Employee Benefits Report

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Retirement Plans: Cash Flow Problem Solver

Cash flow is a big concern for both employers and employees, and the $2 trillion coronavirus economic relief bill and existing regulations provides an unlikely beneficiary — retirement plans.

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) is best known for providing much needed financial assistance to American workers and businesses. However, the bill also relaxes the retirement account withdrawal and borrowing rules. These provisions are similar to what the federal government put in place during Hurricanes Harvey and Irma in 2017.

In addition, existing rules give employers who can show a need a break from providing matching contributions.

The following is what you and your employees need to know if the need for extra cash is of upmost importance:

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Taking the Surprise Out of Surprise Billing

Few people like surprise medical bills. That's why there's an active movement to protect consumers from the financial burdens created by surprise medical bills while addressing the concerns of providers and insurers.

A surprise medical bill occurs when someone who has insurance inadvertently receives care from an out-of-network provider and is charged a higher than expected rate.

Here are the three primary pieces of legislation being considered:

- **The Consumer Protections Against Surprise Medical Bills Act of 2020 (HR 5826) passed**

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Employees

Distributions: The CARES Act allows some employees to borrow up to $100,000 from their retirement accounts for coronavirus-related expenses. The Act eliminates the 10 percent penalty on early withdrawals before the age of 59 ½ of up to $100,000.

Prior to this change, employees were only permitted to borrow the lesser of $50,000, or one-half of their vested account balances from their 401(k) or 403(b) plans. However, now through Sept. 28, 2020, the CARES Act allows for employees to take out loans equal to the lesser of $100,000 or 100% of their balance, and eliminates the limit of 50 percent of the borrower's account balance.

Again, in order to qualify for the higher limit, the loan must be related to the coronavirus and may only apply to those who experience the following conditions between now and Dec. 31, 2020:

- Are officially diagnosed with the SARS-CoV-2 virus or coronavirus disease (COVID-19)
- Have a spouse or dependent who is diagnosed with the virus or disease
- Have experienced financial hardship from quarantine, layoffs, reduced hours or furlough or the closing of a business
- Are unable to work (or work from home) due to lack of childcare

The CARES Act specifies that employers may accept an employee's certification that a coronavirus-related distribution is necessary.

Distributions still will be included in gross income and subject to regular income tax, but the taxes can be spread out and paid over three years.

The CARES Act also drops the requirement for employer plans to withhold 20 percent of any distribution that isn't rolled directly to an IRA or other qualified retirement plan — provided that it is a coronavirus-related distribution.

Salary Deferrals: Federal law has always allowed employees to reduce or cancel the amount of money they put in their qualified retirement plans. Although this is one way for employees to get some extra cash in their paychecks, they need to remember that this amount will now be taxable.

Future Concerns: As always, employers should remind employees to take into consideration their age and likelihood of having enough time to rebuild their account balances before taking advantage of loans or deferring their salaries.

Employers

Matching Contributions: In order to free up cash, employers who offer 401(k) defined benefit pension or other qualified retirement plans may amend their plans to forego their employer matching contributions. Under section 412(c)(2), the IRS may grant a temporary waiver of funding deficiency for an employer that fails to make a timely required minimum contribution to a defined benefit plan for a tax year due to a 'business hardship' which is defined as when:

- An employer is operating at an economic loss
- There's substantial unemployment or underemployment in the trade
- The sales and profits of the industry concerned are depressed or declining
- It's reasonable to expect the plan will be continued only if the waiver is granted

out of the Ways and Means Committee and awaits floor action in the House.

- **The Ban Surprise Billing Act (HR 5800) passed out of the Education and Labor Committee and awaits floor action in the House.**
- **A compromise was reached on two bills — S. 1895, approved by the Senate Committee on Health, Education, Labor, and Pensions, and H.R. 2328, approved by the House Energy Committee.**

While the proposals are very similar to each other, the biggest differences are how payments to out-of-network providers are determined and whether to include ambulance services.

In addition, 28 states have already enacted consumer protections to address surprise medical bills, though the state laws cannot help people covered by their employer's self-funded plans or people who receive surprise bills because of air ambulance services.

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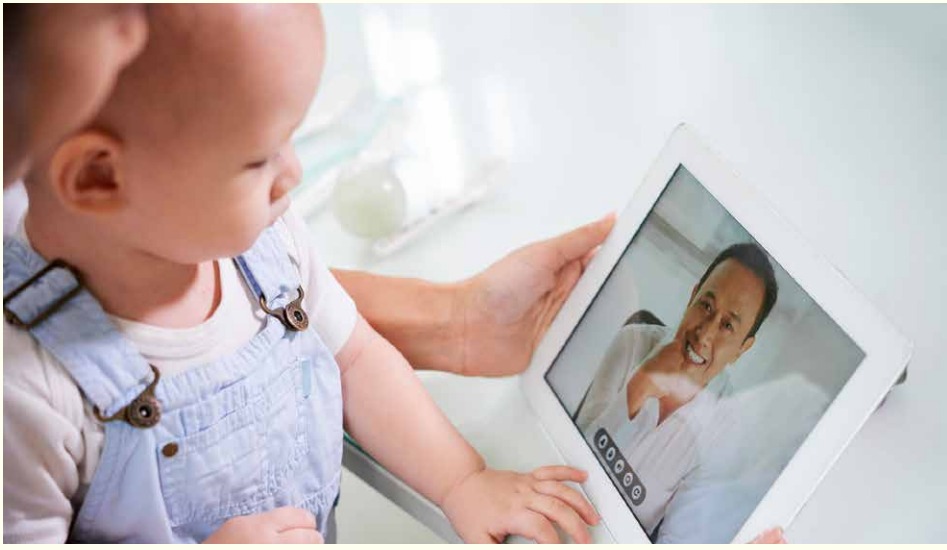
Employers who have 401(k) safe harbor plans are required to make annual contributions. Eliminating safe harbor employer contributions or matching contributions may result in the loss of safe harbor status. To preserve the safe harbor status employers must show that they are operating at an economic loss. Employers must provide employees with a 30-day notice that they are going to suspend employer contributions (unless the IRS grants an exception) and they are required to fund the contribution through the date they suspend contributions.

Employers have until the end of the first year beginning on or after Jan. 1, 2022, to adopt any necessary CARES Act amendments. It's recommended that any decisions made regarding the Employee Retirement Income Security Act (ERISA) or CARES Act be made in consultation with a third-party administrator or legal counsel.

Benefits and Challenges of Telehealth Begin to Emerge

Telehealth's convenience and value were highlighted when fears about the coronavirus pandemic prompted individuals to look for a way to get medical advice without having to go to a doctor's office.



Telehealth is the practice of using computers, tablets and smartphones to provide health care and services at a distance. Telemedicine refers specifically to the practice of using technology to deliver care from one location to a patient at a distant site.

More and more group insurance plans feature telehealth services as part of their benefits. One reason is that a telehealth visit is less expensive for a plan than a visit to a provider's office. For instance, a study published in *JAMA Dermatology* showed that on average a telehealth visit costs about $79, compared with about $146 for an office visit.

Government Support

The federal government has recently jumped on the telemedicine bandwagon. The Trump administration announced a major expansion of telehealth options, including allowing Americans enrolled in Medicare to talk to a doctor by phone or video chat for no additional cost.

In addition, when the COVID-19 outbreak threatened to stress hospital capacities, the House of Representatives included in its $8.3 billion emergency response bill a provision to assist efforts to contain the virus by temporarily lifting restrictions on Medicare telehealth coverage. The bill waives and modifies certain requirements for telehealth services during the pandemic, allowing Medicare to offer telemedicine

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beyond just rural areas.

At the beginning of the coronavirus and COVID-19 pandemic, certain states, such as Massachusetts and Florida, have expanded telehealth coverage to make it easier for doctors and patients to connect online and to ensure that physicians get paid. Some states, like Washington, are acting to permit doctors to treat patients even if they're not licensed in the state as long as they can legally practice in another state.

Benefits

Telehealth gives patients around the clock access to care and enables providers to treat more patients than in office settings. Telehealth providers can ask questions, prescribe medications or if needed refer patients to get treatment at a doctor's office, urgent care or emergency room.

The most obvious benefit of talking to a doctor online or by phone, especially during the pandemic, is that the visit can take place without exposing the patient, the doctor or others in the office or waiting room to any kind of contagion. Not only could others be put at risk, but in the case of health care workers during the pandemic, they could be put out of commission for 14 days of quarantine.

Also, keeping patients who have contracted the virus or any disease at home allows health care workers to provide care at a distance, reserving hospitals for higher need patients.

Future Hurdles

Regulations vary from state to state and there is a lack of clarity about what is allowed, often making it difficult for physicians to get accredited to use telehealth solutions across state borders.

While some states have loosened accreditation requirements, necessitated by the spike in demand for health care during coronavirus pandemic, many telehealth providers are having a hard time keeping up with demand.

There's also a concern that physical exams provided by phone or computer are not as accurate as those that are done in person.

Issues also exist about personal medical data security and its potential to be used for data mining or to create targeted advertising.

Before telehealth can become a truly valuable resource these issues will need to be addressed. ■

States Taking Action to Control Rising Drug Costs

States are taking action to keep prescription drug costs from rising uncontrolled.

Some prescription drug costs have risen so high that patients are being forced to choose between buying prescriptions or buying groceries. As a result, several states are leading the charge to reform the prescription drug industry price structure.

How Prescription Drugs are Priced

KFF (Kaiser Family Foundation) reports that out-of-pocket drug spending for those in large employer plans and Medicare Part D is highest for drugs to treat cancer, multiple sclerosis and rheumatoid arthritis. Why these costs are so high and what can be done about them is yet to be determined.

The American Medical Association, which is running a Truthin-RX campaign, asserts that there are three major market players who they believe significantly impact drug prices:

- **Pharmaceutical companies** make and sell drugs, don't explain pricing or why they often greatly exceed research-and-development (R&D) expenses. Some companies buy existing drugs, spend nothing on R&D and still raise prices.
- **Pharmacy benefit managers (PBMs)** work on behalf of health insurance companies or employers and negotiate upfront discounts or rebates on the prices of prescription drugs. The *FierceHealthcare* publication asserts that many PBMs keep the negotiated cost savings for themselves and some even charge higher drug prices to their customers and keep the difference.
- **Health insurance companies** approve treatments, set co-pays, and set prices with PBMs, often with an eye on what will maximize company profits.

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Current Laws

Congress is debating more than a dozen bills targeting drug costs, but there are concerns that political divisiveness, a packed congressional schedule and a looming election year — not to mention the impact of the pandemic — could stall the passage of any of these bills.

And, while there has been some federal legislation, states are pushing for more regulation. Kaiser Health News reported that 33 states enacted 51 laws in 2019 to address drug prices, affordability and access. The measures focus on:

Price Transparency

The majority of states have enacted laws requiring drug companies to provide information to states and consumers on the list prices of drugs and planned price increases. Most drug companies have complied and post the data on their websites. Oregon's new law goes further and requires manufacturers to notify the state 60 days in advance of any planned increase of 10 percent or more in the price of brand-name drugs or price increases of 25 percent or more in the price of generic drugs.

Gag Rules

Some pharmacy benefit managers (PBMs) include "gag clauses" in their pharmacy contracts. Gag clauses stop pharmacists from discussing whether a drug's cash price would be lower than the customer's out-of-pocket cost under insurance. Several states in 2019 and 2018 enacted laws that ban the practice. Congress in October 2019 passed a federal law banning the clauses in PBM-pharmacy contracts nationwide and under the Medicare Part D prescription drug benefit. Despite that, many of the state PBM laws contain additional gag clause limitations that go beyond the 2018 federal law.

Importing Drugs

Countries like Canada have lower drug costs because they negotiate directly with drug makers to set prices. Colorado, Florida, Maine and Vermont have enacted measures to establish programs to import cheaper prescription drugs from Canada and, in Florida's case, from other countries as well. A 2003 federal law already allows states to import cheaper drugs from Canada, but only if the federal Health and Human Services Department approves a state's plan and certifies its safety. Despite this, the federal government halted drug import efforts in five states between 2004 and 2009.

One big problem to the states' plan is that the Canadian government has opposed any plan that relies solely on Canada as a source of imported drugs.

Drug Affordability Boards

Maryland and Maine have established state agencies to review the costs of drugs and to take action against those whose price increases exceed a specified amount. For instance, state agencies would review drugs that increase $3,000 or more per year; they would also review new medicines that enter the market costing $30,000 or more per year for a drug regime. In addition, starting in 2021, Maine will have a five-member board to set annual spending targets for drugs purchased by state and local governments.

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What Employees Need to Know About COVID-19 and Life Insurance Benefits

With COVID-19 still in the forefront of everyone's mind, your employees may be wondering if the life insurance they purchased or that you provided will pay their beneficiaries if they die from the disease.

The answer is yes — with a few exceptions.

Many employers offer their employees a group life insurance policy. The policy is usually term life and only pays benefits to beneficiaries if the employee is still employed at the company at the time of death. Some employers also offer other types of coverage options, such as accidental death and dismemberment (AD&D) insurance.

The only time a benefit would not be paid to a beneficiary after the employee died from COVID-19 would be if they only had AD&D insurance. This type of policy doesn't pay out if the insured dies of illness or disease. However, employers sometimes add AD&D coverage to a standard life insurance policy as a rider. In that case, the underlying traditional policy would pay out for a death from COVID-19.

Your employees might have their claim denied if they purchased life insurance on their own and the following instances occurred:

- They didn't fill out the application accurately. Insurance companies can refuse to pay benefits if they find false information.

- They fell behind on their insurance premiums. Insurers usually give their members 30 to 31 days to catch up on a payment. However, some state regulators are requiring insurers to extend the grace period during the pandemic.

Social Security Survivors Benefits: Beneficiaries should also check to see if they are eligible to receive Social Security Survivor benefits. If the person who died qualified to collect Social Security when they retired, their spouse or children may be allowed to collect a percentage of their payouts. Most people work and pay Social Security taxes at least 10 years to earn enough to be able to provide survivors benefits.

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