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# OPEN ENROLLMENT 2021: FIVE INSIGHTS TO NAVIGATE REGULATORY CHANGE

Connecting Health and Wealth

## Open enrollment is always a challenging time of year, but the 2021 season promises to be uniquely complex.

The impact of COVID-19 has rocked the benefits landscape. Several emergency relief bills and new regulatory guidelines have changed the rules for businesses and individuals alike.

Now organizations must manage rising costs and facilitate virtual open enrollment experiences, all while trying to navigate often confusing regulatory changes.

To help you make sense of it all, this resource explains mandatory requirements and optional updates affecting your benefits plans. Inside, you'll discover:

- An expanded list of qualified medical expenses
- Updated rules for purchasing over-the-counter medications
- Relief for COBRA participants
- Increased FSA carryover limits
- New options for telemedicine coverage

We'll explain the various changes and suggest some brief action items to help you comply with confidence.

## Let's get started.

1

# MENSTRUAL CARE PRODUCTS ARE NOW QUALIFIED MEDICAL EXPENSES

The Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), passed in March, expanded the list of items and services considered qualified medical expenses.[1]

Menstrual care products—including tampons, pads, liners and other similar items—are now included on the list. This makes HSAs, FSAs and HRAs even more valuable. Americans can use their health accounts to purchase menstrual care products directly, enabling them to save money on taxes for routine care items.

**A recent study of low-income women in St. Louis found that 46 percent report struggling to afford both food and menstrual products.[1]**

If you offer an HSA, FSA or HRA, be sure to communicate these updates to your team. It may impact how they view their benefits and might help drive adoption and utilization. Even with occasional spending, tax savings can add up, so make sure your people take advantage.

Organizations should take stock of existing communications to ensure that lists of qualified medical expenses are up to date. In addition, help your team be ready to facilitate approval of purchases and reimbursements for menstrual care products.

### Status

Optional, but highly recommended*

### Source

The CARES Act

### Effective timeline

Permanent

*Organizations are free to determine qualified medical expenses for FSAs and HRAs. However, industry-standard lists of qualified medical expenses established through SIGIS have been amended to include these items. Practically, this means if a debit card is used in conjunction with the organization's benefit plan, the organization must allow menstrual care products as a qualified medical expense for the cards to continue working.

[1] blog.healthequity.com/cares-act-womens-health-and-menstrual-care

[2] journals.lww.com/greenjournal/Fulltext/2019/02000/Unmet_Menstrual_Hygiene_Needs_Among_Low_Income.2.aspx

2

# REIMBURSEMENT FOR OVER-THE-COUNTER MEDICATIONS IS EASIER THAN EVER

The CARES Act has repealed the ACA prescription requirement for using HSA, FSA and HRA dollars to purchase over-the-counter medication.

Previously, account owners could only be reimbursed for OTC medications if they first acquired a doctor's prescription. The CARES Act eliminates this requirement, making it much easier to use benefit dollars to pay for everyday qualified expenses.

This is great news amid the COVID-19 pandemic, since it helps people limit the contact they make with others when treating illness. It also reduces overall strain on the healthcare system.

**This provision will have a major impact on HSAs, FSAs, and HRAs. Now there's no need to see a physician in order to use tax-free dollars for things like pain relievers, cough syrup and more.**

Similar to the expansion of the qualified medical expenses list, organizations need to communicate these updates so that employees understand their benefits and the best ways to use them. By emphasizing how easy it is to spend and save, organizations can help drive adoption during open enrollment and maximize utilization over time.

In addition, organizations need to be prepared to facilitate the approval of purchases and reimbursement of over-the-counter medicine without a doctor's prescription. This may require a new training session for your benefits team (as this change has already been implemented at merchants accepting a health care payment card).

### Status

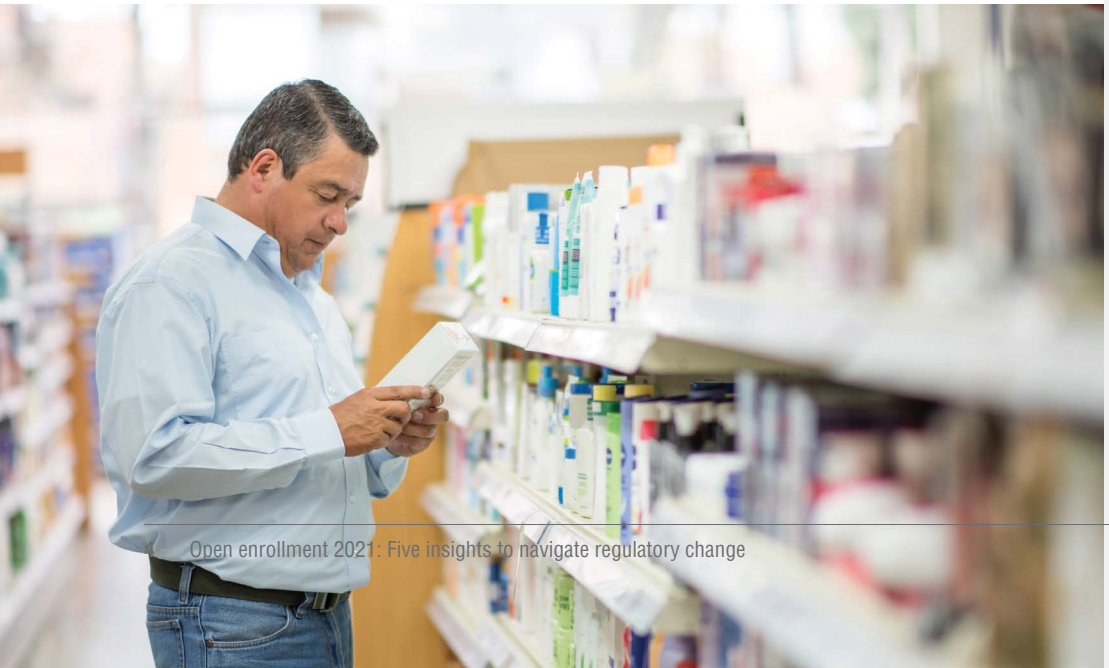
Optional, but highly recommended*

### Source

The CARES Act

### Effective timeline

Permanent



*Organizations are free to determine qualified medical expenses for FSAs and HRAs. However, industry-standard lists of qualified medical expenses established through SIGIS have been amended to include these items. Practically, this means if a debit card is used in conjunction with the organization's benefit plan, the organization must allow menstrual care products as a qualified medical expense for the cards to continue working.

3

# RELIEF FOR COBRA PARTICIPANTS COULD MEAN MORE INDIVIDUALS ARE ELIGIBLE FOR OPEN ENROLLMENT

Guidance issued by the Departments of Labor (DOL) and the Treasury in April[3] grants significant relief for individuals enrolled in COBRA coverage. Notably, it extends certain deadlines for plan participants, including the dates by which they must pay coverage premiums.

Under the guidance, COBRA premium payment deadlines must be disregarded during the "Outbreak Period," defined as March 1, 2020 to 60 days after the declared end of the national emergency related to COVID-19 (which has yet to be announced). After the Outbreak Period ends, participants must remit payment, or they will be retroactively terminated to the last date they paid for coverage.

This means employers may have COBRA plan participants who have not remitted premium payments but may still be considered qualified beneficiaries to whom open enrollment rights may still apply.

## Individuals who are eligible for COBRA but have not yet elected coverage will need to do so before they participate in an open enrollment scenario.

It's important to note that DOL relief itself makes no reference to open enrollment periods, nor do COBRA regulations require that open enrollment periods for COBRA qualified beneficiaries run concurrent with active employee open enrollment periods. Nevertheless, organizations may want to facilitate open enrollment for COBRA participants at the same time – regardless of payment status. Organizations will need to carefully examine their open enrollment population, take account of their COBRA participants and consider various use cases affected by this guidance. This may create some communication challenges, as organizations work to ensure open enrollment materials are sent to all qualified individuals.

### Status

Mandatory for ERISA plans; encouraged for non-ERISA plans

### Source

April relief from the DOL and IRS

### Effective timeline

March 1, 2020 to 60 days after the declared end of the COVID-19 national emergency (which has yet to be announced)

[3] blog.healthequity.com/new-federal-guidance-extends-deadlines-for-employee-benefit-plans

4

# ORGANIZATIONS CAN INCREASE FSA CARRYOVER LIMITS

IRS Notice 2020-33 allows organizations to increase the carryover amount limit for Flexible Spending Accounts.

Normally, organizations have the option to allow carryover amounts of up to $500 for healthcare FSAs. If organizations adopt the optional plan amendment, employees will be able to roll over an additional amount equal to 20 percent of the maximum healthcare FSA salary reduction contribution for the upcoming plan year. This would allow employees to roll over up to $550 into 2021, giving them increased access to tax-advantaged benefits dollars for healthcare.

**If you offer an FSA, consider increasing the carryover limit so participants don't lose money in this crucial time. Carryovers can help boost adoption and participation, enabling organizations to capitalize on FICA tax savings.**

Organizations can adopt this amendment to make their FSA benefit more enticing in 2021. They can also choose to add the amendment retroactively for the 2020 plan year by December 31, 2021. The amount is set in the Internal Revenue Code and is indexed for inflation.

### Status
Optional

### Source
IRS Notice 2020-33

### Effective timeline
Permanent (amendment will apply to all future plan years)

5

# HEALTH PLANS CAN COVER TELEMEDICINE LIKE PREVENTATIVE CARE

Effective immediately, HSA-qualified health plans can (but are not required to) cover telemedicine and remote care services before an HSA participant meets their deductible—or at reduced or no cost-sharing.

Prior to the CARES Act, HSA-qualified health plans were required to assess a fair market value charge for telemedicine services and apply the participant's deductible. HSA-qualified health plans that covered pre-deductible telemedicine services were not considered HSA-qualified and therefore participants couldn't open or contribute to an HSA.

Now, HSA-qualified health plans can cover telemedicine services in the same way they cover preventative care services without interrupting a member's HSA eligibility.

The telemedicine provision is temporary and effective for plan years beginning on or before December 31, 2021. That means these new telemedicine rules will apply to some plans through late 2022.

If the insurance provider you work with has chosen to adopt this safe harbor, it will automatically apply for all covered individuals. If your organization is self-insured and offers an HDHP, you have the option to make this change.

These changes could materially influence open enrollment decisions, so communication is critical. Easy access to telemedicine services continues to be especially important during this public health crisis. Expanding pre-deductible coverage could make HSA-qualified health plans even more appealing. As with the previous two provisions, this update may result in employees enrolling in an HSA-qualified plan for the first time.

### Status

By carrier discretion; optional for self-insured organizations

### Source

The CARES Act

### Effective timeline

Effective March 27, 2020 and applies for plans beginning before January 1, 2022

**Telemedicine is an important part of the future of healthcare, and it's especially important today. Adopting this new safe harbor means your people can gain greater access to telemedicine services and reduce exposure to unnecessary health risks.**

## ABOUT THE AUTHOR

Jody Dietel joined HealthEquity in 2019 through the acquisition of WageWorks and leads the advocacy and government affairs team. Prior to that, Jody founded Creative Benefits, Inc. in 1989, a consumer-directed healthcare benefits company.

Jody navigates federal and state regulations and serves as a liaison between HealthEquity and key industry groups and governing bodies. Jody is a board member and Chair of the Employers Council of Flexible Compensation (ECFC), a board member and Vice President of the Special Interest Group for IIAS Standards, a member of the American Bankers Association's HSA Council Board, and a member of the Policy Board of the American Benefits Council. Previously, she has held various leadership roles at Prudential Insurance Company of America and the Wyatt Company (now Towers Watson).

Jody holds a Bachelor of Arts degree in psychology from Bethel University.

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HealthEquity®

# CHOOSE A PARTNER YOU CAN TRUST

New regulatory and legislative changes mean new opportunities to boost adoption and account utilization. But you need a partner with the experience and expertise to deliver the best benefits experience for your organization.

Avoid the headaches and hassle associated with regulatory change and let HealthEquity manage everything end to end. We've already worked to adapt our solutions to the regulatory changes described in this paper. And we're equipped with the resources and insights you need to be successful this year and beyond.

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