Exhibit 5

COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

» 4/8/21 | 2021-09

New DOL Guidance and Model Notices on the ARPA COBRA Subsidy

Introduction

On April 7, The Department of Labor (DOL) released new resources on the American Rescue Plan Act (ARPA or the Act) COBRA subsidy. This content includes an FAQ series as well as model notices describing the COBRA provisions under ARPA. As discussed in Alert 2021-07, the Act includes a 100% COBRA subsidy for the six-month period beginning on April 1, 2021 and ending September 30, 2021. Assistance Eligible Individuals (AEIs) are entitled to a subsidy for the entire COBRA premium (generally, 102% of the cost of coverage) and the entity to whom premiums are payable, generally the employer plan sponsor, will be responsible for paying the entire COBRA premium. Employer plan sponsors will be eligible for employment tax credits to offset the amount of the premium payments.

The recent DOL FAQs provide additional details on premium assistance and notice requirements. They also answer common questions for employees and their families. The FAQs, however, leave a number of issues relevant to employers unanswered, including what constitutes an "involuntary" termination, and how the subsidy works with state coverage continuation rules. We provide additional information about the FAQs and the new model notices below.

Key Background on the ARPA COBRA Subsidy

The ARPA defines an AEI as a COBRA qualified beneficiary who is eligible for COBRA due to an involuntary termination or a reduction in hours resulting in a loss of coverage during the six-month subsidy period. The Act does not extend the COBRA maximum coverage periods. Importantly, eligibility for the COBRA subsidy ends when an AEI becomes eligible for (not enrolled in) Medicare or any other group health plan other than excepted benefits and qualified small employer health reimbursement arrangements (QSEHRAs). AEIs are subject to penalties for failing to timely notify the group health plan of eligibility for Medicare or other group health plan coverage.

In addition to making subsidized coverage available, the Act created a new COBRA election opportunity for qualified beneficiaries who experienced a reduction in hours or involuntary termination, and declined COBRA or dropped COBRA coverage, before the April 1 effective date of the COBRA subsidy. Group health plans are also allowed—but not required—to give AEIs the option to elect coverage under a lower cost benefit option than the benefit option in which they were enrolled on the day before the qualifying event. This lower cost benefit option must also be available to similarly situated active employees.

Clarifying FAQ Guidance

Covered Plans

The FAQs affirm that the subsidy applies to all private sector group health plans subject to COBRA, and to plans sponsored by state or local governments subject to the continuation provisions under the Public Health Service Act. Notably, the FAQs confirm the subsidy is also available for continued coverage under comparable state mini-COBRA laws, but does not provide guidance on how the subsidy is administered in that situation, e.g., what is the entity to which premiums are paid and receives the tax credit. The FAQs confirm that ARPA does not change any state continuation coverage requirements, and only allows AEIs who elect continuation coverage under state insurance law to receive premium assistance from April 1, 2021 through September 30, 2021.

Alliant note: The FAQs reiterate that subsidized coverage is available for "all group health plans" without any stated exclusion for dental or vision coverage.

Subsidy Eligibility

The FAQs reiterate the eligibility and timeframe requirements for an AEI to obtain premium assistance. Recall that an AEI can be an employee, but also can be a covered dependent, each of whom has an individual right to elect continued coverage under COBRA. In order to be an AEI, the covered employee must have experienced a reduction in hours or an involuntary termination from employment. Notably, and unfortunately, the FAQs do not expand on or provide examples for the most common question to date, which is what constitutes an involuntary termination under this requirement. While certain factual circumstances are clear, many situations call into question whether a termination is actually involuntary. Employers should continue to evaluate that question based on the facts and circumstances, in conjunction with their advisors and employment law counsel.

With respect to individual coverage, the FAQs note that AEIs currently enrolled in individual plans, e.g., through the Health Insurance Marketplace, or Medicaid, can elect COBRA coverage through the applicable employer plan and receive a subsidy. In this situation, however, AEIs will no longer be eligible for a premium tax credit, advance payments of the premium tax credit, or the health insurance tax credit for health coverage during that period.

Alliant note: The FAQs indicate that individuals may be eligible for special enrollment in Exchange plans when the COBRA subsidy ends, but individuals should verify this with the Exchange in the area where they live. Note that special enrollment on to a group health plan usually requires that the entire COBRA coverage period be exhausted, not just the subsidy eligible period.

New Election Opportunity for AEIs Who Previously Dropped or Declined Coverage
The FAQs confirm that individuals who previously declined or dropped COBRA coverage (who would otherwise be AEIs), and whose coverage period would extend into the subsidy eligibility period, now have an additional election opportunity. Employers must provide a notice to these individuals generally by May 31, 2021, after which these AEIs have 60 days to elect COBRA.

The FAQs address a key point related to this new election opportunity noting that the Outbreak Period extensions (related to the COVID-19 national emergency) do not apply to the ARPA election. Specifically, the 60-day election period here is not subject to any special treatment under previous DOL guidance "tolling" certain health plan deadlines. The election period ends 60 days after the notice is provided. See our Alert 2021-05 "DOL Issues Unanticipated New Rule on the End of the Outbreak Period and ERISA Deadline Relief" for additional information on this topic.

With respect to individuals eligible for this new election opportunity, the FAQs note that the subsidy window does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's reduction in hours or involuntary termination). This appears to indicate that employers need not consider individuals who originally experienced an involuntary termination or reduction in hours and then later experienced a second COBRA qualifying event, but additional guidance on this point would be welcome.

Claiming the Subsidy
The FAQs address how an AEI "applies" for the COBRA subsidy when the plan or issuer provides a notice of eligibility to elect COBRA continuation and to receive the subsidy. If an individual believes they are an AEI and have not received a notice from their employer, they may notify the employer and request treatment as an AEI. For example, an individual can use the "Request for Treatment as an Assistance Eligible Individual Form" that is attached to the Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 for periods of coverage starting April 1, 2021.

An AEI will not receive or send payment for any portion of the coverage, and the federal government will reimburse the employer, plan administrator, or insurance company for the subsidy through a tax credit. The FAQs clarify that an AEI does not have to pay the 2% COBRA administration fee during the subsidy window, and AEIs will not receive reimbursements for COBRA premiums paid prior to the subsidy period.

Notice Requirements
The FAQs confirm that plans and issuers are required to notify qualified beneficiaries about their rights under the Act as set forth below, and provide model notices for each of these purposes.

- A general notice outlining the subsidy availability to all qualified beneficiaries who have a qualifying event that is a reduction in hours or an involuntary termination of employment from April 1, 2021 through September 30, 2021. Employers may provide this notice separately or with the COBRA election notice following a COBRA qualifying event.
- A notice of the extended COBRA election period to any AEI (or any individual who would be an AEI if a COBRA continuation coverage election were in effect) who had a qualifying event

before April 1, 2021. This requirement does not include those individuals whose maximum COBRA continuation coverage period would have ended before April 1, 2021 (generally, those with applicable qualifying events before October 1, 2019). Employers must provide this notice within 60 days following April 1, 2021 (by May 31, 2021).

- A notice that subsidized coverage will expire soon, including the expiration date and a statement describing coverage options for which the individual may be eligible (e.g., Exchange coverage, Medicaid, non-subsidized COBRA, or other group coverage). Employers must provide this notice 15 - 45 days before the individual's premium assistance expires.

The DOL Model notices for these purposes are available here. Plan sponsors should work with their COBRA vendors to ensure they provide these notices to AEIs in a timely manner, and continue to use existing COBRA notices for all qualifying events other than a reduction in hours or involuntary termination, including voluntary terminations of employment.

The Option to Elect a Lower Cost Plan

The ARPA gives plan sponsors the option to allow individuals to elect a different coverage option than the coverage in which they were enrolled before the qualifying event. The FAQs clarify that where employers allow this option, individuals currently enrolled in COBRA coverage can also change coverage options and receive premium assistance provided that: the COBRA premium charged for the different coverage is the same or lower than for the coverage the individual had at the time of the qualifying event, the different coverage is also offered to similarly situated active employees, and the different coverage is not limited to only excepted benefits, a QSEHRA , or a health FSA.

DOL Enforcement

Within the FAQs, the DOL emphasizes that it is committed to ensuring individuals receive the benefits to which they are entitled under the ARPA. Employers/plans may be subject to an excise tax under the Internal Revenue Code for failing to satisfy the COBRA continuation coverage requirements. This tax could be as much as $100 per qualified beneficiary, but not more than $200 per family, for each day that the employer/plan is in violation of the COBRA rules. Employers should consider this enforcement posture when addressing issues that lack clarity under the guidance, such as whether a termination is involuntary.

Conclusion

The FAQs confirm much of the previously issued guidance from the ARPA, but still leave a number of open questions. Employer plan sponsors should reach out to their vendors and carrier partners on implementing the COBRA subsidy and distribution of the model notices. It will also be important for employers to work with their tax advisors on seeking reimbursement for the subsidy. We will continue to provide the latest information on the COVID-19 pandemic, including emerging legal challenges and practical recommendations. Our full suite of resources is available on Alliant's COVID-19 Resource Page.

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COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

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DOL FAQs Address Mental Health Parity Requirements under the Appropriations Act

Introduction

On April 2, The Department of Labor (DOL), in conjunction with Health and Human Services (HHS), and the Treasury (the Departments), released FAQs Part 45 on new requirements for employer plan sponsors under the Mental Health Parity and Addiction Equity Act (MHPAEA) added by the Consolidated Appropriations Act of 2021 (the Appropriations Act). (See Alert 2020-23, Year-End Appropriations Act Details New Requirements Under Mental Health Parity.) Under longstanding Mental Health Parity rules, group health plans that cover mental health (MH) or substance use disorder (SUD) benefits must ensure that any financial requirements (copays, deductibles, etc.), quantitative treatment limits (visit limits), and non-quantitative treatment limits (NQTL) (medical management standards, network access, and formulary design) applicable to MH/SUD benefits are not more restrictive than the requirements or limitations for medical/surgical benefits (MS). The Appropriations Act mandated NQTL testing, and requires plans to provide the results of testing on request, in addition to other requirements generally designed to strengthen parity, to the DOL (or appropriate Department) as well as relevant State authorities. The Appropriations Act sets an aggressive compliance timeline in allowing requests to be issued within 45 days of enactment, or as soon as February 10, 2021. This most recent set of FAQs provides additional details on the type of documentation that will be required, outlines a corrections process, and confirms that plan participants can also make these requests. Importantly, the FAQs identify four specific areas on which the DOL initially intends to focus. The FAQs also strongly encourage use of the DOL's MHPAEA Self-Compliance Tool.

NQTL Requirements under the Appropriations Act

Under the Appropriations Act group health plans must make NQTL comparative analyses available to the relevant Department or applicable State authorities, upon request. The analysis must specifically include:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;

4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

As noted above, the Departments can request that a group health plan or health insurance issuer submit their testing and comparative analyses for review beginning in February 2021. Additionally, by December 27, 2021, and annually by October 1 thereafter, the Departments must submit to Congress and make publicly available a report on their NQTL audits.

Clarifying Guidance in the FAQs

Required Information

The FAQs emphasize that a plan's comparative analyses must be sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying an NQTL are comparable and applied no more stringently to MH/SUD benefits than to medical/surgical benefits. The DOL expressly warns that a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet the statutory requirement. At a minimum, sufficient analyses must include a robust discussion of all of the elements listed below.

1. A clear description of the specific NQTL, plan terms, and policies at issue.
2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or

issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

8. A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

The FAQs strongly encourage use of the DOL's MHPAEA Self-Compliance Tool. The MHPAEA Self-Compliance Tool was last updated in 2020, before the enactment of the Appropriations Act, and it recommended that plans and issuers analyze and document as a best practice, but with the passage of the Appropriations Act, this process is no longer a "best practice;" it is required.

In addition to the items listed above, the FAQs identify additional documents that plans should be prepared to make available on request, including:

1. Records documenting NQTL processes and detailing how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under State law.
2. Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support its rationale.
3. Samples of covered and denied MH/SUD and medical/surgical benefit claims.
4. Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

Notably, the precise information needed to support an NQTL analysis will vary depending on the type of NQTL and the processes, strategies, evidentiary standards, and other factors used by the plan or issuer.

Practices to Avoid

The FAQs specifically identify practices that plans should avoid when responding to requests based on past NQTL investigations. The FAQs identify the following problematic practices:

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis;

4. Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice;
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

Corrective Procedures

If the Departments conclude a plan or issuer has not provided sufficient information to review the comparative analyses, the Departments shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request. Where the Departments have reviewed the comparative analyses and any other materials submitted by a plan and determined that the plan is not in compliance with MHPAEA, the plan must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance. Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer is still not in compliance, within 7 days of that determination the plan must notify all individuals enrolled in the plan that the coverage is not compliant with MHPAEA. The Departments will also share findings of compliance and noncompliance with the State where the group health plan is located or where the issuer is licensed to do business. Although not directly addressed in the FAQs Mental Health Parity violations are also subject to Internal Revenue Code Chapter 100 penalties, which are generally $100 per day per participant.

State and Participant Requests

The FAQs confirm that plans must make their comparative analyses of NQTLs and other information available to the applicable State authority upon request. The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or an official or officials designated by the State for enforcement.

The FAQs also confirm that under prior guidance, participants and beneficiaries (or their authorized representatives) in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits. The FAQs emphasize that if a provider or other individual is acting as a patient's authorized representative, the provider may request these documents. This can be problematic where out-of-network providers have every patient sign an authorized representative designation and then attempt to use ERISA and other document requests as a way to leverage higher plan payments for services. Employer plan sponsors may want to tighten their procedures on authorized representative designations as well as anti-assignment language to limit these types of requests.

Areas for Initial Focus

The FAQs confirm that the Departments may request comparative analyses on NQTLs that have been the subject of complaints or potential violations. For example, in the event that the Departments receive a complaint regarding prior authorization requirements for coverage of buprenorphine for the

treatment of opioid use disorder, the Departments may request an NQTL comparative analysis for prior authorization requirements placed on prescription drugs. In addition, the FAQs also identify four specific areas that the DOL expects to focus on in its initial enforcement efforts:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

Plans should also be prepared to make available a list of all other NQTLs for which they have prepared a comparative analysis and a general description of any documentation that exists regarding each analysis.

Conclusion

This set of FAQs includes important information for employers that sponsor group health plans that provide both MS benefits and MH/SUD benefits. If employers have not already done so, it is important to reach out to carriers, Third Party Administrators (TPAs) and any vendor partners supporting carved out benefits (e.g., Pharmacy Benefit Managers) to identify NQTLs and begin an analysis of their parity with respect to MH/SUD benefits. In addition, employers should closely review the MHPAEA Self Compliance tool and go through the compliance review steps outlined for NQTLs. Although the Departments have not made significant NQTL disclosure requests yet, this guidance could indicate that requests are forthcoming. Please contact your Alliant representative with additional questions.

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COMPLIANCE
Friday Fast Facts

» 4/9/2021

Department of Labor Issues COBRA Subsidy FAQs and Model Notices

As discussed in our recent Alert, the Department of Labor (DOL) issued FAQs earlier this week that provide additional details on premium assistance and notice requirements under the American Rescue Plan Act (ARPA). The FAQs also answer common questions for employees and their families. Unfortunately, the FAQs fail to address some of the most pressing questions of employers, including what constitutes an "involuntary" termination, and how the subsidy works with state coverage continuation rules. Among the more notable items in the FAQ guidance are:

- Confirmation that the COBRA subsidy applies to ERISA plans as well as public sector plans that are subject to COBRA through the Public Health Service Act, and comparable state mini-COBRA laws;
- Individuals enrolled in individual market coverage can elect subsidized COBRA, but cannot qualify for subsidized COBRA and premium tax credits for Exchange coverage during the same coverage period (e.g., no double dipping);
- Individuals may be eligible to enroll in other coverage when subsidized COBRA ends, but this should be verified in advance;
- Employers have several new notice requirements under ARPA, and model notices have been provided to help employers comply.
- Individuals who previously declined COBRA or allowed it to lapse may have a second enrollment opportunity; in general, individuals will have 60 days after receiving notice of this opportunity to make a COBRA election. The election period is fixed at 60 days and not subject to DOL guidance delaying certain health plan deadlines.

COBRA Liability in Mergers and Acquisitions

Employers that are part of a business reorganization often inquire about how COBRA will be handled once the transaction closes. In general, the buyer and seller can allocate COBRA liability however they like, but if the issue is not addressed in the transactional documents, IRC guidance will dictate the outcome. The regulations use the term "mergers and acquisitions qualified beneficiaries," which includes individuals in two categories: Those who are already on COBRA when the transaction closes, and those who experience a qualifying event in connection with the sale. The general rule is that if the selling group maintains any group health plan after the sale, this plan retains COBRA liability (regardless if the transaction is a stock or asset purchase). However, if the selling group ceases to maintain any group health plan after the sale, the buying group can be liable: In a stock sale, the plan of the buying group is liable if the seller "ceases all plans in connection with the sale." In an asset sale, the buying group can have COBRA liability if it is a successor employer. To be deemed a "successor employer" the following criteria have to be met: the seller "ceases to provide any group health plan to any employee"; the cessation occurs "in connection with the sale"; and the buying group "continues the business operations associated with the assets purchased…without interruption or substantial change." Other Mergers and Acquisitions questions? See our Alliant Insight regarding ACA Reporting in Mergers & Acquisitions.

FAQ of the Week

Q: Next year, our company will set up an HRA and a health FSA covering the same employees. In what order should reimbursements be paid from these two plans?

A: The general ordering rule is that expenses are paid first from the HRA, until the HRA balance is exhausted, and then from the health FSA. However, this makes it more likely that unused health FSA funds will be forfeited, especially in health FSAs that do not allow carryovers. Other plan designs structure can include the following:

- HRA Pays Last. The HRA and health FSA plan documents could provide that the HRA pays last, after the health FSA has been exhausted. This design is often chosen by employers offering HRAs and health FSAs that cover the same employees for the same medical care expenses, because it reduces health FSA forfeitures
- Plans Cover Different Expenses. The plans could be designed to cover different expenses. For example, the health FSA could reimburse only vision or dental expenses, and the HRA could reimburse only deductibles and copayments not covered by the employer's medical plan.

Employers wishing to explore this approach should consult with legal counsel. In addition, employers with health FSAs that provide for a grace period may want to specifically address which plan pays first for expenses incurred during the grace period.

Happy Friday!!

Compliance team