May 29, 2020

Charles Rettig
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Dear Commissioner Rettig:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health insurance coverage. Many of our members are small business owners, and their professional expertise is in the technicalities of health plan purchasing and administration. Since the start of the COVID-19 pandemic, NAHU members have been working tirelessly to assist companies with employment and benefit plan issues related to the economic downturn.

NAHU appreciates the volume of detailed guidance that your agency has prepared to assist employers and professional advisors. Your extensive use of the FAQ format helps to make the information more approachable for employers, employees, and professional advisors alike. However, with the release of more new guidance and rules about the various COVID-19 economic relief programs, inevitably, more questions arise too. Our members who specialize in employee benefit plan compliance have identified several areas where additional information is needed. Specifically, we request some clarification related to both the Families First Coronavirus Response Act (FFCRA) paid leave tax credits and the retention tax credit established by the Coronavirus Aid, Relief and Economic Security Act (CARES Act). The recent changes to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation of coverage requirements for the duration of the COVID-19 national emergency period also raise numerous issues and concerns.

Employers are making employment and benefit decisions that relate to newly developing CARES Act, FFCRA, and federal state of emergency economic relief programs simultaneously with the development and release of the regulations and sub-regulatory guidance that applies to these programs. In addition to providing more information to employers, employees, and professional advisors, we hope that your agency intends to give employers who are acting in good faith with compliance and penalty relief.

FFRCRA Paid Leave Tax Credits and CARES Act Retention Credit

NAHU members commend your agency for the publication of many detailed FAQs about the application of both the paid leave and retention tax credit. They have been invaluable to the thousands of health insurance agents, brokers, and consultants working with employer groups to assist them in accessing and implementing the credits. Our members particularly appreciate the information about the allocation of group health coverage costs. However, one topic not addressed in these FAQs is if amounts elected by the employee to be paid on a pre-tax basis towards retirement plans and other qualified benefits (that are not group health plan benefits) are ultimately reimbursable to the employer. The retention credit and paid leave credit FAQs each make it clear that employee group health plan costs paid on a pre-tax basis are refundable to the employer. However, the guidance does not address other employee pre-tax elections. This issue is raised in our minds because the definition of qualified paid sick leave and family leave wages in the FFCRA statute is section 3121(a) of the Internal Revenue Code for Social Security and Medicare tax purposes. For both kinds of wages, the FFCRA and the CARES Act use the definition of wages in section 3121(a). However, this definition excludes employee pre-tax elections for retirement benefits and other purposes, which would seem to indicate exclusion for retention and paid leave tax credit calculation purposes.

The use of this definition and the lack of clarity for employers is currently creating a few issues. If employers cannot count other pre-tax elections as part of qualified wages for retention and paid leave tax credits, they will need immediate and explicit guidance, noting this fact and directions on how to calculate qualified wages accordingly. Our concern is that many employers do not understand this definitional nuance and are currently treating different kinds of pre-tax employee elections differently for FFCRA and CARES Act credit calculation purposes. Accordingly, many employers already may be retaining the wrong amounts of payroll tax funds for credit advancement purposes. These employers may ultimately owe money back due to improper credit calculations, and in these economic times, an unexpected tax bill may not be tenable. Accordingly, NAHU requests additional guidance to address this issue. Furthermore, the instructions to tax Forms 941 should be revised to address all specific FFCRA and CARES Act credit directions. The sooner new Form 941 instructions can be made publicly available, the better. Form 7200 directions also need revision to reflect similar information about these calculations.

A related issue concerns retirement plan documents. All retirement plan documents include definitions of compensation and deferrals as part of plan terms. These definitions govern how compensation must be deferred to comply with plan rules. There cannot be alternative ways to define compensation and deferred compensation for these two laws and tax credits. Therefore, NAHU requests clarification as to how to address this discrepancy.

Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak Regulation

The new emergency regulation, “Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak,” is raising many real-world implementation concerns for sponsors of group health plans and other employee benefits professionals. Compliance professionals in our Association have identified numerous areas where group plan sponsors need more information and compliance relief.

First, the new rule provides employers with flexibility regarding required notices that occur during the outbreak period. However, the rule also creates many new deadline changes for employees. An employer-provided notice would seemingly be the best way to inform employees and other plan beneficiaries about how plan deadlines are affected by the outbreak period. NAHU members request clarification for employers about notifying employees and how employers can uphold their fiduciary duties to both their plan and its participants. Employers and plan administrators are stymied by how to craft a notice about deadline relief with no known end-date. Ideally, we would like to see the Trump Administration release notice templates for employers to use, both to ensure appropriate participant protections and also help mitigate any potential employer and plan liability.

The need for an updated notice template is critical, especially since the most recent model COBRA notice templates, released by the Department of Labor (DOL) on May 1, 2020, do not address the new changes to COBRA deadlines at all. Will the IRS, in conjunction with the DOL, address this issue as soon as possible, including by providing sample revised notice text so that employers can notify plan participants appropriately? Along with a model notice, NAHU members request that the IRS and DOL jointly announce that they will use a good faith compliance standard for any employer group plan administrator that already provided a new notice to COBRA-eligible individuals. Many employers want to inform plan participants of their new rights on an immediate basis. These employers should be held harmless, even if their notice is ultimately deemed incorrect or incomplete.

The regulation makes it clear that if a person was enrolled in COBRA continuation coverage on March 1, 2020, and made their February payment but failed to make a March 2020 payment or other payments, the outbreak period does not apply when calculating the 30-day payment grace period. According to the new rule, the insurer or plan may not deny the person's coverage during the outbreak period. However, according to our example, under typical COBRA rules, the person’s coverage would already be terminated for nonpayment of premium. Under the new regulation, the person is still eligible for coverage. So how is the person in the example notified? Also, in our Association's assessment of the example, to comply, it would seem the employer plan needs to reinstate coverage. If this is correct, how do employer plan sponsors handle this situation appropriately?

NAHU members observe that various fully-insured health plans, stop-loss insurers of self-funded plans, and COBRA administrators have different viewpoints on reinstating coverage to people who were terminated for

nonpayment of premiums during the outbreak period before the release of this regulation. Similarly, there are varying opinions in circulation about the ability of a group plan to "pend" a person's eligibility in the outbreak period until premiums are paid. Footnote ten in the regulation, which references 26 CFR 54.4980(b)-8, seemingly addresses the permissibility of retroactive reinstatement for beneficiaries pending the back payment of premiums following the end of the outbreak period. The referenced parts of 26 CFR 54.4980(b)-8 seemingly imply that retroactive reinstatements might be permissible, but only if affected providers are aware and complicit with the affected COBRA beneficiaries are in a suspended state of plan eligibility pending premium payment. If this is true, then NAHU requests additional follow-up guidance addressing how such situations should be handled by employer-sponsored plans, COBRA administrators, insurers, reinsurers, and providers alike. The information provided in footnote ten is proving to be insufficient to meet the needs of plan administrators nationwide.

Additionally, some real-world benefit plan administrative issues arise due to any mandate to provide coverage to beneficiaries with outstanding premium payments during the outbreak period. These challenges exist whether or not the employer must provide full coverage or pending coverage contingent on payment of past-due premiums. Even if clarifying guidance establishes that group health plans do not need to immediately issue claims for people who have elected coverage during the outbreak period but are in arrears on their premiums, existing provider network contracts may not allow a group plan to hold claims payments until the unspecified end-date of the outbreak period. In fact, most contracts prohibit retroactive payment of claims in this manner. Also, carriers are bound by prompt payment laws that will require timely payment of incurred claims.

Right now, confusion abounds about how to handle people with COBRA eligibility and delinquent premiums as per the new regulation. Should the employer group terminate their coverage? Reinstate these people if they've already been terminated? Keep them as eligible for coverage? Create some type of new pending status? Most health plans cannot currently assign a person "pending status" in their systems. The person will either appear as enrolled in the group coverage or as someone whose coverage was terminated. When providers call to check on a person in this position's coverage status, if they are terminated, any provider other than an emergency room will be able to choose whether to provide treatment. Given the COVID-19 precautions currently in place at most medical facilities nationwide, with advance check-ins and insurance confirmations and no means for cash payments, many eligible for the outbreak period COBRA payment relief will not be able to access care. They are, in many cases, being turned away due to lack of insurance eligibility. As such, it is crucial for employers, health plans, and providers to get an immediate resolution to the issue of handling the claims of people in the outbreak period with unpaid premiums.

For self-funded plans, the need for claims payment guidance and relief is especially acute. Many self-funded group health plans do not include immediate access to reinsurance funding. Instead, the funding that makes these plans whole when they incur an abnormal number of claims, or individual catastrophic claims (both of

which are more likely during a global pandemic), comes after the end of the plan year. Unlike other entities in the healthcare delivery system, traditionally, self-funded employer plans have no means to recoup uncompensated claim costs promptly. Given the state of the economy and restrictions on workplace and consumer activity, a disproportionate number of businesses that offer self-funded group coverage to employees are currently cash-strapped and in grave financial distress. These entities are likely compelled by contractual obligation to pay any claims incurred by qualified beneficiaries in the outbreak period without any revenue coming in.

Here are two variations on a real-life example offered by a NAHU member that explains various permutations of the situation at hand for a mid-sized business located in a populous Eastern seaboard state.

> **Example Variation One:** An employer with 65 employees currently offers self-funded group coverage to eligible employees and dependents. The group plan has a reinsurance contract that provides 12-month incurred /15-month paid term coverage. The company's plan year ends on June 30, 2020. For a variety of financial and customer-service related reasons, this business is currently planning to terminate its self-funded plan and existing stop-loss contract at the end of the plan year. They would like to then commence with offering fully-insured coverage to qualified employees instead, beginning on July 1, 2020.
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> This business terminated an employee on April 15, 2020, for reasons not necessarily related to the COVID-19 economic downturn. So far, this former employee has not exercised his right to elect COBRA, so his plan eligibility has been pended until premiums are paid. For this example, we will assume that the outbreak period ends September 30, 2020, so this ex-employee could elect and pay for COBRA as late as November 14, 2020. This employee was hospitalized in late April, and to-date has incurred $275,000 in claims after discounting. The ex-employee's past-due premium payments could legally be paid by either the former employee or by a third-party, such as one of his providers or the hospital involved in these claims. In this scenario (with the outbreak period ending in September and pended plan eligibility), the business sponsoring the group health coverage will have no access to stop-loss coverage for this employee's claims. The reason why is they will be paid more than three months after the term ended on the company's policy, leaving the former employer with a $275,000 bill to pay.
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> **Example Variation Two:** This same employer is also considering maintaining their self-funded group plan, but if they do so, they would like to change reinsurance/stop-loss carriers at renewal due to financial and customer service-related reasons. Unfortunately, the current COVID-19 outbreak period liability will necessitate any new carrier to re-rate the group, causing premium increases for the employer. Some of those costs will need to be passed onto all qualified employee plan participants. Also, the new stop-loss carrier could deny the ex-employee's claims citing lack of eligibility. To recoup claims costs, the employer will likely need to engage in litigation with the new stop-loss carrier, which

is a risky proposition. Or, the business will need to absorb the claims costs independently, at their financial peril.

Example Variation Three: Due to the financial realities of the new claims liability of their group health plan caused by the new regulation, this same employer now needs to consider maintaining their existing self-funded plan with the same stop-loss carrier. The employer must weigh this option, even though they are dissatisfied with their carrier's service and have other, pre-existing financial issues that make them want to make a change. However, now that this catastrophic claim is pending, the insurer will be able to increase its renewal rates dramatically. The employer will need to absorb most of these costs and pass some along to eligible employees as well. Additionally, the group must accept the possibility that their current reinsurer will refuse to renew their contract due to the associated risks. If that is the case, then the business will be left with two equally unappealing options--absorbing all of their former employee's claims costs and electing a new group coverage option, or discontinuing their group plan altogether.

As you can see, by just this one real-life example, the potential costs and consequences for American business owners are severe and could jeopardize employer-based group plan offerings. Guidance and relief for self-funded group plan sponsors is an urgent need. However, all group health plans need additional information and assistance. COBRA generally involves a degree of adverse-selection, but under normal circumstances, the risk period is known – 60 days. Current plan rates, for both fully-insured and self-funded group coverage, are based on the current grace period, not for the possibility of adverse selection for an indeterminant length of time. Catastrophic claims costs, such as those currently incurred by some COVID-19 patients, are not absorbed by the claimant's premiums. Neither are extensive future claims costs that may well be incurred by people who are experiencing delays in necessary care due to pandemic restrictions. Instead, they are spread over the entirety of the risk pool. Without catastrophic cost relief, perhaps through a reinsurance mechanism, and more explicit guidance on coverage parameters and claims payment responsibilities and timeframes, the potential for future health insurance premiums to rise astronomically in 2021 is all but inevitable.

Beyond the COBRA concerns, NAHU members have identified some additional issues with other topics addressed by the new regulation. The HIPAA special enrollment deadline extension rules only apply to major medical plans, putting many plan sponsors in an awkward position. Employers, over time, have often aligned special enrollment periods (SEPs) for excepted benefits, like standalone vision and dental plans, with the HIPAA-required SEP dates for major medical plan options. Additional guidance about how employers should handle this misalignment is needed.

Another area of question involves changes to the claims uniform grace period for claims. Does this apply to flexible spending accounts and health reimbursement arrangements too? Do the uniform grace period for claims apply to all permutations of an HRA (including individual coverage HRAs and qualified small employer

HRAs?) Unlike other forms of relief in the regulation, when it comes to the applicability of the claims deadline provisions, the rule does not reference Title 26 and the internal revenue code, which addresses FSAs and HRAs. It only addresses Title 29, which includes ERISA. NAHU members request clarification so that we can advise employer-plan sponsors on both of these issues accordingly.

Thank you for your attention to these critical concerns. If you have any questions, or if NAHU can be of assistance as you move forward with the development of additional guidance, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
Chief Executive Officer
National Association of Health Underwriters