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Insider

American Rescue Plan enacted

By Ann Marie Breheny, Gary Chase, Anu Gogna, Bill Kalten and Maria Sarli

The American Rescue Plan Act was signed into law on March 11, enacting important pension, health care, compensation and other provisions. The new law is a sweeping COVID-19 relief and economic stimulus package first proposed by President Biden before he took office. Among other provisions, the act reforms the funding rules for single-employer defined benefit (DB) pension plans, subsidizes COBRA and other continuation health care coverage, and expands the number of employees for whom an employer's compensation deduction is limited to $1 million. Some provisions take effect quickly, so employers and plan sponsors should become familiar with the provisions of the act and prepare for implementation.

Pension funding provisions

The act provides interest rate stabilization and longer amortization periods for single-employer DB plans.

The act generally sets the interest rate corridor at 95% to 105% of the 25-year average segment rates through 2025 and gradually widens the corridor to 70% to 130% beginning in 2030, based on the following schedule:

Calendar year	Minimum percentage	Maximum percentage
2012 – 2019	90	110
2020 – 2025	95	105
2026	90	110
2027	85	115
2028	80	120
2029	75	125
2030 on	70	130

The act also establishes a 5% floor on the 25-year average segment rates (so that, for example, the funding interest rate will not drop below 95% of 5%, or 4.75%, through 2025).

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Plan sponsors may defer this change until the 2021 or 2022 plan year, either for all purposes or only for purposes of the benefit restrictions under Internal Revenue Code section 436.

The act also provides for 15-year amortization of funding shortfalls, rather than seven-year amortization, for plan years beginning after December 31, 2021. Plan sponsors have the option to use 15-year amortization for plan years beginning in 2019, 2020 or 2021.

The act also addresses multiemployer pension funding and revises eligibility for the community newspaper funding relief provisions enacted by the Setting Every Community Up for Retirement Enhancement Act.

Health care provisions

The act fully subsidizes the cost of COBRA and other continuation health care coverage until October 1 and expands eligibility for premium tax credits for coverage through the Affordable Care Act (ACA) marketplaces.

Individuals who are eligible for COBRA (or continuation coverage offered by state programs that provide comparable coverage) as a result of involuntary termination

of employment or reduction in hours will receive a 100% premium subsidy for coverage between April 1 and September 30, 2021. Individuals who are eligible for the subsidy (referred to in the act as assistance eligible individuals) but have not elected COBRA or have discontinued their COBRA coverage will have a new opportunity to elect COBRA during a special election period that begins April 1 and ends 60 days after the employer provides notice about the availability of the subsidy. This special election period does not extend an individual's COBRA continuation period, so individuals who elect to begin or resume coverage on or after April 1 will exhaust their COBRA eligibility 18 months after their qualifying event. Plan sponsors also have the option to allow assistance-eligible individuals to elect different coverage if such coverage is otherwise available to similarly situated active employees and the premium does not exceed the premium for the coverage they had on the date of their COBRA-qualifying event. Subsidy eligibility will end on September 30 or when an individual becomes eligible for Medicare or another group health plan, whichever is earliest. Individuals who become eligible for other coverage and fail to notify their former employer will be subject to penalties.

During the period the subsidy is in effect, COBRA notices will have to include information about the availability of the subsidy, the individual's obligation to notify the employer upon eligibility for Medicare or other group health coverage, and the individual's ability to enroll in different coverage (if the employer is offering the option). The notice must be offered to those who would be eligible for the subsidy but do not have a COBRA election in effect or who have discontinued their COBRA coverage. Employers will also be required to notify individuals about the expiration of the COBRA subsidy.

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The act expands eligibility for tax credits that help individuals purchase coverage through the ACA marketplaces.

In addition to subsidizing COBRA coverage, the act expands eligibility for tax credits that help individuals purchase coverage through the ACA marketplaces. For 2021 and 2022, premium tax credits will be calculated based on the following table:

Household income (% federal poverty line)	Initial premium percentage	Final premium percentage
Up to 150%	0	0
150% – 200%	0	2
200% – 250%	2	4
250% – 300%	4	6
300% – 400%	6	8.5
400% and higher	8.5	8.5

The act does not modify the eligibility threshold under the ACA employer mandate provisions of the ACA, which remains 9.83% of household income for 2021. As a result, employers will not necessarily be subject to ACA employer mandate penalties as a result of premium tax credit expansion.

Expansion of section 162(m)

After 2026, the $1 million deduction limit for "covered employees" under Internal Revenue Code section 162(m) will apply to an additional five highest paid employees, other than the CEO, CFO and three highest paid officers under existing rules. "Covered employees" in any year would continue to be subject to the deduction limits for payments received in subsequent years; however, the newly covered five highest paid employees are only subject to the rule for the year they are in this group.

Other provisions

The annual limit for dependent care flexible spending accounts will increase to $10,500 (from $5,000) for 2021.

Payroll tax credits for paid sick leave and paid family leave — which were enacted by the Families First Coronavirus Response Act of 2020 and extended until March 31, 2021, by the Consolidated Appropriations Act, 2021 — will be further extended and expanded. Among other changes, the credits will be available until September 30, 2021; state and local governmental employers will be eligible to claim credits; and

credit will be available for wages paid to employees who are unable to work or telework because they are receiving a COVID-19 vaccine or recovering from illness, injury, condition or disability related to vaccination.

The act also includes a range of additional tax, public health, and economic stimulus and assistance provisions, such as economic stimulus payments, extended unemployment assistance, relief for airlines and other industries, and more.

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Health and benefit implications of the American Rescue Plan Act

By Ann Marie Breheny, Anu Gogna and Ben Lupin

On March 11, 2021, President Biden signed into law the American Rescue Plan Act (ARPA). The ARPA includes important changes for employer-sponsored group health plans and dependent care flexible spending accounts (FSAs), in addition to important pension funding changes, an expansion of the $1 million compensation deduction limit, economic stimulus payments, unemployment changes, and other individual and business-related relief in response to the COVID-19 pandemic. Changes affecting group health plans and health FSAs include: (1) 100% COBRA premium subsidies in certain situations, (2) increases to the 2021 maximum contribution limit to dependent care FSAs, and (3) a temporary expansion of the eligibility requirements for subsidies on the Affordable Care Act (ACA) public marketplace.

The ARPA includes important changes for employer-sponsored group health plans and dependent care FSAs.

Temporary COBRA subsidies (April 1, 2021 – September 30, 2021)

- **Eligibility for COBRA subsidy.** The ARPA provides a temporary subsidy of 100% of COBRA premiums for those who are eligible for COBRA due to an *involuntary termination of employment or a reduction in hours* (referred to as "assistance eligible individuals").[1] Individuals who are eligible for COBRA because of voluntary termination, retirement or death would not qualify as assistance eligible individuals.
- **Availability of COBRA subsidies.** The COBRA subsidy will be available beginning April 1, 2021, and is scheduled to end no later than September 30, 2021. The subsidy will end before September 30, 2021, if the individual's maximum period of COBRA coverage ends prior to that date. The subsidy will also end early if the individual becomes *eligible* for coverage under another group health plan (other than excepted benefits, a health FSA or a qualified small business health reimbursement account) or Medicare. Assistance eligible individuals must notify their group health plan sponsor if they become eligible for such coverage or face a penalty.
- **Enrollment period.** An assistance eligible individual who has not elected COBRA coverage by April 1, 2021, or who elected but then discontinued COBRA coverage, may elect COBRA coverage during an enrollment period starting April 1, 2021, and ending 60 days after the date on which the ARPA-required COBRA notification is delivered. Coverage would be retroactive to April 1, 2021.
- **Employer notice(s).** The ARPA requires employers to provide additional notices with respect to COBRA subsidies, including the following:
  - **General notice.** Employers must include information in the COBRA election notice regarding the availability of the premium subsidy and (if applicable) the option to enroll in different coverage to all assistance eligible individuals.
  - **Notice of extended election period.** Employers must notify assistance eligible individuals of the new 60-day opportunity to elect COBRA prospectively for the subsidy

[1] Assistance eligible individuals are employees subject to termination/reduction in hours with a loss of coverage in the prior 18 months – since November 2019 – and those subject to termination/reduction in hours with loss of coverage between April 1, 2021, and September 30, 2021.

period. The ARPA directs the Department of Labor (DOL) to issue model notices within 30 days.

- **Notice of expiration of subsidy.** The ARPA also requires notice when subsidies will expire. The notice must be sent no more than 45 days and no less than 15 days before expiration. The ARPA directs the DOL to issue a model notice within 45 days.

- **Other discretionary changes.** Under the ARPA, employers *may* provide assistance eligible individuals up to 90 days (following COBRA notice receipt) to elect to enroll *in a different group health plan* offered by the employer. The premium for the alternative coverage cannot be higher than the premium for the plan in which the employee had been enrolled.
- **Assistance eligible individuals in their "Outbreak Period."** The DOL and IRS previously suspended the time period for an individual to elect COBRA until 60 days after the end of the National Emergency, or if earlier, one year after the individual became eligible for the relief (the Outbreak Period).[2] It is unclear how the Outbreak Period relief will be coordinated with the new enrollment and notice rules in the ARPA, and whether a single notice could be used to satisfy all COBRA-related notice obligations.
- **Employer recoupment of COBRA premium subsidy.** The employer (for self-insured plans) or the carrier (for fully insured plans) is obligated to provide COBRA coverage and pay or incur the COBRA premium cost. Employers may recover the cost of the coverage from the federal government by claiming a credit against their quarterly Medicare payroll tax payment. The credit can be advanced and is refundable, so plan sponsors and carriers may claim a refund if the subsidies paid exceed the taxes due.

Employer implications

Employers, plan sponsors and health insurance carriers must act quickly to respond to the COBRA subsidy provisions in the ARPA. Some key actions include:

- Employers and their third-party administrators (TPAs) must identify assistance eligible individuals.
- Employers must revise their general election notice and be prepared to send notices about the extended election period and the expiration of the subsidy period.
- Plan sponsors should prepare for the COBRA enrollment or reenrollment of assistance eligible individuals who are not currently enrolled in COBRA.

Employers, plan sponsors and health insurance carriers must act quickly to respond to the COBRA subsidy provisions in the ARPA.

- Sponsors of group health plans should consider whether to permit individuals to enroll in a different — but not more expensive — plan option than the one in which they were enrolled when coverage was lost.

Dependent care FSA maximum contribution limit (2021)

The ARPA temporarily increases the maximum amount of dependent care FSA benefits that can be excluded from income from $5,000 to $10,500 (from $2,500 to $5,250 for taxpayers who are married filing separately) for the 2021 tax year. The change to temporarily increase the maximum allowed contribution to $10,500 for 2021 is not mandatory, allowing employers to determine whether to permit the higher limits. It would appear that any discretionary carryover allowed under the Consolidated Appropriations Act for dependent care FSAs would not be included in the maximum dollar limit for 2021. Cafeteria plans *may be* amended retroactively for the change so long as the amendment is adopted by the last day of the plan year in which the amendment is effective (e.g., December 31, 2021, for calendar-year plans) and the plan is operated in accordance with the amendment's terms beginning on its effective date.

Employer implications

- Plan sponsors should determine whether to adopt the change.
- Plan sponsors should determine whether plan amendments are needed to adopt the change. The need for plan amendments will depend on the existing dependent care FSA plan language.
- Employers choosing to adopt this change will also want to hold a special enrollment in 2021 to allow employees to change elections. Separate, recently issued IRS guidance already permits prospective election changes.[3]

Eligibility for ACA public marketplace subsidies (2021 and 2022)

The eligibility requirements for premium tax credits on the ACA public marketplace are temporarily expanded for the 2021 and 2022 tax years. Prior to this expansion, subsidies

[2] See "**DOL guidance on end of COVID-19 'Outbreak Period**,'" *Insider*, March 2021

[3] See "**IRS guidance on FSA flexibility under CAA**," *Insider*, March 2021

have been limited to taxpayers with household income between 100% and 400% of the federal poverty line who purchase insurance through the public marketplace. The ARPA eliminates the upper income limit for eligibility and increases the maximum premium tax credit by reducing the percentage of household income that individuals in all income bands must contribute toward the cost of premiums for public marketplace coverage. The law also makes special enhancements to the credit for individuals receiving unemployment compensation in 2021 and provides temporary relief from the reconciliation of any excess advanced premium tax credits.

Employer implications

- Since the ARPA does not modify the affordability requirements under the ACA employer mandate, these premium tax credit changes do not affect an applicable large employer's affordability calculations for 2021 or 2022.
- If the coverage an applicable large employer has offered to its ACA full-time employees is *unaffordable,* however, this change could result in higher employer mandate penalty exposure because more full-time employees may receive ACA premium tax credits under the expanded eligibility provisions, thus triggering additional penalties.

Going forward

Employer plan sponsors should review the practical implications of these rules, and the steps needed to implement and administer these changes, with their carriers/TPAs. In addition, plan sponsors should watch for additional implementation guidance from the IRS, which could affect how these changes are implemented.

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DOL guidance on end of COVID-19 'Outbreak Period'

By Anu Gogna, Ben Lupin and Kathleen Rosenow

On February 26, 2021, the Department of Labor (DOL) issued guidance (**EBSA Disaster Relief Notice 2021-01**) addressing the end of the "Outbreak Period," during which certain deadlines under ERISA and the Internal Revenue Code are extended to provide relief to employer-sponsored welfare benefit plans (including group health plans) as well as participants in those plans who have been affected by the COVID-19 pandemic.[1] The original Outbreak Period was set to expire on February 28, 2021.

Last year, the DOL and Department of Treasury issued Outbreak Period rules that, in general, extended deadlines for the following requirements:

- Making COBRA elections
- Making COBRA premium payments
- Providing COBRA election notices (from the plan administrator to qualified beneficiaries)
- Requesting HIPAA special enrollments
- Filing benefit claims or appeals or requesting an external review of an adverse benefits determination

The departments are only authorized to disregard a period of up to one year after a presidential national emergency declaration.

Under the applicable law, the departments are only authorized to disregard a period of *up to one year* after a presidential national emergency declaration. In this case, former President Trump's COVID-19 national emergency declaration was effective March 1, 2020. President Biden has issued a new **COVID-19 national emergency declaration** effective March 1, 2021; however, Biden's declaration *does not* affect the departments' relief provisions.

One-year period to be applied on an individual-by-individual basis

The new guidance clarifies that individuals and group health plans with time frames that are subject to the relief will have the applicable periods disregarded until *the earlier of* (1) one year from the date they were first eligible

[1] See "**Health and welfare plan time frames extended due to COVID-19**," *Insider*, May 2020.

for relief, or (2) 60 days after the announced end of the National Emergency (i.e., the end of the Outbreak Period). *A disregarded period cannot exceed one year.*

The guidance provides the following examples:

1. If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, that requirement is delayed until February 28, 2021 (i.e., the earlier of one year from March 1, 2020, or the end of the Outbreak Period, which remains ongoing).
2. If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the guidance delays that election requirement until the earlier of one year from that date (i.e., March 1, 2022) or the end of the Outbreak Period.
3. If a plan would have been required to furnish a notice or disclosure by March 1, 2020, the relief would end with respect to that notice or disclosure on February 28, 2021. The responsible plan fiduciary would be required to ensure that the notice or disclosure was furnished on or before March 1, 2021.

Reasonable accommodations

The guidance also reminds employers that the guiding principle for administering employee benefit plans is to act reasonably, prudently, and in the interest of the workers and their families who rely on their health, retirement and other employee benefit plans for their physical and economic wellbeing.

Therefore, plan fiduciaries should make *reasonable accommodations* to prevent the loss of or undue delay in payment of benefits and take steps to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established time frames. This would include 1) sending notices to employees informing them of the end of the relief period, and 2) providing information on other coverage options (e.g., the availability of health insurance coverage on the individual marketplace), if applicable.

Further, plan disclosures issued before or during the pandemic might need to be reissued or amended if they did not provide accurate information regarding the time in which participants and beneficiaries were required to take action (e.g., COBRA election notices and claims procedure notices).

Going forward

Plan sponsors should consult with their insurance carriers, third-party administrators and COBRA administrators on next steps to address the end of this relief, including required notices, communication and necessary actions to administer this guidance.

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Additional FAQs issued on FFCRA and CARES Act

By Maureen Gammon and Kathleen Rosenow

The Departments of Labor, Health and Human Services, and Treasury have released new frequently asked questions (**FAQs Part 44**) on the implementation of the Families First Coronavirus Response Act (FFCRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and other health coverage issues related to COVID-19. These laws require group health plans to provide benefits for certain items and services related to diagnostic testing for COVID-19 and — for group health plans that do not have grandfathered status under the Affordable Care Act[1] — qualifying COVID-19 preventive services (including certain vaccines), without any cost sharing, prior authorization or other medical management requirements. The guidance is effective immediately.

The FAQs specifically cover the following COVID-19 related issues: (1) the diagnostic testing mandate in the FFCRA and the CARES Act, (2) the preventive services mandate in the CARES Act (including whether an employee assistance program [EAP] or onsite clinic can maintain excepted benefit status if the entity provides COVID-19 preventive services), and (3) group health plan notice requirements. Each issue is discussed in detail below.

[1] Grandfathered plans are those that were already in existence on the day the ACA was enacted (March 23, 2010) and have been continuously offered without certain changes.

This is the third set of FAQs the departments have issued to provide guidance on implementing the FFCRA and CARES Act and other COVID-19-related health coverage issues.[2]

Diagnostic testing

The new FAQs clarify several provisions in the FFCRA and the CARES Act regarding the COVID-19 testing mandate:

- **Plans cannot use medical screening criteria to deny (or impose cost sharing on) a claim for COVID-19 diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19.** When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when such provider refers an individual for a COVID-19 diagnostic test, plans generally must provide coverage for the test without cost sharing, prior authorization or other medical management requirements. This means that asymptomatic individuals, without a doctor referral or diagnosis, can receive COVID-19 testing with no cost sharing.
- **Plans may distinguish between COVID-19 diagnostic testing of asymptomatic people that must be covered and testing for general workplace health and safety, for public health surveillance, or for other purposes not primarily intended for individualized diagnosis or treatment of COVID-19.** Plans must provide coverage without cost sharing, prior authorization or other medical management requirements for COVID-19 diagnostic testing of asymptomatic individuals when the purpose of the testing is for *individualized* diagnosis or treatment of COVID-19. Plans are not required, but may choose, to provide coverage of testing for public health surveillance or employment purposes.
- **Plans are required to cover COVID-19 diagnostic tests provided through state- or locality-administered testing sites (e.g., a "drive-through site").** *Any* health care provider acting within the scope of its license or authorization can make an individualized clinical assessment regarding COVID-19 diagnostic testing, including through state- or locality-administered testing sites.
- **Point-of-care tests for COVID-19 must be covered without cost sharing.**
- **Plans should take steps to ensure compliance with the requirements to cover items and services associated with COVID-19 diagnostic testing.** Plans should maintain their claims processing and other information technology systems in ways that protect participants, beneficiaries and enrollees from inappropriate cost sharing and should document any related steps. The FAQs note that the departments will take enforcement action, where appropriate, to ensure consumers receive the protections they are entitled to under the FFCRA and CARES Act.
- **Plans should be prepared to respond if they identify providers of COVID-19 diagnostic testing who are not complying with the CARES Act provisions related to cash price posting or who are otherwise acting in bad faith.**
  - Plans can give participants and beneficiaries information about providers who have negotiated rates for COVID-19 testing with the plan, or about providers who adhere to best practice standards, and encourage participants and beneficiaries to rely on these providers.
  - Plans should report violations to **COVID19CashPrice@cms.hhs.gov**.
  - The departments are requesting feedback on how best to monitor abusive practices and encourage consumers to get tested by providers that are not overcharging for their services or otherwise violating the law.

Non-grandfathered group health plans must cover, within 15 business days, without cost sharing, any qualifying coronavirus preventive services.

Rapid COVID-19 preventive services coverage

Non-grandfathered group health plans must cover, within 15 business days, without cost sharing, any qualifying coronavirus preventive services, including immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).[3] Currently, three vaccines have been approved for emergency use: (1) Pfizer-BioNTech COVID-19 vaccine for persons 16 years of age and older, (2) Moderna COVID-19 vaccine for persons 18 years of age and older, and (3) Johnson & Johnson COVID-19 vaccine for persons 18 years of age and older. No other preventive services have been approved at this time.

The FAQs clarify the following:

- **Plans must cover, without cost sharing, all COVID-19 vaccines (and associated administration) with a recommendation in effect from ACIP.** Plans and issuers

[2] See "**Departments issue FAQs on implementation of FFCRA and CARES Act**," *Insider*, April 2020, and "**Departments issue new FAQs on FFCRA and CARES Act implementation**," *Insider*, July 2020.

[3] See "**Regulations on COVID-19 vaccine and testing requirements issued**," *Insider*, November 2020.

are not permitted to exclude coverage for (or impose cost sharing on) any qualifying coronavirus preventive services.

- **Plans must cover the vaccine administration fee even when the plan is not billed for the vaccine itself (e.g., where a third party, such as the federal government, pays for the preventive immunization).**
- **Plans cannot deny coverage of recommended COVID-19 vaccines because a participant or beneficiary is not in a category of individuals prioritized by the CDC and ACIP for vaccination during the initial phases of the COVID-19 vaccination program.** Plans may inform participants, beneficiaries or enrollees about which individuals will be vaccinated first when supply is limited but should not communicate that coverage is limited only to individuals who are recommended for early vaccination based on state and local plans for allocation of initial doses of the COVID-19 vaccine or the CDC and ACIP recommendations. *Note:* A decision by an individual's provider to decline to give the vaccine to someone because he or she is not within a prioritization category is not an adverse benefit determination made by a group health plan. The provider's decision is not subject to the ERISA internal claims and appeals and external review requirements.

Provision of preventive services through an EAP or onsite clinic

Similar to previous guidance on the effect of including COVID-19 testing in an EAP or onsite clinic offering, the new FAQs clarify that:

- **An employer may offer benefits for COVID-19 vaccines (and their administration) under an EAP that otherwise meets the requirements to be considered an "excepted benefit."** An EAP will not be considered to provide benefits that are significant in the nature of medical care solely because it offers benefits for COVID-19 vaccines and their administration (including when offered in combination with benefits for diagnosis and testing for COVID-19); however, there must be no cost sharing or employee contributions under the EAP for benefits, and the EAP must comply with other applicable requirements.
- **An employer may offer benefits for COVID-19 vaccines (and their administration) at an onsite medical clinic that constitutes an excepted benefit.** Coverage of onsite medical clinics is an excepted benefit in all circumstances.

SBC notice requirements

The departments will not take enforcement action when a plan covers qualifying coronavirus preventive services prior to satisfying the Summary of Benefits and Coverage (SBC) notice of modification requirements. Because a plan must cover coronavirus preventive services (i.e., an approved vaccine) within 15 business days of its approval, it is not possible to provide the 60-day advance notice of modification required for SBCs. Plans must provide notice of the changes as soon as reasonably practicable.

Going forward

In light of the FAQ guidance, employers should:

- Be aware that their group health plan must cover COVID-19 testing without cost sharing for asymptomatic, as well as symptomatic, individuals, but it does not have to cover such testing without cost sharing for employment or public health surveillance purposes.
- Be aware that they may offer COVID-19 vaccines to employees via an EAP or onsite clinic without risking the excepted benefit status of the EAP or onsite clinic.
- Update and distribute their SBCs for any COVID-19 approved preventive care as soon as reasonably practicable.
- Review the FAQs to ensure they are complying with the COVID-19 preventive care mandates and testing rules.

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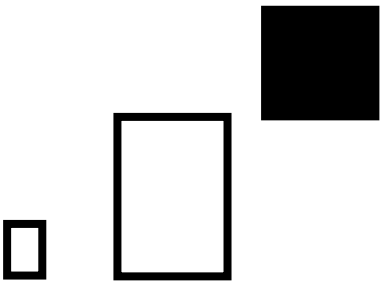

IRS guidance on FSA flexibility under CAA

By Anu Gogna, Ben Lupin and Kathleen Rosenow

The Internal Revenue Service has issued **Notice 2021-15** clarifying the flexible spending account (FSA) provisions of the **Consolidated Appropriations Act, 2021** (CAA). The CAA provides flexibility for unused amounts in health and dependent care FSAs for 2020 and 2021, among other changes.[1] The FSA changes were designed to help participants with unused balances (such as for childcare expenses that were not incurred during the COVID-19 pandemic) who would normally lose the value of the FSA balance at the end of the tax year (due to the "use it or lose it" rule in the tax code).

Employers may adopt any or all of the relief provided in the CAA at their discretion.

Background

Specifically, the CAA allows the following:

- Amounts that are unused in 2020 may be carried over to 2021; amounts that are unused in 2021 may be carried over into 2022.
- Health and dependent care FSA grace periods for plan years ending in 2020 and/or 2021 may be extended for up to 12 months after the end of the plan year.
- Plan participants who stop participating in the plan during 2020 and/or 2021 *(terminated participants)* may continue to be reimbursed for eligible expenses through the end of that plan year if they have unused amounts in their health and/or dependent care FSA.
- Plan participants may make prospective changes to their health and/or dependent care FSAs during 2021 (regardless of change of status).
- Expenses under a dependent care FSA may be reimbursed for dependents who aged out during the COVID-19 pandemic.

IRS guidance

Notice 2021-15 clarifies the following FSA provisions of the CAA:

Increase in carryover of unused amounts and extension of grace periods

- The relief with respect to an increase in carryover amount or extension of a grace period is available to plans that both do and do not currently have a carryover or grace period (subject to the existing rule that health FSAs may adopt a grace period or carryover, but not both).
- Dependent care FSAs may adopt a carryover subject to the same rules that apply to health FSAs.
- Employers may limit the carryover amount to less than all unused amounts and limit the carryover to apply only up to a specified date during the plan year.
- Employers may choose to adopt an extended grace period of less than 12 months.
- Individuals may not contribute to an HSA during a month in which they participate in a general purpose health FSA with a carryover, or during any grace period.
- Employers may amend their plans to allow employees, on an employee-by-employee basis, to opt out of the carryover or extended grace period in order to preserve their HSA eligibility.
- With respect to the extended grace period, an employer may limit the unused amounts in an employee's health FSA to the amount of salary reduction contributions the employee had made during the year in which the employee ceased to be a participant (e.g., due to termination of employment, change in employment status or a new election during calendar year 2020 or 2021).
- Amounts carried over or available during an extended grace period will not be taken into account for purposes of the tax code's nondiscrimination rules for health FSAs and dependent care FSAs.
- Unused amounts carried over from prior years or available during the extended grace period will not count toward the annual contribution limit for the following year.

Employers may adopt any or all of the relief provided in the CAA at their discretion.

Special age limit relief for dependent care FSAs

- The CAA increases the maximum age of a dependent for purposes of incurring eligible dependent care FSA expenses to 14 (up from 13) for certain dependent care FSA participants. An employer that adopts the special age limit relief is not required to adopt the carryover or an extended grace period, or vice versa.

[1] See "**2020 year-end COVID-19 stimulus law: Health and benefit implications**," *Insider*, January 2021

- All amounts from the most recent plan year for which the end of the regular enrollment period was on or before January 31, 2020 (for calendar-year plans, this would be the 2020 plan year), may be applied to dependent care expenses for a dependent who attained age 13 during that plan year.
- Employers with calendar-year plans may allow employees to carry over all unused amounts from the 2020 plan year to reimburse dependent care expenses during the subsequent plan year (the 2021 plan year) for a dependent who attained age 13 during the 2020 plan year (until that dependent attains age 14) and for a dependent who attains age 13 during the subsequent plan year.
- This special age limit relief for dependent care assistance programs does not apply to any unused amounts carried over from the subsequent plan year (the 2021 plan year) and does not permit an employer to reimburse expenses for a child who is age 14 years or older.

Cafeteria plan election changes (including changes to health coverage)

- Employers may permit employees to prospectively revoke an election, make one or more elections, or increase or decrease an existing election regarding their health or dependent care FSA for plan years ending in 2021.
- With respect to employer-sponsored health coverage, employers may permit employees to prospectively make a new election, change their election to enroll in a coverage option, or revoke their election, subject to a written employee attestation (model language provided in the notice). This relief is similar to previous relief issued in **Notice 2020-29**.
- Employers are not required to provide unlimited election changes and may limit the period during which such changes may be made.
- The plan may provide that amounts contributed before the election is revoked 1) remain available to reimburse medical care expenses or dependent care expenses incurred for the rest of the plan year, 2) be available only to reimburse eligible expenses incurred before the revocation takes effect, or 3) be forfeited.

Changes between HSA-compatible and general purpose FSAs

To preserve HSA eligibility, employers may amend their health FSAs to allow employees to make a midyear election change to be covered by a general purpose health FSA for part of the year and an HSA-compatible health FSA for part of the year (e.g., limited-purpose or post-deductible health FSA). In this case, the employee's permissible HSA contribution would be based on the months the employee was covered by the HSA-compatible health FSA.

Employers that decide to implement the relief provided in the CAA must adopt an amendment no later than the last day of the calendar year after the end of the plan year in which the amendment is effective.

Interaction with COBRA

- The notice confirms that an individual who is a COBRA qualified beneficiary under a health FSA must still be provided with a COBRA election notice even if he or she has access to unused salary reduction contributions until the end of the year.
- If an employer adopts an increase in the carryover or extended grace period, those amounts may not be taken into account for purposes of determining the applicable COBRA premium.

Plan amendments

Employers that decide to implement the relief provided in the CAA must adopt an amendment no later than *the last day of the calendar year after the end of the plan year in which the amendment is effective.* For example, if an employer with a calendar-year plan wants to permit an increase in carryover from 2020 to 2021 (based on unused amounts as of December 31, 2020), it must adopt an amendment by December 31, 2021. However, an amendment for a 2020 plan year of a non-calendar-year plan must be adopted by December 31, 2022.

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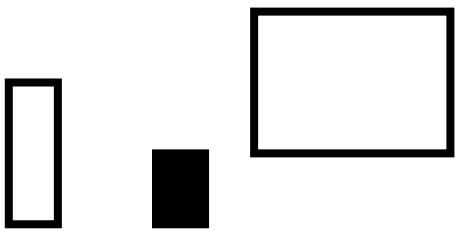


News in Brief

Third COVID-19 vaccine added to preventive care guidelines

By Maureen Gammon and Kathleen Rosenow

On February 27, 2021, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for the Johnson & Johnson COVID-19 vaccine. The following day, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention issued an interim recommendation for use of the Johnson & Johnson COVID-19 vaccine in persons aged 18 years or older for the prevention of COVID-19.

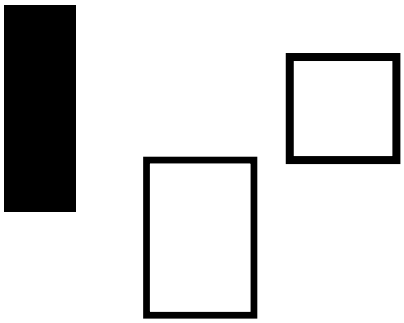
Non-grandfathered group health plans must begin to cover the Johnson & Johnson COVID-19 vaccine with no cost sharing by March 19, 2021.

In accordance with **interim final regulations** issued in October 2020 by the Departments of Labor, Health and Human Services, and Treasury, non-grandfathered group health plans must cover qualifying COVID-19 preventive services, including any vaccine and its administration, without cost sharing, within 15 business days (not including weekends or holidays) of a recommendation from the United States Preventive Services Task Force or the ACIP.[1]

Previously, the FDA issued EUAs for the Pfizer-BioNTech COVID-19 vaccine on December 11, 2020, and the Moderna COVID-19 vaccine on December 18, 2020. The ACIP issued interim recommendations on December 12, 2020, for use of the Pfizer-BioNTech COVID-19 vaccine in persons aged 16 years or older, and on December 19, 2020, for use of the Moderna COVID-19 vaccine in persons aged 18 years or older.

Non-grandfathered group health plans are required to cover the Pfizer-BioNTech and Moderna COVID-19 vaccines with no cost sharing effective January 5, 2021, and January 12, 2021, respectively.

[1] See "**Regulations on COVID-19 vaccine and testing requirements issued**," *Insider*, November 2020.



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