MEMORANDUM

To: Clients and Colleagues
From: Chimento & Webb, P.C.
Date: April 1, 2020 **[Updated as of May 7, 2020]**
Re: CARES Act / Benefit Plan Changes

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1. Background

The CARES Act[1] became law on March 27. Much of its $2.2 trillion cost is meant to help individuals and their employers through the next four months. It also includes helpful features (some optional) for retirement plans and individuals who participate in them.

Unlike the Families First Coronavirus Response Act ("Families First Act"), which was passed on March 18, the CARES Act is not limited to employers with fewer than 500 employees. The SECURE Act, enacted on December 20 with even more changes seems like old news.

To help clients keep these three laws straight, our website is a work in progress, with special pages for these new laws, our guidance, and links to important government sources. We will be updating, but strongly recommend individual consultation.

[1] The Coronavirus, Aid, Relief, and Economic Security Act.

2. Coronavirus-Related Distributions ("CRDs")

Employers may add this optional feature to 401(k) and other qualified profit sharing plans and employer-sponsored 403(b) plans. It can be administered now, provided that amendments are adopted by the extended deadlines described in Section 9.

CRDs get special tax treatment and can be withdrawn from individual retirement vehicles, such as IRAs and 403(b)s. Withdrawals from 457(b)s sponsored by tax-exempt non-governmental employers do not qualify.

A. CRDs defined

A CRD is a distribution in calendar year 2020 to an individual who:

- Has been diagnosed with "COVID-19," meaning either the virus, SARS-CoV-2, or its disease, Coronavirus Disease 2019, by a test approved by the Centers for Disease Control and Prevention ("CDC"); or
- Has a spouse or dependent who is so diagnosed by a CDC-approved test; or
- Experiences adverse financial consequences because of COVID-19, due to being quarantined, furloughed, laid off, or having hours reduced, being unable to work because of lack of child care, or the closure or reduced hours of a business owned or operated by the individual; or
- Satisfies other requirements as the IRS may designate in its guidance.

B. CRDs may not exceed $100,000 in the aggregate for all of an employer's plans.

C. There is no need for a demonstration of financial incapacity.

A plan administrator may rely on employee certification that it is a coronavirus-related distribution, with no additional documentation required.

D. Plan administrators will not be required to withhold income taxes, unless elected by the employee.

E. Special tax rules for CRDs

- There is no 10 percent tax assessed on a CRD that occurs prior to a participant reaching age 59 ½.
- Unless the employee elects to include the full amount of the CRD as taxable income in the year in which it is received, the CRD is deemed to be received at the rate of 1/3 per year, starting in the year of distribution.

- The CRD amount can be repaid through a rollover, in whole or in part and with taxes avoided, in the three years starting with the distribution date. Rollover can be back to the Plan or other source, if it allows for that, or to an IRA.
- If repayment occurs in a year other than in which it was received, the CRD recipient must file an amended tax return to claim a refund of the tax attributable to the amount of the CRD included in income in any prior year(s).[2]
- The overall CRD individual limit for these special tax rules is $100,000. An individual cannot double-dip the limit, for example by taking $100,000 from a qualified plan and $100,000 from the plan of another employer or an IRA.

3. CRD Loans

Qualified plans, including 403(b) plans, may provide for higher loan limits and easier repayment rules for CRD Loans.

A. CRD Loans defined

- A CRD Loan must be granted under the same conditions as apply for CRDs described in Section 2. In other words, they must be to an individual who meets the COVID-19 and employee certification conditions.
- A loan is a CRD Loan only if granted in the period between March 27, 2020 and September 23, 2020.
- If from a qualified plan or employer-sponsored 403(b) plan, it must be amended by the deadline in Section 9.
- Loans from individual 403(b)s – but not IRAs – would also qualify if permitted by the 403(b) sponsor.

B. Expanded CRD Loan limit

A CRD Loan will be allowed even if it exceeds the general IRS limit. Loans for other purposes are still subject to the general limit.

[2] DOL FAQs, May 4, 2020: https://www.irs.gov/newsroom/coronavirus-related-relief-for-retirement-plans-and-iras-questions-and-answers; IRS Notice 2005-92.

General loan limit	50% of vested account, but not more than $50,000 reduced by the highest loan balance in previous 12 months
Special CRD Loan Limit	Taking other loans into account, 100% of vested account, but not more than $100,000 reduced by the highest loan balance in the previous 12 months

C. **Easier payment terms for CRD individuals for all loans**

An individual who meets the requirements for a CRD Loan gets a longer period to repay all loans, including loans that are not CRD loans.

Any payment that comes due from March 27, 2020 to December 31, 2020 can be delayed for up to one year (the "Suspension Period"). If delayed, the term of the loan is extended by the Suspension Period. The interest that accrues during the Suspension Period is added to the outstanding principal of the loan and then reamortized over the extended loan period. A loan will not be deemed distributed if, due to the Suspension Period, its term extends beyond the maximum five-year period typically imposed by IRS rules.

This guidance mirrors that provided by the IRS relating to Sections 101 and 103 of the Katrina Emergency Tax Relief Act of 2005.[3]

4. Required Minimum Distributions: Some are suspended

Required minimum distributions ("RMD's") owed for 2020 may be suspended for some – not all – tax favored vehicles that are subject to RMD rules. This is similar to the relief granted in 2009 after the last market crash.

A. **Which employer plans are allowed to suspend?**

- All defined contribution plans, including 403(b) plans.
- Defined benefit plans are not eligible.
- 457(f) plans sponsored by non-profit organizations are not eligible.

[3] *Id.; Id.*

B. This is optional for employer plans

A plan can continue to pay RMDs without suspension. However, employers may amend to suspend the payments, under the extended amendment deadline of Section 9. If this follows the IRS procedure in 2009, a suspension can be unilateral (without choice) or allow employees to have choice. Choice is clearly the preferable alternative.

C. This applies to all individual arrangements

This includes IRAs, 403(b) contracts, and government sponsored 457(b)s. Individuals who are able to control payments without employer involvement can call the vendors now to suspend further 2020 RMDs.

D. This will apply to RMDs already paid.

In 2009, the IRS allowed persons who had received RMDs to roll them over without regard to the normal 60-day rollover deadline, or the rule that generally prevents rollovers of RMDs. We expect IRS will issue similar guidance to permit rollovers of 2020 RMDs for which the 60-day rollover clock has already run out.

5. Delayed Pension Plan Contributions

Single-employer defined benefit plan sponsors will be able to delay their minimum required contribution until January 1, 2021.

Plan sponsors are generally required to make a contribution to satisfy minimum funding standards within 8 ½ months after the close of the plan year. For sponsors who had a funding shortfall in the prior year, contributions must be made quarterly during the plan year. The CARES Act change applies to either type of payment, as long as the payment was otherwise required to be made in the 2020 calendar year. For a calendar year plan that had a funding shortfall and has to make quarterly payments in 2020 that would mean the first three payments (April 15, July 15, and October 15, 2020) could be made on January 1, 2021. The delayed payments must be increased to include interest at the plan's effective rate of interest for the plan year.

In calculating the Adjusted Funded Target Attainment Percentage for Internal Revenue Code ("IRC") Section 436 funding-based benefit restrictions, a plan sponsor can elect to use the plan year that ended before January 1, 2020.

6. Group and Individual Health Insurance Coverage

A. Mandates apply to group health plans and health insurance issuers

Section 6001 of the Families First Act, as amended by section 3201 of the CARES Act, applies to group health plans[4] and health insurance issuers offering group or individual health insurance coverage.[5] Effective March 18, 2020, plans and health insurance issuers must provide coverage for the items and services described in the Families First Act (as amended by the CARES Act). Such items and services include:

- Eligible in vitro diagnostic tests,[6] which includes "serological tests" used to detect antibodies against the SARS-CoV-2 virus, for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test; and
- Other "items and services" furnished to an individual during healthcare provider visits (including both in-person and telehealth visits), urgent care center visits, and emergency room visits that result in an order for, or administration of, an in vitro diagnostic product, but only to the extent the items and services relate to the furnishing or administration of the product, or to the evaluation of the individual, for purposes of determining the need of the individual for such product.

A group health plan or health insurance issuer must provide the above coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or requiring prior authorization or other medical management requirements. In addition, plans and issuers must provide coverage for items and services furnished by out-of-network providers. See below for more information on provider reimbursements.

The Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") have issued guidance indicating that an individual's attending health care provider has discretion in the course of treatment regarding a patient showing signs and symptoms compatible with COVID-19, and that all such tests and treatments performed are considered either to relate to the "furnishing or administration" of COVID-19 diagnostic testing or to the "evaluation of such individual for purposes of determining the need" for COVID-19

[4] "Group Health Plan" includes both insured and self-insured group health plans.

[5] "Individual Health Insurance Coverage" includes coverage offered in the individual market through or outside of an Exchange.

[6] 21 CFR Section 809.3. An "in vitro diagnostic product" means those reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease.

diagnostic testing.[7] In addition, the Departments note that the Centers for Disease Control and Prevention ("CDC") strongly encourages testing for other causes of respiratory illness prior to testing for COVID-19.

> For example: If an attending health care provider determines that other tests (e.g., blood work, flu tests, etc.) should be performed to determine the need for COVID-19 diagnostic testing, and such tests demonstrate the need for COVID-19 diagnostic testing, the health plan or health insurance issuer must provide coverage for all treatment without imposing cost sharing on the covered individual.

Group health plans and health insurance issuers must comply with the mandates imposed by the Families First Act and CARES Act for all applicable claims relating to coverage provided during the Public Health Emergency related to COVID-19. As of now, the Public Health Emergency, declared as of January 27, 2020, is effective through April 25, 2020.[8]

B. Providers must be reimbursed

The Families First Act requires that a group health plan or health insurance issuer providing coverage of items and services (as described above) reimburse the provider of the diagnostic testing, even if such provider is out-of-network.

If the plan or issuer has a negotiated rate with the provider in effect before the Public Health Emergency, such negotiated rate applies. If, however, the plan or issuer does not have a negotiated rate with the provider, the plan or issuer will reimburse the provider in an amount that equals that cash price for such service as listed by the provider on a "public internet website," or the plan or issuer may negotiate a rate with the provider for less than such cash price.[9]

C. Flexibility for high deductible health plans

The Families First Act allowed high deductible health plans (HDHPs) to cover diagnostic testing and treatment of COVID-19 without a deductible, and now the CARES Act adds telehealth and "other remote care services" to the list of acceptable no-deductible services for HDHPs. The telehealth care does not have to relate to COVID-19 treatment. Plans that provide these health services prior to application of a deductible will not lose their qualified status. This

[7] "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Implementation Part 42," April 11, 2020.

[8] A "Public Health Emergency" declaration lasts until the Secretary of HHS declares that the Public Health Emergency no longer exists, or upon the expiration of the 90-day period beginning on the date the Secretary declared a Public Health Emergency exists, whichever occurs first.

[9] Section 3202(b) of the CARES Act requires providers of diagnostic tests for COVID-19 to make public the cash price of such diagnostic testing on the provider's "public internet website."

provision expires for plan years beginning on and after December 31, 2021. In addition, Health Savings Accounts and Health Flexible Spending Accounts may allow for payment of over the counter menstrual products after December 31, 2019.

D. Waiver of certain requirements for changes in health insurance coverage

The Departments have announced a temporary period of non-enforcement in order to permit group health plans and health insurance issuers to take otherwise prohibited action to comply with both the Families First Act and the CARES Act.

Typically, plans and issuers may not modify health insurance coverage mid-year, subject to certain exceptions.[10] However, the Departments will allow health insurance issuers to change the benefits or cost-sharing structure of its plans mid-year to provide increased coverage for services related to the diagnosis and/or treatment of COVID-19. The Departments have also waived the 60-day advance notice requirement prior to a mid-year "material modification" to any of the terms of the plan or coverage that would affect the content of the most recently provided Summary of Benefits and Coverage (SBC). The Departments note that plans and issuers must provide notice of changes "as soon as readily practicable."

These non-enforcement policies apply with respect to changes made during the period of the Public Health Emergency related to COVID-19. To the extent a plan or issuer maintains any of the changes described above beyond the period of the Public Health Emergency, plans and issuers must comply with all applicable statutes and regulations regarding requirements to update plan documents or terms of coverage.

The Departments will take, however, enforcement action against any plan or issuer that attempts to limit or eliminate other benefits, or to increase cost sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

E. States may impose further regulations

Nothing in either the Families First Act or the CARES Act prevents any state from imposing additional standards or requirements on health insurance issuers with respect to the diagnosis or treatment of COVID-19, to the extent that such standards or requirements do not prevent the application of a federal requirement. Accordingly, employers must always stay current on the latest guidance from their respective states, as it may be more comprehensive than that at the Federal level.[11]

[10] 42 USC Section 300gg-2.

[11] "FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Implementation Part 42," April 11, 2020.

7. Employer Payment of Student Loans

The CARES Act has added a temporary feature to IRC Section 127 education assistance plans. Ordinarily, these plans allow employers to pay or reimburse employees for certain education expenses, such as tuition, fees, and course materials. The education does not have to be job-related or for the employer's benefit, but is limited to $5,250 per year and cover a group that does not discriminate in favor of highly compensate employees.

The CARES Act adds student loan payments as an eligible expense that can be paid through these plans, either directly to the lender or as reimbursement to the employee. The overall annual benefit limit of $5,250 remains, and payments may be made only for the employee (not a spouse or dependent) and only between March 27, 2020 and December 31, 2020.

These reimbursements are in lieu of any deduction of student loan interest the employee would otherwise be able to claim on a tax return.

8. Extended Deadlines for Plans, Participants, and Qualified Beneficiaries

The DOL has announced the extension of certain deadlines under ERISA and the IRC as related to participants, qualified beneficiaries, and beneficiaries of pension plans, group health plans, and other welfare benefit plans.[12]

All pension plans, group health plans, and other welfare benefit plans must disregard the period beginning March 1, 2020 and ending 60 days after the end of the National Emergency (the "Outbreak Period") for all plan participants, beneficiaries, and qualified beneficiaries in determining the following periods and dates:[13]

- The 30-day period (or 60-day period if loss of coverage relates to Medicaid or CHIP) under HIPAA to request special enrollment in a group health plan;
- The 60-day period to elect COBRA continuation coverage under a group health plan;
- Deadlines to pay COBRA premiums, including the initial premium payment;
- The date to notify a plan of a qualifying event or determination of disability;

[12] 85 FR 26351, May 4, 2020.

[13] On March 13, President Trump issued the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, establishing the National Emergency.

- Deadlines related to filing and appealing a claim under a plan's internal procedures; and
- Deadlines related to filing a request for an external review of a benefit claim.

In addition, group health plans must disregard the Outbreak Period when determining the date for providing a COBRA election notice to qualified beneficiaries.

The DOL may provide additional relief "as warranted," as ERISA and the CARES Act give it authority to extend the deadline for a variety of plan sponsor and administrator actions for sponsors and plans "affected by …a public health emergency declared by the Secretary of Health and Human Services." This would include the current coronavirus crisis, as well as any future public health crisis.

9. Required Amendments

Plan sponsors may administer their plans according to the new hardship, loan, and RMD rules before amending their plans. The amendment deadline is the last day of the first plan year beginning on or after January 1, 2022, and the amendments will be retroactive provided the affected plans have been administered throughout the period as if the amendment were in effect.

10. Future Guidance and Legislation

We expect to see lots of guidance from the IRS and DOL in the weeks to come. There is already talk in Congress of a fourth relief package that will add more complexity. We are here to help our clients navigate through this.

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