration employers' strategic goals and address employers' unique compliance challenges as they work toward a better response to COVID-19.

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The information in this article is current through April 17, 2020. However, given the fast changing nature of the nation's response to the COVID-19 pandemic, we acknowledge that facts will change and invite you to visit our pandemic **site** where we maintain up-to-date information.

Introduction

The 2019 Novel Coronavirus (COVID-19) has caused a pandemic that very few predicted. Tragically, it has resulted in the loss of many lives. And while the loss of life is of upmost importance, it has also impacted every employer, in every industry in the country. However, the impact on each employer is different. The challenges that each business faces are unique. As a result, how those employers respond is also different and must be customized to their specific circumstances. Many employers face temporary closures and the grim decision of reducing employee hours, introducing furloughs, or even laying off employees. Given the nature of the crisis, employers are required to act quickly. And while a perfect option is not always available, all employers have an option that is, at a minimum, a bit better than the others. However, to make an informed decision when choosing the best path forward, employers must consider all the issues, which is difficult given the many laws and regulations that may affect each employer's decision. For that reason, to help employers understand the issues that they must consider when deciding how to approach benefits compliance issues related to ongoing employees, furloughed employees, employees experiencing a reduction in hours, and even laid off employees, we created this handbook. The handbook is organized by employee status (e.g., furloughed employees), which will allow employers to focus on all of the material consideration by outcome.

We hope that you find this material useful as you try to navigate in this temporary normal.

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Ongoing Employees without a Change in Status due to COVID-19

Introduction

Although COVID-19 has caused many employers to make difficult decisions to furlough, lay off, or reduce hours of service for their employees in response to economic conditions or local requirements forcing closures, such as stay-at-home orders, many other employers, particularly those who have been able to deploy their workforce on a remote work basis, have continued operations. Regardless of an employer's current response to conditions related to COVID-19, new legislation, as well as prior requirements related to employee benefits, creates compliance challenges. For employers with ongoing employees, we outline below some important compliance considerations in light of the COVID-19 pandemic and legislation related to COVID-19.

Leave under the Families First Coronavirus Response Act

For an overview of the FFCRA Temporary Rule click here.

With the passage of the Families First Coronavirus Response Act (FFCRA), two new types of leave were introduced into the work place – Emergency Paid Sick Leave (EPSL) and Public Health Emergency Leave (PHEL) (often referred to as expanded FMLA leave) – for employers with fewer than 500 employees on the date an employee's leave would begin and all governmental employers. There is a possible exception for employers with fewer than 50 employees. In addition to EPSL and PHEL, an employee who is diagnosed with COVID-19 may also qualify for leave under the Family and Medical Leave Act (FMLA). In addition, an employee may qualify for leave to take care of a family member under FMLA or state law. (State leave is beyond the scope of this article.) Both PHEL and EPSL are only available between April 1, and December 31, 2020.

Public Health Emergency Leave (PHEL)

For information about PHEL, please see our section on **Employees on Leaves of Absence**.

Emergency Paid Sick Leave (EPSL)

For information about PHEL, please see our section on **Employees on Leaves of Absence**.

Health Plan Implications

Coverage for COVID-19 diagnosis and testing

The FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The CARES Act amends the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Additionally, the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

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HSA-compatible High Deductible Health Plans

Internal Revenue Code Section 223 permits eligible individuals to deduct contributions to health savings accounts (HSAs). Among the requirements for an individual to qualify as an eligible individual under Section 223(c)(1) is that the individual be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including minimum deductibles and maximum out-of-pocket expenses. For example, for 2020, HSA-compatible HDHPs must have minimum deductibles of $1,400 for self-only coverage and $2,800 for other than self-only coverage.

On March 11, 2020, the IRS released Notice 2020-15 in response to questions about whether health plans that cover testing and treatment for the 2019 Novel Coronavirus (COVID-19) without cost sharing would cause individuals with HDHP coverage to lose their eligibility to contribute to HSAs. The Notice indicates that such coverage will not cause individuals to lose their eligibility. Under the Notice, a health plan may provide 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. In other words, HDHPs that are HSA-compatible may cover both testing *and* treatment prior to the satisfaction of applicable deductibles.

Additionally, after the passage of the CARES Act, HSA-compatible HDHPs are permitted to cover telehealth services before a patient reaches the deductible, without regard to whether the telehealth services relate to COVID-19. This provision is effective upon enactment and lasts through plan years beginning in 2021.

OTC Drugs and Menstrual Products reimbursable as medical care

After passage of the CARES Act, patients may use funds in HSAs, health reimbursement arrangements (HRAs), and health flexible spending accounts (FSAs) to purchase over-the-counter (OTC) menstrual care products. In addition, patients may use funds from HSAs, FSAs, or HRAs to cover OTC drugs without a prescription (thus repealing a prohibition under the Patient Protection and Affordable Care Act (ACA)). These changes are effective for amounts paid and expenses incurred in 2020 and apply indefinitely. Changes to cover OTC drugs without prescriptions and menstrual care products under account-based plans (e.g., health FSAs) will likely trigger a need for plan amendments, and for employers subject to ERISA, summaries of material modification (SMMs).

For a deeper dive into plan amendment changes triggered by COVID-19, check out our article on Plan Documents and COVID-19.

Telehealth

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. For example, individuals may receive evaluation and management visits (common office visits), mental health counseling, and preventive health screenings through telehealth services, which may include phone calls, video conferences, and similar activities. In the wake of COVID-19 and the need for social distancing, many health care providers have turned to telehealth solutions for their patients. In response, federal and state governments have taken action to permit the use of technology to help individuals who need routine care, and keep vulnerable individuals with mild COVID-19 symptoms in their homes while maintaining access to the care they need. Such efforts are also intended to limit community spread of the virus, as well as limit the exposure to other patients and staff members in order to slow viral spread.

As a result, many employers have expanded or introduced the use of telehealth services. When doing so, employers should consider whether that expansion or introduction triggers the need for a plan amendment, and for employers

subject to ERISA, a need to release an SMM. Additionally, all employers making changes related to telehealth should also consider whether that change triggers a change to their summaries of benefits and coverage (SBC).

Implications for Other Benefits

Student Loan Programs

Due to the significant increase of the cost of higher education, many employers have established student loan repayment programs. However, until passage of the CARES Act, payments to or on behalf of employees resulted in taxable income to those employees. The CARES Act expands Section 127 of the Internal Revenue Code, which allows employers to pay up to $5,250 per year for certain educational expenses, to include student loan payments made by the employer after the enactment of the Act and before January 1, 2021. Any such payment made by the employer on behalf of the employee is excluded from the employee's income.

ACA Implications

Under the Patient Protection and Affordable Care Act (ACA), an employee's status as full-time or not full-time is important for multiple reasons, including determining how to treat employees for purposes of Forms 1094 and 1095 reporting and application of the Employer Shared Responsibility Mandate. Specifically, Applicable Large Employers (ALEs) must offer affordable, minimum value coverage to at least 95% of their full-time employees to avoid Employer Shared Responsibility penalties. Under the ACA, an employee who works an average of 30 or more hours per week is considered to be a full-time employee. Only full-time employees can trigger penalties for ALEs, and full-time employees are the primary focus of Forms 1094 and 1095 reporting. In general, an ALE is an employer with 50 or more full-time employees and full-time equivalent (FTE) employees in the prior year.

Under the ACA, an employer identifies its full-time employees based on each employee's hours of service. Generally, "hours of service" include any hour for which an employee is paid or entitled to payment when duties are not performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. The ACA permits employers to determine an employee's full-time status using either a monthly measurement method or a look-back measurement method. Under the monthly measurement method, an employee's hours of service are calculated for a given month, and the employee's ACA status is determined based on the hours of service in that particular month. If an employee has at least 130 hours of service for a month, then that employee is considered to be full-time for that month. Under the look-back measurement method, an employee's status as full-time or not full-time is determined during a measurement period for a corresponding stability period (which follows the measurement period). In that case, when an employee has been determined to be a full-time employee during the measurement period, his or her full-time status during the corresponding stability period is protected.

For more information on counting hours for purposes of the ACA, check out our Counting Hours Toolkit.

For employees not impacted by furloughs, layoffs, or reductions in hours, tracking and reporting should continue as per your usual methods.

Cafeteria Plan Election Issues

Although many, if not all, of your employees may continue working on their regular schedules and thus not experience changes in status based upon changes in employment, there may be other possible changes in status as a result of COVID-19 that can impact their ongoing benefits. For example, an employee's need for dependent child coverage may be impacted by school closure and the ability of a spouse or other family member to care for a child. So, it is important to consider possible changes in the context of broader circumstances. However, before discussing

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what changes may occur as a result of COVID-19, it is important to understand some basics of the IRC Section 125 regulations governing employee mid-year elections.

Changes in underlying benefits may create permissible changes in status for ongoing employees.

Cafeteria plan election basics

Determining whether a mid-year election is allowed depends on a several factors. First, the change must be permitted by the underlying benefit plan. Second, any requested change must be permitted both under the Internal Revenue Code (IRC) Section 125 regulations and your cafeteria plan or Section 125 plan document. Note that a plan cannot be more generous than what the IRS allows, but it can be more restrictive. So, you should verify that both the underlying benefit and your cafeteria (or Section 125) plan document permit a requested change.

Under the IRC Section 125 regulations, there are six categories of events that encompass permissible change in status events:

- change in legal marital status;
- change in number of dependents;
- change in employment status (including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in worksite);
- dependent satisfies or ceases to satisfy dependent eligibility requirements;
- residence change; and
- for adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

Health benefit coverage changes due to the FFCRA

As a result of the FFCRA, group health plans and health insurers are required to cover, without cost-sharing, testing for COVID-19, as well as office visits, telehealth, urgent care visits, or emergency room visit costs associated with the administration of testing. If your plan did not cover these expenses without cost-sharing before, the addition of this new benefit could be considered a significant improvement of the benefit package option. The Section 125 cafeteria plan regulations permit mid-year election changes due to the addition or significant improvement of a benefit package option. If a benefit package option is significantly improved mid-year, and the employer's written cafeteria plan document allows, the employer may permit election changes that are consistent with that improvement within the time frame for making requests specified in the cafeteria plan document.

Additionally, some insurers have been allowing “special enrollments” outside annual enrollment for eligible employees who may not have been previously enrolled in coverage. Questions have been raised as to whether these special enrollments would provide for permissible mid-year cafeteria plan election changes. The cafeteria plan regulations do not address this issue specifically; however, employers faced with this situation can permit employees to pay premiums on an after-tax basis. It is important to note that some insurer contracts permit employees to drop coverage at any point in the year. In that case, the situation would be treated the same with premiums being paid on a post-tax basis. Note that some plan sponsors may take the position that if the COVID-19 special enrollment periods are associated with additional coverage for COVID-19 diagnosis and testing or both COVID-19 testing/diagnosis and treatment, an argument may exist that the additional benefits would qualify for a permissible election change based on a significant improvement in or addition to benefits, which would allow individuals who had not been previously enrolled to change their salary reduction agreements to pay for the new coverage on a pre-tax basis. However, no changes made be made in a health FSA election because the change in cost or coverage rules do not apply to a health FSA.

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Below is a chart of some common events that may occur in response to COVID-19:

Event	Change Permitted
Spouse or eligible dependent loses coverage under other employer's plan (i.e., termination of employment, reduction of hours, layoff, furlough)	Yes. The employee would be permitted to change his or her health election to add spouse and/or dependent or enroll employee plus spouse and/or dependent in coverage. This also triggers a HIPAA Special Enrollment Right for medical.
Exhaustion of COBRA coverage at end of 18, 29, or 36 months	Yes. The employee would be permitted to change his or her health election to add spouse and/or dependent or enroll employee plus spouse and/or dependent in coverage. This also triggers a HIPAA Special Enrollment Right for medical. HIPAA special enrollment based on the loss of other coverage is available to the employee and other individuals who are eligible under the plan, including domestic and civil union partners and their children. The HIPAA special enrollment right is only available as the result of exhaustion of the maximum COBRA duration. Voluntary termination does not give the individual special enrollment rights even if the individual loses free COBRA coverage. For example, if a former employer does not charge for COBRA for three months after a layoff, there is no special enrollment with a new employer at the end of that three-month period.
Addition of new benefit package option or increase in benefit offering	Maybe. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or enroll. This may be applicable related to changes for to COVID-19 coverage.
Rehire and gain eligibility within 30 days	Coverage should be reinstated at the same level as prior to the termination or plan may be designed to not allow the employee to re-enroll on pre-tax basis. However, employees rehired within their stability period with a break in service of less than 13 weeks must be offered coverage at the same level as prior to break.
Rehire and gain eligibility more than 30 days	Coverage can be reinstated at the same level as prior to the termination, a new election can be made, or plan may be designed to not allow the employee to re-enroll on pre-tax basis. However, the Employer Shared Responsibility rules require that employees who return to work within their stability periods with breaks in service of less than 13 weeks (26 weeks for an academic employer) must be offered coverage at the same level as prior to break. Employees returning later than 13 weeks (26 weeks for an academic employer) can be treated as new employees.

Permitted election changes for DCAPs and health FSAs

With respect to health FSAs, an employee's change to his or her FSA is limited based on the event that has occurred. Generally, when election changes dealing with changes in eligibility occur, an employee can increase or decrease the applicable election provided that the change is consistent with the event. If the election change event is related to changes in cost or coverage options, the employee cannot change his or her health FSA election; however, the employee may be able to change his or her DCAP election.

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Below is a chart of events that may occur that would allow employees to change their health FSA elections:

Event	Change Permitted
Spouse or eligible dependent loses coverage under other employer's plan (i.e., termination, reduction of hours, layoff, furlough)	Yes. Employee can enroll or increase election.
Exhaustion of COBRA coverage at end of 18, 26, or 36 months	Yes. Employee can enroll or increase election.
Addition of new benefit package or increase in benefit offering	No change.

Lastly, with the passage of CARES Act, expenses for both over-the-counter (OTC) drugs without prescriptions and menstrual care products can now be paid with pre-tax dollars from account-based plans. These are permanent changes and effective for expenses incurred on or after December 31, 2019. However, no changes may be made in a health FSA election because the change in cost or coverage rules do not apply to health FSAs.

The IRS has not yet released new official guidance on the expansion of reimbursement for OTC drugs and menstrual care products. Employers may need to rely on previous IRS Revenue Ruling 2003-102 until the IRS is able to update its guidance.

Employers that provide reimbursement through health FSAs may need to amend their plan documents to allow for the reimbursement. Employer should review their governing plan documents for amendment procedures and follow those procedures accordingly. Once an amendment is adopted, employers should notify employees of the changes. Lastly, the reimbursements should only be permitted on a prospective basis (unless subsequent IRS guidance allows for retroactive coverage).

However, note that health FSA and other administrators for account-based plans may not yet have had the opportunity to reconfigure their systems and update their card payments systems, so you should check with your administrators or vendors, as applicable, to ensure that your health FSA can be administered to accept these newly reimbursable products.

The election change rules for dependent care assistance programs (DCAPs) are more flexible in allowing employees to change elections. Changes to DCAP elections may be relevant to employees if their spouses are subject to stay-at-home orders or terminated from employment, or their eligible dependent child care providers are closed.

Some relevant DCAP changes that may occur:

Event	Change Permitted
Change in dependent care provider to parent (e.g., employee and/or spouse at home to care for child)	Yes. The employee would be able to reduce or revoke his or her election. An employee may not have eligible dependent care expenses if the employee or spouse is able to stay home with the child.

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Event	Change Permitted
Change in the number of hours of dependent care	Yes. Consistency rule would apply (e.g., an employee could decrease an election if she decreased her work hours and needed fewer hours of day care for her child).
Change in the cost of day care	Yes. Decrease or revoke election. Election change is permitted only if the provider is not related to the employee.

Permissible election changes for life and disability insurance

Most changes in status permit life and disability coverage election changes, even when eligibility is not affected, to reflect the following: enrollment of employee, increase in coverage, decrease in coverage, or end of coverage. For example, in the event of marriage, an employee may either increase or decrease her life insurance coverage. In the event of a divorce, an employee may either increase or decrease her life insurance. However, when an employee is rehired within 30 days, the only permitted changes are to reflect: reinstatement of the prior election or to denial of reinstatement until the next plan year. When an employee is rehired after 30 days, the following changes are permitted: selection of new plans, reinstatement of a prior election, or denial of reinstatement until the next plan year.

Note: Life or disability insurance that is provided on an after-tax basis outside of the cafeteria plan is not subject to the IRS election change rules. Carrier rules will apply.

HIPAA Special Enrollment Issues

Typically, employers provide eligible employees and their dependents an opportunity to enroll in employer-sponsored group health plans when the employees are first eligible (e.g., after completing a waiting period or an initial measurement period). In addition, most employers also provide annual enrollment periods that allow enrollment by employees (and dependents) who are eligible for coverage but did not enroll during their initial or a prior annual enrollment period.

The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries, in the following situations:

- a loss of eligibility for group health coverage or health insurance coverage;
- becoming eligible for a state premium assistance subsidy; and
- the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

Ongoing employees may lose health coverage under their spouse's plans or may acquire new spouses or dependents during the COVID-19 pandemic (video conference weddings can occur!), and those employees would be entitled to special enrollment rights under HIPAA. Other changes may occur giving rise to special enrollment rights, but it will be important to consider that there may be an increase over the next several months as economic conditions continue to change. Below, we highlight some special issues for ongoing employees in light of COVID-19.

Losing other coverage

A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

- The employee and the dependents are otherwise eligible to enroll in the benefit package;
- When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and

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- The employee or dependent lost eligibility for the other coverage as the result of an event identified in the regulations, such as termination of a spouse's employment.

Note that for this type of special enrollment, the employee must have been eligible for coverage under your employer-sponsored coverage and had other coverage when either initially eligible or during any of your annual enrollment opportunities. Employees who have been covered under their spouses' employers' plans may be the most likely individuals to experience a HIPAA special enrollment right due to loss of other coverage. So, for example, if an ongoing employee was covered under his spouse's employer's plan, and that spouse is laid off due to COVID-19, triggering a loss of coverage under the spouse's employer's plan, then the employee, his spouse, and their dependent children would have a special enrollment right under your employer-sponsored coverage.

Gaining eligibility for state premium assistance

If an employee or dependent becomes eligible for assistance for coverage under the plan through either a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, a special enrollment right arises. An employee who is eligible, but not enrolled, or a dependent of an employee if the dependent is eligible, but not enrolled, is eligible for the special enrollment and may enroll in the plan upon becoming eligible for state premium assistance subsidy so long as the special enrollment is requested in a timely manner. A timely request is one that is made within 60 days after the individual is determined to be eligible for the state premium assistance.

Note that Pandemic Unemployment Compensation created by the CARES Act will not be counted as income for purposes of determining eligibility for Medicaid, CHIP, or any other program established under titles XIX and title XXI of the Social Security Act. So, it is possible that individuals (or really their dependent children) may gain eligibility for premium assistance during this time and will be eligible for a special enrollment right.

Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

Under HIPAA, group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) must offer a special enrollment opportunity to specific newly acquired spouses and dependents of participants and to current employees who have previously declined coverage but who have since acquired a new spouse or dependent. However, such a special enrollment right applies only if a group health plan otherwise offers dependent coverage, and only if the new dependent is acquired through marriage, birth, adoption, or placement for adoption.

So, if an employee marries, adopts a child (or has a child placed for adoption), or has a newborn child, that employee is entitled to enroll himself or herself and the child. The individual must be allowed at least thirty days from the date of the event giving rise to the special enrollment to seek enrollment. If the enrollment is based upon marriage, the effective date of the coverage must be no later than the first of the month following the request for enrollment. If the special enrollment is based upon birth, adoption, or placement for adoption, coverage must be retroactive back to the date of the birth, adoption, or placement for adoption.

COBRA Implications

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires certain employers to make temporary health coverage ("continuation coverage") available to certain individuals upon the occurrence of specific events. Those individuals may then elect to continue group health plan coverage for a limited time on a self-pay basis. COBRA applies to private sector employers (both for-profit and nonprofit) and state and local governments that offer group health insurance. Employers that are exempt from COBRA are: small employers (i.e., employers who employed less than 20 employees on at least half of the typical business days during the prior

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year), non-electing church employers recognized under IRS Code Section 501, the federal government, and Indian Tribal governments that perform purely governmental functions.

COBRA only applies to "group health plans" that provide health care and are maintained by an employer subject to COBRA. Examples include:

- Health insurance, HMOs, and self-insured plans
- Dental and/or vision plans
- Disease-specific plans
- Prescription drug plans
- Healthcare FSAs
- HRAs
- Drug or alcohol treatment
- Medical clinics that offer services beyond free minor first aid for injuries and illnesses
- Wellness programs, employee assistance programs (EAPs), and employee discount programs that provide medical care and are maintained by the employer

The following are not group health plans subject to COBRA:

- HSAs
- Long-term care plans
- Accidental Death and Dismemberment (AD&D)
- Group term life insurance plans
- Long-term and short-term disability
- On-site first aid facilities
- Hospital (or other) indemnity plans

For a deeper dive into COBRA and state continuation obligations, check out our Employer COBRA Guide.

There are seven "qualifying events" which, if they cause a loss of health plan coverage, trigger COBRA continuation coverage. Those events are as follows:

- Termination of employment (unless for gross misconduct)
- Reduction of hours (e.g., when an employee moves from full-time to part-time; it could also occur during a strike, lockout, or when an employee takes an unpaid leave of absence)
- Employer's bankruptcy
- Divorce or legal separation
- Death of a covered employee
- Dependent child ceases to be a dependent under the terms of the plan
- Covered employee's entitlement to Medicare (but only if eligibility is impacted)

Ongoing employees will not likely experience COBRA qualifying events unless they experience a reduction in hours that triggers a loss of coverage. For employees who experience a reduction in hours that triggers a loss of coverage, see the section on Employees Experiencing a Reduction in Hours. If your organization, however, as a response to business concerns, terminates a group health plan or amends the plan to reduce coverage, then that is not a COBRA qualifying event. Similarly, there is no entitlement to COBRA if, due to your organization's nonpayment of premiums, an insurer cancels a group health policy effective before a covered employee's termination of employment. (Note, however, that many states and carriers have implemented premium grace periods, so check with your carrier about a possible grace period for your premiums.) Nonetheless, employers with ongoing employees should continue to be cognizant of their ongoing COBRA obligations.

Furloughed Employees

Introduction

A furlough is defined as a temporary period of time during which an employer requires an employee to take unpaid time off work. Furloughing an employee does not permanently terminate the employment relationship between the employer and the employee. An employee who is furloughed is expected to return to work after a temporary, unpaid leave, which will generally last a few weeks to a few months. Furloughs can include giving an employee a full week or multiple weeks off, or designating a "furlough day" during regular intervals of time (e.g., weekly or monthly). Furloughs allow employees to return to their jobs, and the employees are considered to be active employees within the organization. Employers considering furloughing employees should understand how that decision will impact both the employer as well as the employee.

Leave under the Families First Coronavirus Response Act

The Families First Coronavirus Response Act (FFCRA) created two new types of leave associated with the COVID-19 pandemic – Emergency Paid Sick Leave (EPSL) and Public Health Emergency Leave (PHEL) (often referred to as expanded FMLA leave). Both types of leave are only available between April 1, and December 31, 2020. The FFCRA applies to private employers (for profit and nonprofit) with fewer than 500 employees and all governmental agencies. There is a possible exception for employers with fewer than 50 employees.

Public Health Emergency Leave (PHEL)

PHEL is available for up to 12 weeks when an employee is unable to work or telework due to a need to care for a son or daughter whose school or place of care has been closed or the child care provider is unavailable, due to COVID-19 precautions. Employees who have been on the payroll of a covered employer for at least 30 calendar days are eligible for PHEL. Employees will be treated as eligible if they were on your payroll for 30 calendar days immediately before taking leave.

Furloughed employees are unlikely to qualify for leave under the Families First Coronavirus Response Act.

PHEL is unpaid leave for the first two weeks. Thereafter, the employee must be paid two-thirds (66 2/3%) of her regular wages for a period of up to 10 weeks. The employee may take EPSL or use other available leave or paid time off, such as vacation days, for the first two weeks.

Note that PHEL only applies when an employee is unable to work or telework because the employee needs to care for his or her son or daughter because the child's school or place of care has closed or the child care provider is unavailable, due to COVID-19-related reasons, and only if the employer has work for the employee to perform. In other words, eligibility for PHEL means that an individual must be able to work or telework ***but for*** the need to care for a child who meets the criteria above. By the very nature of a furlough, an employer does not have work for its employees. Thus, individuals on furlough are unlikely to meet this particular element of the requirement to qualify for PHEL. For example, suppose a coffee shop closed due to a downturn in business related to COVID-19. An employee who was previously employed at the coffee shop and who must care for a child whose school is closed due to a stay-at-home order may not take PHEL because his inability to work is not due to his need to care for a child in order to comply with the stay-at-home order, but rather due to the closure of his place of employment. This analysis would hold even if the coffee shop's closure was substantially caused by the stay-at-home order.

However, the timing of a furlough may impact an employee's ability to qualify for PHEL. If an employee is placed on furlough on April 15, then the employee could qualify for PHEL for the period between April 1 and April 15. If, however, you furloughed an employee before April 1, 2020 because you did not have enough work or business, a

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furloughed employee is not entitled to take PHEL. In other words, an employee is not entitled to PHEL while his or her worksite is closed. If you close your worksite, even for a short period of time, employees are not entitled to take EPSL or PHEL during the closure. However, employees may be eligible for unemployment insurance benefits. This is true whether you close your worksite for lack of business or because you were required to close pursuant to a Federal, State, or local directive.

Emergency Paid Sick Leave (EPSL)

Under the FFCRA, up to two weeks of EPSL is available when an employee is unable to work or telework due to one of the following reasons:

(1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

(2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

(3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

(4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1), above, or has been advised as described in (2), above.

(5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions.

(6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

As noted above, one of the reasons employees may qualify for EPSL is when they are unable to work or telework because of a Federal, State, or local quarantine or isolation order related to COVID-19. Importantly, the term "subject to a quarantine or isolation order" includes quarantine, isolation, containment, shelter-in-place, or stay-at-home orders issued by any Federal, State, or local government authority. However, to be eligible for EPSL, there must be work or telework that the employee could perform ***but for the order***. Thus, an employee may take EPSL only if being subject to one of these orders is the factor that prevents him or her from working or teleworking. As with PHEL, it is thus unlikely that an employee on furlough will qualify for EPSL due to the fact that you do not have work for the employee.

For more information about the DOL's Temporary Rule on leave under the FFCRA, check out our article.

As with PHEL, the timing of a furlough may impact eligibility. If, for example, an employee is not furloughed until May 1, the employee may be eligible for EPSL for a two-week period between April 1 and April 30. However, an employee is not entitled to EPSL while his or her worksite is closed. If you close your worksite, even for a short period of time, employees are not entitled to take EPSL or PHEL during the closure. However, employees may be eligible for unemployment insurance benefits. This is true whether you close your worksite for lack of business or because you were required to close pursuant to a Federal, State, or local directive.

Health Plan Implications

Eligibility

Employers who implement a furlough in response to COVID-19 should consider how the furlough will affect employees' eligibility for health plan benefits. Generally, the terms of the health plan will govern an employee's eligibility for benefits. For example, a health plan may require full-time status (as that term is defined in the plan) for an employee to be eligible for continuing coverage. An employee who is furloughed will have zero hours of service and, therefore, may cease to satisfy the eligibility definition and will no longer be eligible for benefits. However, employers should pay careful attention to employee eligibility tied to ACA status; employees in stability periods may remain eligible for coverage based upon their status as full-time during a stability period even with a reduction in current hours. See the discussion below on ACA Implications for furloughed employees.

Further, depending on the terms of the plan, an insurer or stop-loss carrier may take the position that employees lose eligibility for coverage during a furlough. Alternatively, a plan might include a provision that permits continued eligibility during the furloughed period regardless of the hours of service. In either case, the determination is governed by plan terms. In the absence of a provision that allows for coverage during the furloughed period, it is possible that the insurer would agree to continue coverage during a COVID-19-related furlough for impacted employees to the extent that they no longer satisfy the plan's hours of service requirements. In that case, the plan may need to be amended and a summary of material modification delivered to participants to explain the change.

If an employee loses coverage as a result of a furlough, the employee has experienced a COBRA qualifying event (i.e., a reduction of hours) (if your organization is subject to COBRA). For a discussion of COBRA rights and obligations for furloughed employees who experience a COBRA-qualifying event, please see the section on COBRA below.

If an employee does not lose eligibility for coverage as a result of the furlough, then the employee will continue coverage as an active employee.

Communication

Employers should review their plan documents to determine employees' eligibility for coverage and should discuss with their carriers the implications of a furlough in response to COVID-19. Employers have flexibility to determine eligibility for their plans and may choose to be more generous than the law requires in this unique situation, but should do so with agreement from their carriers.

Employers should communicate any new eligibility requirements or furlough policies to employees to explain which benefits, if any, will be continued and for how long. Additionally, the employer should determine, and communicate, how the furloughed employee can pay their premium contributions, which may require an employee to make payments on a regular basis, or allow the employee to catch up their contributions when the furlough ends and the employee returns to active service. Although pre-pay is theoretically available, it is likely to be impractical because there may not be sufficient advance notice of the need for reduced hours. You should determine which method or methods to use and communicate with affected employees as soon as practicable.

Coverage for COVID-19 diagnosis and testing

The FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and

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issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The CARES Act amends the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Additionally, the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

HSA-compatible High Deductible Health Plans

Internal Revenue Code Section 223 permits eligible individuals to deduct contributions to health savings accounts (HSAs). Among the requirements for an individual to qualify as an eligible individual under Section 223(c)(1) is that the individual be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including minimum deductibles and maximum out-of-pocket expenses. For example, for 2020, HSA-compatible HDHPs must have minimum deductibles of $1,400 for self-only coverage and $2,800 for other than self-only coverage.

On March 11, 2020, the IRS released Notice 2020-15 in response to questions about whether health plans that cover testing and treatment for the 2019 Novel Coronavirus (COVID-19) without cost sharing would cause individuals with HDHP coverage to lose their eligibility to contribute to HSAs. The Notice indicates that such coverage will not cause individuals to lose their eligibility. Under the Notice, a health plan may provide 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. In other words, HDHPs that are HSA-compatible may cover both testing *and* treatment prior to the satisfaction of applicable deductibles.

Additionally, after the passage of the CARES Act, HSA-compatible HDHPs are permitted to cover telehealth services before a patient reaches the deductible, without regard to whether the telehealth services relate to COVID-19. This provision is effective upon enactment and lasts through plan years beginning in 2021.

OTC Drugs and Menstrual Products reimbursable as medical care

After passage of the CARES Act, patients may use funds in HSAs, health reimbursement arrangements (HRAs), and health flexible spending accounts (FSAs) to purchase over-the-counter (OTC) menstrual care products. In addition, patients may use funds from HSAs, FSAs, or HRAs to cover over-the-counter drugs without a prescription (thus repealing prohibition under the Patient Protection and Affordable Care Act (ACA)). These changes are effective for amounts paid and expenses incurred in 2020 and apply indefinitely. Changes to cover OTC drugs without prescriptions and menstrual care products under account-based plans (e.g., health FSAs) will likely trigger a need for plan amendments, and for employers subject to ERISA, summaries of material modification (SMMs).

For a deeper dive into plan amendment changes triggered by COVID-19, check out our article on Plan Documents and COVID-19.

Telehealth

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient’s health. For example,

individuals may receive evaluation and management visits (common office visits), mental health counseling, and preventive health screenings through telehealth services, which may include phone calls, video conferences, and similar activities. In the wake of COVID-19 and the need for social distancing, many health care providers have turned to telehealth solutions for their patients. In response, federal and state government have taken action to permit the use of technology to help individuals who need routine care, and keep vulnerable individuals with mild COVID-19 symptoms in their homes while maintaining access to the care they need. Such efforts are also intended to limit community spread of the virus, as well as limit the exposure to other patients and staff members in order to slow viral spread.

As a result, many employers have expanded or introduced the use of telehealth services. When doing so, employers should consider whether that expansion or introduction triggers the need for a plan amendment, and for employers subject to ERISA, a need to release an SMM. Additionally, all employers making changes related to telehealth should also consider whether that change triggers a change to their summaries of benefits and coverage (SBC).

Implications for Other Benefits

Although much of the attention during the pandemic has been focused on health benefits, particularly requirements to cover COVID-19 testing with no cost-sharing and continuation of health coverage during the COVID-19 pandemic, other employer-sponsored benefits are also impacted, such as life insurance, short and long term disability insurance, and voluntary benefits coverage. Issues may arise regarding eligibility for coverage, payment of premiums, collection of employee contributions, and continuation of coverage if employer-provided coverage is terminated and then reinstated when the furlough ends and the employee returns to work. Following is a brief discussion of each of these topics.

Eligibility

Under virtually all insurance contracts, employees must work a minimum number of hours per week in order to be eligible for coverage. If an employee's hours of work drop below the required minimum, the employee loses eligibility and coverage ends. When an employee is placed on furlough, coverage will generally end within a short period of time – typically at the end of the month in which the furlough starts or the end of the following month. When coverage ends, the employee has a limited amount of time to port coverage (i.e., the employee pays the premium to continue the coverage) or convert coverage (i.e., the employee converts to an individual policy).

Existing insurance contracts were not written with a pandemic such as COVID-19 in mind. As a result, insurers are attempting to make changes to address the potential problems that may arise. For example, several national insurers have indicated that under current conditions they will consider furloughed employees to be under approved temporary layoff status and eligible for continued coverage for a specified period of time, such as 60 days. Others have stated that they are willing to continue coverage until a certain date such as April 30 or June 30, 2020. Although the details vary from insurer to insurer, for some insurers, the extension of coverage may be available, but it may not be automatic. If you want to continue coverage for furloughed employees, you should contact each insurer to determine exactly what coverage can be continued, for which employees, and for how long.

Premiums and contributions for coverage

A typical group insurance contract requires payment of premium at the beginning of the coverage period with a grace period, which is generally 30 or 31 days. If the premium is not paid by the end of the grace period, coverage terminates retroactive to the beginning of the grace period. With the involuntary closure of many businesses, and the fact that many businesses that remain open are operating with reduced staff, it may be difficult for employers to perform all of their regular tasks. For example, in a small business the individual responsible for payroll and accounting functions may be quarantined and unable to report to work to complete those tasks and with a reduced staff, others may not be able to take on those tasks making it difficult for the employer to have all of its bills paid on

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time. In recognition of this unfortunate circumstance, a number of state insurance departments have begun to recommend, or require, insurers to use longer grace periods, such as 60 or 90 days, in which to make the necessary premium payments. The details vary from state to state, with some states requiring a longer grace period and others simply recommending or strongly suggesting it. For some states, the rule applies to all types of insurance coverage; for others, it applies only to medical or health. For example, several national insurers are offering extended grace periods for coverage such as life and disability. But like state insurance departments, the details vary from insurer to insurer. And similar to accommodations relating to eligibility for coverage, unless required by a state insurance department, the extension may not be automatic. The employer may need to request an extension.

Similar to premium payments, employers may need to change the manner of collection of employee contributions for coverage such as group term life insurance, disability insurance, and voluntary benefits. With no paycheck from which to make salary reductions, you may need to use other methods. You may want to use one of two methods approved for FMLA leave – pay-as-you-go, and catch-up contributions upon the employee's return to work. Although pre-pay is theoretically available, it is likely to be impractical because there may not be sufficient advance notice of the need for the furlough. You should determine which method or methods to use and communicate with affected employees as soon as practicable.

Claims and evidence of insurability

The claims process may also be affected by COVID-19. First, although insurers are an essential business and remain open and many of their employees may be able to telework, they may also be affected by reduced staffing. Reduced staffing may mean that claims take longer to adjudicate. In addition, some claims, such as disability claims, typically require information from one or more physicians. Because physicians and other medical professionals are on the "front lines" of handling the COVID-19 crisis, it may take more time and be more difficult than usual to obtain all of the needed information. Employers should work with their insurers to find ways to ease the burden on claimants. Similarly, employees in the process of providing evidence of insurability – for example to increase the amount of life insurance coverage – may find that the process takes longer.

Coverage termination and continuation rights

Under some circumstances, an employer may not be able to continue coverage for employees who are on furlough. Should that occur, you will need to notify employees and provide them with appropriate information about porting or converting coverage such as life and disability insurance and insured voluntary benefits. Because most insurance contracts provide only a limited amount of time to port or convert coverage – such as 30 or 31 days – you will need to provide the information to employees as soon as possible. If you terminate coverage for furloughed employees, consider continuing coverage for a short period of time such as one month (with insurer agreement) before terminating coverage so that employees have sufficient time to convert or port their coverage.

Hopefully, the duration of these furloughs will be a short period of time such as a month or two. Unfortunately, the duration of the furlough for some employers and employees may be longer than the period of time the insurer is willing to continue coverage as if your employees were actively employed. In other cases, you may need to end the employment relationship rather than have the employee return from furlough. In both of these situations, you will need to notify employees when coverage will end and provide information about porting and converting coverage as soon as possible.

Return from furlough

If insurance coverage is continued during a furlough, no changes should be needed when an employee returns to full-time employment. If the employee returns from furlough with reduced hours, however, unless you amend the applicable insurance contracts to reduce the minimum hours requirement, the employee's coverage will end when

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the furlough ends and his reduced work schedule begins. At that time, you would then provide the employee with information about porting or converting coverage.

If insurance coverage was discontinued at the beginning (or during) the furlough, the insurance contract provisions will govern what happens when the furlough ends and the employee returns to work. In some cases, the contract may permit immediate reinstatement subject to an actively-at-work requirement. In other cases, the employee may need to satisfy a new waiting period before coverage begins. An evidence of insurability requirement may apply, for example if the amount of life insurance being reinstated exceeds the guaranteed issue amount under the contract. If the employee converted some of her group term life insurance to an individual contract, she may need to surrender that individual policy in order to be eligible under the group term life contract when she returns.

Similar provisions may apply to disability insurance. In addition, a long term disability insurance contract may continue a prior preexisting condition limitation when the employee returns from a furlough, or in some cases may apply a new preexisting condition limitation.

If employees continued coverage using the pay-as-you-go method during the furlough, then normal payroll deductions should be resumed when the employee returns. If you chose to use catch-up upon return to work payment method, then you will also need to make arrangements to recover employee contributions owed for coverage continued during the furlough.

ACA Implications

Under the Patient Protection and Affordable Care Act (ACA), an employee's status as full-time or not full-time is important for multiple reasons, including determining how to treat employees for purposes of Forms 1094 and 1095 reporting and application of the Employer Shared Responsibility Mandate. Specifically, Applicable Large Employers (ALEs) must offer affordable, minimum value coverage to at least 95% of their full-time employees to avoid Employer Shared Responsibility penalties. Under the ACA, an employee who works an average of 30 or more hours per week is considered to be a full-time employee. Only full-time employees can trigger penalties for ALEs, and full-time employees are the primary focus of Forms 1094 and 1095 reporting. In general, an ALE is an employer with 50 or more full-time employees and full-time equivalent (FTE) employees in the prior year.

Furloughs may impact employee status under the ACA, but stability periods may result in fewer than anticipated changes.

Under the ACA, an employer identifies its full-time employees based on each employee's hours of service. Generally, "hours of service" include any hour for which an employee is paid or entitled to payment when duties are not performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. When an employee is placed on a furlough, the employee experiences a reduction in hours of service to zero. The reduction in hours to zero for a period of time can thus impact an employee's current status as full-time or not full-time for purposes of the ACA. For example, if an employee's status is determining using the monthly measurement method, then if that employee has zero hours of service for a particular month, that employee is not a full-time employee for that month. In contrast, if an employee's status is determined using the look-back method and the employee is in a current stability period (either an initial stability period or a standard stability period), then the employee's reduction in hours to zero will not impact his or her status, but will impact the employee's current measurement period (and thus likely a future stability period). Below, we address the implications of a furlough on an individual's status under the ACA.

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Stability and measurement periods

Full-time status is determined based on an employee's hours of service and is defined as working an average of 30 hours per week (or 130 hours per month). Generally, "hours of service" include any hour for which an employee is paid or is entitled to payment when duties are not performed, such as during a vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Based on IRS regulations, employers may determine the hours of service for hourly and non-hourly employees (e.g., salaried employees, *per diem* employees, etc.) using either the monthly measurement method or the look-back method.

Employers considering furloughs must consider how that decision will impact their employees' status as full-time or not full-time for purposes of the ACA. In the case of a furlough, it would seem that because the employee is not working, the employee would no longer be offered health coverage. However, depending on the method used to determine full-time status (monthly measurement method or look-back method), an employee's status as full-time (or not) may be locked in for a period of time.

With the monthly measurement method, to avoid an ACA Employer Shared Responsibility penalty for a particular employee, the employee's hours of service are calculated for a given month and an offer of coverage must be made for any month in which the employee has at least 130 hours of service. For example, an employee has at least at least 130 hours of service from January through March, but is furloughed for two weeks in April and all of May, and then resumes normal working 130 hours per month for June through December. To avoid a penalty, the employer must offer coverage for January through March and June through December, but does not have to offer coverage for April or May.

In contrast, under the look-back measurement method, an employee's status is locked in for a period of time, even if the employee is not working due to a furlough. Using the look-back measurement method, an employee's full-time status is determined during a measurement period for a corresponding stability period (following the measurement period). Therefore, when an employee has been determined to be a full-time employee during the measurement period, his or her full-time status during the corresponding stability period is protected. This means an employee who originally met the full-time employee threshold under the measurement period will continue to be considered a full-time employee for the corresponding stability period, even if he or she is furloughed and no longer meets the full-time hours of service threshold.

Breaks in service

As a general rule, an employee retains his or her status as either full time or not full time during an entire stability period regardless of the number of hours worked, as long as employment continues. But what happens with an employee who is furloughed and later returns to work? How that employee is treated upon resumption of service depends on whether he is considered to be a continuing employee or a new employee.

Under the ACA, an employer may treat an employee as a new employee if the employee has had a "break in service." A break in service occurs if the employee has at least 13 consecutive weeks (26 for educational employers) during which the employee is not credited with an hour of service. Alternatively, under a "rule of parity," an employer may treat a shorter-term employee as a new hire if the employee's break in service is at least four weeks (but less than 13/26 weeks) and is as long as the employee's preceding period of employment. For example, suppose an employee has six weeks of service, then is furloughed for eight weeks, and then resumes services. Because the period the employee was not working was at least four weeks long and was longer than his period of employment, he is considered to have had a break in service and may be treated as a new employee.

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An employer using the monthly measurement method must offer coverage to a continuing full-time employee by the first day of the next calendar month to avoid potential ACA liability.

If an employee who was on furlough resumes services during a stability period and is a continuing employee, he retains the status he had prior to the period of absence as though he had not ceased providing services. That is, if the employee was in a stability period where he was treated as full-time, he should be treated as full-time upon resumption of services. In that case, for the employer to avoid an employer shared responsibility penalty, the continuing employee should be offered coverage as of the first day the employee is credited with an hour of service, or, if later, as soon as administratively practicable (i.e., no later than the first day of the calendar month following return to work). Note, however, that the employer need not make a new offer of coverage to the employee if the employee had previously been offered coverage for the stability period and declined it.

Similarly, an employer using the monthly measurement method must offer coverage to a continuing full-time employee by the first day of the next calendar month to avoid potential liability.

In contrast, if the employee is considered to be a new employee, upon resumption of services, the employer may treat him as it would any new employee. If the employer is using the monthly measurement method, it would begin counting hours with the first month of employment. An employer using the lookback method would begin counting the employee's hours in an initial measurement period.

For more information on counting hours for purposes of the ACA, check out our Counting Hours Toolkit.

Keep in mind that when an employee is on an unpaid leave such as a furlough, an employer may not "unlock" an employee's status as full time as soon as the employee has an unpaid absence of 13 (or 26, as applicable) weeks. The employer may treat the employee as a new employee upon return to work, but not before.

Cafeteria Plan Election Issues

A furlough in the context of the COVID-19 pandemic may take a variety of forms. One likely scenario is a temporary leave of absence with or without loss of benefits eligibility. A second likely scenario is a "rolling furlough" through which employees on are intermittent furlough with either designated "furlough days" or "furlough weeks" when employees stay home and are not paid for that period of time, but they otherwise continue to work "full-time" or on reduced schedules. Health plan eligibility and cafeteria plan benefit status of affected employees may change during the furlough period, particularly at the beginning and end of the furlough. For many employers, employee elections and how to handle them may be new, uncharted territory. Before discussing what changes may occur during a furlough period, it is important to understand some basics of the IRC Section 125 regulations governing employee mid-year elections.

The beginning or ending of an unpaid furlough will likely trigger a permissible cafeteria plan election change.

Cafeteria plan election basics

Determining whether a mid-year election is allowed depends on a several factors. First, the change must be permitted by the underlying benefit plan. For example, if an employee wishes to drop his or her medical coverage at the beginning of a furlough, the underlying medical plan must permit the employee to drop coverage. Second, any requested change must be permitted both under the Internal Revenue Code (IRC) Section 125 regulations and your cafeteria plan or Section 125 plan document. Note that a plan cannot be more generous

than what the IRS allows, but it can be more restrictive. So, you should verify that both the underlying benefit plan and your cafeteria (or Section 125) plan document permit a requested change.

Under the IRC Section 125 regulations, there are six categories of events that encompass permissible change in status events:

- change in legal marital status;
- change in number of dependents;
- change in employment status;
- dependent satisfies or ceases to satisfy dependent eligibility requirements;
- residence change; and
- for adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

Of these six categories, a change in employment status is likely the most relevant for furloughed employees. More specifically, a change in employment status includes:

- a termination or commencement of employment;
- a strike or lockout;
- a commencement of or return from an unpaid leave of absence; or
- a change in worksite.

Under this list, a furlough may be an unpaid leave of absence, and the beginning or ending of a furlough may constitute a permissible change in status. In addition, a furlough (particularly a “rolling furlough”) may constitute a reduction in hours, which is also a permissible change in status event provided that certain conditions are met. Specifically, a plan may permit a participant whose hours of service are reduced below 30 hours per week as a result of a change in employment status to drop employer-sponsored health coverage midyear (whether or not eligibility for the coverage is changed) if the participant intends to enroll in another plan offering minimum essential coverage, and other specific conditions are met.

Permissible changes when an employee begins furlough

Generally, one of three things may happen at the beginning of a furlough: (1) the employee does not lose eligibility; (2) the employee loses eligibility because of the beginning of an unpaid leave of absence; (3) the employee experiences a reduction in hours. (Other events may occur, but these are the three most common.) Below is a chart of common election change issues that may arise when an employee begins furlough:

Event	Change Permitted
Beginning a furlough causes employee to lose eligibility under the terms of the underlying plan (e.g., employee no longer considered to be full-time, furlough causes change from full-time to part-time, furlough is equal to beginning of unpaid leave of absence)	Yes. The employee would be permitted to revoke his or her elections and drop underlying coverage.

Event	Change Permitted
Beginning a furlough does NOT cause a loss of eligibility (e.g., all employees on furlough remain eligible for coverage, employee is in a stability period and is considered to be full-time for both ACA and plan eligibility purposes)	Generally, no. Since no loss of eligibility has occurred, the employee would not be permitted to change his or her election. However, see Reduction in Hours without Loss of Eligibility.
Employer contributions are decreased at the beginning of furlough	Maybe. If you decrease the amount of employer contributions towards an employee's share of the health plan premium and the amount is significant enough, the employee can change his or her election to a less expensive option or revoke an election entirely if a less expensive option is not available.
Addition of new benefit package option or increase in benefit offering	Yes. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or elect coverage.
Pay is reduced due to furlough	No. Reduction of pay is not an IRC Section 125 permitted election change event. Another permitted event would have to occur to allow a change.
Furloughed employee experiences a Reduction of Hours without loss of eligibility (e.g., changes from full-time to part-time status)	Maybe. A special permissible change in status exists for employees who experience a reduction in hours below 30 hours per week. The employee must be in a position that was expected to average at least 30 hours of service per week and the furlough must trigger a change in hours of service so that the employee will reasonably be expected to average less than 30 hours of service per week. The cancellation of coverage under an employer's health plan must correspond to the intended enrollment of the employee (and any related individuals) in another plan that provides minimum essential coverage. Coverage under the new plan must be effective no later than the first day of the second month following the month that the employer coverage is cancelled. You may rely on a reasonable representation of the employee and related individual(s) that they have enrolled or intend to enroll in another plan. If above conditions are not met, employee cannot change her election.
Furloughed employee fails to pay premiums	No election change has occurred. If the employee fails to pay his or her premium, you may be able to cancel the employee's health plan coverage. However, many States have required extended grace periods for missed premiums. If you have fully insured plan, you should check with your insurers. Also, you are permitted to require employees to make catch-up premium payments after returning from furlough, subject to any State law requirements on premium grace periods.

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Permitted election changes for DCAPs and health FSAs

Under IRS Section 125, there are special rules that apply to health flexible spending accounts (health FSAs) and dependent care assistance programs (DCAPs or dependent care FSAs). With respect to Health FSAs, an employee on furlough whose eligibility under the plan was lost will be able to change his or her election to reflect a drop of coverage. However, employees who have no change in eligibility will not be permitted to change their elections.

The IRS 125 election change rules are more flexible in allowing employees to change elections for DCAPs. Some relevant DCAP changes that may occur when an employee begins a furlough or while an employee is on furlough are noted below.

Event	Change Permitted
Change in dependent care provider to parent (e.g., employee and/or spouse at home to care for child) either because of the employee's furlough or because a spouse is now able to care for the child due, for example, to a closure of the spouse's place of business	Yes. The employee would be able to reduce or revoke his or her election. A furloughed employee may not have eligible dependent care expenses if the employee or spouse is able to stay home with the child.
Decrease in the number of hours of dependent care	Yes. The consistency rule would apply (e.g., an employee could decrease an election if she decreased her work hours and needed fewer hours of day care for her child).

Potential election changes when employee returns from furlough

Below is a chart showing relevant changes that may occur when an employee returns from furlough.

Event	Change Permitted
Return from furlough with gain of eligibility (e.g., increase in hours, move from PT to FT, return from unpaid leave of absence)	Yes. The employee would be permitted to enroll in coverage along with spouse or dependents. This would also include other benefit elections in which they are eligible under the cafeteria plan (e.g., dental, vision, FSA)
Return from furlough that did NOT result in a loss of eligibility or coverage	No change. Since no loss of eligibility has occurred the employee would not be permitted to change their election.
Return from furlough in same stability period without a loss of eligibility but following	No change. If plan permitted furloughed employees to change their elections due to a reduction of hours even if the employee remained eligible because they were in a stability period, no loss of eligibility occurred so the employee would not be permitted to change his or her election to re-enroll in coverage.

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Event	Change Permitted
change in election due to a reduction of hours	
Return from furlough in different stability period	Maybe. If employee was determined to be full-time based on the corresponding measurement period, employee would be permitted to elect coverage.
Addition of new benefit package option or increase in benefit offering	Maybe, yes. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or switch his or her election.

HIPAA Special Enrollment Issues

Typically, employers provide eligible employees and their dependents an opportunity to enroll in employer-sponsored group health plans when the employees are first eligible (e.g., after completing a waiting period or an initial measurement period). In addition, most employers also provide annual enrollment periods that allow enrollment by employees (and dependents) who are eligible for coverage but did not enroll during their initial or a prior annual enrollment period.

The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries, in the following situations:

- a loss of eligibility for group health coverage or health insurance coverage;
- becoming eligible for a state premium assistance subsidy; and
- the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

If you continue coverage for employees who are on furlough, then those employees would be entitled to special enrollment rights under HIPAA (like any active employee). In addition, if an employee was not previously enrolled in coverage, and coverage is continued for furloughed employees, then that employee still has a special enrollment right.

Losing other coverage

A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

- The employee and the dependents are otherwise eligible to enroll in the benefit package;
- When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and
- The employee or dependent lost eligibility for the other coverage as the result of an event identified in the regulations, such as termination of a spouse's employment.

Note that for this type of special enrollment, the employee must have been eligible for coverage under your employer-sponsored coverage and had other coverage either when initially eligible or during any of your annual enrollment opportunities. Furloughed employees who were covered under their spouses' employers' plans may be the most likely individuals to experience a HIPAA special enrollment right due to loss of other coverage. So, for

example, if a furloughed employee was covered under his spouse's employer's plan, and that spouse is laid off due to COVID-19, triggering a loss of coverage under the spouse's employer's plan, then the employee, his spouse, and their dependent children would have a special enrollment right under your employer-sponsored coverage.

If coverage is terminated for individuals on furlough, and furloughed individuals are offered COBRA continuation coverage, then they retain their special enrollment rights during COBRA continuation as COBRA qualified beneficiaries. However, individuals who were not covered prior to the beginning of the furlough (i.e., the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to furlough but was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights.

So, if you continue coverage on the same terms as active employment during a furlough (meaning that none of your furloughed employees lose eligibility), individuals who were not previously covered can gain coverage through a special enrollment due to loss of other coverage. But if you terminate coverage for furloughed employees and offer COBRA (or other continuation coverage), then those employees who had not previously enrolled for coverage do not have a special enrollment right due to the loss of other coverage.

Gaining eligibility for state premium assistance

If an employee or dependent becomes eligible for premium assistance for coverage under the plan through either a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, a special enrollment right arises. An employee who is eligible, but not enrolled, or a dependent of an employee if the dependent is eligible, but not enrolled, is eligible for the special enrollment and may enroll in the plan upon becoming eligible for state premium assistance so long as the special enrollment is requested in a timely manner. A timely request is one that is made within 60 days after the individual is determined to be eligible for the state premium assistance.

Note that Pandemic Unemployment Compensation created by the CARES Act will not be counted as income for purposes of determining eligibility for Medicaid, CHIP, or any other program established under titles XIX and title XXI of the Social Security Act. So, it is possible that individuals (or really their dependent children) may gain eligibility for premium assistance during a furlough, but the administrative reality of applications for assistance and the hopefully short-lived period of furlough may not trigger any additional special enrollment rights during furlough than in the normal course of a plan year.

As with individuals who face a loss of other coverage, if coverage is terminated for individuals on furlough, and furloughed individuals are offered COBRA continuation coverage, then they retain their special enrollment rights during COBRA continuation. Thus, if you terminate coverage for individuals placed on furlough and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to the beginning of the furlough (i.e., the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to furlough was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights.

So, if you continue coverage during furlough on the same grounds as during active employment, then individuals who qualify or have dependents who qualify for state premium assistance may add themselves and their dependents to coverage. If you terminate coverage for furloughed employees and offer them COBRA (or other) continuation

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coverage, then the COBRA qualified beneficiaries may add qualifying dependents to coverage. If, however, an individual was not enrolled in coverage prior to the date he or she would have been eligible for COBRA continuation coverage, then that individual does not have a special enrollment right on the basis of gaining premium assistance.

Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

Under HIPAA, group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) must offer a special enrollment opportunity to specific newly acquired spouses and dependents of participants and to current employees who have previously declined coverage but who have since acquired a new spouse or dependent. However, this special enrollment right applies only if a group health plan otherwise offers dependent coverage, and only if the new dependent is acquired through marriage, birth, adoption, or placement for adoption.

So, if health benefits continue during a furlough, then an employee who marries, adopts a child (or has a child placed for adoption), or who has a newborn child is entitled to enroll himself or herself and the child. The individual must be allowed at least thirty days from the date of the event giving rise to the special enrollment to seek enrollment. If the enrollment is based upon marriage, the effective date of the coverage must be no later than the first of the month following the request for enrollment. If the special enrollment is based upon birth, adoption, or placement for adoption, coverage must be retroactive back to the date of the birth, adoption, or placement for adoption.

If coverage is terminated for individuals on furlough, and furloughed individuals are offered COBRA continuation coverage, then they retain their special enrollment rights during COBRA continuation. Thus, if you terminate coverage for individuals placed on furlough and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to the beginning of the furlough (i.e., the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that “neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.” In other words, if an employee eligible for coverage prior to furlough was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights based on the acquisition of a new dependent due to marriage, birth, adoption, or placement for adoption.

COBRA Implications

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires certain employers to make temporary health coverage (“continuation coverage”) available to certain individuals upon the occurrence of specific events. Those individuals may then elect to continue group health plan coverage for a limited time on a self-pay basis. COBRA applies to private sector employers (both for-profit and nonprofit) and state and local governments that offer group health insurance. Employers that are exempt from COBRA are small employers (i.e., employers who employed less than 20 employees on at least half of the typical business days during the prior year), non-electing church employers recognized under IRS Code Section 501, the federal government, and Indian Tribal governments that perform purely governmental functions.

COBRA only applies to “group health plans” that provide health care and are maintained by an employer subject to COBRA. Examples include:

- Health insurance, HMOs, and self-insured plans
- Dental and/or vision plans
- Disease-specific plans
- Prescription drug plans
- Healthcare Flexible Spending Accounts (FSAs)

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- Health Reimbursement Arrangements (HRAs)
- Drug or alcohol treatment
- Medical clinics that offer services beyond free minor first aid for injuries and illnesses
- Wellness programs, employee assistance programs (EAPs), and employee discount programs that provide medical care and are maintained by the employer

The following are not group health plans subject to COBRA:

- Health Savings Accounts (HSAs)
- Long-term care plans
- Accidental Death and Dismemberment (AD&D)
- Group term life insurance plans
- Long-term and short-term disability
- On-site first aid facilities
- Hospital (or other) indemnity plans

For a deeper dive into COBRA and state continuation obligations, check out our Employer COBRA Guide.

There are seven "qualifying events" that, if they cause a loss of health plan coverage, trigger COBRA continuation coverage. Those events are as follows:

- Termination of employment (unless for gross misconduct)
- Reduction of hours (e.g., when an employee moves from full-time to part-time; it could also occur during a strike, lockout, or when an employee takes an unpaid leave of absence)
- Employer's bankruptcy
- Divorce or legal separation
- Death of a covered employee
- Dependent child ceases to be a dependent under the terms of the plan
- Covered employee's entitlement to Medicare (but only if eligibility is impacted)

If an employee did not lose coverage as a result of beginning a furlough, then the employee will have continued coverage as an active employee. If coverage was terminated for the employee as a result of a failure to pay premiums during furlough, which would not constitute a COBRA qualifying event, but the employer's coverage should likely be reinstituted upon the return from furlough. For potential issues related to ACA status, please see our section above on Breaks in Service for furloughed employees.

If an employee lost coverage as a result of furlough, then the employee would have experienced a COBRA qualifying event based on a reduction of hours, and you must fulfill your COBRA obligations. Specifically, you must offer Qualified Beneficiaries the same coverage they were receiving immediately before a qualifying event. This is true even if that coverage is no longer of use to the Qualified Beneficiary. For example, if employer offers HMO coverage and the Qualified Beneficiary moves out of state, the employer must nonetheless offer COBRA continuation for the HMO coverage.

Because a reduction in hours triggering a loss of coverage is a COBRA qualifying event, you (or your COBRA administrator on behalf of your plan) will be responsible for providing a COBRA Election Notice and for the ensuing COBRA obligations. The Election Notice must be furnished by the plan administrator within 14 days after receiving a notice of a Qualifying Event. If you and the plan administrator are the same (i.e., you do not use a third-party to administer your COBRA or other continuation), the Election Notice must be furnished within 44 days from the Qualifying Event itself (in other words, when the layoff occurs). This is because employers have 30 days to provide a notice of Qualifying Event plus 14 days to furnish the Election Notice.

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Each Qualified Beneficiary has 60 days to elect COBRA coverage. The 60-day election period starts from the date the notice is “provided” or the date coverage is lost, whichever is later. If the election is not made prior to the expiration of the 60-day election period, then you are not obligated to offer COBRA coverage. If you accept an election after the 60 day period, your insurance carrier contract might not allow that person to be covered under the plan. In this case, you may ultimately be self-insuring that person and be liable for the costs. If the coverage is self-insured, your stop loss carrier may refuse to provide coverage if stop loss is invoked.

The maximum amount a Qualified Beneficiary can be required to pay as a COBRA premium is 102% of the applicable premium. Broken down, the 102% is 100% of the applicable premium plus a 2% administrative fee. The purpose of the administrative fee is to help defray the cost of additional administration. However, you have the discretion to pay all or part of that premium for the Qualified Beneficiary, but you should check with your tax advisor for any potential tax implications.

Special Return to Work Issues

Even though employees returning from furlough did not experience a termination of employment during the furlough, a number of issues will arise upon their return. Below, we highlight some special return-to-work issues for furloughed employees.

- Furloughed employees may have evidence of insurability or waiting periods associated with their non-health benefits. Be sure to have a game plan in place to communicate applicable issues to employees, and coordinate with carriers or administrators to ensure a smooth return to work.
- Employees may have missed premium payments while on furlough. Ensure that appropriate documentation is in place to recoup payments from paychecks, if appropriate.
- If employees dropped coverage during furlough, ensure that employees understand how benefits will be handled upon return to work. For example, employees whose coverage terminated for less than 30 days should be returned to their prior cafeteria plan elections unless they experienced a permissible change in status during the furlough.
- Unpaid hours during a furlough are likely to impact employee status for purposes of the ACA. Review payroll and other processes to ensure that time during furlough is accurately tracked.

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Employees Experiencing a Reduction in Hours

Introduction

Either due to a decline in business or in order to continue as a viable concern during the COVID-19 pandemic, employers may choose to reduce the number of hours of service for some or all of their employees. When a reduction in hours occurs, the change may impact an employee's status as full-time or not full-time. A reduction in hours may impact not only an employee's status for purposes of the Patient Protection and Affordable Care Act (ACA), but also for benefits eligibility and eligibility for certain types of leave. Employers considering reducing an employee's hours should understand how that decision will impact both the employer as well as the employee.

Leave under the Families First Coronavirus Response Act

The Families First Coronavirus Response Act (FFCRA) created two new types of leave associated with the COVID-19 pandemic – Emergency Paid Sick Leave (EPSL) and Public Health Emergency Leave (PHEL) (often referred to as expanded FMLA leave). Both types of leave are only available between April 1, and December 31, 2020. The FFCRA applies to private employers (for profit and nonprofit) with fewer than 500 employees and all governmental agencies. There is a possible exception for employers with fewer than 50 employees.

For an overview of the FFCRA Temporary Rule click here.

Public Health Emergency Leave (PHEL)

PHEL is available for up to 12 weeks when an employee is unable to work or telework due to a need to care for a son or daughter whose school or place of care has been closed or the child care provider is unavailable, due to COVID-19 precautions. Employees who have been on the payroll of a covered employer for at least 30 calendar days are eligible for PHEL. Employees will be treated as eligible if they were on their employers' payroll for 30 calendar days immediately before taking leave.

PHEL is unpaid leave for the first two weeks. Thereafter, the employee must be paid two-thirds (66 2/3%) of her regular wages for a period of up to 10 weeks. The employee may take EPSL (described below) or use other available leave or paid time off, such as vacation days, for the first two weeks.

Note that PHEL only applies when an employee is unable to work or telework because the employee needs to care for his or her son or daughter because the child's school or place of care has closed or the child care provider is unavailable, due to COVID-19 related reasons, and only if the employer has work for the employee to perform. In other words, eligibility for PHEL means that an individual must be able to work or telework ***but for*** the need to care for a child who meets the criteria above. Because PHEL is available to both full-time and not full-time employees regardless of how long an employee has been on an employer's payroll, even employees who experience a reduction in hours due to COVID-19-related reasons are eligible for PHEL – so long as all of the criteria are met. Thus, even employees who are considered to be part-time after experiencing a reduction in hours may be eligible for PHEL.

> *Employees may take PHEL and EPSL based on care of a child whose school or place or care has closed or caregiver is unavailable due to COVID-19 on an intermittent basis.*

Interestingly, PHEL is available on an intermittent basis, but both the employer and employee must agree on intermittent leave, including the increments of time to be used for the intermittent leave. Intermittent leave is permitted for telework, but for employees who report to the employer's worksite, intermittent leave is permitted **solely** when the leave is to care for the employee's son or daughter whose place of school is closed or whose child care provider is unavailable because of COVID-19. Thus, even employees who experience a reduction in hours because of the pandemic may be eligible for intermittent leave; however, in order to take leave because of a child's school or care closure or the unavailability of a care giver, another suitable individual – such as a co-parent, co-guardian, or the usual child care provider – must not be available to provide the care the child needs.

Note that if you reduce an employee's work hours because you do not have work for the employee to perform, the employee may not use PHEL for the hours that he or she is no longer scheduled to work. This is because the employee is not prevented from working those hours due to a COVID-19 qualifying reason, even if the employee's reduction in hours was somehow related to COVID-19. The employee may, however, take PHEL if a COVID-19 qualifying reason prevents that employee from working his or her full schedule.

Emergency Sick Leave (EPSL)

Under the FFCRA, up to two weeks of EPSL is available when an employee is unable to work or telework due to one of the following reasons:

(1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

(2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

(3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

(4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1), above, or has been advised as described in (2), above.

(5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions.

(6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Note that both part-time and full-time employees are eligible for EPSL. However, the amount of paid leave varies depending upon an employee's status as full-time or not full-time prior to the beginning of leave. For purposes of EPSL, a full-time employee is an employee who is normally scheduled to work 40 or more hours per week. A part-time employee is an employee who is normally scheduled to work fewer than 40 hours per week.

According to the DOL, if you reduce an employee's hours because of COVID-19 conditions, the employee's number of hours of EPSL depends upon the employee's schedule *before* his or her hours were reduced. So, for example, if the employee was regularly scheduled to work 40 hours per week until May 17, and then you reduced the employee's hours of service to 30 hours per week because of reduced business traffic due to COVID-19, for

example, the employee would be entitled to 80 hours of EPSL as of April 1 because he was a full-time employee under the FFCRA before the pandemic impacted your business.

If the employee's schedule varies, you may use a six-month average to calculate the average daily hours. That employee may take EPSL for this number of hours per day for up to a two-week period.

If this calculation cannot be made because the employee has not been employed for at least six months, you should use the number of hours that you and your employee agreed that the employee would work upon hiring. And if there is no such agreement, you may calculate the appropriate number of hours of leave based on the average hours per day the employee was scheduled to work over the entire term of his or her employment.

Note that if you reduce an employee's work hours because you do not have work for the employee to perform, the employee may not use EPSL for the hours that he or she is no longer scheduled to work. This is because the employee is not prevented from working those hours due to a COVID-19 qualifying reason, even if the employee's reduction in hours was somehow related to COVID-19. The employee may, however, take EPSL if a COVID-19 qualifying reason prevents that employee from working his or her full schedule.

Health Plan Implications

Eligibility

Employers who reduce employees' hours in response to the COVID-19 pandemic should consider how the reduction in hours will affect employees' eligibility for benefits. Reviewing plan terms, which govern plan eligibility, should be the first step in understanding the impact a reduction in hours will have on employees. For example, a plan may require full-time status (as that term is defined in the plan) for an employee to be eligible for coverage. An employee who has a reduction in hours may cease to satisfy the eligibility definition and consequently no longer be eligible for health plan benefits. Employers should pay careful attention to employee eligibility tied to ACA status; employees in stability periods may remain eligible for coverage based upon their status as full-time during a stability period even with a reduction in current hours. See the discussion below on ACA Implications for employees experiencing a reduction in hours.

Depending on the terms of the plan, the carrier or stop-loss carrier may take the position that employees lose their eligibility for coverage following a reduction in hours. However, it is possible that the carrier may be willing to allow continued coverage for employees whose hours are temporarily reduced to the extent that they no longer satisfy the plan's hours of service requirement. In that case, the plan may need to be amended and a summary of material modification delivered to participants to explain the change.

If an employee loses coverage as a result of a reduction in hours, then the employee will have experienced a COBRA qualifying event (if your organization is subject to COBRA). For a discussion of COBRA implications, please see the section on COBRA below. If an employee does not lose coverage when his hours are reduced, his coverage will continue as normal.

Communication

Employers should review their plan documents for each benefit offered to determine employees' eligibility for coverage and should discuss with their carriers the implications of a reduction in hours in response to COVID-19. Employers have flexibility to determine eligibility for their plans and may choose to be more generous than the law requires in this unique situation, but should do so with agreement from their carriers.

Employers should communicate any new eligibility requirements or policies to employees to explain which benefits, if any, will be continued and the duration the benefits will be continued. Employers will also want to consider how

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employees will cover their premium contribution payments. Unlike other circumstances such as a furlough or an unpaid leave of absence, employees working reduced hours still have paychecks from which to make salary reductions to cover the employee's required contributions. If the employee's reduced paycheck is not sufficient to cover the total amount of contributions, you will need to use other methods to collect the remaining amounts. You may want to use one of the methods approved for FMLA leave – pay-as-you-go or catch-up contributions upon the employee's return to work. Although pre-pay is theoretically available, it is likely to be impractical because there may not be sufficient advance notice of the need for reduced hours. You should determine which method or methods to use and communicate with affected employees as soon as practicable.

Coverage for COVID-19 diagnosis and testing

The FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The CARES Act amends the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Additionally, the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

HSA-compatible High Deductible Health Plans

Internal Revenue Code Section 223 permits eligible individuals to deduct contributions to health savings accounts (HSAs). Among the requirements for an individual to qualify as an eligible individual under Section 223(c)(1) is that the individual be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including minimum deductibles and maximum out-of-pocket expenses. For example, for 2020, HSA-compatible HDHPs must have minimum deductibles of $1,400 for self-only coverage and $2,800 for other than self-only coverage.

On March 11, 2020, the IRS released Notice 2020-15 in response to questions about whether health plans that cover testing and treatment for the 2019 Novel Coronavirus (COVID-19) without cost sharing would cause individuals with HDHP coverage to lose their eligibility to contribute to HSAs. The Notice indicates that such coverage will not cause individuals to lose their eligibility. Under the Notice, a health plan may provide 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. In other words, HDHPs that are HSA-compatible may cover both testing *and* treatment prior to the satisfaction of applicable deductibles.

Additionally, after the passage of the CARES Act, HSA-compatible HDHPs are permitted to cover telehealth services before a patient reaches the deductible, without regard to whether the telehealth services relate to COVID-19. This provision is effective upon enactment and lasts through plan years beginning in 2021.

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OTC Drugs and Menstrual Products reimbursable as medical care

After passage of the CARES Act, patients may use funds in HSAs, health reimbursement arrangements (HRAs), and health flexible spending accounts (FSAs) to purchase over-the-counter (OTC) menstrual care products. In addition, patients may use funds from HSAs, FSAs, or HRAs to cover over-the-counter drugs without a prescription (thus repealing prohibition under the Patient Protection and Affordable Care Act (ACA)). These changes are effective for amounts paid and expenses incurred in 2020 and apply indefinitely. Changes to cover OTC drugs without prescriptions and menstrual care products under account-based plans (e.g., health FSAs) will likely trigger a need for plan amendments, and for employers subject to ERISA, summaries of material modification (SMMs).

For a deeper dive into plan amendment changes triggered by COVID-19, check out our article on Plan Documents and COVID-19.

Telehealth

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. For example, individuals may receive evaluation and management visits (common office visits), mental health counseling, and preventive health screenings through telehealth services, which may include phone calls, video conferences, and similar activities. In the wake of COVID-19 and the need for social distancing, many health care providers have turned to telehealth solutions for their patients. In response, federal and state government have taken action to permit the use of technology to help individuals who need routine care, and keep vulnerable individuals with mild COVID-19 symptoms in their homes while maintaining access to the care they need. Such efforts are also intended to limit community spread of the virus, as well as limit the exposure to other patients and staff members in order to slow viral spread.

As a result, many employers have expanded or introduced the use of telehealth services. When doing so, employers should consider whether that expansion or introduction triggers the need for a plan amendment, and for employers subject to ERISA, a need to release an SMM. Additionally, all employers making changes related to telehealth should also consider whether that change triggers a change to their summaries of benefits and coverage (SBC).

Implications for Other Benefits

A lot of attention has focused on requirements to cover COVID-19 testing with no cost-sharing and continuation of health coverage during the COVID-19 pandemic. But other employee benefits, such as life insurance, short and long term disability insurance, and voluntary benefits, are also impacted. Provisions concerning eligibility for coverage, payment of premiums, collection of employee contributions, and continuation of coverage may be impacted if employer-provided coverage is terminated due to an employee's reduction in hours, and reinstated when the employee returns to full-time status. Following is a brief discussion of significant issues related to these topics for non-health plan benefits.

Eligibility

Under virtually all insurance contracts, employees must work a minimum number of hours per week in order to be eligible for coverage. If an employee's hours of work drop below the required minimum, the employee loses eligibility and coverage ends – generally on the date the employee's hours are reduced. In some cases, the coverage may continue until the end of the month. When coverage ends, the employee has a limited amount of time to port coverage (i.e., the employee pays the premium to continue the coverage) or convert coverage (i.e., the employee converts to an individual policy).

Existing insurance contracts were not written with a pandemic such as COVID-19 in mind. As a result, insurers are attempting to make changes to address the potential problems that will arise. For example, several national insurers

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have indicated that under current conditions they may be willing to continue coverage for a specified period of time, such as 60 days, for employees whose hours have been temporarily reduced because of COVID-19. Others have stated that they are willing to continue coverage until a certain date, such as April 30 or June 30, 2020. Although the details vary from insurer to insurer, some insurers may make the extension of coverage available, but it may not be automatic. If an employer wants to continue coverage for employees whose hours are temporarily reduced as the result of COVID-19, the employer will need to contact each insurer to determine exactly what coverage can be continued, for which employees, and for how long.

Premiums and contributions for coverage

A typical group insurance contract requires payment of the premium at the beginning of the coverage period, with a grace period that is generally 30 or 31 days. If premium is not paid by the end of the grace period, coverage terminates retroactive to the beginning of the grace period. With the involuntary closure of many businesses and the fact that many businesses that remain open are operating with reduced staff, it may be difficult for employers to perform all of their regular tasks. For example, in a small business, the individual responsible for payroll and accounting functions may be quarantined and unable to report to work to complete those tasks and, with a reduced staff, others may not be able to take on those tasks, making it difficult for the employer to have all of their bills paid on time. In recognition of this unfortunate circumstance, a number of state insurance departments have begun to recommend, or require, insurers to use longer grace periods, such as 60 or 90 days, in which to make the necessary premium payments. The details vary from state to state, with some states requiring a longer grace period and others simply recommending or strongly suggesting it. For some states, the rule applies to all types of insurance coverage; for others, it applies only to medical or health. For example, several national insurers are offering extended grace periods for coverage such as life and disability. But like state insurance departments, the details vary from insurer to insurer, and, like accommodations relating to eligibility for coverage, unless required by a state insurance department, the extension may not be automatic. You may need to request an extension.

Unlike other circumstances like a furlough or an unpaid leave of absence, employees working reduced hours still have paychecks from which to make salary reductions to cover the employee's required contributions. If the employee's reduced paycheck is not sufficient to cover the total amount of contributions, you will need to use other methods to collect the remaining amounts. You may want to use one of the methods approved for FMLA leave – pay-as-you-go or catch-up contributions upon the employee's return to work. Although pre-pay is theoretically available, it is likely to be impractical because there may not be sufficient advance notice of the need for reduced hours. You should determine which method or methods to use and communicate with affected employees as soon as practicable.

Claims and evidence of insurability

The claims process may also be affected by COVID-19. First, although insurers are an essential business and remain open and many of their employees may be able to telework, they may also be affected by reduced staffing. Reduced staffing may mean that claims take longer to adjudicate. In addition, some claims, such as disability claims, typically require information from one or more physicians. Because physicians and other medical professionals are on the "front lines," it may take more time and be more difficult to obtain all of the needed information. You should work with your insurers to find ways to ease the burden on claimants. Similarly, employees in the process of providing evidence of insurability – for example to increase the amount of life insurance coverage – may find that the process takes longer.

Coverage termination and continuation rights

Under some circumstances, you may not be able to continue coverage for employees whose hours are reduced. If coverage is to be discontinued when the employee's hours are reduced, you will need to notify employees and

provide them with appropriate information about porting or converting coverage, such as life and disability insurance and voluntary benefits. Because most insurance contracts provide only a limited amount of time to port or convert coverage – such as 30 or 31 days – you must provide the information to employees as soon as possible. If your organization will be terminating coverage for employees, consider continuing coverage for a short period of time, such as one month, (with insurer agreement) before terminating coverage so that employees have sufficient time to convert or port their coverage.

Hopefully, many of these reductions in hours will be for a short period of time, such as a month or two. Unfortunately, the duration of reduced hours for some employers and employees may be longer than the period of time the insurer is willing to continue coverage. In other cases, an employer will need to end the employment relationship rather than have the employee return to full-time status. In either of these situations, you will need to notify employees when coverage will end and provide information about porting and converting coverage as soon as possible.

Return to full-time status

If insurance coverage is continued during a temporary reduction in hours, no changes should be needed when an employee returns to full-time status. If the employee's hours will be permanently reduced, then the employee's coverage will end based on applicable insurance contract provisions. If an employee's coverage will terminate based on a permanent reduction in hours, you should provide the employee with information about continuing coverage – i.e., porting and/or conversion.

If insurance coverage was discontinued at the beginning (or during) the temporary reduction in hours, the insurance contract provisions will govern what happens when the employee returns to work on a full-time basis. In some cases, the contract may permit immediate reinstatement, subject to an actively-at-work requirement. In other cases, the employee may need to satisfy a new waiting period before coverage begins. An evidence of insurability requirement may apply, for example if the amount of life insurance being reinstated exceeds the guaranteed issue amount under the contract. If the employee converted some of her group term life insurance to an individual contract, she may need to surrender that individual policy in order to be eligible under the group term life contract when she returns.

Similar provisions may apply to disability insurance. In addition, a long term disability insurance contract may continue a prior preexisting condition limitation when the employee returns to full-time status, or in some cases, may apply a new preexisting condition limitation.

If employees continued coverage using the pay-as-you-go method during the period that hours were reduced, then normal payroll deductions should be resumed when the employee returns. If you chose to use catch-up contributions upon return to work, then you will also need to make arrangements to recover employee contributions owed for coverage continued during the period of reduced hours.

ACA Implications

Under the Patient Protection and Affordable Care Act (ACA), an employee's status as full-time or not full-time is important for multiple reasons, including determining how to treat employees for purposes of Forms 1094 and 1095 reporting and application of the Employer Shared Responsibility Mandate. Specifically, Applicable Large Employers (ALEs) must offer affordable, minimum value coverage to at least 95% of their full-time employees to avoid Employer Shared Responsibility penalties. Under the ACA, an employee who works an average of 30 or more hours per week is considered to be a full-time employee. Only full-time employees can trigger penalties for ALEs, and full-time employees are the primary focus of Forms 1094 and 1095 reporting. In general, an ALE is an employer with 50 or more full-time employees and full-time equivalent (FTE) employees in the prior year.

Under the ACA, an employer identifies its full-time employees based on each employee's hours of service. Generally, "hours of service" include any hour for which an employee is paid or entitled to payment when duties are not

performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Based on IRS regulations, employers may determine the hours of service for hourly and non-hourly employees (e.g., salaried employees, *per diem* employees, etc.) using either the monthly measurement method or the look-back method. Below, we address the implications arising from a reduction in hours on an individual's status under the ACA.

Stability and measurement periods

Employers who reduce their employees' work hours must consider how that decision will impact their employees' status as full-time or not full-time for purposes of the ACA. In the case of a reduction in hours, if an employer bases an employee's health plan eligibility upon that employee's ACA status as a full-time employee, it would seem that an employee whose hours are reduced such that he or she is no longer considered to be a full-time employee would no longer be offered health coverage. However, depending on the method used to determine full-time status (monthly measurement method or look-back method), an employee's status as full-time (or not) may be locked in for a period of time.

With the monthly measurement method, to avoid an ACA Employer Shared Responsibility penalty for a particular employee, the employee's hours of service are calculated for a given month and an offer of coverage must be made for any month in which the employee has at least 130 hours of service. For example, an employee has at least at least 130 hours of service from January through March, but has his hours reduced to half time (e.g., 80 per month) for two weeks in April and all of May, and then resumes normal working hours (at least 130 per month) for June through December. To avoid a penalty, the employer must offer coverage for January through March and June through December, but does not have to offer coverage for April or May.

For more information on counting hours for purposes of the ACA, check out our Counting Hours Toolkit.

In contrast, under the look-back measurement method, an employee's status is locked in for a period of time, even if the employee's hours are reduced below full time. Using the look-back measurement method, an employee's full-time status is determined during a measurement period for a corresponding stability period (following the measurement period). Therefore, when an employee has been determined to be a full-time employee during the measurement period, his or her full-time status during the corresponding stability period is protected. This means an employee who originally met the full-time employee threshold under the measurement period will continue to be considered a full-time employee for the corresponding stability period even if his or her hours are reduced to the extent that he or she no longer meets the full-time hours of service threshold.

Breaks in service

As a general rule, an employee retains his or her status as either full time or not full time during an entire stability period regardless of the number of hours worked, as long as employment continues. If an employee has a "break in service," how that employee is treated upon resumption of service depends on whether he is considered to be a continuing employee or a new employee.

Under the ACA, an employer may treat an employee as a new employee if the employee has had a "break in service." A break in service occurs if the employee has at least 13 consecutive weeks (26 for educational employers) during which the employee is not credited with an hour of service. Alternatively, under a "rule of parity," an employer may treat a shorter-term employee as a new hire if the employee's break in service is at least four weeks (but less than 13/26 weeks) and is as long as the employee's preceding period of employment. For example, suppose an employee has six weeks of service, then is furloughed for eight weeks, and then resumes services. Because the

period the employee was not working was at least four weeks long and was longer than his period of employment, he is considered to have had a break in service and may be treated as a new employee.

An employee whose hours are reduced, but continues to perform services for the employer does not have a break in service.

Cafeteria Plan Election Issues

The COVID-19 pandemic has raised a number of issues for employers and employees alike. With business interruptions and many States issuing stay-at-home orders, many employees may be unable to report to work for a period of time or drastically reduces the number of hours an employee is able to work. The health and cafeteria benefit status of affected employees may change during the stay-at-home period, or any business decisions that result in furloughs, reduction of hours, or terminations.

Some businesses may have had to reduce employee's hours either due to business reason or to comply with stay-at-home orders. Before discussing what changes may occur when an employee has a reduction of hours, it is important to understand some basics of the IRC Section 125 regulations surrounding employee mid-year elections.

Cafeteria plan election basics

Determining whether a mid-year election is allowed depends on a several factors. First, the change must be permitted by the underlying benefit. For example, if an employee wishes to drop his or her medical coverage at the beginning of a reduction in hours, the underlying medical plan must permit the employee to drop coverage. Second, any requested change must be permitted both under the Internal Revenue Code (IRC) Section 125 regulations and your cafeteria plan (or Section 125) plan document. Note that a plan cannot be more generous than what the IRS allows, but it can be more restrictive. So, you should verify that both the underlying benefit plan and your cafeteria (or Section 125) plan document permit a requested change.

Under the IRC Section 125 regulations, there are six categories of events that encompass permissible change in status events:

- change in legal marital status;
- change in number of dependents;
- change in employment status;
- dependent satisfies or ceases to satisfy dependent eligibility requirements;
- residence change; and
- for adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

A change in status occurs if the reduction in hours causes the employee to lose eligibility In addition, a permissible change in status based upon a reduction in hours may also arise without the loss of eligibility. Under IRS Notice 2014- 55, an employee may change his or her cafeteria plan election with respect to medical coverage to reflect termination of major medical plan coverage if:

> (1) The employee has been in an employment status under which the employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee ceasing to be eligible under the group health plan; and
> (2) The revocation of the election of coverage under the group medical plan corresponds to the intended enrollment of the employee, and any related individuals who cease coverage due to the revocation, in

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another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

It may be unlikely that the employee enrolls in other coverage during a after experiencing a reduction in hours, but if you have adopted all permissible Section 125 permissible changes in status or have specifically adopted this change in status rule, then the employee may be entitled to make a cafeteria plan election change.

Permissible changes in status as a result of a reduction in hours

If a reduction in hours changes benefits eligibility, the following election changes may arise:

Event	Change Permitted
Loss of eligibility under the terms of the plan (e.g., no longer considered full-time, move from full-time to part-time)	Yes. The employee would be permitted to revoke his or her election including spouse or dependent election.
Decrease in employer contributions (e.g., change from full-time to part time with higher employee contributions for part-time employees)	Yes, if the amount is significant. If you decrease the amount of employer contributions towards an employee's share of the premium and the amount is significant enough, the employee can change his or her election to a less expensive option or revoke an election entirely if a less expensive option is not available.
Addition of new benefit package option or increase in benefit offering	Yes. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or elect coverage.
Reduction in pay due to reduction of hours	No. Reduction of pay is not an IRC Section 125 permitted event. Another permitted event would have to occur to allow a change.
Employee in a stability period considered to be full-time who experiences a reduction of hours	Generally, no. It depends on the plan eligibility language. If eligibility is tied to status based on a stability period, then the individual would still be considered eligible under the terms of the plan. If eligibility is not tied to ACA determination, then it is possible that the individual could change their election. This may have Employer Shared Responsibility penalty consequences. However, see Reduction in Hours without Loss of Eligibility.
Reduction of Hours without loss of eligibility (e.g., change from full-time to part-time status)	Maybe. If an employee was in a position that was expected to average at least 30 hours of service per week and there was a change so that the employee will reasonably be expected to average less than 30 hours of service per week, the employee may change his or her medical plan election. No changes would be permitted in dental or vision plan elections. The cancellation of coverage under employer-sponsored medical coverage must correspond to the intended enrollment of the employee (and any related individuals) in another plan that provides minimum essential coverage. Coverage under the new plan must be effective no later than the first day of the second month following the month that the employer coverage is cancelled. You may rely on a reasonable representation from an employee and related individual that they have enrolled or intent to enroll in another plan.

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Event	Change Permitted
	If above conditions are not met, the employee cannot change his or her election.
Employee fails to pay premiums	No election change has occurred. If the employee fails to pay his or her premium, you may be able to cancel the employee's underlying coverage. However, many states have required extended grace periods for missed premiums. If you have a fully insured plan, check with your carriers.

Permitted election changes for DCAPs and health FSAs

With respect to health FSAs, an employee whose eligibility under the plan was lost due to a reduction in hours will be able to change his or her health FSA election and corresponding salary reduction amount. However, employees who have no change in eligibility will not be permitted to change their elections. This applies even if the employee was able to change his or her medical election under the rules related to a Reduction of Hours without a loss of eligibility.

The election change rules related to DCAPS are more flexible than for health FSAs in allowing employees to change elections. Some relevant DCAP changes that may occur while an employee has a reduction of hours are below.

Event	Change Permitted
Change in dependent care provider to parent (e.g., employee and/or spouse at home to care for child)	Yes. The employee would be able to reduce or revoke his or her election. An employee may not have eligible dependent care expenses if the employee or spouse is able to care for the child.
Change in the number of hours of dependent care	Yes. The consistency rule would apply (e.g., an employee could decrease an election if she decreased her work hours and needed fewer hours of day care for her child).
Reduction of hours with or without a loss of eligibility	Yes. Decrease or revoke election. The employee may need fewer hours of day care following a reduction in hours.

Permissible Election Changes when Employee is Able to Return to Regular Full-Time Hours

Below is a chart showing relevant changes that may occur when an employee has an increase in hours:

Event	Change Permitted
Gain of eligibility (e.g., increase in hours, move from part-time to full-time)	Yes. The employee would be permitted to enroll in coverage along with spouse or dependents. This would also include other benefit elections in which they are eligible under the cafeteria plan (e.g., dental, vision, FSA)
Eligibility was not affected by reduction of hours	No change. Since no loss of eligibility had occurred the employee would not be permitted to change their election.
Employee did not have a loss of eligibility but changed their election due to a reduction of hours.	No change. Since no loss of eligibility had occurred, the employee would not be permitted to change their election to enroll back in coverage.

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Event	Change Permitted
Addition of new benefit package option or increase in benefit offering	Yes. If the employee is eligible for a new plan or a plan that has been modified to increase benefits, the employee would be permitted to elect the new benefit or switch their election to the new benefit package option.

Permissible election changes for life and disability insurance

A reduction in hours may result in the loss of eligibility under a life or disability insurance plan. If eligibility is lost under the terms of the plan, the employee may revoke his or her cafeteria plan election. When the employee's hours are increased so that he or she gains eligibility, the employee may make new elections. Insurer rules will apply.

Note: Life or disability insurance that is provided on an after-tax basis outside of the cafeteria plan is not subject to the IRS election change rules.

HIPAA Special Enrollment Issues

Typically, employers provide eligible employees and their dependents an opportunity to enroll in employer-sponsored group health plans when the employees are first eligible (e.g., after completing a waiting period or an initial measurement period). In addition, most employers also provide annual enrollment periods that allow enrollment by employees (and dependents) who are eligible for coverage but did not enroll during their initial or a prior annual enrollment period.

The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries, in the following situations:

- a loss of eligibility for group health coverage or health insurance coverage;
- becoming eligible for a state premium assistance subsidy; and
- the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

If you continue coverage for employees who experience a reduction in hours, then those employees would be entitled to special enrollment rights under HIPAA. In addition, if an employee was not previously enrolled in coverage, and employees with reduced hours remain eligible for coverage, then that employee still has a special enrollment right.

Losing other coverage

A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

- The employee and the dependents are otherwise eligible to enroll in the benefit package;
- When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and
- The employee or dependent lost eligibility for the other coverage as the result of an event identified in the regulations, such as termination of a spouse's employment.

Note that for this type of special enrollment, the employee must have been eligible for coverage under your employer-sponsored coverage and had other coverage either when initially eligible or during any of your annual enrollment opportunities. Employees who were covered under their spouses' employers' plans may be the most likely

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individuals to experience a HIPAA special enrollment right due to loss of other coverage due to the current pandemic. So, for example, if an employee was covered under his spouse's employer's plan, and that spouse is laid off due to COVID-19, triggering a loss of coverage under the spouse's employer's plan, then the employee, his spouse, and their dependent children would have a special enrollment right under your employer-sponsored coverage.

If you terminate coverage for individuals who experience a reduction in hours (and thus lose plan eligibility) and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to their reduction in hours (i.e., the beginning of what would have been the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to his or her reduction in hours but was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights.

So, if you continue coverage on the same terms as prior to a reduction in hours (meaning that comparable employees do not lose eligibility), individuals who were not previously covered can gain coverage through a special enrollment due to loss of other coverage. But if you terminate coverage for employees who similarly experience a reduction in hours (e.g., all employees scheduled for fewer than 30 hours per week lose eligibility) and offer COBRA (or other continuation coverage), then those employees who had not previously enrolled for coverage do not have a special enrollment right due to the loss of other coverage.

Gaining eligibility for state premium assistance

If an employee or dependent becomes eligible for assistance for coverage under the plan through either a Medicaid plan under Title XIX of the Social Security Act or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, a special enrollment right arises. An employee who is eligible, but not enrolled, or a dependent of an employee if the dependent is eligible, but not enrolled, is eligible for the special enrollment and may enroll in the plan upon becoming eligible for state premium assistance subsidy so long as the special enrollment is requested in a timely manner. A timely request is one that is made within 60 days after the individual is determined to be eligible for the state premium assistance.

Note that Pandemic Unemployment Compensation created by the CARES Act will not be counted as income for purposes of determining eligibility for Medicaid, CHIP, or any other program established under titles XIX and title XXI of the Social Security Act. So, it is possible that individuals (or really their dependent children) may gain eligibility for premium assistance during a period an employee works reduced hours, but the administrative reality of applications for assistance and the hopefully short-lived period of reduced hours may not trigger any additional special enrollment rights during this period than would occur in the normal course of a plan year.

As with individuals who face a loss of other coverage, if you terminate coverage for individuals who experience a similar reduction in hours (e.g., all employees who have their hours reduced below 30 hours per week) and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to their reduction in hours triggering a loss of coverage (i.e., the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to his or her reduction in hours, but was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and, thus, would not be eligible for special enrollment rights.

So, if you continue coverage for employees who experience a similar reduction of hours on the same grounds as employees who do not experience a reduction in hours, then individuals who qualify or have dependents who qualify

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for state premium assistance may add themselves and their dependents to coverage. If you terminate coverage for employees who experience a reduction in hours and offer them COBRA (or other) continuation coverage, then the COBRA qualified beneficiaries may add qualifying dependents to coverage. If, however, an individual was not enrolled in coverage prior to the date he or she would have been eligible for COBRA continuation coverage, then that individual does not have a special enrollment right on the basis of gaining premium assistance.

Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

Under HIPAA, group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) must offer a special enrollment opportunity to specific newly acquired spouses and dependents of participants and to current employees who have previously declined coverage but who have since acquired a new spouse or dependent. However, that special enrollment right applies only if a group health plan otherwise offers dependent coverage, and only if the new dependent is acquired through marriage, birth, adoption, or placement for adoption.

So, if health benefits continue after a reduction in hours, then an employee who marries, adopts a child (or has a child placed for adoption), or who has a newborn child is entitled to enroll himself or herself and the child. The individual must be allowed at least thirty days from the date of the event giving rise to the special enrollment to seek enrollment. If the enrollment is based upon marriage, the effective date of the coverage must be no later than the first of the month following the request for enrollment. If the special enrollment is based upon birth, adoption, or placement for adoption, coverage must be retroactive back to the date of the birth, adoption, or placement for adoption.

If you terminate coverage for individuals who experience a reduction in hours and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to their reduction in hours (i.e., the beginning of the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that “neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.” In other words, if an employee was eligible for coverage prior to a reduction in his or her hours, but was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights based on the acquisition of a new dependent due to marriage, birth, adoption, or placement for adoption.

COBRA Implications

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires certain employers to make temporary health coverage (“continuation coverage”) available to certain individuals upon the occurrence of specific events. Those individuals may then elect to continue group health plan coverage for a limited time on a self-pay basis. COBRA applies to private sector employers (both for-profit and nonprofit) and state and local governments that offer group health insurance. Employers that are exempt from COBRA are small employers (i.e., employers who employed less than 20 employees on at least half of the typical business days during the prior year), non-electing church employers recognized under IRS Code Section 501, the federal government, and Indian Tribal governments that perform purely governmental functions.

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COBRA only applies to "group health plans" that provide health care and are maintained by an employer subject to COBRA. Examples include:

For a deeper dive into COBRA and state continuation obligations, check out our Employer COBRA Guide.

- Health insurance, HMOs, and self-insured plans
- Dental and/or vision plans
- Disease-specific plans
- Prescription drug plans
- Healthcare Flexible Spending Accounts (FSAs)
- Health Reimbursement Arrangements (HRAs)
- Drug or alcohol treatment
- Medical clinics that offer services beyond free minor first aid for injuries and illnesses
- Wellness programs, employee assistance programs (EAPs), and employee discount programs that provide medical care and are maintained by the employer

The following are not group health plans subject to COBRA:

- Health Savings Accounts (HSAs)
- Long-term care plans
- Accidental Death and Dismemberment (AD&D)
- Group term life insurance plans
- Long-term and short-term disability
- On-site first aid facilities
- Hospital (or other) indemnity plans

There are seven "qualifying events" that, if they cause a loss of health plan coverage, trigger COBRA continuation coverage. Those events are as follows:

- Termination of employment (unless for gross misconduct)
- Reduction of hours (e.g., when an employee moves from full-time to part-time; it could also occur during a strike, lockout, or when an employee takes an unpaid leave of absence)
- Employer's bankruptcy
- Divorce or legal separation
- Death of a covered employee
- Dependent child ceases to be a dependent under the terms of the plan
- Covered employee's entitlement to Medicare (but only if eligibility is impacted)

If a reduction in hours triggers a loss of coverage for a health benefit, and your organization is subject to COBRA, then that employee has COBRA continuation rights. You must offer Qualified Beneficiaries the same coverage they were receiving immediately before a qualifying event. This is true even if that coverage is no longer of use to the Qualified Beneficiary. For example, if an employer offers HMO coverage and the Qualified Beneficiary moves out of state, the employer must nonetheless offer COBRA continuation for the HMO coverage.

Because a reduction in hours is a COBRA qualifying event, you (or your COBRA administrator on behalf of your plan) will be responsible for providing a COBRA Election Notice and for the ensuing COBRA obligations. The Election Notice must be furnished by the plan administrator within 14 days after receiving a notice of a Qualifying Event. If you and the plan administrator are the same (i.e., you do not use a third-party to administer your COBRA or other continuation), the Election Notice must be furnished within 44 days from the Qualifying Event itself (in other words, when the layoff occurs). This is because employers have 30 days to provide a notice of Qualifying Event plus 14 days to furnish the Election Notice.

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Each Qualified Beneficiary has 60 days to elect COBRA coverage. The 60-day election period starts from the date the notice is "provided" or the date coverage is lost, whichever is later. If the election is not made prior to the expiration of the 60-day election period, then you are not obligated to offer COBRA coverage. If you accept an election after the 60 day period, your insurance carrier contract might not allow that person to be covered under the plan. In this case, you may ultimately be self-insuring that person and be liable for the costs. If the coverage is self-insured, your stop loss carrier may refuse to provide coverage if stop loss is invoked.

The maximum amount a Qualified Beneficiary can be required to pay as a COBRA premium is 102% of the applicable premium. Broken down, the 102% is 100% of the applicable premium plus a 2% administrative fee. The purpose of the administrative fee is to help defray the cost of additional administration. However, you have the discretion to pay all or part of that premium for the Qualified Beneficiary, but you should check with your tax advisor for any potential tax implications.

Special Return to Work Issues

If employees have an increase in their hours of work after the end of the pandemic period, administrative issues are likely to arise when normal operations resume. Below, we highlight some special issues for employees when normal operations resume.

- Employees who lost coverage as a result of the reduction in their hours may have evidence of insurability or waiting periods associated with their non-health benefits. Be sure to have a game plan in place to communicate applicable issues to employees, and coordinate with carriers or administrators to ensure a smooth return to work.
- Employees may have missed premium payments if their pay became insufficient to cover premiums. Ensure that appropriate documentation is in place to recoup payments from paychecks, if appropriate.
- Employees who regain eligibility after their hours of service increase may be able to make new salary reduction elections, but if they regain eligibility in less than 30 days or less, they may be subject to a rule requiring reinstatement of their prior elections.
- Reduced hours are likely to impact employee status for purposes of the ACA. Review payroll and other processes to ensure that their time is accurately tracked.

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Employees on Leaves of Absence

Introduction

With the passage of the Families First Coronavirus Response Act (FFCRA), two new types of leave were introduced into the work place – Emergency Paid Sick Leave (EPSL) and Public Health Emergency Leave (PHEL) (often referred to as expanded FMLA leave) – for employers with fewer than 500 employees on the date an employee's leave would begin and all governmental employers. There is a possible exception for employers with fewer than 50 employees. In addition to EPSL and PHEL, an employee who is diagnosed with COVID-19 may also qualify for leave under the Family and Medical Leave Act (FMLA) and may qualify for leave to take care of a family member under FMLA or state law. (State leave is beyond the scope of this article.)

For an overview of the FFCRA leave Temporary Rule click here.

Leave under the Families First Coronavirus Response Act

Both PHEL and EPSL are only available between April 1, and December 31, 2020.

Public Health Emergency Leave (PHEL)

PHEL is available for up to 12 weeks when an employee is unable to work or telework due to a need to care for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions. Employees who have been on the payroll of a covered employer for at least 30 calendar days are eligible for PHEL. Employees will be treated as eligible if they were on their employers' payroll for 30 calendar days immediately before taking leave.

PHEL is unpaid leave for the first two weeks. Thereafter, the employee must be paid two-thirds (66 2/3%) of her regular wages for a period of up to 10 weeks. The employee may take EPSL or use other available leave or paid time off, such as vacation days, for the first two weeks.

The FFCRA created two additional types of leave for those impacted by COVID-19.

As stated above, PHEL is only available for one reason – an employee is unable to work or telework because of a need to care for the employee's son or daughter whose school or place of care is closed or whose child care provider is unavailable due to COVID-19-related reasons. The FFCRA created this new leave by temporarily amending Title I of the FMLA. As a result, many of the rules that apply to the FMLA will also apply to PHEL. However, there are a number of significant differences:

- Private employers with fewer than 500 employees that do not qualify for the small business exemption (outlined below) are required to provide PHEL. FMLA generally applies to employers with 50 or more employees.
- Employees who have been on the payroll of a covered employer for at least 30 calendar days are eligible for PHEL. Employees will be treated as eligible if they were on their employers' payroll for 30 calendar days immediately before taking leave. In addition, an employee who is laid off on or after March 1, 2020, will be considered to have been employed for at least 30 calendar days if she is rehired on or before December 30, 2020 and had been on the employer's payroll for 30 or more of the 60 calendar days prior to the date of layoff. In contrast, under the FMLA, an employee must have been employed for at least 12 months with at least 1,250 hours of service.

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- PHEL is unpaid leave for the first two weeks. Thereafter, the employee must be paid two-thirds (66 2/3%) of her regular wages for a period of up to 10 weeks. The employee may take EPSL or use other available leave or paid time off, such as vacation days, for the first two weeks. FMLA leave is generally unpaid.
- For PHEL, the use of intermittent leave is more limited than under "traditional" FMLA, and both the employer and employee must agree on intermittent leave, including the increments of time to be used for the intermittent leave. Intermittent leave is permitted for telework, but for employees who report to the employer's worksite, intermittent leave is permitted **solely** when the leave is to care for the employee's son or daughter whose place of school is closed or whose child care provider is unavailable because of COVID-19.
- An employee may take up to 12 weeks of PHEL between April 1, 2020 and December 31, 2020. No PHEL is available after 2020, but payments may be made in early 2021 for leave taken in late 2020 where payment is delayed due to the timing of payroll periods. In addition, because the FFCRA amended Title I of the FMLA, PHEL counts toward the FMLA maximum leave time. For example, if an employer uses the calendar year for FMLA and an employee used eight weeks of FMLA before April 1, 2020 for a serious illness, that employee would only be eligible for up to four weeks of PHEL. Further, if the employee uses 10 weeks of PHEL through August 2020, she would have two weeks of FMLA remaining for 2020 to care for a newborn child. An employee who has already used her 12-week FMLA entitlement would not be eligible for PHEL, but may be eligible for EPSL.
- Employees and employee notice requirements are more flexible (described below) than those for traditional FMLA.

In addition, an employee is not eligible for PHEL to care for a child whose school or place of care has closed or whose child care provider is unavailable due to COVID-19 if another suitable individual (such as a spouse) is available to care for the child. In addition, an employee may not take PHEL to care for his or her child unless, but for a need to care for the child, the employee would be able to perform work either at the employer's normal workplace or through telework.

The first two weeks of PHEL is unpaid leave; however, employees are entitled to use EPSL during the first two weeks of PHEL or to substitute other available paid leave. PHEL is paid leave after the first two weeks. The amount payable is two-thirds (66 2/3%) of the greater of (1) the employee's regular pay; (2) federal minimum wage, or (3) applicable state or local minimum wage – up to a maximum of $200 per day ($10,000 in aggregate).

After the first two weeks of PHEL, an employee may not request, and an employer may not require, an employee to substitute paid leave for PHEL. However, employers and eligible employees may agree, where Federal or state law permits, to have paid leave supplement pay under the PHEL so that the employee receives the full amount of his or her normal pay. For example, an employee and employer may agree to supplement PHEL by substituting one-third hour of accrued vacation leave for each hour of PHEL. If the eligible employee and employer do not agree to supplement paid leave in the manner described above, the employee will remain entitled to all the paid leave earned or accrued under the terms of the employer's plan for later use. The employer's eligibility for tax credits is limited to $200 per day and $10,000 in aggregate per employee.

Emergency Paid Sick Leave (EPSL)

Under the FFCRA, up to two weeks of EPSL is available when an employee is unable to work or telework due to one of the following reasons:

(1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

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(2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

(3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

(4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1), above, or has been advised as described in (2), above.

(5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions.

(6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

As noted above, one of the reasons employees may qualify for EPSL is when they are unable to work or telework because of a Federal, State, or local quarantine or isolation order related to COVID-19. Importantly, the term "subject to a quarantine or isolation order" includes quarantine, isolation, containment, shelter-in-place, or stay-at-home orders issued by any Federal, State, or local government authority. However, there must be work or telework that the employee could perform ***but for the order***. Thus, an employee may take EPSL only if being subject to one of these orders is the factor that prevents him or her from working or teleworking. For example, suppose a coffee shop closes due to a downturn in business related to COVID-19. An employee who was previously employed at the coffee shop and who is subject to a stay-at-home order may not take EPSL because his inability to work is not due to his need to comply with the stay-at-home order, but rather due to the closure of his place of employment. This is true even if the coffee shop's closure was substantially caused by the stay-at-home order.

The same analysis would apply if the employee's reason for leave is the need to care for an individual, such as a spouse, who has been quarantined for COVID-19 reasons. The qualifying reason applies only if "but for" the need to care for the individual subject to the order, the employee would be able to work. If the employer does not have work for the employee, he would not be eligible for EPSL. Note also that the employee must have a genuine need to care for the individual. That is, the person being cared for must be an immediate family member, roommate, or a similar person with whom the employee has a relationship that creates an expectation that the employee would care for the person.

Similarly, EPSL is available when an employee is unable to work or telework because the employee needs to care for his or her son or daughter if the child's school or place of care has closed or the child care provider is unavailable, due to COVID-19 related reasons, but only if the employer has work for the employee to perform. In addition, the employee is not eligible for emergency paid sick leave if another suitable individual – such as the spouse – is available to care for the child.

Further, an employee subject to an order to quarantine or isolate may not take EPSL if (a) the employer has work for the employee to perform; (b) the employer permits the employee to perform that work from the location where the employee is being quarantined or isolated; and (c) there are no extenuating circumstances that prevent the employee from performing that work. This is intended to encourage employers and employees to implement highly flexible telework arrangements during such unconventional times. The DOL has provided an example where an employee works 7-9 a.m., 12:30-3 p.m. and 7-9 p.m. on weekdays with the employer paying the employee for the 7.5 hours per day actually worked (rather than use the DOL's continuous workday rule).

All employees employed by a covered employer are eligible to take EPSL regardless of their duration of employment. If an employee is eligible for both EPSL and PHEL, the employee may first use the two weeks of

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EPSL, which would run concurrently with the first two weeks of PHEL. Note that the first two weeks of PHEL would otherwise be unpaid (unless the employee elects to use accrued PTO, vacation, or sick time, in any order).

A full-time employee is entitled to 80 hours of EPSL, and a part-time employee is entitled to the number of hours that he works, on average, over a two-week period. If the part-time employee's schedule varies from week to week, the number of hours should be calculated using the average number of hours per week that the employee was scheduled over the six-month period ending on the date on which the employee takes the paid sick leave – including hours for which the employee took leave (if any). As a general rule, if the employee has been employed for less than six months, the number of hours of paid leave is based on the average hours worked for his entire period of employment. It is of important note that the 80 hour maximum of EPSL applies on a per person basis, not a per employer basis. Consequently, an employee who uses 60 of his 80 EPSL hours is only eligible for 20 hours, either from the current employer or a subsequent employer.

An employee taking paid sick leave because the employee is unable to work or telework because of (1) a Federal, State, or local quarantine or isolation order related to COVID-19; (2) advice by a health care provider to self-quarantine due to concerns related to COVID-19; or (3) symptoms of COVID-19 while seeking medical diagnosis, is eligible to receive, as paid leave, for each applicable hour, the greater of:

- the employee's regular rate of pay;
- the federal minimum wage in effect under the FLSA; or
- the applicable State or local minimum wage.

In these circumstances, the employee's paid leave is subject to a maximum of $511 per day, or $5,110 total over the entire paid sick leave period.

In contrast, an employee taking EPSL because the employee is: (1) caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; (2) caring for a child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons; or (3) experiencing any other substantially-similar condition that may arise, as specified by the Secretary of Health and Human Services, is entitled to compensation at 2/3 of the greater of the amounts above. Finally, an employee's entitlement to, or use of, EPSL may not be used to reduce or eliminate any other right or benefit to which the employee is entitled under any other Federal, State or local law, bargaining agreement, or employer policy that existed prior to April 1, 2020. EPSL is in addition to other sources of sick leave to which the employee is entitled.

Health plan coverage under FFCRA

Similar to the FMLA, an employee who takes EPSL or PHEL, is entitled to continue health coverage during the leave. Group health plan coverage must be provided to the employee on the same terms as if the employee did not take leave - including medical, dental, vision, and other health benefits. Coverage under an account-based plan, such as a health reimbursement arrangement (HRA) or a health flexible spending account (health FSA), must also be continued. The employee may, however, choose to discontinue health coverage during the leave period. If the employee discontinues coverage during the leave, she is entitled to have the coverage reinstated when she returns from leave. If there is a change in the health benefits plan while the employee is on leave, the employee is entitled to the modified benefits to the same extent as if the employee was not on leave.

Employees in a group health plan who take EPSL or PHEL are required to pay their regular contributions. Employee contributions should be made using the normal method if the leave is paid. If the leave is unpaid, the

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employer may use the FMLA rules, which include three possible methods – pay-as-you-go, post-pay and pre-pay. Pre-pay may not be the only option.

Except as required by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), an employer's obligation to maintain health benefits while an employee is taking EPSL or PHEL ceases if and when the employment relationship would have terminated if the employee had not taken EPSL or PHEL (e.g., if the employee fails to return from leave, or if the entitlement to leave ceases because an Employer closes its business).

Neither the FFCRA nor FMLA require employers to continue other types of coverage, such as life and disability insurance, during a leave. Employers should work with their insurers to determine what options may be available for continuing coverage.

Return to work under FFCRA

In most cases, an employee who takes EPSL or PHEL is entitled to be restored to the same or an equivalent position upon return from leave. Similar to the FMLA, the new leave does not change the rules concerning employment changes, such as layoffs, that would have affected the employee regardless of whether leave was taken. Under certain circumstances, an employer may deny job restoration to a key employee who took PHEL (but not EPSL) if it is necessary to prevent substantial and grievous economic injury to the operations of the employer.

There is also an exception to the return-to-work rule after PHEL for an employer who has fewer than 25 employees. In order to use the exception, the employer must satisfy **all** of the following four criteria:

1. The employee took leave to care for her son or daughter whose school or place of care was closed or whose child care provider was unavailable;
2. The employee's position no longer exists due to economic or operating conditions caused by a public health emergency (i.e., the COVID-19 pandemic) during the employee's leave;
3. The employer made reasonable efforts to restore the employee to the same or an equivalent position; and
4. If the employer's reasonable efforts to restore the employee fail, the employer makes reasonable efforts for a period of time to contact the employee if an equivalent position becomes available for one year beginning either on the date the leave related to COVID-19 reasons concludes or the date twelve weeks after the employee's leave began, if earlier.

Small Business Exemption

A small business with fewer than 50 employees can deny an employee EPSL or PHEL to care for the employee's son or daughter whose school or place of care is closed or child care provider is unavailable, for COVID-19-related reasons only if:

1. Providing the leave would cause the small employer's expenses and financial obligations to exceed available business revenue and cause the small employer to cease operating at a minimal capacity;
2. The absence of the employee or employees requesting such leave would pose a substantial risk to the financial health or operational capacity of the small employer because of their specialized skills, knowledge of the business, or responsibilities; or
3. The small employer cannot find enough other workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services the employee or employees

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requesting leave provide, and these labor or services are needed for the small employer to operate at a minimal capacity.

A small employer who decides to deny EPSL or PHEL must document the facts and circumstances that satisfy these criteria. Documentation need not be provided to the DOL, but should be retained by the employer.

NOTE: A business claiming the exemption is not entitled to tax credits for any qualified leave wages that it is exempt from providing.

Notice requirements

Employer Notice

Employers required to provide leave must post on their premises in conspicuous places a notice explaining the FFCRA's leave provisions, including information concerning procedures for filing complaints with the DOL. The DOL has created a model notice that employers may use for this purpose. Employers may use another format for the notice as long as the employer's notice includes all of the information contained in the DOL's model notice. An employer is not required to provide the notice in any language other than English; however, the DOL has posted model notices available in multiple languages, for example: Spanish and Korean. The employer may also mail or email the notice to employees or it may post the notice on an internal or external website. For employers that are required to provide FFCRA leave, but are not subject to the FMLA, this notice will satisfy their notice obligation.

The FFCRA created new notice obligations for employers.

Employee Notice

An employer may require an employee to follow reasonable notice procedures after the first workday for which an employee takes EPSL. Whether a procedure is reasonable will be determined based on the facts and circumstances of each case. Generally, it will be reasonable for notice to be given by the employee's spouse or an adult family member if the employee is unable to do so. If an employee fails to give notice, the employer should notify the employee of the failure and give the employee an opportunity to provide the necessary documentation before denying a request. A similar rule applies if the employee requests leave in order to care for a child whose school or place of care is closed, or if the child care provider is unavailable, due to COVID-19.

The employee must provide basic information to document the need for leave, such as the dates for which leave is requested, the qualifying reason for the leave, and an oral or written statement that the employee is unable to work because of the qualified reason. If the reason for the leave is related to quarantine, the employee must provide the name of the health care provider who advised the employee (or individual for whom the employee is caring) to self-quarantine due to COVID-19 or the name of the government entity that issued the quarantine or isolation order, as applicable. If the leave is due to the closure of the employee's son or daughter's school or the unavailability of the child care provider, the employee must provide the name of the child being cared for and the name of the school or child care provider. In addition, the employee must provide a statement that no other suitable person will be caring for the employee's child while the employee is on EPSL or PHEL, and, if the leave is needed to care for a child older than fourteen during daylight hours, the employee should provide a statement that special circumstances exist requiring the employee to provide care.

Recording keeping under FFCRA

An employer is required to retain all documentation concerning leaves – whether granted or denied – for a period of four years. If the employer denies an employee's request for leave based on the small business exemption, the

> *Employers wishing to obtain tax credits for providing leave under the FFCRA should maintain appropriate documents based on IRS guidance.*

employer's authorized officer must make the determination using the specified criteria and must retain documentation of that determination for four years. The employer will also need to create and maintain documentation needed to support its application for tax credits from the Internal Revenue Service using Forms 7200 and 941. Instructions for Form 7200 include a list of required documentation.

Leave under FMLA

Employees are eligible to take FMLA leave if they work for a covered employer and:

- have worked for their employer for at least 12 months;
- have at least 1,250 hours of service over the previous 12 months; and
- work at a location where at least 50 employees are employed by the employer within 75 miles.

Special hours of service requirements apply to airline flight crew employees and to breaks in service to fulfill National Guard or Reserve military service obligations pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

An employee who is sick or whose family members are sick may be entitled to leave under the FMLA under certain circumstances. The FMLA entitles eligible employees of covered employers to take up to 12 weeks of unpaid, job-protected leave in a designated 12-month leave year for specified family and medical reasons. This may include the flu where complications arise that create a "serious health condition" as defined by the FMLA. A serious health condition is defined as "an illness, injury, impairment, or physical or mental condition that involves:

- inpatient care in a hospital, hospice, or residential medical care facility; or
- continuing treatment by a health care provider."

Inpatient care means an overnight stay in a hospital, hospice or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with such inpatient care. Continuing treatment by a health care provider means one of the following:

> (1) Treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
>
> (2) Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider.
>
> (3) The requirement in paragraphs (1) and (2) above for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.
>
> (4) Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

In the context of COVID-19, it will not always be clear whether the employee (or the employee's family member) meets the standard for continuing care of a health care provider because of the definitions above, but given the highly contagious nature of COVID-19, employers may consider telehealth visits to be equivalent to in-person visits.

Employees on FMLA leave are entitled to the continuation of group health insurance coverage under the same conditions as coverage would have been provided if the employee had been continuously employed during the leave period.

Workers who are ill with COVID-19 or who have a family member with COVID-19 are urged to stay home to minimize the spread of the pandemic. Employers are encouraged to support these and other community mitigation strategies and should consider flexible leave policies for their employees.

An employer may require an employee who is out sick with COVID-19 to provide a doctor's note, submit to a medical exam, or remain symptom-free for a specified amount of time before returning to work. However, employers should consider that during a pandemic, healthcare resources may be overwhelmed, and it may be difficult for employees to get appointments with doctors or other health care providers to verify they are well or no longer contagious.

More specifically, during a pandemic health crisis, under the ADA, an employer may require a doctor's note, a medical examination, or a time period during which the employee has been symptom free where it has a reasonable belief – based on objective evidence – that the employee's present medical condition would:

- impair his ability to perform essential job functions (i.e., fundamental job duties) with or without reasonable accommodation, or,
- pose a direct threat (i.e., significant risk of substantial harm that cannot be reduced or eliminated by reasonable accommodation) to safety in the workplace.

In situations in which an employee's leave is covered by the FMLA, you may have a uniformly-applied policy or practice that requires all similarly-situated employees to obtain and present certification from the employee's health care provider that the employee is able to resume work. You are required to notify employees in advance if you will require a fitness-for-duty certification to return to work. If state or local law or the terms of a collective bargaining agreement govern an employee's return to work, those provisions shall be applied. You should be aware that fitness-for-duty certifications may be difficult to obtain during a pandemic.

If an employee is covered and eligible under the FMLA and is needed to care for a spouse, daughter, son, or parent who has a serious health condition, then the employee is entitled to up to 12 weeks of job-protected, unpaid leave during any 12-month period. Some states may have similar family leave laws. In those situations, covered employers must comply with the federal or state provision that provides the greater benefit to their employees.

For more information on FMLA leave in the context of COVID-19, see the DOL's FAQs on COVID-19 and FMLA leave.

Health Plan Implications

If your organization provides group health coverage and an employee has elected that coverage, the employee is entitled to continued group health coverage during PHEL on the same terms as if the employee continued to work. If the employee is enrolled in family coverage, your organization must maintain coverage during the employee's PHEL. However, the employee generally must continue to make any normal contributions to the cost of your health coverage. See WHD Fact Sheet 28A.

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An employee may choose not to retain group health plan coverage while an employee is taking EPSL or PHEL. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages, without any additional qualifying period, physical examination, exclusion of pre-existing conditions, etc.

If an employee does not return to work at the end of PHEL, that employee should check with you to determine whether he or she is eligible to continue health coverage on the same terms (including contribution rates). If the employee is no longer eligible, he or she may be able to continue coverage under COBRA. COBRA, which generally applies to employers with 20 or more employees, allows the employee and family to continue the same group health coverage at group rates. The employee's share of that cost may be higher than what the employee was paying before taking leave but may be lower than what the employee would pay for private individual health insurance coverage. (If your organization has fewer than 20 employees, the employee may be eligible to continue health insurance coverage under State laws that are similar to COBRA. These laws are sometimes referred to as "mini COBRA" and vary from state to state.)

If the employee elects to take EPSL, your organization must continue health coverage for that employee. Under the Health Insurance Portability and Accountability Act (HIPAA), an employer cannot establish a rule for eligibility or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

Employees are entitled to continue health insurance coverage during PHEL, EPSL, and FMLA leave.

Health insurance coverage for an employee who takes "traditional" FMLA for a COVID-19-related qualifying reason (e.g., the employee's own hospitalization due to COVID-19) is subject to the regular FMLA requirements. You must maintain coverage under any group health plan for the duration of FMLA leave at the level (e.g., family coverage if the individual had family coverage prior to leave) and under the conditions that coverage would have been provided if the employee had been continuously working for the duration of FMLA leave. As such, while an employee is on FMLA leave, you must pay the same share of the premiums for health coverage as you would have paid if the employee had not been on leave. Moreover, the same group health plan benefits provided to an employee prior to taking FMLA leave must be maintained during the FMLA leave. For example, if family member coverage is provided to an employee, family member coverage must be maintained during the FMLA leave. The requirement to maintain group health plan benefits during FMLA leave extends to any medical care, surgical care, hospital care, dental care, eye care, mental health counseling, and substance abuse treatment provided under the employer's group health plan, whether or not provided through a health FSA or as part of a cafeteria plan. However, the FMLA does not require you to provide health benefits to employees on leave if such benefits are not provided to active employees.

If you provide a new health plan or change health benefits or plans while an employee is on FMLA leave, then the employee is entitled to the new or changed plans/benefits to the same extent as if the employee were not on leave. For instance, if you add a new coverage option under its group health plan providing coverage for dental care, each employee on FMLA leave must be given the same opportunity as other employees to obtain the dental care coverage. Any other plan changes (e.g., in coverage, premiums, or deductibles) that apply to all employees of the workforce would also apply to an employee on FMLA leave. Notice of an opportunity to change health plans or benefits must also be given to an employee on FMLA leave. If your group health plan permits an employee to change from single to family coverage upon the birth of a child or otherwise added family members, such a change in benefits must be made available while an employee is on leave. If the employee requests the changed coverage, it must be provided.

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If an employee takes FMLA leave on an intermittent or reduced leave schedule basis, you must maintain the employee's coverage under a group health plan as if the employee were still working full-time. For example, if a full-time employee switches to a part-time or reduced leave schedule under FMLA, the employee must continue to receive the same (full) level of benefits which the employee enjoyed before starting the FMLA leave, and may not be required to pay more to maintain that same level of benefits enjoyed prior to the start of the FMLA leave reduced leave schedule, regardless of any employer policy applicable to its part-time employees that would suggest a different result.

Coverage for COVID-19 diagnosis and testing

The FFCRA generally requires group health plans and health insurance issuers offering group or individual health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (referred to collectively as COVID-19) when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The CARES Act amends the FFCRA to include a broader range of diagnostic items and services that plans and issuers must cover without any cost-sharing requirements, prior authorization, or other medical management requirements. Additionally, the CARES Act generally requires plans and issuers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or issuer may negotiate a rate with the provider that is lower than the cash price.)

HSA-compatible High Deductible Health Plans

Internal Revenue Code Section 223 permits eligible individuals to deduct contributions to health savings accounts (HSAs). Among the requirements for an individual to qualify as an eligible individual under Section 223(c)(1) is that the individual be covered under a high deductible health plan (HDHP) and have no disqualifying health coverage. As defined in section 223(c)(2), an HDHP is a health plan that satisfies certain requirements, including minimum deductibles and maximum out-of-pocket expenses. For example, for 2020, HSA-compatible HDHPs must have minimum deductibles of $1,400 for self-only coverage and $2,800 for other than self-only coverage.

On March 11, 2020, the IRS released Notice 2020-15 in response to questions about whether health plans that cover testing and treatment for the 2019 Novel Coronavirus (COVID-19) without cost sharing would cause individuals with HDHP coverage to lose their eligibility to contribute to HSAs. The Notice indicates that such coverage will not cause individuals to lose their eligibility. Under the Notice, a health plan may provide 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. In other words, HDHPs that are HSA-compatible may cover both testing *and* treatment prior to the satisfaction of applicable deductibles.

Additionally, after the passage of the CARES Act, HSA-compatible HDHPs are permitted to cover telehealth services before a patient reaches the deductible, without regard to whether the telehealth services relate to COVID-19. This provision is effective upon enactment and lasts through plan years beginning in 2021.

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OTC Drugs and Menstrual Products reimbursable as medical care

After passage of the CARES Act, patients may use funds in HSAs, health reimbursement arrangements (HRAs), and health flexible spending accounts (FSAs) to purchase over-the-counter (OTC) menstrual care products. In addition, patients may use funds from HSAs, FSAs, or HRAs to cover over-the-counter drugs without a prescription (thus repealing prohibition under the Patient Protection and Affordable Care Act (ACA)). These changes are effective for amounts paid and expenses incurred in 2020 and apply indefinitely. Changes to cover OTC drugs without prescriptions and menstrual care products under account-based plans (e.g., health FSAs) will likely trigger a need for plan amendments, and for employers subject to ERISA, summaries of material modification (SMMs).

For a deeper dive into plan amendment changes triggered by COVID-19, check out our article on Plan Documents and COVID-19.

Telehealth

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. For example, individuals may receive evaluation and management visits (common office visits), mental health counseling, and preventive health screenings through telehealth services, which may include phone calls, video conferences, and similar activities. In the wake of COVID-19 and the need for social distancing, many health care providers have turned to telehealth solutions for their patients. In response, federal and state government have taken action to permit the use of technology to help individuals who need routine care, and keep vulnerable individuals with mild COVID-19 symptoms in their homes while maintaining access to the care they need. Such efforts are also intended to limit community spread of the virus, as well as limit the exposure to other patients and staff members in order to slow viral spread.

As a result, many employers have expanded or introduced the use of telehealth services. When doing so, employers should consider whether that expansion or introduction triggers the need for a plan amendment, and for employers subject to ERISA, a need to release an SMM. Additionally, all employers making changes related to telehealth should also consider whether that change triggers a change to their summaries of benefits and coverage (SBC).

Implications for Other Benefits

Although the FFCRA Temporary Rule addresses the requirement to continue health benefits during PHEL and EPSL, and the FMLA regulations address handing non-health benefits during FMLA, the FFCRA does not address how other employee benefits such as life insurance, short and long term disability insurance, and voluntary benefits, should be handled during PHEL or EPSL. Thus, employers likely have questions concerning eligibility for coverage, payment of premiums, collection of employee contributions, continuation if employer-provided coverage is terminated, and reinstatement when the employee returns from a leave of absence for non-health benefits. Following is a brief discussion of each of these topics.

Eligibility

Under virtually all insurance contracts, employees must work a minimum number of hours per week in order to be eligible for coverage. If an employee's hours of work drop below the required minimum, the employee loses eligibility and coverage ends. When an employee is placed on a leave of absence, coverage may be continued for a short period of time – typically from one to three months – but unless the employee returns within that timeframe, coverage will end. An employer is generally not required to continue non-health coverages such as life insurance during a leave of absence (an employer is required to continue non-health coverages during an FMLA leave if it does so for other types of leave). What coverage may be continued and for what time period will be determined by the employer,

with insurer agreement, and reflected in the insurance contract(s). When coverage under the insurance contract ends, the employee has a limited amount of time to port or convert coverage.

Existing insurance contracts were not written with a pandemic such as COVID-19 in mind. As a result, insurers are attempting to make changes to address the potential problems that may arise. Some insurers may be willing to expand the timeframe on an existing leave of absence provision. Others may be willing to add a leave of absence provisions. Employers will need to review their insurance contracts and work with their insurers to determine what options are available. Employers may want to work with their insurers to modify any existing leave of absence provision to adjust for the impact of COVID-19. For example, if the current contract provision terminates coverage at the end of the month following the beginning of a leave of absence, this may create a coverage gap for employees who were placed on leave in March. The employer may want to request a longer timeframe – such as until the end of April or May – in order to make adjustments in response to COVID-19. The employer will need to discuss contract provisions with its insurer(s).

Premiums and contributions for coverage

Changes may need to be made in how you collect employee contributions for coverage such as group term life insurance, disability insurance, and voluntary benefits. If the leave is paid – for example, an employee is receiving PHEL payments -- you should be able to continue making deductions to cover the employee's contributions during the leave. If the leave is paid, but you are unable to deduct an amount sufficient to cover all of the employee's required contributions, you have several options available. You can pay the employee's portion during the leave (you should discuss tax issues with your tax advisor). Alternatively, you may want to use one of methods approved for FMLA leave – pay-as-you-go or catch-up contributions upon the employee's return to work. Although pre-pay is theoretically available, it is likely to be impractical because there may not be sufficient advance notice of the need for the leave.

If the leave is unpaid, you will not be able to make deductions. For example, an employee may not be able to report to work because she is caring for a spouse who has tested positive for COVID-19 and has been advised by a health care professional to self-quarantine. She would be eligible for up to two weeks of EPSL, but would not be eligible for PHEL payments. Unless she is eligible for another type of paid leave, her leave of absence will be unpaid after the first two weeks. Under these circumstances, you should be able to use the same methods that you use when your organization is unable to collect the full amount of contributions via deduction. You may pay the employee's portion of premiums during the leave (with tax advice), require the employee to pay contributions on a regular (e.g., monthly) basis during the leave, or cover the cost during the leave but then require the employee to repay the contributions upon return from leave.

You will need to determine which method or methods to use and communicate with affected employees as soon as practicable.

Claims and evidence of insurability

The claims process may be affected by COVID-19. First, although insurers are an essential business and remain open and many of their employees may be able to telework, they may also be affected by reduced staffing. Reduced staffing may mean that claims take longer to adjudicate. In addition, some claims such as disability claims typically require information from one or more physicians. Because physicians and other medical professionals are on the "front lines," it may take more time and be more difficult to obtain all of the needed information. You should work with your insurers to find ways to ease the burden on claimants. Similarly, employees in the process of providing evidence of insurability – for example to increase the amount of life insurance coverage – may find that the process is more challenging and takes longer.

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Coverage termination and continuation rights

Under some circumstances, you may not be able to continue non-health coverage for employees who are on leave of absence. Should that occur, you will need to notify employees and provide them with appropriate information about porting coverage (i.e., the employee pays the premium to continue the coverage) or converting coverage (i.e., the employee converts to an individual policy. Because most insurance contracts provide only a limited amount of time to port or convert coverage – such as 30 or 31 days – you should provide the information to employees as soon as possible. If you will be terminating coverage for employees on leave of absence, consider continuing coverage for a short period of time such as one month (with insurer agreement) before terminating coverage so that employees have sufficient time to convert or port their coverage.

Hopefully, the duration of these leaves will be a short period of time such as a month or two. Unfortunately, the duration of the leave for some employers and employees may be longer than the period of time the insurer is willing to continue coverage. In other cases, you may need to end the employment relationship rather than have the employee return from leave. In both of these situations, you will need to notify employees when coverage will end and provide information about porting and converting coverage as soon as possible.

Return from leave of absence

If insurance coverage for non-health benefits is continued during a leave of absence, no changes should be needed when an employee returns from leave. However, if the employee returns from leave with reduced hours, unless your organization amends the applicable insurance contracts to reduce the minimum hours requirement, the employee's coverage will end when the leave ends and his reduced work schedule begins. At that time, you should provide the employee with information about continuing coverage – i.e., porting and/or conversion.

If insurance coverage was discontinued at the beginning of (or during) the leave, the insurance contract provisions will govern what happens when the leave ends and the employee returns to work. In some cases, the contract may permit immediate reinstatement subject to an actively-at-work requirement. In other cases, the employee may need to satisfy a new waiting period before coverage begins. An evidence of insurability requirement may apply, for example, if the amount of life insurance being reinstated exceeds the guaranteed issue amount under the contract. And if the employee converted some of her group term life insurance to an individual contract, she may need to surrender that individual policy in order to be eligible under the group term life contract when she returns.

Similar provisions may apply to disability insurance. In addition, a long term disability insurance contract may continue a prior preexisting condition limitation when the employee returns from a leave, or in some cases may apply a new preexisting condition limitation.

If employees continued coverage using the pay-as-you-go method during the leave, then normal payroll deductions should be resumed when the employee returns. If the employer chose to use catch-up contributions upon return to work, then the employer will also need to make arrangements to recover employee contributions owed for coverage continued during the leave.

ACA Implications

Under the Patient Protection and Affordable Care Act (ACA), an employee's status as full-time or not full-time is important for multiple reasons including determining how to treat employees for purposes of Forms 1094 and 1095 reporting and application of the Employer Shared Responsibility Mandate. Specifically, Applicable Large Employers (ALEs) must offer affordable, minimum value coverage to at least 95% of their full-time employees to avoid Employer Shared Responsibility penalties. Under the ACA, an employee who works an average of 30 or more hours per week is considered to be a full-time employee. Only full-time employees can trigger penalties for employers for Applicable Large Employers (ALEs), and full-time employees are the primary focus of Forms 1094 and 1095 reporting. In

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general, an ALE is an employer with 50 or more full-time employees and full-time equivalent (FTE) employees in the prior year.

Under the ACA, an employer identifies its full-time employees based on each employee's hours of service. Generally, "hours of service" include any hour for which an employee is paid or entitled to payment when duties are not performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. When an employee is placed on a furlough, the employee experiences a reduction in hours of service to zero. Based on IRS regulations, employers may determine the hours of service for hourly and non-hourly employees (e.g., salaried employees, *per diem* employees, etc.) using either the monthly measurement method or the look-back method. Below, we address the implications arising from a leave of absence on an individual's status under the ACA.

Stability and measurement periods

Employers with employees who take leaves of absence will need to consider the impact of those leaves on the employee's status as either full-time or not full-time for purposes of the ACA. Depending on the method used to determine full-time status (monthly measurement method or look-back method), an employee's status as full-time (or not) may be locked in for a period of time.

With the monthly measurement method, to avoid an ACA Employer Shared Responsibility penalty for a particular employee, the employee's hours of service are calculated for a given month and an offer of coverage must be made for any month in which the employee has at least 130 hours of service. And, only paid leave (including EPSL and PHEL) would count toward the determination of whether that employee was full-time. For example, an employee has at least at least 130 hours of service from January through March, but takes an unpaid leave of absence for two weeks in April and all of May, and then resumes normal working 130 hours per month for June through December. To avoid a penalty, the employer must offer coverage for January through March and June through December, but does not have to offer coverage for April or May.

In contrast, under the look-back measurement method, an employee's status is locked in for a period of time, even if the employee is on an unpaid leave of absence. Using the look-back measurement method, an employee's full-time status is determined during a measurement period for a corresponding stability period (following the measurement period). Therefore, when an employee has been determined to be a full-time employee during the measurement period, his or her full-time status during the corresponding stability period is protected. This means an employee who originally met the full-time employee threshold under the measurement period will continue to be considered a full-time employee for the corresponding stability period, even if he or she is on an unpaid leave of absence and no longer meets the full-time hours of service threshold.

For more information on counting hours for purposes of the ACA, check out our Counting Hours Toolkit.

Counting hours during a leave of absence

An additional issue for employers to consider for an employee who is on a leave of absence is whether to count that employee's hours for the current measurement period.

Employers using the monthly measurement method need not provide credit toward hours of service for time off due to unpaid leave, including unpaid FMLA, USERRA or jury duty leave. However, paid time off for FMLA, USERRA, or jury duty is counted toward an employee's "hours of service," and, therefore, must be counted in determining whether an employee is full time. Thus, EPSL and PHEL leave would be counted for this purpose. Additionally, because paid time off is included in an employee's hours of service, if an employee is on paid disability leave, which runs concurrently with FMLA leave, those hours will count toward the employee's status for that month.

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For employers using the look-back method, paid leaves of absence would count toward the employees' hours of service. Additionally, the ACA provides for a special averaging rule for when an employee is on "special unpaid leave," which is defined as unpaid leave under FMLA, USERRA, and jury duty. Note that PHEL does not fall within the FMLA definition of special unpaid leave. If the employer is not an academic institution, it must determine the employee's average hours of service for a measurement period either by

- computing the average after excluding any special unpaid leave during that measurement period and by using that average as the average for the entire measurement period; or
- treating the employee as credited with hours of service for any periods of special unpaid leave during that measurement period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of a period of special unpaid leave.

For example, if an employee is on unpaid FMLA leave for one month, then the employer may calculate the employee's status for a twelve-month measurement period either by using only the hours worked during the eleven months of active employment or by calculating the average over the eleven-month period and using that average to "fill in" for the one month of unpaid FMLA leave.

Employers should be mindful of rules on treating leaves of absence for purposes of determining employee status under the ACA.

Breaks in service

As a general rule, an employee retains his or her status as either full time or not full time during an entire stability period regardless of the number of hours worked, as long as employment continues. But what happens with an employee who is on an unpaid leave of absence and later returns to work? How that employee is treated upon resumption of service depends on whether he is considered to be a continuing employee or a new employee. (Note that an employee on a paid leave is treated the same as an employee who is actively working. And, see above for discussion of employees on special unpaid leave.)

Under the ACA, an employer may treat an employee as a new employee if the employee has had a "break in service." A break in service occurs if the employee has at least 13 consecutive weeks (26 for educational employers) during which the employee is not credited with an hour of service. Alternatively, under a "rule of parity," an employer may treat a shorter-term employee as a new hire if the employee's break in service is at least four weeks (but less than 13/26 weeks) and is as long as the employee's preceding period of employment. For example, suppose an employee has six weeks of service, then takes an unpaid leave of absence for eight weeks, and then resumes services. Because the period the employee was not working was at least four weeks long and was longer than his period of employment, he is considered to have had a break in service and may be treated as a new employee.

If an employee who was on an unpaid leave resumes services during a stability period and is a continuing employee, he retains the status he had prior to the period of absence as though he had not ceased providing services. That is, if the employee was in a stability period where he was treated as full-time, he should be treated as full-time upon resumption of services. In that case, for the employer to avoid an employer shared responsibility penalty, the continuing employee should be offered coverage as of the first day the employee is credited with an hour of service, or, if later, as soon as administratively practicable (i.e., no later than the first day of the calendar month following return to work). Note, however, that the employer need not make a new offer of coverage to the employee if the employee had previously been offered coverage for the stability period and declined it.

Similarly, an employer using the monthly measurement method must offer coverage to a continuing full-time employee by the first day of the next calendar month to avoid potential liability.

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In contrast, if the employee is considered to be a new employee, upon resumption of services, the employer may treat him as it would any new employee. If the employer is using the monthly measurement method, it would begin counting hours with the first month of employment. An employer using the lookback method would begin counting the employee's hours in an initial measurement period.

Keep in mind that when an employee is on an unpaid leave of absence, an employer may not "unlock" an employee's status as full time as soon as the employee has an unpaid absence of 13 (or 26, as applicable) weeks. The employer may treat the employee as a new employee upon return to work, but not before.

Cafeteria Plan Election Issues

The COVID-19 pandemic has raised a number of issues for employers and employees alike. With business interruptions and many states issuing stay-at-home orders, many employees may be unable to report to work for a period of time or drastically reduces the number of hours an employee is able to work. The health and cafeteria benefit status of affected employees may change during the stay-at-home period, or any business decisions that result in furloughs, reduction of hours, leave of absence, or terminations.

Many employers may already have established FMLA and, in many cases, non-FMLA leave policies and already have the mechanisms in place to manage employee pre-tax elections. For other employers, the decision to place employees on leave employees may have been an immediate decision due to the rapid evolution of COVID-19 and in response to state actions. Before discussing what changes may occur during a leave of absence, it is important to understand some basics of the IRC Section 125 regulations surrounding employee mid-year elections.

Cafeteria plan election basics

Determining whether a mid-year election is allowed depends on a several factors. First, the change must be permitted by the underlying benefit. For example, if an employee wishes to drop his or her medical coverage at the beginning of a furlough, the underlying medical plan must permit the employee to drop coverage. Second, any requested change must be permitted both under the Internal Revenue Code (IRC) Section 125 regulations and your cafeteria plan or Section 125 plan document. Note that a plan cannot be more generous than what the IRS allows, but it can be more restrictive. So, you should verify that both the underlying benefit and your cafeteria (or Section 125) plan document permit a requested change.

Under the IRC Section 125 regulations, there are six categories of events that encompass permissible change in status events:

- change in legal marital status;
- change in number of dependents;
- change in employment status;
- dependent satisfies or ceases to satisfy dependent eligibility requirements;
- residence change; and
- for adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

Of these six categories, a change in employment status is likely the most relevant for employees on leaves of absence. More specifically, a change in employment status includes:

- a termination or commencement of employment;
- a strike or lockout;
- a commencement of or return from an unpaid leave of absence; or
- a change in worksite.

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Note that leave under the FFCRA is paid leave; thus, beginning EPSL or PHEL is not considered to be an unpaid leave of absence under the FFCRA. However, the DOL's Temporary Rule includes a right for individuals on EPSL or PHEL to discontinue their health coverage. Although this conflicts with the IRS guidance noted above, employers will likely also permit salary reduction election changes to correspond with discontinuation of coverage while on EPSL or PHEL. Given that EPSL is only available for two weeks, and the basis for leave may be an employee's or family member's illness or potential illness due to COVID-19, employees are not likely to take advantage of the DOL's position on an employee's right to terminate their health coverage. However, employees taking PHEL may choose to discontinue coverage.

Employees taking an unpaid FMLA leave may also choose to discontinue coverage and thus may have a permissible change in status event when unpaid leave begins.

Permissible changes in status when an employee begins a leave of absence

For employees on an unpaid non-FFCRA or non-FMLA leave, how an employee's salary reduction election is treated while an employee begins leave or is out on leave depends on the employer's leave policy. When an employee begins an unpaid leave and as a result of the leave loses eligibility, the employee would be permitted to drop coverage and change his or her corresponding salary reduction election. However, some employers may extend eligibility to employees that take leave whether FMLA or non-FMLA and retain plan coverage for those employees.

An employer may allow an employee going on **unpaid FMLA** leave to either revoke or continue health coverage (including health FSA coverage), or an employer may require that health coverage continue, but allow the employee to discontinue contributions. If the employer continues coverage during an unpaid leave, the employer may recover the employee's share of the premiums when the employee returns to work. Note, however, that an employee has a right to drop health coverage during FMLA leave.

FMLA leaves of absences, FFCRA leaves, and non-FMLA leaves are treated comparably with regard to election changes, differently for continuation of coverage while on leave, and comparably for the collection of contributions. In general, the normal election change rules apply (e.g., an employee would be permitted to change medical options or add coverage for a spouse only if there was a change in status event that would permit the new election). With respect to FMLA leaves and FFCRA leaves, the employee must be permitted to continue health coverage during the leave. Employers are not required to continue health coverage for employees on non-FMLA and non-FFCRA leaves except to the extent that COBRA or state continuation will apply if those individuals lose health plan eligibility. FMLA rules permit an employer to use one of three methods to collect employee contributions during a leave: (1) pre-pay before the leave begins via salary reduction, (2) pay-as-you-go during the leave on an after-tax basis, or (3) post-pay (sometimes called catch-up) contributions when the employee returns from leave. Catch-up contributions may be made via salary reduction or on an after-tax basis.

Below is a chart of election changes that may arise however these changes rely on the employer's leave policies:

Event	Change Permitted
FMLA Leave of Absence	
Commencement of Public Health Emergency Leave (PHEL)	Yes. Employee can revoke election unless employer requires employees to continue with coverage while on FMLA (but only if employees on non-FMLA paid leave are required to do so). If eligible employees meet the conditions for

Event	Change Permitted
	Public Health Emergency Leave, employee elections should be treated in the same manner as when “traditional” FMLA leave is taken.
Commencement of Emergency Paid Sick Leave (EPSL)	Yes. Employee can revoke election unless required to continue with coverage while on FMLA (but only if employees on non-FMLA paid leave are required to do so). Due to FFCRA, if eligible employees meet the conditions for Emergency Paid Sick Leave, employee elections should be treated in the same manner as when “traditional” FMLA leave is taken. This is leave is protected in the same manner as “traditional” FMLA.
Commencement of “traditional” paid FMLA	Yes. Employee can revoke election unless required to continue with coverage while on FMLA (but only if employees on non-FMLA paid leave are required to do so).
Commencement of unpaid “traditional” FMLA leave of absence	Yes. Employee can revoke election unless required to continue with coverage while on FMLA. However, employee must be allowed to discontinue contributions during the leave.
Addition of new benefit package option or increase in benefit offering	Yes. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or elect coverage.
Reduction in pay due to reduction of hours	No. Reduction of pay is not an IRC Section 125 permitted event. Another permitted event would have to occur to allow a change.
Non-FMLA/Non-PHEL/Non-EPSL Leave of Absence	
Commencement of paid non-FMLA/Non-PHEL/Non-EPSL leave of absence with loss of eligibility	Yes, employee can revoke election.
Commencement of paid non-FMLA/Non-PHEL/Non-EPSL leave of absence without loss of eligibility.	Generally, no. Change is not permitted since there is no loss of eligibility.
Commencement of unpaid non-FMLA leave of absence with loss of eligibility	Yes. Employee can revoke election.
Commencement of unpaid non-FMLA leave of absence without loss of eligibility	Generally, no. Change is not permitted since there is no loss of eligibility.
Employee fails to pay premiums	No election change permissible event has occurred. If the employee fails to pay his or her premium, employer may be able to cancel the employee’s election. However, many States have required extended grace periods for

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Event	Change Permitted
	missed premiums. If you have a fully insured plan, you should check with your insurers.

Permitted election changes for DCAPs and health FSAs

With respect to health FSAs, an employee whose eligibility under the plan was lost will be able to make a change in his or her salary reduction election. However, employees who have no change in eligibility will not be permitted to change their elections. When employees begin leave, they can make corresponding health FSA election changes. For example, if an employee goes on FMLA leave and revokes her health plan coverage, she can also make a change in her health FSA.

The election change rules for DCAPs are more flexible than those for health FSAs and allow employees to change elections for a broader range of reasons. Some relevant DCAP changes that may occur when an employee takes a leave of absence are below.

Event	Change Permitted
Change in dependent care provider to parent (e.g., employee and/or spouse at home to care for child)	Yes. The employee would be able to reduce or revoke his or her election. An employee may not have eligible dependent care expenses if the employee or spouse are able to stay home with the child.
Change in the number of hours of dependent care	Yes. The consistency rule would apply (e.g., an employee could decrease an election if she decreased her work hours and needed fewer hours of day care for her child).
Reduction of hours with or without a loss of eligibility	Yes. Decrease or revoke election. The employee may need fewer hours of day care if, for example, PHEL is taken on an intermittent basis.

Permissible election changes when leave ends

Below is a chart showing relevant changes that may occur when an employee returns from leave:

Event	Change Permitted
FMLA Leave of Absence	
Return from Public Health Emergency Leave (PHEL)	Reinstate previous coverage if not continued during the leave. No change permitted after returning from a paid leave unless another event which would permit a change occurs.
Return from Emergency Paid Sick Leave (EPSL)	Reinstate previous coverage if not continued during the leave. No change permitted after returning from a paid leave unless another event which would permit a change occurs.

Event	Change Permitted
Return after paid FMLA leave of absence	Reinstate previous coverage if not continued during the leave. No change permitted after returning from a paid leave unless another event which would permit a change occurs.
Return after unpaid FMLA leave of absence	Employer may require an employee to be reinstated to his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections. Employee may make new election only if another event, such as birth of a child, would permit a new election. For health FSA, employee has the choice to reinstate prior election or pro-rated reduction. For example, an employee with a two-month unpaid FMLA and a $1,200 election amount could continue the $1,200 or $1,000 election (10/12 x $1,200).
Addition of new benefit package option or increase in benefit offering	Yes. If the employee is eligible for a new plan or a plan has been modified to increase benefits, the employee would be permitted to elect the new benefit or enroll.
Non-FMLA/Non-PHEL/Non-EPSL Leave of Absence	
Return after paid leave of absence (non FMLA) with gain eligibility	May reinstate if eligibility was lost upon commencement of leave. FSA may reinstate with blended dollar election or new short period.
Return after unpaid leave of absence (non-FMLA) with gain eligibility	May reinstate if eligibility was lost upon commencement of leave. FSA may reinstate with new dollar amount – short period.

HIPAA Special Enrollment Issues

Typically, employers provide eligible employees and their dependents an opportunity to enroll in employer-sponsored group health plans when the employees are first eligible (e.g., after completing a waiting period or an initial measurement period). In addition, most employers also provide annual enrollment periods that allow enrollment by employees (and dependents) who are eligible for coverage but did not enroll during their initial or a prior annual enrollment period.

The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries, in the following situations:

- a loss of eligibility for group health coverage or health insurance coverage;
- becoming eligible for a state premium assistance subsidy; and
- the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

Although employees may drop their health coverage during PHEL, EPSL, or FMLA leave, employers are required to continue their health insurance coverage during leave. Additionally, because employees on PHEL, EPSL, and FMLA

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leave are continuing employees, they retain their special enrollment rights during leave, and, more particularly, an employee on FMLA leave has the right to revoke or change elections under the same terms and conditions that apply to employees participating in the cafeteria plan who are not on FMLA leave. Thus, individuals on PHEL, EPSL, and FMLA leave in connection with the COVID-19 pandemic will retain not only their special enrollment rights, but also their rights to make changes to their salary reduction elections during paid leave.

Losing other coverage

A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

- The employee and the dependents are otherwise eligible to enroll in the benefit package;
- When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and
- The employee or dependent lost eligibility for the other coverage as the result of an event identified in the regulations, such as termination of a spouse's employment.

Note that for this type of special enrollment, the employee must have been eligible for coverage under your employer-sponsored coverage and had other coverage when either initially eligible or during any of your annual enrollment opportunities. Employees who were covered under their spouses' employers' plans may be the most likely individuals to experience a HIPAA special enrollment right due to loss of other coverage. So, for example, if an employee on PHEL was covered under his spouse's employer's plan, and that spouse is laid off due to COVID-19, triggering a loss of coverage under the spouse's employer's plan, then the employee, his spouse, and their dependent children would have a special enrollment right under your employer-sponsored coverage.

Gaining eligibility for state premium assistance

If an employee or dependent becomes eligible for assistance for coverage under the plan through either a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, a special enrollment right arises. An employee who is eligible, but not enrolled, or a dependent of an employee if the dependent is eligible, but not enrolled, is eligible for the special enrollment and may enroll in the plan upon becoming eligible for state premium assistance subsidy so long as the special enrollment is requested in a timely manner. A timely request is one that is made within 60 days after the individual is determined to be eligible for the state premium assistance.

Note that Pandemic Unemployment Compensation created by the CARES Act will not be counted as income for purposes of determining eligibility for Medicaid, CHIP, or any other program established under titles XIX and title XXI of the Social Security Act. So, it is possible that individuals (or really their dependent children) may gain eligibility for premium assistance during a furlough, but the administrative reality of applications for assistance and the hopefully short-lived period of leave related to COVID-19 may not trigger any additional special enrollment rights during furlough than in the normal course of a plan year.

Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

Under HIPAA, group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) must offer a special enrollment opportunity to specific newly acquired spouses and dependents of participants and to current employees who have previously declined coverage but who have since acquired a new spouse or dependent. However, such a special enrollment right applies only if a group health plan otherwise offers dependent coverage, and only if the new dependent is acquired through marriage, birth, adoption, or placement for adoption.

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So, an employee on PHEL, EPSL, or FMLA leave related to COVID-19 who marries, adopts a child (or has a child placed for adoption), or who has a newborn child is entitled to enroll himself or herself and the child. The individual must be allowed at least thirty days from the date of the event giving rise to the special enrollment to seek enrollment. If the enrollment is based upon marriage, the effective date of the coverage must be no later than the first of the month following the request for enrollment. If the special enrollment is based upon birth, adoption, or placement for adoption, coverage must be retroactive back to the date of the birth, adoption, or placement for adoption.

COBRA Implications

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires certain employers to make temporary health coverage ("continuation coverage") available to certain individuals upon the occurrence of specific events. Those individuals may then elect to continue group health plan coverage for a limited time on a self-pay basis. COBRA applies to private sector employers (both for-profit and nonprofit) and state and local governments that offer group health insurance. Employers that are exempt from COBRA are small employers (i.e., employers who employed less than 20 employees on at least half of the typical business days during the prior year), non-electing church employers recognized under IRS Code Section 501, the federal government, and Indian Tribal governments that perform purely governmental functions.

COBRA only applies to "group health plans" that provide health care and are maintained by an employer subject to COBRA. Examples include:

- Health insurance, HMOs, and self-insured plans
- Dental and/or vision plans
- Disease-specific plans
- Prescription drug plans
- Healthcare Flexible Spending Accounts (FSAs)
- Health Reimbursement Arrangements (HRAs)
- Drug or alcohol treatment
- Medical clinics that offer services beyond free minor first aid for injuries and illnesses
- Wellness programs, employee assistance programs (EAPs), and employee discount programs that provide medical care and are maintained by the employer

The following are not group health plans subject to COBRA:

- Health Savings Accounts (HSAs)
- Long-term care plans
- Accidental Death and Dismemberment (AD&D)
- Group term life insurance plans
- Long-term and short-term disability
- On-site first aid facilities
- Hospital (or other) indemnity plans

For a deeper dive into COBRA and state continuation obligations, check out our Employer COBRA Guide.

There are seven "qualifying events" which, if they cause a loss of health plan coverage, trigger COBRA continuation coverage. Those events are as follows:

- Termination of employment (unless for gross misconduct)
- Reduction of hours (e.g., when an employee moves from full-time to part-time; it could also occur during a strike, lockout, or when an employee takes an unpaid leave of absence)
- Employer's bankruptcy

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- Divorce or legal separation
- Death of a covered employee
- Dependent child ceases to be a dependent under the terms of the plan
- Covered employee's entitlement to Medicare (but only if eligibility is impacted)

As a reminder, employers are required to continue health coverage for employees on PHEL, EPSL, and FMLA leave on the same terms and conditions as employees not on leave. However, employees on any of those types of leaves may choose to drop coverage during leave. If an employee on PHEL or EPSL voluntarily drops coverage during leave, that action would not constitute a COBRA qualifying event because a voluntary termination of coverage is not a COBRA qualifying event.

If an employee does not return to work at the end of PHEL or EPSL, the employee may be eligible to continue health coverage on the same terms (including contribution rates). If, however, the employee is no longer eligible, the employee may be able to continue coverage under COBRA. If your organization has fewer than 20 employees, the employee may be eligible to continue health insurance coverage under state laws that are similar to COBRA. These laws are sometimes referred to as "mini COBRA" and vary from state to state.

If your organization is subject to COBRA, you must offer Qualified Beneficiaries the same coverage they were receiving immediately before a qualifying event. This is true even if that coverage is no longer of use to the Qualified Beneficiary. For example, if employer offers HMO coverage and the Qualified Beneficiary moves out of state, the employer must nonetheless offer COBRA continuation for the HMO coverage.

Because a termination of coverage due to the commencement of an unpaid leave of absence is a COBRA qualifying event, you (or your COBRA administrator on behalf of your plan) will be responsible for providing a COBRA Election Notice and for the ensuing COBRA obligations. The Election Notice must be furnished by the plan administrator within 14 days after receiving a notice of a Qualifying Event. If you and the plan administrator are the same (i.e., you do not use a third-party to administer your COBRA or other continuation), the Election Notice must be furnished within 44 days from the Qualifying Event itself (in other words, when the layoff occurs). This is because employers have 30 days to provide a notice of Qualifying Event plus 14 days to furnish the Election Notice.

Each Qualified Beneficiary has 60 days to elect COBRA coverage. The 60-day election period starts from the date the notice is "provided" or the date coverage is lost, whichever is later. If the election is not made prior to the expiration of the 60-day election period, then you are not obligated to offer COBRA coverage. If you accept an election after the 60 day period, your insurance carrier contract might not allow that person to be covered under the plan. In this case, you may ultimately be self-insuring that person and liable for the costs. If the coverage is self-insured, your stop loss carrier may refuse to provide coverage if stop loss is invoked.

The maximum amount a Qualified Beneficiary can be required to pay as a COBRA premium is 102% of the applicable premium. Broken down, the 102% is 100% of the applicable premium plus a 2% administrative fee. The purpose of the administrative fee is to help defray the cost of additional administration. However, you have the discretion to pay all or part of that premium for the Qualified Beneficiary, but you should check with your tax advisor for any potential tax implications.

Special Return to Work Issues

Special job protection is provided to individuals who take PHEL, EPSL, or FMLA leave. The FFCRA requires employers to provide the same (or a nearly equivalent) job to an employee who returns to work following leave.

In most instances, an employee is entitled to be restored to the same or an equivalent position upon return from EPSL or PHEL. Thus, an employer is prohibited from firing, disciplining, or otherwise discriminating against an

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employee because the employee took EPSL or PHEL. An employer cannot fire, discipline, or otherwise discriminate against an employee because the employee filed any type of complaint or proceeding relating to the FFCRA, or has testified or intends to testify in any such proceeding.

However, an employee is not protected from employment actions, such as layoffs, that would have affected that employee regardless of whether he or she took leave. This means your organization can lay off an employee for legitimate business reasons, such as the closure of a worksite. However, employers who lay off employees on EPSL or PHEL must be able to demonstrate that the employee would have been laid off even if the employee had not taken leave.

Your organization may also refuse to return an employee to work in the same position if that employee is a highly compensated "key" employee as defined under the FMLA, or if your organization has fewer than 25 employees, and the employee took leave to care for his or her own son or daughter whose school or place of care was closed, or whose child care provider was unavailable, and all four of the following hardship conditions exist:

- The employee's position no longer exists due to economic or operating conditions that affect employment and due to COVID-19-related reasons during the period of the leave;
- Your organization made reasonable efforts to restore the employee to the same or an equivalent position;
- Your organization makes reasonable efforts to contact that employee if an equivalent position becomes available; and
- Your organization continues to make reasonable efforts to contact that employee for one year beginning either on the date the leave related to COVID-19 reasons concludes or the date 12 weeks after the employee's leave began, whichever is earlier.

When an employee returns from FMLA leave, he or she must be restored to the same job that the employee held when the leave began or to an "equivalent job." The employee is not guaranteed the actual job he or she held prior to the leave. An "equivalent job" means a job that is virtually identical to the original job in terms of pay, benefits, and other employment terms and conditions (including shift and location). Equivalent pay includes the same or equivalent pay premiums, such as a shift differential, and the same opportunity for overtime premium pay as the job held prior to FMLA leave. An employee is entitled to any unconditional pay increases that occurred while he or she was on FMLA leave, such as cost of living increases. In addition, an employer must grant pay increases conditioned upon seniority, length of service, or work performed if employees taking the same type of leave (i.e., paid or unpaid leave) for non-FMLA reasons receive the increases. Equivalent pay also includes any unconditional bonuses or payments. If a bonus is conditioned on achieving a specified goal, such as hours worked or products sold, and the employee does not meet the goal due to FMLA leave, payment of the bonus is not required, unless the employer pays it to employees taking the same type of leave for a non-FMLA reason. If the employer pays the bonus to such employees taking leave for a non-FMLA reason, it must also pay the bonus to an employee taking FMLA leave.

Moreover, any benefits an employee accrues prior to a period of FMLA leave must be available to the employee when he or she returns from leave. These benefits provided to employees must be resumed in the same manner and at the same level as when the leave began, subject to any changes in benefit levels affecting the entire workforce. An employee returning from FMLA leave cannot be required to requalify for any benefits the employee enjoyed before the leave began.

An employee on FMLA leave is not protected from actions that would have affected him or her if the employee was not on FMLA leave. For example, if a shift has been eliminated, or overtime has been decreased, an employee would not be entitled to return to work that shift or the original overtime hours. If an employee is laid off during the period of FMLA leave, the employer must be able to show that the employee would have been laid off whether or not the employee took the leave.

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A covered employer may deny restoration to a “key employee” if necessary to prevent substantial and grievous economic injury to its operations. A key employee is a salaried FMLA-eligible employee who is among the highest paid 10% of all employees, both eligible and not eligible, within 75 miles of the worksite. However, a decision not to reinstate a “key employee” should be made under with the advice of legal counsel.

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Employees who are Laid Off and Rehired

Introduction

In response to the COVID-19 pandemic's impact on business operations, an employer may choose to downsize its workforce by laying off some or all of its employees, resulting in a permanent reduction in its workforce and a termination of the employment relationship. Employees who have been laid off are not considered active employees of an organization and are terminated from the organization's payroll. However, some employers intend to rehire laid off employees when business circumstances permit. Employers who lay off employees should understand how that decision will impact both the employer as well as the employee. There are also implications if the employer later rehires laid off employees.

The employment relationship with laid off employees is terminated.

Leave under the Families First Coronavirus Response Act

The Families First Coronavirus Response Act (FFCRA) created two new types of leave associated with the COVID-19 pandemic – Emergency Paid Sick Leave (EPSL) and Public Health Emergency Leave (PHEL) (often referred to as expanded FMLA leave) -- for employers with fewer than 500 employees on the date leave would begin and all governmental employers. Both types of leave are only available between April 1, and December 31, 2020. There is a possible exception for employers with fewer than 50 employees.

Public Health Emergency Leave (PHEL)

PHEL is available for up to 12 weeks when an employee is unable to work or telework due to a need to care for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions. Employees who have been on the payroll of a covered employer for at least 30 calendar days are eligible for PHEL. Employees will be treated as eligible if they were on their employers' payroll for 30 calendar days immediately before taking leave. In addition, an employee who is laid off on or after March 1, 2020, will be considered to have been employed for at least 30 calendar days if she is rehired on or before December 31, 2020 and had been on the employer's payroll for 30 or more of the 60 calendar days prior to the date of layoff. Thus, even if you lay off an employee, if that employee is rehired on or before December 31, 2020, that employee is entitled to PHEL – so long as the other conditions of PHEL are met.

PHEL is unpaid leave for the first two weeks. Thereafter, the employee must be paid two-thirds (66 2/3%) of her regular wages for a period of up to 10 weeks. The employee may take EPSL or use other available leave or paid time off, such as vacation days, for the first two weeks.

Emergency Sick Leave (EPSL)

Under the FFCRA, up to two weeks of EPSL is available when an employee is unable to work or telework due to one of the following reasons:

(1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

(2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

(3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

Employees who were laid off prior to April 1, 2020 do not qualify for leave under the Families First Coronavirus Response Act unless rehired by December 31, 2020.

(4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1), above, or has been advised as described in (2), above.

(5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions.

(6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

If you lay off an employee any time after March 1, 2020, and later rehire the employee by December 31, 2020, the employee will be eligible for paid EPSL – so long as the other conditions of EPSL are met. The FFCRA's paid leave provisions are effective on April 1, 2020, and apply to leave taken between April 1, 2020, and December 31, 2020. EPSL expires on December 31, 2020, and any unused paid leave granted by the FFCRA does not carry over into 2021.

Health Plan Implications

When an employee is laid off, the employment relationship is terminated and the employee is longer be eligible for benefits under the employer-sponsored health plan. When an employee loses coverage as a result of a layoff, the employee experiences a COBRA qualifying event (if your organization is subject to COBRA). For a discussion of COBRA implications on employees who have been laid off and experience a COBRA-qualifying event, please see the section on COBRA below. Note that COBRA qualified beneficiaries will also be entitled to coverage changes as if they are active employees, so expanded coverage, for example, of telehealth services, will also extend to COBRA qualified beneficiaries.

If and when an employee is rehired, consideration should be given to the employee's eligibility for health plan benefits. If an employee is rehired within 30 days, the employee may be entitled to reinstatement in the health plan. If the employee is rehired more than thirty days following termination, the employee's eligibility to enroll and participate in the health plan will be governed by the terms of the plan. For example, for an employee to be eligible for coverage, a health plan may require the employee to satisfy a waiting period or have full-time status, as defined in the plan.

If an employee who was laid off is rehired during a stability period and is a continuing employee, upon rehire, he retains the status he had prior to the period of time during which he was laid off as though he had not ceased providing services. That is, if the employee was in a stability period where he was treated as full-time, he should be treated as full-time upon rehire. In that case, for the employer to avoid an employer shared responsibility penalty, the continuing employee should be offered coverage as of the first day the employee is credited with an hour of service, or, if later, as soon as administratively practicable (i.e., no later than the first day of the calendar month following return to work). Note, however, that the employer need not make a new offer of coverage to the employee if the employee had previously been offered coverage for the stability period and declined it. See the discussion below on ACA Implications for employees who are laid off and rehired.

Implications for Other Benefits

Although the employment relationship is terminated with laid off employees, it is important for employers to address issues regarding non-health benefits – such as life, disability, and similar benefits – particularly if laid off employees are reinstated after the COVID-19 pandemic ends. Following is a brief discussion of non-health benefits topics.

Coverage termination and continuation rights

Under virtually all insurance contracts, employees must work a minimum number of hours per week in order to be eligible for coverage. When an employee is laid off, her employment has been terminated, and insurance coverage will generally end within a short period of time – typically either on the day of the layoff or at the end of the month in

which the layoff occurred. When coverage ends, the employee has a limited amount of time to port coverage (i.e., the employee pays the premium to continue the coverage) or convert coverage (i.e., the employee converts to an individual policy). The employer will need to notify employees and provide them with appropriate information about porting or converting coverage such as life and disability insurance and voluntary benefits. Because most insurance contracts provide only a limited amount of time to port or convert coverage – such as 30 or 31 days – you need to provide the information to employees as soon as possible.

Claims

The claims process may also be affected by COVID-19. Although insurers are an essential business and remain open, and many of their employees may be able to telework, they may also be affected by reduced staffing. Reduced staffing may mean that claims take longer to adjudicate. In addition, some claims such as disability claims typically require information from one or more physicians. Because physicians and other medical professionals are on the "front lines," it may take more time and be more difficult to obtain all of the needed information. Employers should work with their insurers to find ways to ease the burden on claimants.

Return from layoff

The insurance contract provisions will govern what happens when the layoff ends and the employee returns to work. In some cases, the contract may permit immediate reinstatement subject to an actively-at-work requirement. In other cases, the employee may need to satisfy a new waiting period before coverage begins. An evidence of insurability requirement may apply, for example, if the amount of life insurance being reinstated exceeds the guaranteed issue amount under the contract. If an employee converted some of her group term life insurance to an individual contract, she may need to surrender that individual policy in order to be eligible under the group term life contract when she returns.

Similar provisions may apply to disability insurance. In addition, a long term disability insurance contract may continue a prior preexisting condition limitation when the employee returns from a layoff, or in some cases may apply a new preexisting condition limitation.

ACA Implications

Under the Patient Protection and Affordable Care Act (ACA), an employee's status as full-time or not full-time is important for multiple reasons including determining how to treat employees for purposes of Forms 1094 and 1095 reporting and application of the Employer Shared Responsibility Mandate. Specifically, Applicable Large Employers (ALEs) must offer affordable, minimum value coverage to at least 95% of their full-time employees to avoid Employer Shared Responsibility penalties. Under the ACA, an employee who works an average of 30 or more hours per week is considered to be a full-time employee. Only full-time employees can trigger penalties for ALEs, and full-time employees are the primary focus of Forms 1094 and 1095 reporting. In general, an ALE is an employer with 50 or more full-time employees and full-time equivalent (FTE) employees in the prior year.

Under the ACA, an employer identifies its full-time employees based on each employee's hours of service. Generally, "hours of service" include any hour for which an employee is paid or entitled to payment when duties are not performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. When an employee is placed on a furlough, the employee experiences a reduction in hours of service to zero. The reduction in hours to zero for a period of time can thus impact an employee's current status as full-time or not full-time for purposes of the ACA. For example, if an employee's status is determining using the monthly measurement

> *Employers rehiring previously laid off employees should be aware of the ACA's breaks in service rules when employees return to service.*

method, then if that employee has zero hours of service, that employee is not a full-time employee if he or she has fewer than 130 hours of service during a particular month. In contrast, if an employee's status is determined using the look-back method and the employee is in a current stability period (either an initial stability period or a standard stability period), then the employee's reduction in hours to zero will not impact his or her status, but will impact the employee's current measurement period (and thus likely a future stability period). Below, we address the implications arising from a layoff and rehire on an individual's status under the ACA.

Stability and measurement periods

Regardless of whether an employer is using the monthly measurement method or the look-back method, when an employee experiences a lay-off or otherwise has a termination of employment, he loses his status as full-time or not full-time on termination of employment. However, how soon an employee is rehired impacts how the employee is treated upon rehire. See information below for breaks in service.

Breaks in service

As a general rule, an employee retains his or her status as either full time or not full time during an entire stability period regardless of the number of hours worked, as long as employment continues. But if an employee is terminated, as is the case with a lay-off, he loses his status on termination. What happens when an employee is laid off temporarily and is later rehired? How that employee is treated upon rehire depends on whether he is considered to be a continuing employee or a new employee.

Under the ACA, an employer may treat an employee as a new employee upon rehire if the employee has had a "break in service." A break in service occurs if the employee has at least 13 consecutive weeks (26 for educational employers) during which the employee is not credited with an hour of service. Alternatively, under a "rule of parity," an employer may treat a shorter-term employee as a new hire if the employee's break in service is at least four weeks (but less than 13/26 weeks) and is as long as the employee's preceding period of employment. For example, suppose an employee has six weeks of service, then is laid off for eight weeks, and then is rehired. Because the period the employee was not working was at least four weeks long and was longer than his period of employment, he is considered to have had a break in service and may be treated as a new employee upon rehire.

If an employee who was laid off is rehired during a stability period and is a continuing employee, upon rehire, he retains the status he had prior to the period of time during which he was laid off as though he had not ceased providing services. That is, if the employee was in a stability period where he was treated as full-time, he should be treated as full-time upon rehire. In that case, for the employer to avoid an employer shared responsibility penalty, the continuing employee should be offered coverage as of the first day the employee is credited with an hour of service, or, if later, as soon as administratively practicable (i.e., no later than the first day of the calendar month following return to work). Note, however, that the employer need not make a new offer of coverage to the employee if the employee had previously been offered coverage for the stability period and declined it.

Similarly, an employer using the monthly measurement method must offer coverage to a continuing full-time employee by the first day of the next calendar month to avoid potential liability.

In contrast, if the rehired employee is considered to be a new employee, the employer may treat him as it would any new employee. If the employer is using the monthly measurement method, it would begin counting hours with the first month of employment. An employer using the lookback method would begin counting the employee's hours in an initial measurement period.

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Cafeteria Plan Election Issues

The COVID-19 pandemic has raised a number of issues for employers and employees alike. With business interruptions and many States issuing stay-at-home orders, many employees may be unable to report to work for a period of time or drastically reduces the number of hours an employee is able to work. The health and cafeteria benefit status of affected employees may change during the stay-at-home period, or any business decisions that result in furloughs, reduction of hours, leave of absence, or terminations.

Cafeteria plan basics

Some employers may have had to make the difficult decision to terminate or lay off employees in response to the economic downturn or in response to stay-at-home orders. When an employee is terminated from employment he or she ceases to be eligible under the terms of the cafeteria plan and therefore their elections will automatically terminate along with any other elections under the plan. However, when an employee who was laid off is rehired, there are potential cafeteria plan issues.

Under the IRC Section 125 regulations, there are six categories of events that encompass permissible change in status events:

- change in legal marital status;
- change in number of dependents;
- change in employment status;
- dependent satisfies or ceases to satisfy dependent eligibility requirements;
- residence change; and
- for adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

Of these six categories, a change in employment status is likely the most relevant for employees who are laid off. More specifically, a change in employment status includes:

- a termination or commencement of employment;
- a strike or lockout;
- a commencement of or return from an unpaid leave of absence; or
- a change in worksite.

A termination or commencement of employment is a change in employment status that impacts an employee’s ability to change his or her cafeteria plan election. Below, we highlight cafeteria plan issues arising when an employee is laid off (i.e., at termination of employment) and when that employee is rehired (i.e., when employment commences).

Changes when employment is terminated

Once an employee is terminated from employment, generally eligibility for benefits coverage ends, there’s no longer a salary from which to draw a reduction to cover premiums, and thus an employee’s salary reduction agreement terminates. Presumably, the employee, spouse, and any dependents would be removed from plan coverage and offered COBRA or state continuation, as applicable.

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Below is a chart of election changes that may arise:

Event	Change Permitted
Loss of eligibility due to termination of employment	Yes. The employee would be removed from the plan along with spouse or dependents. This would also include other benefit elections in which they are enrolled and lose eligibility under the cafeteria plan (e.g., dental, vision, FSA).

Permissible changes for DCAPs and Health FSAs when employment is terminated

With respect to health FSAs, an employee whose eligibility under the plan was lost due to termination will also lose eligibility for both the health FSA and DCAP. The employee may be entitled to elect COBRA for the health FSA. Conversely, DCAPs are not subject to COBRA, and thus DCAP participation will end when the employee is laid off.

Permissible changes when an employee is rehired

Below is a chart showing relevant changes that may occur when an employee returns as a rehire:

Event	Change Permitted
Rehire and gain eligibility within 30 days	Coverage may be reinstated at the same level as prior to the termination or plan may be designed to not allow the employee to re-enroll on pre-tax basis until the next plan year. However, employees rehired within their stability periods with break in service of less than 13 weeks (26 weeks for academic employers) must be offered coverage at the same level as prior to break.
Rehire and gain eligibility within 30 days with an addition of new benefit package or benefit enhancement	If you added a benefit package or enhanced a benefit package, the employee may elect the new plan or enhanced plan instead of having the prior election reinstated.
Rehire and gain eligibility more than 30 days	Coverage can be reinstated at the same level as prior to the termination, a new election can be made, or plan may be designed to not allow the employee to re-enroll on pre-tax basis. However, Employer Shared Responsibility Mandate requires that employees that return to work within their stability period with a break in service of less than 13 weeks (26 weeks for academic employers) must be offered coverage at the same level as prior to break in order to avoid penalties. Employees returning later than 13 weeks (26 for academic employers) can be treated as new employees.

HIPAA Special Enrollment Issues

Typically, employers provide eligible employees and their dependents an opportunity to enroll in employer-sponsored group health plans when the employees are first eligible (e.g., after completing a waiting period or an initial measurement period). In addition, most employers also provide annual enrollment periods that allow enrollment for employees (and dependents) who are eligible for coverage but did not enroll during their initial or a prior annual enrollment period.

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The Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities to certain employees, dependents, and COBRA qualified beneficiaries, in the following situations:

- a loss of eligibility for group health coverage or health insurance coverage;
- becoming eligible for a state premium assistance subsidy; and
- the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

Presumably, employers who lay off employees, terminating the employment relationship, will also terminate health insurance coverage for the laid off employees and their dependents. Thus, laid off employees who elect continuation coverage will only have special enrollment rights available to COBRA qualified beneficiaries.

Losing other coverage

A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

- The employee and the dependents are otherwise eligible to enroll in the benefit package;
- When coverage under the plan was previously offered, the employee (or dependent seeking special enrollment) had coverage under another group health plan or health insurance coverage; and
- The employee or dependent lost eligibility for the other coverage as the result of an event identified in the regulations, such as termination of a spouse's employment.

However, special enrollment rights are only available to employees whose employment has been terminated if they (or their dependents) elect COBRA or other continuation coverage. However, individuals who were not covered prior to their layoff (i.e., the beginning of what would have been the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to his or her layoff, but was not enrolled in coverage, he or she would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights.

Gaining eligibility for state premium assistance

If an employee or dependent becomes eligible for assistance for coverage under the plan through either a Medicaid plan under Title XIX of the Social Security Act or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, a special enrollment right arises. An employee who is eligible, but not enrolled, or a dependent of an employee if the dependent is eligible, but not enrolled, is eligible for the special enrollment and may enroll in the plan upon becoming eligible for state premium assistance subsidy so long as the special enrollment is requested in a timely manner. A timely request is one that is made within 60 days after the individual is determined to be eligible for the state premium assistance.

COBRA Qualified Beneficiaries have special enrollment rights.

If you terminate coverage for individuals who are laid off and offer COBRA continuation coverage, then those COBRA qualified beneficiaries retain their special enrollment rights. However, individuals who were not covered prior to their layoff (i.e., the beginning of what would have been the COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former

qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to his or her lay off, but was not enrolled in coverage, then the employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights.

Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

Under HIPAA, group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) must offer a special enrollment opportunity to specific newly acquired spouses and dependents of participants and to current employees who have previously declined coverage but who have since acquired a new spouse or dependent. However, such a special enrollment right applies only if a group health plan otherwise offers dependent coverage, and only if the new dependent is acquired through marriage, birth, adoption, or placement for adoption.

So, a COBRA qualified beneficiary who marries, adopts a child (or has a child placed for adoption), or who has a newborn child is entitled to enroll himself or herself and the child. However, the added dependents do not become COBRA qualified beneficiaries. The individual must be allowed at least thirty days from the date of the event giving rise to the special enrollment to seek enrollment. If the enrollment is based upon marriage, the effective date of the coverage must be no later than the first of the month following the request for enrollment. If the special enrollment is based upon birth, adoption, or placement for adoption, coverage must be retroactive back to the date of the birth, adoption, or placement for adoption.

Individuals who were not covered prior to their lay off (i.e., prior to the beginning of the otherwise applicable COBRA continuation period) do not have special enrollment rights. Specifically, COBRA regulations state that "neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules." In other words, if an employee was eligible for coverage prior to a reduction in his or her hours but was not enrolled in coverage, then the former employee would not be eligible for COBRA continuation and thus would not be eligible for special enrollment rights based on the acquisition of a new dependent due to marriage, birth, adoption, or placement for adoption.

COBRA Implications

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires certain employers to make temporary health coverage ("continuation coverage") available to certain individuals upon the occurrence of specific events. Those individuals may then elect to continue group health plan coverage for a limited time on a self-pay basis. COBRA applies to private sector employers (both for-profit and nonprofit) and state and local governments that offer group health insurance. Employers that are exempt from COBRA are small employers (i.e., employers who employed less than 20 employees on at least half of the typical business days during the prior year), non-electing church employers recognized under IRS Code Section 501, the federal government, and Indian Tribal governments that perform purely governmental functions.

COBRA only applies to "group health plans" that provide health care and are maintained by an employer subject to COBRA. Examples include:

- Health insurance, HMOs, and self-insured plans
- Dental and/or vision plans
- Disease-specific plans
- Prescription drug plans
- Healthcare Flexible Spending Accounts (FSAs)
- Health Reimbursement Arrangements (HRAs)
- Drug or alcohol treatment

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- Medical clinics that offer services beyond free minor first aid for injuries and illnesses
- Wellness programs, employee assistance programs (EAPs), and employee discount programs that provide medical care and are maintained by the employer

The following are not group health plans subject to COBRA:

- Health Savings Accounts (HSAs)
- Long-term care plans
- Accidental Death and Dismemberment (AD&D)
- Group term life insurance plans
- Long-term and short-term disability
- On-site first aid facilities
- Hospital (or other) indemnity plans

There are seven "qualifying events" which, if they cause a loss of health plan coverage, trigger COBRA continuation coverage. Those events are as follows:

- Termination of employment (unless for gross misconduct)
- Reduction of hours (e.g., when an employee moves from full-time to part-time; it could also occur during a strike, lockout, or when an employee takes an unpaid leave of absence)
- Employer's bankruptcy
- Divorce or legal separation
- Death of a covered employee
- Dependent child ceases to be a dependent under the terms of the plan
- Covered employee's entitlement to Medicare (but only if eligibility is impacted)

Because a layoff is a termination of the employment relationship, a layoff triggers COBRA continuation for applicable employers. You must offer Qualified Beneficiaries the same coverage they were receiving immediately before a qualifying event. This is true even if that coverage is no longer of use to the Qualified Beneficiary. For example, if employer offers HMO coverage and the Qualified Beneficiary moves out of state, the employer must nonetheless offer COBRA continuation for the HMO coverage.

For a deeper dive into COBRA and state continuation obligations, check out our Employer COBRA Guide.

Because a layoff is a COBRA qualifying event, you (or your COBRA administrator on behalf of your plan) will be responsible for providing a COBRA Election Notice and for the ensuing COBRA obligations. The Election Notice must be furnished by the plan administrator within 14 days after receiving a notice of a Qualifying Event. If you and the plan administrator are the same (i.e., you do not use a third-party to administer your COBRA or other continuation), the Election Notice must be furnished within 44 days from the Qualifying Event itself (in other words, when the layoff occurs). This is because employers have 30 days to provide a notice of Qualifying Event plus 14 days to furnish the Election Notice.

Each Qualified Beneficiary has 60 days to elect COBRA coverage. The 60-day election period starts from the date the notice is "provided" or the date coverage is lost, whichever is later. If the election is not made prior to the expiration of the 60-day election period, then you are not obligated to offer COBRA coverage. If you accept an election after the 60 day period, your insurance carrier contract might not allow that person to be covered under the plan. In this case, you may ultimately be self-insuring that person and liable for the costs. If the coverage is self-insured, your stop loss carrier may refuse to provide coverage if stop loss is invoked.

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The maximum amount a Qualified Beneficiary can be required to pay as a COBRA premium is 102% of the applicable premium. Broken down, the 102% is 100% of the applicable premium plus a 2% administrative fee. The purpose of the administrative fee is to help defray the cost of additional administration. However, you have the discretion to pay all or part of that premium for the Qualified Beneficiary, but you should check with your tax advisor for any potential tax implications.

Special Return to Work Issues

Because the employment relationship was terminated for employees who were laid off, a number of issues will arise after their rehire. Below, we highlight some special return-to-work issues for laid off, but rehired employees.

- Rehired employees may have evidence of insurability or waiting periods associated with their non-health benefits. Be sure to have a game plan in place to communicate applicable issues to employees, and coordinate with carriers or administrators to ensure a smooth return to work.
- Employee status for purposes of the ACA should be reviewed with consideration for breaks in service rules, and employees should be designated as either continuing or new employees.
- Employees rehired within 30 days after layoff may be entitled to have their prior salary reduction agreement elections reinstated.
- Rehired employees may be eligible for wage payments related to PHEL or EPSL if rehired before December 31, 2020.

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Additional Resources

Gallagher, COVID-19 Employer FAQs: https://ajg.adobeconnect.com/covid19benefitsfaqs/

DOL, Families First Coronavirus Response Act: Questions and Answers: https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

IRS, COVID-19-Related Tax Credits for Required Paid Leave Provided by Small and Midsize Businesses FAQs: https://www.irs.gov/newsroom/covid-19-related-tax-credits-for-required-paid-leave-provided-by-small-and-midsize-businesses-faqs

WHO, Coronavirus Disease (COVID-19) Advice for the Public: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

WHO, Q&A on Corona Viruses: https://www.who.int/news-room/q-a-detail/q-a-coronaviruses

CDC, Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fguidance-business-response.html

OSHA, Guidance on Preparing Workplaces for an Influenza Pandemic: https://www.osha.gov/Publications/influenza_pandemic.html

EEOC, What You Should Know About the ADA, the Rehabilitation Act and the Coronavirus: https://www.eeoc.gov/eeoc/newsroom/wysk/wysk_ada_rehabilitaion_act_coronavirus.cfm

HHS, Bulletin: HIPAA Privacy and Novel Coronavirus: https://list.nih.gov/cgi-bin/wa.exe?A2=ind2002&L=OCR-PRIVACY-LIST&P=69

IRS, Notice 2020-15, High Deductible Health Plans and Expenses Related to COVID-19: https://www.irs.gov/pub/irs-drop/n-20-15.pdf

Department of Labor, COVID-19 or Other Public Health Emergencies and the Family and Medical Leave Act Questions and Answers: https://www.dol.gov/agencies/whd/fmla/pandemic

For further information on organizational responses to COVID-19, please see Gallagher's COVID-19 Pandemic Response Hub: https://www.ajg.com/us/coronavirus-covid-19-pandemic/

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