Reinhart
Boerner Van Deuren s.c. Attorneys at Law

CLIENT MEMORANDUM

CONFIDENTIAL ATTORNEY/CLIENT COMMUNICATION

To:	Board of Trustees
Date:	March 20, 2020
Client:	Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund ("Plan" or "Health Plan") (020980)
Subject:	COVID-19 and the Families First Coronavirus Response Act

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OVERVIEW

On March 18, 2020, President Trump signed the Families First Coronavirus Response Act (the "Act") into law. Among other things, the Act:

- Requires employers under 500 employees to provide two weeks of paid leave for employees who cannot work for certain reasons related to COVID-19;
- Requires employers under 500 employees to extend paid Family Medical Leave Act ("FMLA") leave to employees who need to care for their children due to school and childcare closures from COVID-19;
- Requires group health plans to cover COVID-19 testing and items and services related to testing without cost-sharing, prior authorization or other medical management requirements; and
- Allows employers payroll tax credits for providing the paid leave benefits.

The paid leave requirements take effect no later than April 2, 2020. These requirements end on December 31, 2020. The testing requirement took effect on March 18, 2020. This

requirement ends when the Secretary of Health and Human Services ("HHS") declares the end of the public health emergency.

This memorandum identifies the action items the Trustees must take and the corresponding items the Trustees should consider and summarizes the applicable requirements under the Act.

ACTION ITEMS AND CONSIDERATIONS

The Trustees must amend the Plan to:

- Provide for coverage of the COVID-19 test at no cost sharing and without prior authorization or other medical management requirements;
- Waive any applicable copay or cost sharing for office visits (including telehealth visits), urgent care visits and emergency room visits when they lead to a COVID-19 test; and
- Add coverage at 100% for telehealth or virtual office visits that result in a COVID-19 test, if currently excluded.

Additionally, the Board of Trustees should consider the following when determining the extent of coverage the Plan will provide and how to respond to the Act and COVID-19 generally.

Considerations Related to Medical Benefits

1. The effective date for the testing changes required by the Act is March 18, 2020. Will the Plan provide additional retroactive coverage, and if so, to what extent and back to what date?

2. In addition to covering the COVID-19 testing at no cost, will the Plan also provide treatment for a COVID-19 diagnosis at a reduced cost-sharing level or subject to the

normal cost-sharing rules? For plans that do not currently provide coverage for out-of-network services, will the plan expand coverage for COVID-19 treatment?

3. How should the claims administrator determine which charges are for the COVID-19 test and items and services related to the test (i.e., administration, furnishing the test, and evaluation to determine whether a test is needed)?

(a) The claims administrator potentially could rely on the medical codes submitted to determine what should be paid with no cost-sharing, but this may not be possible for certain types of claims (e.g., telehealth visits) and there may be other administrative barriers. The Act requires HHS to designate a modifier (or other identifier) to include on claims to identify COVID-19 testing-related services.

(b) Alternatively, the Plan could simply cover the visit and all services performed during the visit at no cost-sharing when the visit includes a test for COVID-19.

4. Should the Plan amendment include a provision that automatically ends the expanded testing benefits after the public health emergency ends? If the Trustees adopt other changes that are not mandatory, will those changes have an automatic expiration date?

5. Will the Plan impose usual, customary, and reasonable ("UCR") charge limits on the testing and visit coverage (subject to applicable law)?

- The Act does not clearly allow plans to cap coverage at UCR limits—cost-sharing, prior authorization, and other medical management requirements are prohibited. We understand that tests generally cost $100-$300.

6. The Act requires coverage of telehealth visits that result in an order for a test without cost-sharing. We understand "telehealth" to be both online visits with a third party provider (*e.g.*, LiveHealth Online) and virtual visits with a provider's office (*e.g.*, the participant's

primary care provider). Will the Plan also cover telemedicine or virtual visits at a primary care provider that do not result in a COVID-19 test, if the Plan does not currently cover those visits? Some providers are encouraging virtual visits instead of in-person visits to minimize the number of people physically in an office space.

7. Will the Plan provide for a limited extension of coverage, credit hours, or otherwise account for a period when a participant is unable to work for reasons related to COVID-19 to avoid a loss of coverage? Will the Plan provide continuation for other benefits, and if so, to what extent?

Considerations Related to Loss of Time or Short-Term Disability Benefits

1. The Act allows multiemployer plans to pay the emergency paid sick leave and paid FMLA amounts on the employer's behalf, on a pass-through basis. Do the Trustees want to offer this service to participating employers?

(a) Allowing employers to pay for employees' leave under the Act through the Plan may make it easier to coordinate employees' Act-mandated paid leave with any loss of time or short-term disability (collectively, "disability benefits") under the Plan.

(b) However, there are a number of reasons why the Trustees may not want to offer this service:

(i) The Act's obligations are on qualifying employers, not on the Plan and not on all employers;

(ii) The tax credits provided under the Act presume that the employer is paying the paid leave, and the employer therefore may have difficulty claiming the credits;

(iii) Administration may be difficult;

(iv) Employers may become delinquent in making payments, or not make payments for all eligible employees, creating new or additional collection obligations for the Plan;

(v) The new payment obligations are not described in the collective bargaining agreements ("CBA"). Therefore, employers who wish to pay through the Plan will need to enter into a new agreement with the Plan that describes their obligations.

2. Will the Plan provide a new disability benefit to accommodate participants who are unable to work for reasons related to COVID-19, but do not qualify for the regular disability benefit (*e.g.*, because they are not diagnosed, but are in quarantine or otherwise fall within circumstances described in the emergency paid sick leave benefits section of the Act or similar scenarios)? Alternatively, will the Trustees modify the current disability benefit to provide "day one" disability benefit coverage for these participants?

3. If the Trustees amend the Plan for one of the disability options above, how long will the new or modified benefit last? What will happen to participants' benefits if they do not meet the definition of "disability" after the new or modified disability benefit expires?

4. Will any new or modified disability benefit provisions sunset after a certain time?

5. Will any new or modified disability benefit be offset by any amounts the participant receives under the Act?

(a) The Act provides that the emergency paid sick leave is to be in addition to any other benefits the employee might have, including those that were already bargained for and are required under a CBA.

(b) Administering an offset will very likely be difficult to administer.

(c) The current CBAs may not allow for offset.

(d) Alternatively, the new/modified disability benefit could be paid after the participant exhausts any amounts received under the Act.

6. What are the financial consequences of offering new or expanded disability benefits?

DETAIL ON THE TESTING REQUIREMENT

Group health plans, including self-funded plans and grandfathered plans, and most health insurers must cover COVID-19 testing and visits for testing at no cost to the individual, and without prior authorization or other medical management requirements. Specifically, plans and insurers must cover and cannot impose cost-sharing for: (1) the tests and their administration, and (2) items and services provided during an office visit (including a telehealth visit), urgent care visit, or emergency room visit that result in an order for a test or its administration, to the extent they relate to the furnishing or administration of, or evaluation for, the test.

The Act does not specifically state whether coverage without cost-sharing, prior authorization or other medical management must be provided both in- and out-of-network. However, because the Act flatly mandates coverage, and also prohibits cost-sharing, etc., we understand the Act to require coverage of testing and the related items and services both in-network and out-of-network. Therefore, the Plan should provide out-of-network coverage, even if the Plan otherwise covers only in-network claims.

The Act's mandatory coverage without cost-sharing does not include treatment, either before or after a COVID-19 diagnosis. The requirements applied beginning March 18, 2020 and will last until the end of the public health emergency declared by the Secretary of HHS.

Examples:

1. A person visits a provider and the provider evaluates him or her only for COVID-19 and orders or administers a COVID-19 test. The entire cost of the visit and the test must be exempt from cost sharing.

2. A person who thinks he or she is exhibiting COVID-19 symptoms visits a provider and the provider does not order or administer a COVID-19 test. The visit would be subject to regular cost sharing.

3. A person visits a provider for a reason unrelated to COVID-19. During the visit, the provider determines that the person should be tested for COVID-19. Only the evaluation for the test, the test itself, and the test's administration are exempt from cost-sharing under the Act. Charges for the visit and for other items and services provided during the visit could be subject to regular cost sharing.

DETAIL ON THE EMERGENCY PAID SICK LEAVE REQUIREMENTS

The Act requires covered employers to provide paid sick leave to qualifying employees. An employee qualifies for the leave if he or she is unable to work onsite or remotely and satisfies any of the following:

1. The employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19.

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

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

4. The employee is caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

5. The employee is caring for his or her son or daughter if their school or place of care is closed, or their child care provider is unavailable, due to COVID-19 precautions.

6. The employee is experiencing any other substantially similar condition specified by the Secretary of HHS.

Employers do not need to provide this leave to health care providers or emergency responders. Otherwise, all full-time employees are entitled to 80 hours of paid sick leave. All part-time employees are entitled to leave equal to the average number of hours worked over a two-week period. Employees who take leave for reasons 1, 2, or 3 above must be paid at their regular rate, up to a maximum of $511 per day and $5,110 in the aggregate. Employees who take leave for reasons 4, 5, or 6 above must be paid at two-thirds of their regular rate, up to a maximum of $200 per day and $2,000 in the aggregate. The Act allows the Department of Labor ("DOL") to exempt employers with fewer than 50 employees from providing emergency paid sick leave if complying would jeopardize the viability of their businesses.

The leave must be in addition to any paid leave employers already provide. Employers must allow qualified employees to use leave under the Act before any other paid leave. Employers must also post a notice that the DOL will publish by March 25, 2020. The emergency paid sick leave requirements under the Act will sunset at the end of 2020.

The Act allows employers who have signed a multiemployer CBA to pay the emergency paid sick leave through a multiemployer plan, as long as the plan will make those payments. The employer still must fulfill its bargaining obligations under the CBA. However, as long as the

multiemployer plan allows it, the employer may legally fulfill its obligations with respect to the emergency paid sick leave by making contributions to the plan. These contributions must be based on the hours of emergency paid sick time each employee is entitled to while working under the CBA. To allow this option for its employers, the Plan would need to enable the qualifying employees to receive their pay for their emergency paid sick time through the Plan.

DETAIL ON THE EMERGENCY FMLA EXPANSION REQUIREMENTS

The Act would also expand FMLA leave for employers with under 500 employees by adding "Public Health Emergency Leave" to the categories of FMLA leave. An employee of a covered employer who has been employed for at least 30 days qualifies for Public Health Emergency Leave if the employee is unable to work (or telework) because he or she must care for his or her son or daughter who is under 18 if their school or place of care has been closed, or their child care provider is unavailable, due to a federal, state, or local emergency declared for COVID-19.

Qualifying employees would have up to 12 weeks of leave available. For the first 10 days, employers may provide unpaid leave. However, employees may substitute any other accrued leave they have available. Alternatively, if qualified, employees may use their emergency paid sick leave under the Act.

After the first 10 days, Public Health Emergency Leave must be *paid* leave, and paid at no less than two-thirds of the employee's regular rate multiplied by the number of hours that the employee would normally be scheduled to work. The amount of pay is capped, however, at $200 per day and $10,000 in the aggregate.

Employees would have the right to return to their positions after returning from leave. However, that right to return is limited when employers with fewer than 25 employees must eliminate the position due to economic circumstances caused by the COVID-19 pandemic.

The Act allows the DOL to exempt employers with fewer than 50 employees from providing Public Health Emergency Leave if complying would jeopardize the viability of those employers' businesses.

Similar to the emergency paid sick leave, employers who signed a multiemployer CBA may have the option to pay the FMLA leave through a multiemployer plan. The employer must continue to fulfill its bargaining obligations under the CBA, but if the plan allows it, the employer may also fulfill its obligations with respect to the paid FMLA leave by making contributions to the plan. These contributions would be based on the paid FMLA leave each employee is entitled to while working under the CBA. The Plan would need to enable the employees to receive their pay for their paid FMLA leave through the Plan.

DETAIL ON THE EMPLOYER PAYROLL TAX CREDITS

The Act provides tax credits for covered employers against the employer portion of Social Security taxes. The credits may be for up to 100% of the Act's sick leave and FMLA leave wages that the employer paid. If the amount of the credits exceed the amount of federal payroll taxes on all wages the employer paid that quarter, the excess is refundable to the employer. The excess also may be applied to the employer's other IRS tax liabilities.

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