2021: Year in Review

Compliance Digest

Compliance Bulletins Released January - December

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2021 Compliance Bulletins

Quarter One: January - March

Quarter Two: April - June

Quarter Three: July - September

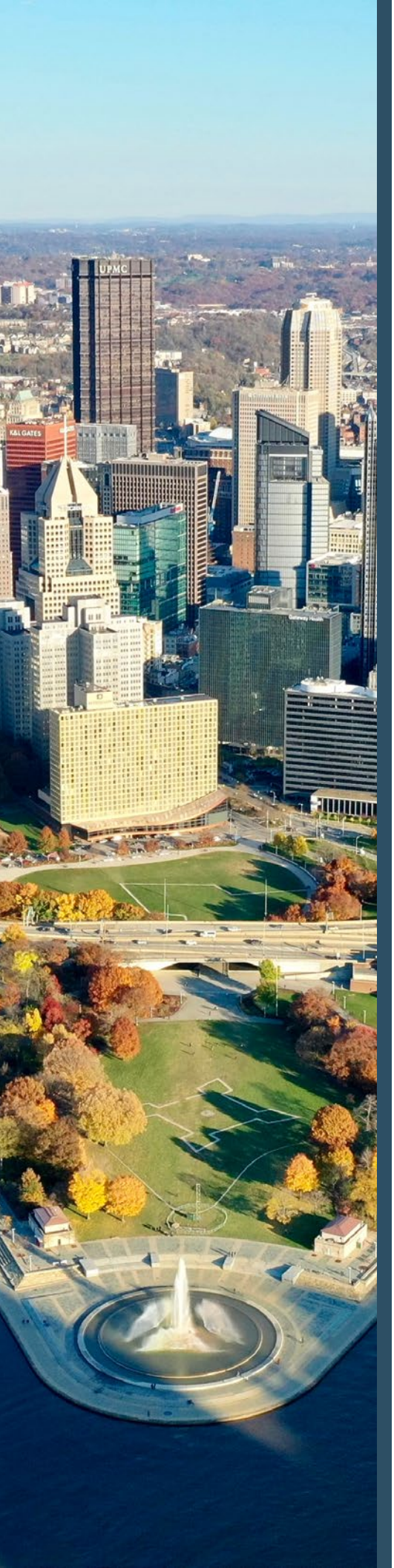
Quarter Three: October - December

2021 Compliance Bulletins: Quarter One

January

February

March



Pittsburgh COVID-19 Paid Sick Leave Ordinance Enacted

Published: January 8, 2021

In response to the COVID-19 pandemic, on December 9, 2020, the City of Pittsburgh adopted a Temporary COVID-19 Emergency Paid Sick Leave Ordinance (the "Ordinance") which gives certain workers up to 80 hours of paid sick leave due to COVID-19. The Ordinance was effective immediately and amends the Pittsburgh Paid Sick Days Act. It will remain effective until one week after the expiration of the public health emergency.

Background

Effective on March 15, 2020, the Pittsburgh Paid Sick Days Act ("PSDA") requires all employers of employees located within the City of Pittsburgh to provide their full-time and part-time employees paid sick leave. Employers with 15 or more employees are required to provide up to 40 hours of paid sick leave per year (24 hours if less than 15 employees), at a rate of one hour of leave for every 35 hours worked in Pittsburgh. Covered employees must have been employed for a minimum of 90 days in order to use this sick time. While the Families First Coronavirus Response Act ("FFCRA") provides mandatory family and medical leave and paid sick leave for employees for COVID-19 reasons (where the employer has less than 500 employees), the FFCRA expired at the end of 2020 and employees are not permitted to use FFCRA leave after December 31, 2020. The Ordinance was introduced to amend the PSDA so that employees can continue to have COVID-19-related paid sick leave.

PSDA

Employers with 50 or more employees within the City of Pittsburgh must immediately provide COVID-19 sick time to covered employees without any waiting period or accrual requirements. Employees are covered if they have been employed by the employer for a minimum of 90 days and they (i) work in Pittsburgh, (ii) normally work in Pittsburgh, but are currently teleworking from any other location as a result of COVID-19, or (iii) work for the employer from multiple locations or from mobile locations so long as 50% or more of the employee's time is spent within the City of Pittsburgh. COVID-19 sick time must be in addition to any paid or sick leave provided by the employer. Employers are prohibited from changing any paid leave policies on or after the effective date of the Ordinance to avoid compliance.

Employees who work 40 hours or more per week must be provided up to 80 hours of COVID-19 sick time. If an employee works less than 40 hours per week, the amount of COVID-19 sick time shall be equal to the amount of time the employee is otherwise scheduled to work or works on average in a 14-day period, whichever is greater. For employees working variable hours, the amount can be equal to the average number of hours the employee was scheduled to work over the past 90 days of work, including any hours taken for any type of leave. Of course, employers may designate a higher amount of sick time if they choose.

Covered employees are eligible for COVID-19 sick time for the following reasons:

- Determination by a public official or public health authority, health care provider or the employee's employer that the employee's or employee's family member's presence on the job or in the community would jeopardize the health of others because of the employee's or employee's family member's exposure to COVID-19 or because the individual is exhibiting symptoms that might jeopardize the health of others, regardless of whether the individual has been diagnosed with COVID-19;

- The employee's need to (a) self-isolate and care for oneself because the employee is diagnosed with COVID-19; (b) self-isolate and care for oneself because the employee is experiencing symptoms of COVID-19; (c) seek or obtain medical diagnosis, care or treatment if experiencing symptoms of an illness related to COVID-19; or

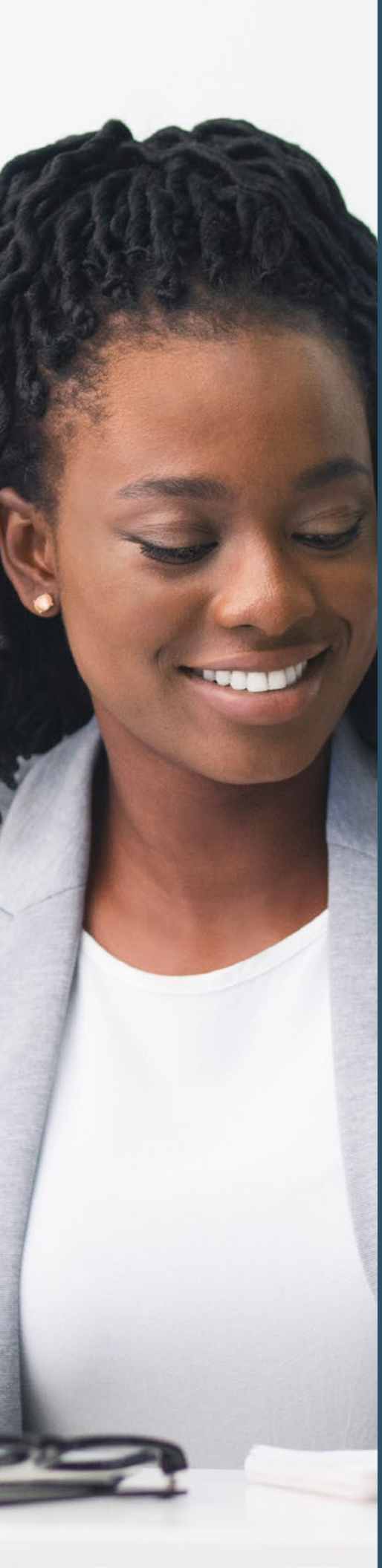
- Care of a family member who (a) is self-isolating due to being diagnosed with COVID-19; (b) is self-isolating due to experiencing symptoms of COVID-19; (c) needs medical diagnosis, care, or treatment if experiencing symptoms of an illness related to COVID 19.

Covered employees must provide notice to their employers of the need for the above leave as soon as practicable, but there is no prescribed time set forth in the Ordinance. Employers cannot require that employees find a replacement worker to cover their hours.

Unless federal or state law requires, employers may not require employees to use other employer-paid leave prior to using the COVID-19 sick time. To the extent that federal or state laws require employers to provide paid leave or paid sick time related to COVID-19, employers are permitted to substitute leave under the federal or state law for their obligations under the Ordinance to the extent they coincide and the federal/state law allows concurrent use of paid leave. Additionally, if an employer has adopted a paid sick time policy specifically for use during COVID-19 after March 13, 2020 (the declaration of emergency), employers are permitted to substitute leave under such employer policy for the leave required under the Ordinance, to the extent they coincide.

Employer Action

Employers should review the Ordinance, as well as their paid leave policies and procedures and ensure they are complying with the Ordinance. Further guidance regarding notice obligations and required documentation would be welcome. It is important to note that the Ordinance does not provide tax incentives for employer, thus, employers will bear the burden of this cost.



DOL FAQs Address Expiration of FFCRA Leave

Published: January 12, 2021

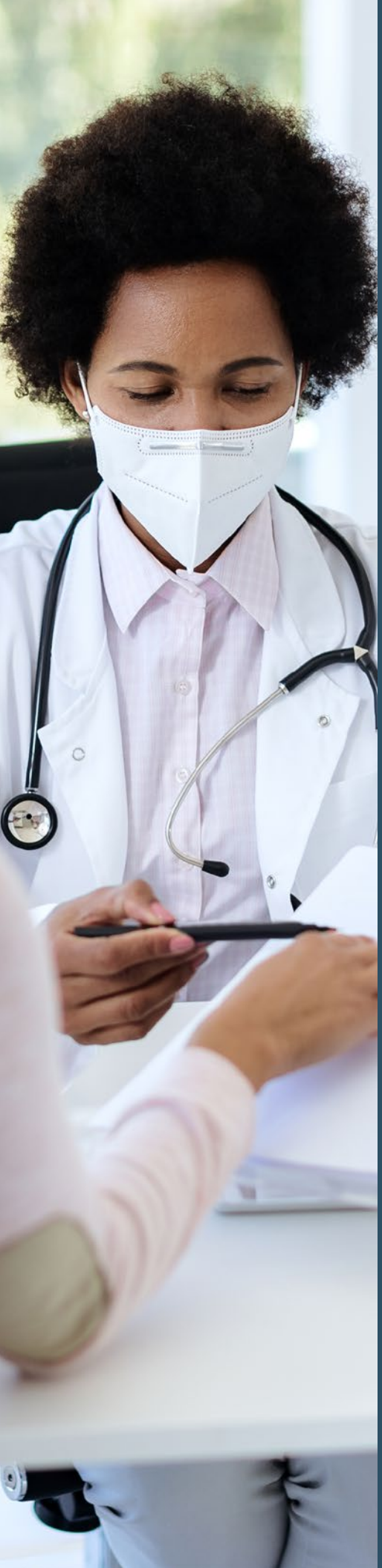
On the last day of 2020, the Wage and Hour Division of the Department of Labor ("DOL") issued two additional FAQs (#104 and #105) related to the Families First Coronavirus Response Act ("FFCRA"), addressing the three-month voluntary extension of FFCRA leave into 2021, and clarifying payment of leave taken during 2020.

The FFCRA required most employers with less than 500 employees to provide paid sick leave and paid family leave to employees who are unable to work or telework due to COVID-19 specific reasons. In addition, the FCRA provided refundable tax credits that reimburse employers, dollar for dollar (up to a prescribed limit), for the cost of providing sick and family leave wages to their eligible employees for leave related to COVID-19.

The paid leave provisions of the FFCRA expired on December 31, 2020. The Consolidated Appropriations Act, 2021 ("the Act"), signed into law on December 27, 2020, provides that eligible employers may voluntarily extend FFCRA paid leaves through March 31, 2021, and receive associated tax credits. Notably, the Act does not require the extension of paid FFCRA leave beyond December 31, 2020.

FAQ #104 makes clear that applicable employers are not required to extend FFCRA leave to employees after December 31, 2020. However, it reiterates that employers may decide to provide such paid leave on a voluntary basis and are eligible for the tax credits associated therefrom through March 31, 2021.

FAQ #105 clarifies that all qualified FFCRA leave taken on or before December 31, 2020 must be paid to the employee, even if such payments are made in 2021. The DOL also reiterated that the statute of limitations for bringing a claim of a violation of FFCRA is two years (or three years in the case of a willful violation) and that employees may potentially bring a private right of action for alleged violations.



EEOC Provides Proposed Wellness Rules

Published: January 15, 2021

On January 7, 2021, the Equal Employment Opportunity Commission ("EEOC") released two notices of proposed rulemaking ("Proposed Rules") on wellness programs under the Americans with Disabilities Act ("ADA") and the Genetic Information Nondiscrimination Act ("GINA"). Briefly, if finalized in their current form, the Proposed Rules:

- generally align ADA rules to existing rules applicable to "health contingent" wellness programs under the Health Insurance Portability and Accountability Act ("HIPAA").
- restrict incentives tied to "participatory" wellness programs, such as those that provide incentives for individuals to disclose health information through health risk assessments or biometric screenings, to "de minimis" amounts. Examples of de minimis amounts are "a water bottle or gift card of modest value."
- under the GINA rules, apply restrictions to incentives related to a spouse's participation in health risk assessments.

Background

There are three sets of laws governing wellness programs and incentive limits currently in effect: HIPAA rules, ADA rules and GINA rules.

HIPAA

The HIPAA rules contain five requirements health contingent programs must satisfy, one of which involves incentives. When rewards are used in a group health plan to promote involvement in an activity (e.g., walking, diet, or exercise program) or to attain a certain outcome (e.g., not smoking or achieving certain results on biometric screenings), incentives cannot exceed 30% of the total cost of coverage under the group health plan (or up to 50% when the program is tobacco-related).

ADA

A wellness program involving a medical test or disability-related inquiries of an employee must be "voluntary." EEOC regulations issued in 2016 had generally provided that incentives could not exceed 30% of the total cost of self-only coverage in the lowest cost plan option offered to an employee in order for the program to be considered voluntary. However, the incentive portion of the 2016 regulations was vacated by court order, effective January 1, 2019.

GINA

As with the ADA rules, a wellness program involving a medical test or disability-related inquiries of a spouse must be "voluntary." GINA regulations had generally provided that incentives could not exceed 30% of the total cost of self-only coverage in the lowest cost plan option offered to an employee in order for the program to be considered voluntary. Those too were partially vacated by court order, effective January 1, 2019.

Proposed Rules

Health contingent programs continue viability under HIPAA requirements

For health contingent wellness programs (activity based or outcomes based), the Proposed Rules will permit incentives that align with the rules under HIPAA (currently 30% of the total cost of coverage or 50% to the extent the wellness program is designed to prevent or reduce tobacco use), as long as the program is part of, or qualifies as, a group health plan and complies with the HIPAA five factor requirements for such plans.

For this purpose, the Proposed Rules set forth four factors that are helpful in determining when a wellness program is part of the group health plan:

- The program is offered only to employees who are enrolled in an employer-sponsored group health plan;

- Any incentives offered are tied to cost-sharing or premium reductions (or increases) under the group health plan;
- The program is offered by a vendor that has contracted with the group health plan or insurer; and,
- The program is a term of coverage under the terms of a group health plan.

Participatory programs would be subject to severe limitations

For participatory programs, the Proposed Rules would sharply reduce the value of incentives many employers have historically utilized, such as a reduction in employee health insurance premiums for meeting wellness criteria. A participatory program is typically a wellness program that simply collects employee health information through health risk assessments or biometric screenings without tracking results and requiring employees to achieve certain health goals in order to earn an award or avoid a penalty. Under the ADA Proposed Rule, those programs are subject to a "de minimis" incentive standard. To be considered voluntary, a wellness program may offer no more than a de minimis incentive (such as a water bottle or gift card of modest value) in exchange for the employee participating in the wellness program.

According to the Proposed Rules, charging an employee $50 per month more for health insurance (or a total of $600 per year) for not completing a health risk assessment as part of a participatory wellness program would not be a de minimis incentive and would violate the ADA because the employee would be treated less favorably with respect to the cost of health insurance than employees who chose to provide their health information. This is much more stringent than the 2016 ADA regulations which would have allowed participatory programs that included medical exams or disability related inquiries to offer up to a 30% incentive based on the cost of self-only coverage in the lowest plan option.

GINA rules would subject participatory programs for spouses to severe limitations

Under the original rule, there was an exception to the general prohibition on providing incentives in return for genetic information that allowed limited incentives (up to 30%) to spouses who provide information (via risk assessment) about their manifestation of a disease or disorder to a wellness program. Under the Proposed Rule, wellness programs would be limited to de minimis incentives to all family members (not just spouses) in exchange for family members providing information about their manifestation a disease or disorder (which is considered the employee's genetic information). As described above, de minimis means very low value incentives such as a water bottle or gift card of modest value.

ADA Notice Not Required

The Proposed Rule would remove the unique ADA notice requirement that currently exists under the 2016 regulations.

Employer Action

At this time the above rules are simply proposed and employers are not required to rely on them or to comply with them. There will be a 60-day notice and comment period before the Proposed Rules are finalized and the finalized version may be different from what is included in the Proposed Rules. Typically, new regulations will apply prospectively starting at a future date (e.g., plan years starting in 2022). Further, the change to a new administration under President Biden may also have an impact. It is also possible that the rules may be challenged by others, such as the AARP, since they are so aggressive towards incentives. Additionally, the EEOC is seeking comments on the regulations. Employers should review their existing wellness programs in light of the EEOC's guidance. We will keep you apprised on new developments.

HHS Extends the Public Health Emergency Again

Published: January 19, 2021

On January 7, 2021, the Secretary of Health and Human Services ("HHS") announced the administration will renew the COVID-19 pandemic Public Health Emergency, scheduled to expire on January 21, 2021. This will once again extend the period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

It should be noted that there is a difference between the emergency period and the outbreak period as follows:

Emergency Period: HHS Secretary issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire April 21, 2021 (unless further extended or shortened by HHS).

Outbreak Period: The Outbreak Period runs from March 1, 2020 until 60 days after the announced end of the National Emergency (note that the end of the National Emergency may not be the same date as the end of the Public Health Emergency period). The Departments are expected to announce the end date; at this time, no end date has been announced. According to the regulations, a period of "up to one year" may be disregarded. Therefore, it appears the latest the Outbreak Period may end is February 28, 2021. However, further guidance would be helpful.

While there are other temporary benefit plan provisions and changes that are allowed due to the public health emergency, below you will find a summary of only those provisions directly impacted by the Emergency Period extension.

Benefit Plan Changes in Effect through the End of the EMERGENCY PERIOD

COVID-19 Testing. All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing, prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.

COVID-19 Vaccines. All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

Excepted Benefits and COVID-19 Testing. An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.

Expanded Telehealth and Remote Care Services. Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.

Summary of Benefits and Coverage ("SBC") Changes. Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.

Grandfathered plans. If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g. added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

Benefit Plan Changes in Effect through the End of the OUTBREAK PERIOD

Group health plans, disability, and other employee welfare benefit plans will disregard the period from March 1, 2020 until the end of the Outbreak Period when determining the following:

COBRA. Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.

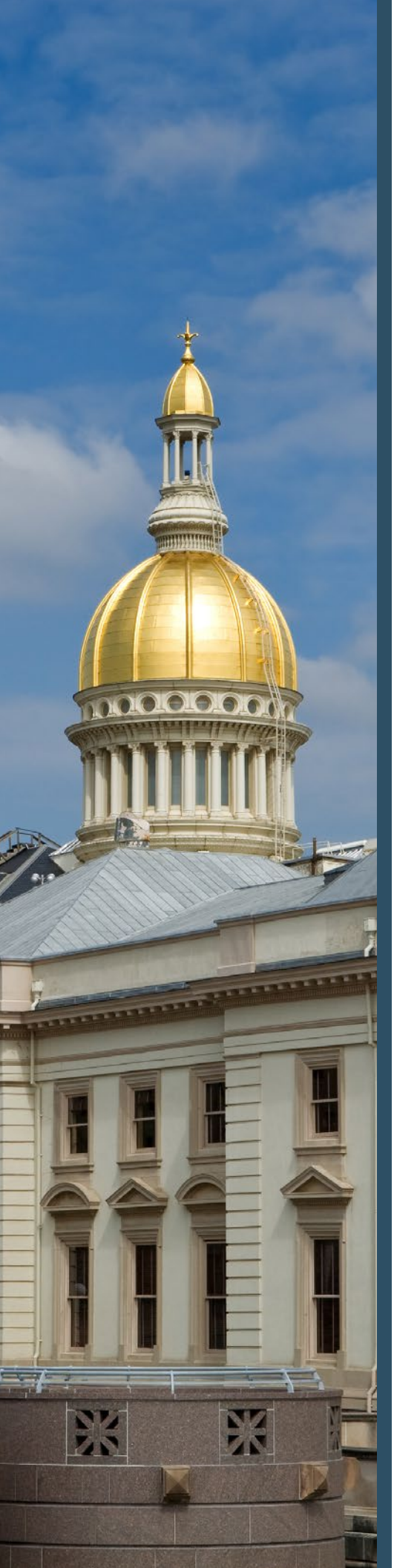
HIPAA Special Enrollment. 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth adoption, or placement for adoption.

ERISA Claims Deadlines. Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request. This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans. A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 coverage and other required plan notifications. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements.



New Jersey Issues 2020 Individual Mandate Reporting Requirements

Published: January 27, 2021

The State of New Jersey has provided information for employer reporting for the 2020 calendar year under New Jersey's individual health insurance mandate that went into effect January 1, 2019. All employers (including out-of-state employers) who provided health coverage to New Jersey residents should review their obligations to issue participant statements and file health coverage information with the state. Reporting obligations differ depending on whether the coverage is provided under an insured or self-funded arrangement.

Employers, insurers and other coverage providers must:

- Transmit 1095 health coverage forms (1095-B, 1095-C or NJ-1095) to the New Jersey Division of Taxation no later than March 31, 2020.

- Issue a 1095 health coverage form no later than March 2, 2020 to each primary enrollee who was a New Jersey resident and to whom minimum essential coverage was provided during 2020.

Background

Beginning January 1, 2019, the New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance. Failure to do so, absent an exemption, will result in an individual penalty imposed by the state when a person files his or her 2020 New Jersey Income Tax return. This New Jersey individual insurance mandate essentially replaces the individual mandate imposed under ACA, which was effectively eliminated beginning January 1, 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report to covered individuals and to the state affirming such individuals maintained health coverage during the calendar year.

Required Forms

Forms are required to be issued to all primary enrollees no later than March 2, 2021 and filed with the state no later than March 31, 2021 on behalf of all part-year and full-year New Jersey residents for 2020. A part-year resident is an individual who lives in the state for at least 15 days in any month in 2020.

Certain employers and other providers of minimum essential health insurance coverage such as insurance carriers, multiemployer plans, government entities, etc. must electronically file the forms with the New Jersey Division of Taxation no later than March 31, 2021 as paper forms will not be accepted. Insurers or employers can file 1095 forms in two ways:

- Registered filers can use the Division of Revenue and Enterprise Services' (DORES) MFT SecureTransport (Axway) service. MFT (Axway) is the required system for filers of 100 or more forms. Taxpayers who have MFT SecureTransport (Axway) service user credentials use them to submit the required health insurance coverage returns. Those without a current account should request account setup.

- As an alternative to MFT SecureTransport (Axway), coverage providers with under 100 forms can use Form NJ-1095 to file one form at a time. New Jersey will post a link to the NJ-1095 form for 2020 before the 1095 filing deadline. The NJ-1095 form is valid for federal filers of either 1095-B or 1095-C forms.

Employers should only send Forms 1095-C to the state for individuals subject to New Jersey's individual mandate. While the state will accept 1095 data files containing records for individuals who are not New Jersey residents, employers should be cognizant that privacy and other laws may limit or prohibit

Employers with Fully Insured Coverage

The insurance carrier will generally be required to file form 1095-B with the state for each covered member of the plan and furnish Form 1095-B to NJ residents. However; an employer must file if its insurer or multi-employer plan does not file the required 1095 forms on time.

Employers with Self-Insured Coverage

The employer files with the state a fully completed 1095-C, 1095-B or NJ-1095 form for each primary enrollee (employee, COBRA participant, retiree, non-employee member) covered under the plan for at least one month of the calendar year and furnishes a form to NJ residents.

Employers Participating in a Multiemployer Arrangement

The plan sponsor should file Form 1095-B (or 1095-C) for each primary enrolled although an employer must file if the multi-employer plan does not file and furnish the required 1095 forms on time.

Separate 1095 forms to spouses, dependents, or adult children of primary enrollees are not required.

Employer Action

Employers with fully insured plans (especially employers with insured coverage issued outside of New Jersey) should confirm that the insurer will issue Forms 1095-B to New Jersey primary enrollees by March 2, 2021. It's important to note that the IRS again has issued guidance relaxing the ACA reporting rules for insurance carriers who are no longer required to automatically issue Forms 1095-B to plan participants, although carriers must still file Forms 1095-B with the IRS.

Employers with fully insured plans (especially employers with insured coverage issued outside of New Jersey) should confirm that the insurer will file the Forms 1095-B with the state no later than March 31, 2021.

Employers with self-insured plans should discuss with their payroll vendor or forms provider to determine if they will file the forms with the state and issue participant statements on the employer's behalf.

As New Jersey will not require that separate forms be prepared for adult children who were covered under their parents' group health plan, the state suggests that employees provide a copy of Form 1095-B or 1095-C to their adult children who reside in New Jersey.

New York Issues Guidance Expanding COVID-19 Sick Leave

Published: January 29, 2021

On January 20, 2021, the New York State Department of Health (the "Agency") issued guidance on the use of COVID-19 sick leave, which appears to expand the ability of individuals to access COVID-19 sick leave beyond the scope of the original New York legislation. However, the guidance prohibits an employee from qualifying for sick leave under New York's COVID-19 sick leave law for more than three orders of quarantine or isolation.

It should be noted that this guidance is not a regulation and there is some concern that the Agency may be exceeding its authority by expanding the scope of the enacted legislation, which limits COVID-19 sick leave to up to 14 days for larger employers and does not include provisions for multiple quarantines or absences from work. Thus, the guidance may be challenged.

Background

On March 18, 2020, Governor Cuomo signed legislation (the "Act") that implements emergency sick leave benefits to employees subject to a mandatory or precautionary order of quarantine or isolation issued by a governmental entity duly authorized to issue such order due to COVID-19 ("Quarantine Period"). The legislation provides impacted employees these benefits through the termination of the Quarantine Period.

As a reminder, employers cannot require employees to use existing sick leave accruals or other accruals (e.g., paid time off) for a COVID-19 quarantine. Employers required to provide paid COVID-19 sick leave must provide leave separate from any accruals.

Generally speaking, the minimum amount of leave is based on the employer's size as of January 1, 2020 and is as follows:

Employer Size	Minimum Sick Leave Requirements
Up to 10 employees* with net income of $1M or less in the prior tax year	Unpaid leave during the Quarantine Period
Up to 10 employees* with net income greater than $1M in the prior tax year	5 days of paid sick leave and unpaid leave thereafter**
11 – 99 employees*	5 days of paid sick leave and unpaid leave thereafter**
100 or more employees* and public employers	14 days of paid sick leave

*Counting employees both within and without the city.

**Following the expiration of the Minimum Sick Leave Requirements, employees may also be eligible for benefits under the New York Paid Family Leave and Disability Leave Law.

What has Changed?

New York employers now appear to be required to provide COVID-19 paid sick leave for up to three orders of quarantine or isolation if the employee is under a subsequent order of quarantine or isolation because they test positive for COVID-19. This latest guidance states that additional COVID-19 sick leave may be available in the following three instances:

- An employee who returns to work following a period of mandatory quarantine or isolation, who subsequently receives a positive diagnostic test result for COVID-19 (precluding a return to work) shall be deemed to be subject to a mandatory order of isolation from the Department of Health and shall be entitled to COVID-19 sick leave whether or not the employee already has received sick leave as required by the law for the first period of quarantine or isolation.

- An employee who is subject to an order of quarantine or isolation but continues to test positive for COVID-19 after the end of such quarantine or isolation period (precluding a return to work) shall also be deemed to be subject to a second mandatory order of isolation from the Department of Health and shall be entitled to COVID-19 sick leave for the second period of isolation.

- If an employer mandates that an employee who is not otherwise subject to a mandatory or precautionary order of quarantine or isolation to remain out of work due to exposure or potential exposure to COVID-19, regardless of whether such exposure or potential exposure was in the workplace, the employer shall continue to pay the employee at the employee's regular rate of pay until such time as the employer permits the employee to return to work or the employee becomes subject to a mandatory or precautionary order of quarantine or isolation. At that time, the employee shall receive COVID-19 sick leave for the period of time the employee is subject to such mandatory or precautionary order of quarantine or isolation.

Employer Action

Employers should review their obligations with employment counsel to ensure the appropriate amount of COVID-19 sick leave as well as other New York paid leave is available to employees.

DOL Penalties Increase for 2021

Published: February 1, 2021

The Department of Labor (DOL) published the annual adjustments for 2021 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2021

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	2020 Penalty	2021 Penalty
Failure to file Form 5500	Up to $2,233 per day	Up to $2,259 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,625 per day	Up to $1,644 per day
Failure to provide CHIP Notice	Up to $119 per day per employee	Up to $120 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$119 per day per violation (per participant/beneficiary)	$120 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,176 per failure	Up to $1,190 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL on request	$159 per day $1,594 cap per request	$161 per day $1,613 cap per request
Genetic information failures	$119 per day (per participant/beneficiary)	$120 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$2,970 minimum	$3,005 minimum
Failure to meet genetic information requirements – not de minimis failures	$17,824 minimum	$18,035 minimum
Cap on unintentional failures to meet genetic information requirements	$594,129 maximum	$601,152 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Reminders for Medicare CMS Notice and 1094-1095 filing

Published: February 9, 2021

Medicare Part D – CMS Notification Reminder

Employers sponsoring a group health plan are required by federal law to inform the Centers for Medicare and Medicaid Services within 60 days after the beginning of the plan year about the creditable status of the plan's prescription drug coverage.

Reminder: Final 2020 Forms 1094-C and 1095-C Issued

Applicable large employers must furnish the 2020 Forms 1095-C to its full-time employees by no later than Tuesday, March 2, 2021.

Medicare Part D – CMS Notification Reminder

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the beginning date of each plan year;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

For example, an employer with a calendar year plan (January 1 – December 31, 2021) must complete this reporting no later than Monday, March 1, 2021.

Additional guidance on completing the form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

Reminder: Final 2020 Forms 1094-C and 1095-C Issued

The IRS released final 2020 Forms 1094-C, 1095-C, and applicable instructions. Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., COBRA qualified beneficiaries).

Due to the COVID-19 pandemic and challenges to business operations, ALEs may have variations to their reporting for 2020 due to furloughs and/or layoffs. ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2020 in preparation to complete, furnish and file these forms for 2020.

As a reminder, IRS Notice 2020-76 provided the following extended relief related to 2020 reporting:

- Extension of due date to furnish Form 1095-C. 2020 Forms 1095-C are due to employees by March 2, 2021 (instead of January 31, 2021).
  - Filing the 2020 Form 1094-C and all Forms 1095-C with the IRS has not been extended and is due March 31, 2021 (for filing electronically) or March 1, 2021 (for paper filing, as permitted).

- Extension of good faith relief for reporting and furnishing. The IRS will not impose a penalty for incorrect or incomplete information on Form 1095-C, if there is a good faith effort to comply

What's New?

For 2020, there are some notable changes to the Forms, specifically addressing individual coverage health reimbursement arrangements ("ICHRAs"). For employers that do not sponsor an ICHRA, much of the reporting remains the same.

- On Form 1095-C, Part II the "Plan Year Start Month" is a required field. An ALE must enter a two-digit number to reflect the plan year start month (e.g., for January 2020, use "01", for June 2020, use "06"). In previous years, this was optional.

- To accommodate reporting associated with ICHRAs:
  - In Part II, there is a new reference to the "Employee's Age on January 1" and "Line 17 Zip Code".
    - If an ICHRA is not offered, do not complete these fields.
  - In Part II, there are new Codes (used in Line 14) used to report offers of ICHRAs. The new Codes are 1L, 1M, 1N, 1O, 1P, 1Q, 1R, 1S, 1T, and 1U.
    - If an ICHRA is not offered, these new codes should not be used.
  - There is also information in the instructions on how to calculate the amount reported on Form 1095-C, Line 15 for an ICHRA offer of coverage.
  - Part III must be completed with respect to coverage through an ICHRA.

Note to non-ALEs. While small employers (non-ALEs) are not subject to reporting for purposes of the employer mandate, if offering a self-insured group health plan or ICHRA, reporting under Section 6055 to the IRS and to covered employees or other primary insured individuals who have coverage provided through a self-insured group health plan is required. In most cases, a non-ALE will use Forms 1094-B and 1095-B to satisfy this requirement. If a non-ALE is offering an ICHRA,

that coverage is considered a self-insured health plan and is subject to this reporting requirement. According to the instructions, a new code "G" must be entered on Form 1095-B, line 8 to identify an ICHRA.

Penalties

Failure to furnish a correct Form 1095-C may result in penalties of $280/form with an annual calendar year maximum of $3,392,000. Failure to file correct Forms 1095-C and 1094-C with the IRS may result in penalties of $280/form with an annual calendar year maximum of $3,392,000.

As announced in Notice 2020-76, there is good faith penalty relief available with respect to incorrect or incomplete information on the applicable Forms.

In addition, penalties may be waived if the failure was due to reasonable cause and not willful neglect.

Forms and Instructions

2020 Form 1094-C, https://www.irs.gov/pub/irs-pdf/f1094c.pdf

2020 Form 1095-C, https://www.irs.gov/pub/irs-pdf/f1095c.pdf

2020 Instructions for Forms 1094-C and 1095-C, https://www.irs.gov/pub/irs-pdf/i109495c.pdf

Marketplace Special Enrollment Period Announced

Published: February 21, 2021

On January 28, 2021, in response to the COVID-19 pandemic, President Biden issued an executive order requiring the U.S. Department of Health and Human Services ("HHS") to consider having a mid-year special enrollment period for the federally-facilitated Marketplace ("FFM") to enable uninsured and under-insured consumers to obtain healthcare coverage. As a result, HHS designated February 15 to May 15, 2021, as a special enrollment period for consumers to obtain individual health insurance coverage from the FFM without a qualifying event (such as birth of a child).

The President's executive order also requires federal agencies to review their existing actions for the purpose of protecting and strengthening Medicaid and the Affordable Care Act ("ACA"), and for the purpose of making high-quality healthcare accessible and affordable.

Mid-Year Marketplace Special Enrollment Period

HHS announced that consumers in 36 states served by the FFM have a special enrollment period from February 15 to May 15, 2021 to apply for and enroll in an individual health insurance policy (also called a "qualified health plan") from the FFM. The following rules apply during the mid-year special enrollment period:

- Consumers in any of the 36 states served by the FFM can apply for an individual health insurance policy or plan by accessing the HealthCare.gov platform directly, or by telephoning the FFM's call center, or through direct enrollment channels.
- Consumers are not required to provide documentation of a qualifying event (such as loss of a job or birth of a child), which is typically required to elect coverage during a special enrollment period.
- Consumers have 30 days after they submit their application to choose a plan. Healthcare coverage begins prospectively on the first day of the month after plan selection.
- Current enrollees can change to any available plan in their area without restriction to the same level of coverage as their current plan.

The President's executive order does not apply to the 14 states (which include New York, New Jersey, Pennsylvania and California) and the District of Columbia that have their own state-based Marketplace. However, states with a state-based Marketplace are expected to adopt a similar mid-year special enrollment period. To date, California and New Jersey have adopted a similar special enrollment period. Each state-based Marketplace may impose different restrictions on the mid-year special enrollment period (for example, regarding whether consumers can switch from one plan to another). Consumers with access to a state-based Marketplace should be advised to contact the Marketplace directly with any questions that they may have.

As a reminder, IRS Notice 2014-55 allows for an optional plan amendment that would permit employees to make a mid-year election under a section 125 cafeteria plan to revoke coverage for the employee and related individuals under a group health plan (other than a health flexible spending arrangement), if the following requirements are met:

1. The employee and related individuals are eligible for a special enrollment period to enroll in an individual health insurance policy or plan from an insurance marketplace; and

2. The employee and related individuals are enrolling in the marketplace plan; and

3. The new coverage from the marketplace constitutes "minimum essential coverage" for purposes of the ACA and is effective beginning no later than the day immediately following the last day of the group coverage that is being revoked.

According to IRS Notice 2014-55, the employer may rely on the employee's reasonable representation that the above requirements have been met. Cafeteria plan documents must include this permitted election change provision and carrier approval would be necessary.

Review of Past Agency Actions

The President's executive order directs all federal agencies to review existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether they are inconsistent with the policy of protecting and strengthening Medicaid and the ACA and making high-quality healthcare accessible and affordable. The agencies are also directed to consider – as soon as practicable and appropriate – whether to suspend, revise, or rescind past agency actions that are inconsistent with the above policy.

Guidance Issued on Outbreak Period

Published: February 26, 2021

On February 26, 2021, the Departments of Labor and the Treasury ("the Departments") issued guidance addressing the COVID-19 Outbreak Period – specifically, the associated period of "up to one year" that may be disregarded for certain benefit plan deadlines. Unexpectedly, they have taken the interpretation that these benefit plan deadline extensions generally apply on an individual-by-individual basis. Individuals with timeframes that are subject to the extensions will have until the following deadlines to make benefit elections, payments, file a claim or benefit appeal as follows:

- one (1) year from the date they were first eligible for relief, or
- 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

This is a different approach to what most practitioners thought, which would have had the clock start running on the disregarded timelines after February 28, 2021. Note, under this latest guidance, employers must notify affected individuals as to the end of the relief period. You will find further details follow.

Background

In May of 2020, the Departments issued a final rule that required all group health plans, disability plans, and other employee welfare benefit plans to disregard the period ("the Outbreak Period") from March 1, 2020 until 60 days after the announced end of the National Emergency relating to the coronavirus pandemic with respect to the following periods and dates:

	Plans Affected	What's Extended
Special enrollment rights	Medical Only	Date to exercise a special enrollment right (30 days for loss of eligibility or acquisition of a dependent, 60 days for Medicaid/CHIPRA eligibility or premium assistance)
COBRA	Medical, Dental, Vision, Health FSA, EAPs, Onsite Clinics	• Date for the plan to provide COBRA election notice • 60-day election period • Due date for timely COBRA premium payments • Due date to notify of a qualifying event or disability determination
Claims for benefits	All ERISA covered benefits	Date to file a benefit claim
Appeals of denied claims	All ERISA covered benefits	Date to file an appeal of an Adverse Benefit Determination ("ABD")
External review	Non-grandfathered medical plans	• Date to request an external review after receipt of an ABD • Date to file information to perfecta request for external review

In addition, under Disaster Relief Notice 2020-01 deadlines to furnish certain required notices to plan participants, beneficiaries and other persons were likewise extended. A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document that must be furnished between March 1, 2020 and the end of the Outbreak Period if the plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances.

Importantly, according to the regulations, the Departments could only prescribe "up to one year" that can be disregarded for these purposes. So, while the Outbreak Period remains ongoing, the one-year mark, February 28, 2021, has almost arrived.

What's New?

The Departments issued joint guidance on the application of the one-year expiration limitation as it applies to employee benefit plans. The Departments have determined:

- Individuals and plans with timeframes that are subject to the deadline extensions (as noted above) will have the applicable periods disregarded until the earlier of:
  - one (1) year from the date they were first eligible for relief, or
  - 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under COVID-19 relief will resume. In no case will a disregarded period exceed one year. The agencies provide the following examples:

- If a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the relief delays that requirement until February 28, 2021, which is the earlier of one year from March 1, 2020 or the end of the Outbreak Period (which remains ongoing).

- If a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the relief delays that election requirement until the earlier of one year from that date (i.e., March 1, 2022) or the end of the Outbreak Period.

If a plan would have been required to furnish a notice or disclosure by March 1, 2020, the relief would end with respect to that notice or disclosure on February 28, 2021. The plan fiduciary would be required to ensure that the notice or disclosure was furnished on or before March 1,

2021. The Department of Labor understands that many plans may have already returned to normal compliance procedures for furnishing notices and disclosures. Notices and disclosures properly furnished without relying on the relief in Notice 2020-01 do not need to be re-furnished.

Similarly, to the extent the plan can demonstrate that a notice or disclosure was actually received, it would not need to be refurnished even if it was initially furnished in reliance on the relief in Notice 2020-01.

Employer Action

The Departments stress that employers should make every effort to ensure that benefits to which employees and other individuals are entitled are made available. Importantly the latest guidance requires employers/plans to affirmatively send a notice regarding the end of the relief period to impacted individuals.

Employers should work closely with their plan administrators and COBRA vendors to:

- Provide notice regarding the end of the relief period to affected individuals.

- Reissue or amend any plan disclosures that were issued prior to or during the pandemic if the earlier disclosures failed to provide accurate information regarding the time in which participants and beneficiaries were required to take action, (e.g., COBRA election notices and claims procedure notices).

- Ensure that group health plans, consider ways to ensure that participants and beneficiaries who are losing coverage under their group health plans are made aware of other coverage options that may be available to them, including the opportunity to obtain coverage through the Health Insurance Marketplace in their state.
  - There is a special enrollment period in the 36 states that use the HealthCare.gov platform starting on February 15 and continuing through May 15. At least 13 states plus the District of Columbia, which operate their own Marketplace platforms, are offering a similar opportunity.

We will continue to monitor guidance in this area and provide updates as they become available.

COBRA Subsidy in the Works

Published: March 04, 2021

A COBRA subsidy is included in early drafts of the proposed fiscal year 2021 budget reconciliation package. If finalized, the COBRA subsidy would apply to workers who have lost group coverage during the COVID-19 pandemic due to involuntary termination or reduction in hours of employment.

Briefly,

- The COBRA premium subsidy will be available to assistance eligible individuals beginning the first month following the date of enactment through September 30, 2021.
  - The proposed definition of an assistance eligible individual means, with respect to a period of coverage beginning on the first day of the month follow the date of enactment and ending on September 30, 2021, a qualified beneficiary who:
    - Is eligible for COBRA continuation of coverage due to involuntary termination or a reduction in hours (excludes voluntary termination); and
    - Elects such coverage.

- Assistance eligible individuals pay 15% of their total COBRA premium during this period.

- A payroll tax credit will subsidize 85% of the total COBRA premium.

- An extended election period is available to allow workers who previously experienced a COBRA qualifying event to enroll in coverage and take advantage of this relief.

- Employers will be required to provide clear and understandable written notices about the availability of the COBRA subsidy.

Under the proposed reconciliation bill, additional ACA Marketplace premium assistance would also become available to individuals not eligible for COBRA.

Employer Action

The legislation is in the early stages and is not final. However, if finalized "as-is," the COBRA subsidy, extended COBRA election period and notification requirements would raise a host of additional compliance issues and responsibilities for employers. Coordination between COBRA vendors, insurance carriers (including stop loss) and third-party administrators will be important to ensure compliance with this requirement (if enacted).

We will continue to monitor developments and provide additional details if the COBRA subsidy is enacted into law.

Departments Issue Guidance

Re: FFCRA and CARES Act

Published: March 11, 2021

On February 26, 2021, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ 44 addressing health coverage issues related to COVID-19.

Briefly, the new FAQs focus on diagnostic testing and coverage for testing and clarify previous guidance in FAQs.

Background

Section 6001 of the FFCRA requires group health plans (including grandfathered health plans) and health insurance issuers to provide coverage for certain items and services related to testing or the diagnosis of COVID-19 without any cost-sharing requirements, prior authorization or other medical requirements. Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic items and services that must be covered the same way. Since the FFCRA and CARES Act have been enacted, the Departments have issued several sets of FAQs to help people better understand the laws.

The guidance clarifies that:

- medical screening criteria may not be used to deny (or impose cost sharing on) a claim for COVID-19 diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19. Plans and carries may still distinguish between asymptomatic people and general workplace testing.
- referrals for COVID-19 testing that come from a licensed or authorized health care provider are assumed to reflect an "individualized clinical assessment" and the test should be covered without cost sharing, prior authorization, or other medical management requirements.
- providers may limit eligibility for testing based on clinical risk or management of testing supplies
- plans and issuers are not required to provide coverage for testing for employment purposes (though they may)

- there is no distinction between point-of-care testing (i.e., drive through) and other testing for coverage purposes

- all COVID-19 vaccines recommended by Centers for Disease Control and Prevention ("CDC") must be covered without cost sharing. As of the date of this bulletin, the Pfizer and Moderna vaccines must be covered. The Johnson and Johnson vaccine is expected to require coverage by March 18, 2021.

- COVID-19 vaccines must be covered without cost sharing regardless of how it is billed and regardless of whether the vaccine requires the administration of multiple doses in order to be considered a complete vaccination

- coverage of a recommended COVID-19 vaccine may not be denied because an individual is not in a category recommended for early vaccination – the coverage must be provided regardless of priority set by states and local jurisdictions.

- although on-site medical clinics are always excepted benefits, COVID-19 vaccines may be offered at on-site medical clinics as excepted benefits.

- an Employee Assistance Plan (an "EAP") will not be considered an excepted benefit solely because it offers benefits for COVID-19 vaccines and their administration but there must be no cost-sharing.

- The Departments will not take enforcement action against any plan or issuer that does not provide at least 60 days' advance notice of a change affecting the SBC to reflect the addition of coverage for qualifying coronavirus preventive services, as such services must be covered on an expedited timeframe. However, plans and issuers must provide any required notice of the changes as soon as reasonably practicable.

Employer Action

Plan sponsors should review the Departments' new guidance and confirm with their carriers or TPAs that the plans they sponsor are meeting the requirements contained in the new FAQs.

New COBRA Subsidy

Published: March 12, 2021

Congress passed the American Rescue Plan Act of 2021 ("the Act") on March 10, 2021 and it was signed into law on March 11, 2020. The Act includes a 100% COBRA subsidy available to certain COBRA qualified beneficiaries who lose group health plan coverage as the result of an involuntary termination or reduction in hours. This is different from the original House legislation, which included an 85% subsidy (with the COBRA beneficiary responsible for 15% of the COBRA premiums). Employers will be able to claim a credit against payroll taxes to reimburse the cost of the subsidy.

The COBRA subsidy begins April 1, 2021 (the first day of the month following enactment) and last through September 30, 2021.

While this subsidy provides welcome relief for many COBRA qualified beneficiaries, it will be administratively challenging for employers, especially given other relief afforded to COBRA elections and premiums payments under the Outbreak Period guidance.

The following FAQs explain the Act's COBRA subsidy in more detail.

Who Qualifies for a Subsidy?

An assistance eligible individual ("AEI") qualifies for the subsidy.

An AEI is, for the period of April 1, 2021 – September 30, 2021, an individual who is eligible for COBRA due to an involuntary termination of employment or a reduction in hours and who elects COBRA continuation of coverage. Individuals who voluntarily terminate from employment are not AEIs.

AEIs include:

- **New COBRA qualified beneficiaries.** Individuals who become COBRA qualified beneficiaries due to involuntary termination of employment or reduction in hours on or after April 1, 2021 but before September 30, 2021.

- **Existing COBRA qualified beneficiaries.** COBRA qualified beneficiaries due to an involuntary termination of employment or reduction in hours who currently have COBRA coverage and continue COBRA between April 1, 2021 – September 30, 2021.

- **Second chance COBRA qualified beneficiaries.** Individuals who were COBRA qualified beneficiaries due to an involuntary termination of employment or reduction in hours but, either (1) did not elect COBRA or (2) elected then dropped COBRA. Had they elected COBRA (or not dropped the coverage), they would have had COBRA coverage between April 1, 2021 – September 30, 2021.

How Much is the Subsidy?

The COBRA subsidy is 100%. This means AEIs will not pay any portion of their COBRA premium during the subsidy period (April 1, 2021 – September 30, 2021) so long as they remain subsidy eligible.

Employers are allowed a credit against Medicare payroll taxes to be reimbursed for the subsidy.

Is There a "Second Chance" to Elect COBRA?

Yes. There is a second chance for an individual who otherwise would be an AEI except the individual:

- Does not have a COBRA election in effect on April 1, 2021; or
- Elected COBRA coverage and later dropped the coverage.

In this case, the AEI may elect COBRA coverage (and the subsidy) beginning April 1, 2021. The maximum COBRA coverage period will be measured from their original qualifying event date had they elected COBRA (or not dropped the coverage).

As described later, a special notice will need to be provided and, upon receipt, these "second chance" individuals will have 60 days to elect COBRA continuation of coverage (retroactive to April 1, 2021).

This is likely to get very complicated with delayed election relief for the Outbreak Period which permits retroactive enrollment back to the original qualifying event date. Note, however, that subsidized premiums are only available beginning April 1, 2021. An individual who is eligible for both types of relief would be permitted to enroll in the subsidized coverage April 1, 2021 going forward. That said, more guidance on the interaction of the Outbreak period and COBRA subsidy would be helpful.

When Does the Subsidy End?

The subsidy naturally expires September 30, 2021. After that date, the full COBRA premium will be owed to continue COBRA coverage or to elect new COBRA coverage. Employers must provide notice within a specific window prior to expiration of the subsidy.

Additionally, if an AEI becomes eligible for other group health plan coverage or Medicare, the subsidy is no longer available. Mere eligibility (versus enrollment) is all that is required.

An AEI must notify the group health plan when the AEI is no longer eligible for the subsidy due to other coverage. Regulations will provide guidance as to the time and manner of this notification. A penalty of $250 applies for failure to notify. There is an exception when the failure is due to reasonable cause and not willful neglect. Note that It is possible for Congress to extend the subsidy beyond September 30, 2021 through future legislation.

How Far Back will we Have to Look for AEIs?

COBRA coverage due to a termination of employment or reduction in hours runs 18 months. Thus, individuals who experienced an involuntary termination of employment or reduction in hours and were in their COBRA election window beginning in November 2019 (or later) may be eligible for the subsidy relief.

What Coverage does the COBRA Subsidy Apply to?

The statute defines group health plan coverage broadly to include an employee welfare benefit plan providing medical care. While further guidance is likely to clarify this, we expect a subsidy to be available with respect to the following coverage:

- Major medical
- Dental
- Vision

This includes fully insured and self-funded group health plans.

Can AEIs Change their COBRA Coverage?

An employer may, but is not required to, allow an AEI to enroll in a different, lower cost plan option than the coverage the individual was enrolled in at the time the qualifying event occurred. The different plan option must be offered to similarly situated active employees of the employer at the time the election to change the plan is made. The different plan option cannot be excepted benefits (e.g., dental coverage), a qualified small employer health reimbursement arrangement (QSEHRA) or a health flexible spending account (health FSA).

An AEI has 90 days after the date of notice of this plan enrollment option to elect to enroll in the different coverage option.

Employers considering allowing enrollment in a lower cost plan option should obtain carrier (including stop loss carrier) approval. Not all carriers may allow for this flexibility.

Are there Notice Requirements?

There are multiple notice requirements associated with the subsidy.

Election Notice

COBRA election notices for AEIs who become entitled to COBRA coverage between April 1, 2021 – September 30, 2021 must be updated to include information on the availability of premium assistance and, if applicable the ability to enroll in a lower cost plan option. Employers may use a separate document that includes the required information.

In addition, notice must be provided to AEIs who have a "second chance" to elect COBRA and obtain the subsidy. This notice must provide by May 31, 2021 (60 days from April 1, 2021 – first of the month following enactment). Failure to provide such notice will be treated as a failure to meet the notice requirements under COBRA.

Briefly, the notice must include:

- forms necessary to establish eligibility for the subsidy;
- contact information for the employer or other entity maintaining information in connection with the subsidy;
- a description of the:
  - extended election period;
  - obligation of qualified beneficiaries to notify the plan when no longer eligible for the subsidy and the penalty for failure to notify;
  - qualified beneficiaries' right to a subsidized premium and any conditions on entitlement to the subsidy (displayed prominently); and
  - option (if available) for the qualified beneficiary to enroll in a different coverage option.

A model notice will be available within 30 days after the date of enactment. It is possible the Departments will require additional notifications as part of their guidance.

Notice of Option to Change COBRA Coverage

If an employer allows AEIs to change to a different, lower cost plan option notice must be provided to inform the AEI of this option.

Notice of the Expiration Period for Premium Assistance

A notice must be provided to an AEI about the upcoming expiration of the available subsidy except in cases where the subsidy is no longer available due to eligibility for other group health plan coverage or Medicare.

The notice must be provided beginning on the date that is 45 days before the subsidy ends and ending on a day that is 15 days before the expiration and must be written in clear and understandable language. It must be provided to the AEI and indicate that the AEI's subsidy will expire soon and include the date of the expiration in a prominent manner.

A model notice will be available 45 days after enactment.

Who May Claim the Tax Credit?

The "person to whom premiums are payable" may claim the tax credit. In the case of a group health plan that is subject to COBRA, this is the employer maintaining the plan.

Employers may apply to credit against Medicare payroll taxes to reimburse the cost for the COBRA subsidy.

What Should Employers Do Now?

- Connect with your COBRA vendor to discuss administration for this new COBRA subsidy. This will include:
  - issuing notices to the "second chance" AEIs by May 31, 2021;
  - updating election notices to reflect the subsidy for COBRA events between April 1, 2021 and September 20, 2021; and
  - issuing notice to AEIs when their individual subsidy is set to expire in accordance with required timeframes.

- Identify all individuals who may qualify as AEIs. This will include individuals who may not have elected COBRA (or dropped COBRA) but are still within the 18-month maximum COBRA period. Employers may need to look back to individuals who experienced an involuntary termination of employment or reduction and were otherwise eligible for COBRA beginning in November 2019.

- Discuss the COBRA subsidy with payroll departments and await further guidance for clarification on claiming the tax credit.

- Await further guidance and model notices. Hopefully, any guidance or notices will address the COBRA deadlines impacted by the Outbreak Period and how this intersects with the COBRA subsidy and applicable notices.

IRS Guidance on Health FSA and DCAP Relief

Published: March 16, 2021

Section 214 of the Consolidated Appropriations Act, 2021 ("CAA") included optional and temporary relief for health flexible spending accounts ("health FSAs") and dependent care assistance programs ("DCAPs") offered in a Section 125 cafeteria plan ("cafeteria plan"). On February 18, 2021, the Internal Revenue Service ("IRS") issued Notice 2021-15 providing guidance addressing these optional plan changes.

Briefly, highlights from the guidance include:

- **Sec. 214 Health FSA and DCAP carryovers and extended grace period.**
  - The Sec. 214 carryover and extended grace period are only available for plan years that end in 2020 and/or 2021.
  - The amount available to carry over may be less than the full unused amount at the end of the plan year.
  - The length of the extended grace period may be shorter than the allowable 12 months.
  - The carryover or grace period extension will not affect the maximum FSA and DCAP salary reductions for the year.

- **Improved coordination with HDHP/HSA arrangements.** Notice 2021-15 provides welcome relief to help participants preserve eligibility to contribute to a health savings account ("HSA") when a health FSA includes a carryover or extended grace period. Employees would be able to "opt-out" of the traditional health FSA or make a mid-year election change to an HSA-compatible FSA.

- **NEW: Mid-year election change relief for group health plan coverage.** The guidance extends 2020 relief permitting mid-year election changes to prospectively enroll, disenroll, or change benefit options for group health plan coverage (medical, dental or vision) for plan years ending in 2021. Note, prior to adopting this relief, employers should obtain carrier (including stop loss carrier) approval.

- **Form W-2 Reporting for DCAPs.** Employers adopting the carryover or extended grace period relief for DCAPs will report the yearly salary reduction amount elected by the employee for the DCAP (plus any

employer matching contributions). Employers are not required to adjust the amount reported in Box 10 due to the carryover or grace period.

- **NEW: Retroactive amendment permitted for health FSAs or HRAs that offer over-the-counter ("OTC") drugs and menstrual care products.** Plans may be retroactively amended to allow reimbursement of expenses incurred on or after January 1, 2020, for menstrual care products and OTC drugs without a prescription.

Additional details on the above are below.

Sec. 214 Health FSA and DCAP Carryovers & Extended Grace Periods

Traditional Rules

A health FSA may permit a carryover of unused amounts remaining in the health FSA as of the end of the plan year (up to $550). A carryover is not permitted in a DCAP.

A health FSA and/or DCAP may permit a participant to apply unused amounts at the end of a plan year to pay expenses incurred for qualified benefits during a period of up to two (2) months and fifteen (15) days immediately following the end of the plan year. This is known as the "grace period."

While inclusion of a carryover or grace period is not required, a health FSA may not have both a carryover and a grace period.

Sec. 214 Carryover and Extended Grace Period Relief

The Sec. 214 carryover relief allows an employer to amend the cafeteria plan to provide a carryover of all (or part of) the unused amounts remaining in a health FSA (including an HSA-compatible health FSA) or a DCAP as of the end of a plan year ending in 2020 and/or 2021 to the immediately subsequent plan year.

Under the extended grace period relief, an employer may amend the cafeteria plan to permit employees to apply unused amounts remaining in a health FSA or a DCAP as of the end of a plan year ending in 2020 and/or 2021 to reimburse expenses incurred for the same qualified benefit (medical care or dependent care) up to 12 months after the end of the plan year.

With respect to both the Sec. 214 carryover and the extended grace period, the following rules apply:

- The carryover and grace period are available to plans that currently have a grace period or provide for a carryover as well as plans that do not currently have these features. However, a plan may not have both a carryover and grace period. The plan amendment must specify which option is adopted for the applicable years.

- The amount available for carryover may be limited to less than all unused amounts and/or the employer may limit the carryover to apply only up to a specific date during the plan year.

- An employer may adopt an extended grace period that is less than 12 months.

- Amounts available because of the carryover and extended grace period will not impact the maximum salary reduction amount permitted in the calendar year.
  - For example, funds carried over from the 2020 plan year to a health FSA or DCAP will not impact an employee's ability to elect $2,750 and $5,000 respectively, for 2021.

- The employer may require employees to enroll in the health FSA or DCAP at a minimum election amount to have access to unused amounts from the Sec. 214 carryover or extended grace period.

- Amounts carried over or available during an extended grace period are not taken into account for purposes of the nondiscrimination rules.

- If the employer adopts the carryover or extended grace period for the health FSA, the COBRA premium associated with the health FSA may not include unused amounts carried over or available during the extended grace period.

Coordination with HDHPs and HSAs

Generally, a carryover or grace period in a "traditional" or "general-purpose" health FSA is an extension of coverage by a health plan that is not a qualified high deductible health plan ("HDHP") for purposes of determining whether an individual qualifies to make contributions to an HSA, except in the case of an HSA-compatible health FSA, such as a limited-purpose health FSA.

Notice 2021-15 provides welcome relief that allows an employer to amend the cafeteria plan in one of several ways to allow employees to maintain HSA eligibility as follows:

- Permit employees to opt out of the carryover or grace period on an employee-by-employee basis.
- Provide a mid-year election change that allows the employee to be covered by a general-purpose health FSA for part of the year and an HSA-compatible health FSA for part of the year.
- Permit each employee to choose between an HSA-compatible health FSA or general-purpose health FSA during the period when the Sec. 214 carryover or extended grace period applies.
- Automatically enroll employees who elect an HDHP into an HSA-compatible health FSA.
- To the extent changes result in an employee being ineligible for an HSA mid-year on a prospective basis, the employee would not be considered HSA ineligible for the earlier part of the plan year.

Mid-Year Election Changes

Health FSA and DCAPs

Employers have the option to amend their cafeteria plan to permit employees to make prospective mid-year election changes for health FSAs and DCAPs for plan years ending in 2021 without a specific change in status event.

If adopted, an employee may make the following changes on a prospective basis with respect to health FSA and/or DCAP election for plan years ending in 2021:

- revoke an election,
- make one or more elections; or
- increase or decrease an existing health FSA or DCAP election.

A prospective election change may include an initial election to enroll in the health FSA and/or DCAP for the year. For example, an employee who initially declined to enroll in the health FSA, may make a prospective election to enroll in the health FSA to use a newly available Sec. 214 carryover or extended grace period.

The following applies with respect to these mid-year election changes:

- There is no "cash out" of the health FSA or DCAP permitted.
- Employers may limit mid-year election changes to amounts no less than amounts already reimbursed and to certain types of mid-year election changes, such as decreases in elections only.
- Employers may allow mid-year election changes without a status change up to a certain date (e.g., by March 31, 2021) during the plan year, but require a status change after that date.
- Employers may limit the number of election changes during the plan year that are not associated with a status change (e.g., allow only one election change in the 2021 plan year without a status change).

- Although salary reductions may only be applied prospectively under any revised election, employers may allow amounts contributed to the health FSA or DCAP after the revised election to be used for any medical care expense or dependent care expense, respectively, incurred during the first plan year that begins on or after January 1, 2021 through the end of the 2021 plan year.

If an employee's election under a health FSA or DCAP is revoked, then the employer may adopt one of the following rules on a uniform basis:

- Amounts contributed before the election is revoked remain available to reimburse healthcare expenses or dependent care expenses (respectively) incurred for the rest of the plan year; or

- The amounts will be available only to reimburse eligible expenses incurred before the revocation takes effect (and not expenses incurred later).

Group Health Plan Coverage

While not included in the CAA, the IRS is again granting relief permitting employers to amend their cafeteria plan to allow employees to make prospective election changes for group health plan coverage (medical, dental or vision coverage) to:

- Enroll if the employee initially declined to elect employer-sponsored health coverage for the plan year;

- Enroll in a different level of health coverage (e.g., self-only or family) and/or modify their health coverage plan option (e.g., HMO to PPO) under the employer's plan; or

- Revoke an existing election provided that the employee attests in writing that the employee is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer that is not coverage solely for dental or vision benefits. The Notice provides an example of an acceptable attestation that may be used.

Employers may also determine a timeframe and the extent to which prospective election changes are permitted and applied (provided such changes comply with the Section 125 nondiscrimination rules) and may limit election changes to circumstances where the employee's coverage will be increased or improved to avoid adverse selection.

The additional relief relating to employer-sponsored health coverage applies to employers who sponsor fully insured health coverage as well as those who sponsor self-funded health coverage.

It is important to note that nothing in the IRS guidance requires carriers or self-funded health plans (including stop loss insurance) to permit mid-year enrollment and/or coverage changes. Prior to implementing any mid-year election changes to the group health plan coverage, it is important to understand whether the carrier (including stop loss insurers) will allow for such changes mid-year.

Health FSA Spend Down

An employer may amend the health FSA to permit employees who cease participation in the health FSA during calendar year 2020 or 2021 to "spend down" their unused health FSA contributions through the end of the plan year in which participation ceased, plus any grace period thereafter (including an extended grace period). However, the Sec. 214 carryover relief (if adopted) will not apply after the end of the plan year in which participation ceased.

Notice 2021-15 clarifies:

- For this purpose, an employee may cease to be a participant because of a termination of employment, change in employment status, or a new election during calendar year 2020 or 2021.

- The employer may limit the unused amounts in the health FSA to the amount of salary reduction contributions the employee had made for the plan year through termination.

- If the employer offers this spend down feature, COBRA obligations still exist in the event the health FSA has a positive balance and the individual loses eligibility for the health FSA due to a termination of employment or reduction in hours.

Special Age Limit Relief- DCAP

Under this rule, if a dependent child reaches age 13 during the last plan year with respect to which the end of the regular enrollment period for the plan year was on or before January 31, 2020 (the "first plan year"), the employee can continue to receive reimbursements for such child's dependent care expenses for:

- the remainder of the first plan year and, to the extent a balance remains at the end of the first plan year,
- the following plan year until the child turns age 14 (but only with respect to the unused amount from the first plan year).

This relief appears rather limited. For a calendar year plan, it only applies with respect to the January 1, 2020 – December 31, 2020 plan year (the last plan year where the enrollment period was before January 31, 2020), and, with respect to the 2021 plan year, to any unused amounts from 2020.

This special age limit relief for certain dependents is separate from the Sec. 214 carryover relief and extended grace period relief. An employer that adopts the special age limit relief is not required to adopt the carryover or grace period extensions in order to adopt the special age limit relief.

The special age limit relief does not permit a DCAP to reimburse expenses for a child who is age 14 or older.

In addition, Notice 2021-15 affirms that employers are permitted under a DCAP to limit reimbursements to expenses incurred for the care of a dependent child who is under a specified age that is less than age 13.

Reporting Requirements for DCAPs

Generally, amounts contributed to a DCAP are required to be reported in Box 10 of Form W-2. Under existing guidance, employers may report in Box 10 the yearly salary reduction amount elected by the employee for the DCAP (plus any employer matching contributions) and are not required to adjust the amount reported in Box 10 to take into account amounts that remain available in a grace period.

Notice 2021-15 extends this rule for Sec. 214 carryover and the extended grace period and will treat amounts carried forward or extended as an amount that remains available in the grace period.

The Treasury Department and the IRS anticipate that for the 2021 and 2022 Forms W-2 and 2441, instructions will provide for similar rules that DCAP amounts carried forward from prior years under this relief will be treated as amounts remaining available during a grace period for reporting purposes and no change to the reporting requirements will be necessary. Clarification as to how the individual may be taxed when the total benefits used in a calendar year exceed IRS thresholds would be welcome.

Plan Amendments

If any of the changes described in the CAA and Notice 2021-15 are implemented, the cafeteria plan must be amended no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective.

- For a January 1, 2020 to December 31, 2020 plan year, this means an amendment must be adopted no later than December 31, 2021.
- For a non-calendar year plan that begins in 2020 (e.g., June 1, 2020 – May 31, 2021), this means an amendment must be adopted by December 31, 2022.

In addition:

- The plan must be operated in a manner consistent with the terms of such amendment during the period

beginning on the effective date of the amendment and ending on the date the amendment is adopted.

- The employer must inform all employees eligible to participate in the plan of the applicable changes being adopted. In addition, ERISA notification requirements may apply to any amendment of a health FSA or group health plan that is subject to ERISA.

Retroactive Amendments for OTC Drugs and Menstrual Care Products

In general, retroactive amendments are not permitted in a cafeteria plan, health FSA, or health reimbursement arrangement ("HRA"). Notwithstanding this general prohibition, Notice 2021-15 allows for a retroactive amendment in a health FSA and/or HRA to provide for reimbursements of expenses incurred on or after January 1, 2020 for menstrual care products and OTC drugs without a prescription. This relief includes amendments made prior to the issuance of this Notice.

Employer Action

Employers should:

- Consider what, if any, changes they wish to implement to their Section 125 plans in accordance with the CAA and this guidance.
- Work closely with FSA vendors to ensure any adopted provisions are being administered in accordance with the requested changes.
- Communicate all amended provisions, terms, and conditions with employees and consider incorporating limits on the allowable changes.
- Confirm with insurance carriers, third party administrators and stop loss insurers (if applicable) if you are considering allowing a mid-year change in elections under the group medical, dental and/or vision plans that the changes can be implemented.

DCAP Update and Other Highlights from the ARPA

Published: March 18, 2021

Along with the COBRA subsidy discussed in the alert issued March 11, 2021, the American Rescue Plan Act of 2021 ("ARPA" or the "Act") provides the following additional relief:

- For calendar year 2021 only, an increase in the amount of pre-tax salary reduction election for a dependent care assistance plan ("DCAP" or "dependent care FSA") to $10,500;
- Expansion of tax credits available to employers who voluntarily extend paid sick and family leave under the Families First Coronavirus Response Act (the "FFCRA") through September 30, 2021; and
- An increase in premium tax credits for calendar year 2021 and 2022 for coverage purchased in the Marketplace.

While the COBRA subsidy is the most significant requirement for group health plans pursuant to the ARPA, this additional relief is discussed in more detail below.

Dependent Care Assistance Plan Relief

For 2021 only, the maximum pre-tax contribution limit to a DCAP has been increased from $5,000 to $10,500 (and from $2,500 to $5,250 for married filing individual returns).

Employers may amend their cafeteria plans to increase the pre-tax salary reduction to this higher limit for 2021 only. DCAP contributions are tracked on a calendar year. An amendment reflecting this change must be adopted not later than the last day of the plan year to which the amendment is effective (for a calendar year plan, by December 31, 2021). This change appears to be optional, rather than mandatory.

This change does not affect the ability for a plan to offer an unlimited carryover or grace period from the DCAP that ended in 2020 to 2021.

Voluntary Extension of Tax Credits for Emergency Paid Sick and Family Leave Through September 31, 2021

As of December 31, 2020, employers are no longer required to provide emergency paid sick leave and emergency family and medical leave. While the Consolidated Appropriations Act of 2021 did not extend the requirement to offer FFCRA emergency leave beyond December 31, 2020, it did extend the availability of tax credits for employers voluntarily providing this paid sick leave and expanded family and medical leave through March 31, 2021.

ARPA again extends the availability of these tax credits for up to an additional 10 days of paid sick leave taken between April 1, 2021 and September 31, 2021. The additional tax credits are allowed even if an employer obtained the maximum amount of tax credits and an employee previously exhausted paid sick leave or family leave days allowed under the FFCRA prior to April 1, 2021. Providing such leave remains voluntary as ARPA did not reinstate the required leave under FFCRA.

ARPA adds two additional reasons to the original six reasons where emergency sick leave may be provided by employers where:

- the employee is seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 and such employee has been exposed to COVID-19 or the employee's employer has requested such test or diagnosis; and

- the employee is obtaining immunization related to COVID-19 or recovering from any injury, disability, illness, or condition related to such immunization after medical diagnosis thereof.

Employers may now receive tax credits for all the original reasons plus the above additional two reasons for taking leave.

Under ARPA, these tax credits are not available to employers that discriminate in favor of highly compensated employees, full-time employees or employees on the basis of employment tenure in providing the leave. on the basis of tenure.

Where the tax credit is claimed for family leave, ARPA increases the aggregate amount of wages that may be claimed from $10,000 to $12,000, removing the two-week waiting period on the emergency FMLA leave.

It is important to note that only private sector employers with fewer than 500 employees are eligible for these tax credits.

Increased Marketplace Subsidies

ARPA increases the premium subsidies that certain individuals who purchase health insurance coverage through the Marketplace exchange will receive and makes certain individuals newly eligible for subsidies for 2021 and 2022. Individuals who make more than 400% of the Federal Poverty Level (the "FPL") will have a cap on their premium costs of 8.5% of their household income. Ordinarily, individuals who make more than 400% of the FPL do not qualify for premium assistance. Given the expansion of subsidies available to individuals above 400% of FPL, some large employers (50 or more full-time employees) may see increased exposure to penalty assessments under the ACA's employer mandate to the extent coverage is not offered to full-time employees or is not affordable and full-time employees receive subsidies in the Marketplace to purchase coverage.

Employer Next Steps

- Employers should consider whether they want to increase the maximum pre-tax contribution limit to dependent care FSAs and, if so, must amend their cafeteria plans accordingly.

- Employers should determine whether it makes sense to voluntarily provide paid sick leave and paid family medical leave to continue to receive tax credits and should review and revise their policies. Remember that state laws may offer additional leave protections and should be reviewed.

- Large employers subject to the ACA's employer mandate should be aware that more of their employees may be eligible for subsidies in the Marketplace for 2021 and 2022. This may increase the risk of penalty assessment when the employer is not offering group health plan coverage to at least 95% of full-time employees, offering unaffordable coverage or excluding up to 5% of full-time employees from an offer of coverage. Employers should continue to regularly review their exposure to penalties under the ACA.

New York Requires Paid Leave for COVID-19 Vaccinations

Published: March 19, 2021

To encourage New York employees to schedule and receive their COVID-19 vaccinations, Governor Cuomo signed legislation on March 12, 2021 requiring all New York public and private employers to provide employees up to four (4) hours of paid leave per required dose of the COVID-19 vaccine. Employees requiring two separate injections (e.g., the Pfizer and Moderna COVID-19 vaccines) will be entitled to up to eight (8) hours of paid leave. This legislation took effect immediately and will be in effect through December 21, 2022.

Briefly, the legislation provides the following:

- The leave must be paid at the employee's regular rate of pay.
- Time off to receive the vaccination may not be charged against any other leave to which the employee may be entitled to such as accrued sick or vacation time.
- Employees covered under a collective bargaining agreement ("CBA") are entitled to at least eight (8) hours of vaccination leave unless additional time is specifically granted under the CBA.
- The provisions of the bill may only be waived by a CBA that explicitly references the new provision of the New York labor law provided under this legislation.
- An employer may not retaliate against an employee for exercising his or her rights under this legislation.

The law does not address timing of employee notification of the need for this leave and what, if any, documentation an employer can request from employees to verify proof of vaccination. We hope to receive further guidance from the NYS Department of Labor.

Employer Action

New York employers should update leave policies and communicate the required COVID-19 leave policy with their employees to help encourage vaccine scheduling.

California Enacts 2021 COVID-19 Supplemental Paid Sick Leave Law

Published: March 30, 2021

On March 19, 2021, California Governor Newsom signed Senate Bill No. 95 ("SB 95") into law. SB 95 adds a new section 248.2 to the California Labor Code which requires employers to provide 2021 COVID-19 Supplemental Paid Sick Leave that is broader-reaching than the previous version that expired on December 31, 2020.

Under the new 2021 COVID-19 Supplemental Paid Sick Leave provisions, employers with more than 25 employees are required to provide up to two weeks of additional paid sick leave to employees who are not able to work or telework for expanded reasons related to COVID-19 between January 1, 2021 and September 30, 2021.

The California Department of Industrial Relations has published additional guidance on 2021 COVID-19 Supplemental Paid Sick Leave in the form of Frequently Asked Questions ("2021 FAQs"), and a side-by-side comparison of paid leave options under California law (both linked below).

It should be noted that SB 95 also adds a new section 248.3 to the California Labor Code which provides special COVID-19 supplemental paid sick leave requirements for employees of in-home supportive service providers and waiver personal care service providers. Those requirements are not addressed in this Compliance Update.

Period of Coverage

Effective March 29, 2021, employers are required to provide 2021 COVID-19 Supplemental Paid Sick Leave to covered employees during the period beginning January 1, 2021 and ending September 30, 2021. Refer below to the section entitled "Payment of Retroactive Benefits" for guidance on handling retroactive benefits for leave taken between January 1, 2021 and March 28, 2021.

There is an important exception to SB 95's sunset date: If an employee is taking 2021 COVID-19 Supplemental Paid Sick Leave at the time the state law requirement to provide such leave expires, the employee must be allowed to continue and complete the full amount of paid leave.

Covered Employees

All public and private employers that employ more than 25 employees are required to provide 2021 COVID-19 Supplemental Paid Sick Leave to "covered employees." It is not clear from the text of SB 95 whether for this purpose an employer counts all employees nationwide or only those who work within California. A "covered employee" is an employee who:

- is unable to work or telework for the employer because of a reason listed in the following section entitled "Reasons for Taking Leave," and
- is working in California and subject to the Healthy Workplaces, Healthy Families Act of 2014.

Reasons for Taking Leave

An employer is required to provide 2021 COVID-19 Supplemental Paid Sick Leave to a covered employee if the employee is unable to work or telework for the employer because of any of the following reasons:

- **Caring for Self:** The covered employee is subject to a quarantine or isolation period related to COVID-19 (see note below), or has been advised by a healthcare provider to quarantine due to COVID-19, or is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- **Caring for a Family Member:** The covered employee is caring for a family member who is either subject to a quarantine or isolation period related to COVID-19 (see note below) or has been advised by a healthcare provider to quarantine due to COVID-19, or the employee is caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.
- **Vaccine-Related:** The covered employee is attending a vaccine appointment or cannot work or telework due to vaccine-related symptoms.

It should be noted that the quarantine or isolation period related to COVID-19 is the period defined by an order or guidelines of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer with jurisdiction over the workplace.

According to the 2021 FAQs, an employer may not deny 2021 COVID-19 Supplemental Paid Sick Leave to a covered employee based solely on a lack of certification from a health care provider. However, it may be reasonable in certain circumstances to ask for documentation before paying sick leave to an employee, when the employer has other information indicating that the employee is not requesting sick leave for a valid purpose. For example, if a covered employee informs the employer that the employee is subject to a local quarantine order and qualifies for 2021 COVID-19 Supplemental Paid Sick Leave, but the employer subsequently learns that the employee was out at a park, the employer could reasonably request documentation.

Number of Hours of Leave

The covered employee determines how many hours of 2021 COVID-19 Supplemental Paid Sick Leave to use, up to the total number of hours that the employee is entitled to take (as calculated below). When the covered employee makes an oral or written request to the employer to take 2021 COVID-19 Supplemental Paid Sick Leave, the employer is required to make the leave available to the employee for immediate use.

The total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that a covered employee is entitled to take is calculated as follows:

Covered Employee	Entitlement to 2021 COVID-19 Supplemental Paid Sick Leave
A covered employee who is an active firefighter and scheduled to work more than 80 hours for the employer in the two weeks preceding the leave	The total number of hours the covered employee was scheduled to work for the employer in the two weeks preceding the leave
Any other covered employee: • who is considered by the employer to work "full-time," or • who worked (or was scheduled to work) an average of at least 40 hours per week for the employer in the two weeks preceding the leave	80 hours
A covered employee who does not satisfy any of the above criteria	If the covered employee has a normal weekly schedule: • The total number of hours that the employee is normally scheduled to work for the employer over two weeks, but not more than 80 hours If the covered employee works a variable number of hours, and has worked for the employer for: • More than 14 days: 14 times the average number of hours that the employee worked each day for the employer in the six months preceding the leave (or the entire period worked for the employer, if less than six months), but not more than 80 hours • 14 days or fewer: the total number of hours the employee worked for the employer

Rate of Pay During Leave

2021 COVID-19 Supplemental Paid Sick Leave is paid at the following rate of pay (subject to limits set forth after the chart):

Covered Employee	Rate of Pay
A covered employee who is an active firefighter and scheduled to work more than 80 hours for the employer in the two weeks preceding the leave	The regular rate of pay to which the covered employee would be entitled as if the employee had been scheduled to work those hours, pursuant to existing law or an applicable collective bargaining agreement
A covered employee who does not satisfy the above criteria and who is classified as exempt under applicable wage-hour laws	Calculated in the same manner as the employer calculates wages for other forms of paid leave time
A covered employee who does not satisfy the above criteria and who is classified as nonexempt under applicable wage-hour laws	The highest of the following rates: • The employee's regular rate of pay for the workweek in which the covered employee uses the leave • The rate calculated by dividing the employee's total wages (not including overtime premium pay) by the total hours worked in the full pay periods of the prior 90 days of employment • The state minimum wage • The local minimum wage

However, an employer is not required to pay more than $511 per day or $5,110 in the aggregate to a covered employee for 2021 COVID-19 Supplemental Paid Sick Leave taken by the employee. If this limit applies, the employee may utilize other paid leave available to the employee in order to be fully compensated for the leave taken by the employee.

Coordination with Other Paid Leave

The employer is prohibited from requiring a covered employee to use any other paid or unpaid leave, paid time off, or vacation time provided by the employer before the employee uses 2021 COVID-19 Supplemental Paid Sick Leave or in lieu of such leave. For example, an employer cannot require covered employees to use State Disability Insurance (SDI) benefits before or in lieu of 2021 COVID-19 Supplemental Paid Sick Leave.

The total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave available to a covered employee is in addition to any paid sick days that may be available to the employee under the Healthy Workplaces, Healthy Families Act of 2014.

Important Exception: If the employer pays another supplemental benefit to a covered employee for leave taken on or after January 1, 2021, the employer may count the hours of other paid benefit or leave towards the total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that the employer is required to provide to the employee, as long as all of the following requirements are met:

- The other supplemental benefit is payable for one of the qualifying reasons listed above in the section entitled "Reasons for Taking Leave."

- To pay for the other supplemental benefit, the employer did not require the covered employee to use any other paid leave or paid time off available to the employee under a policy that is not specific to COVID-19, or vacation time.

- The other supplemental benefit compensates the employee at a rate of pay equal to or greater than the rate of pay for 2021 COVID-19 Supplemental Paid Sick Leave (as discussed above in the section entitled "Rate of Pay During Leave"). If the employer paid for the supplemental benefit at a lesser rate than what is required for 2021 COVID-19 Supplemental Paid Sick Leave, then the employer may make a retroactive payment to make up the difference between what was paid and what is required for 2021 COVID-19 Supplemental Paid Sick Leave, to satisfy this "rate of pay" requirement.

The other supplemental benefit may include paid leave provided by the employer under any federal or local law in effect or that became effective on or after January 1, 2021, if the paid leave is provided to the covered employee under the law for any of the same reasons set forth above in the section entitled "Reasons for Taking Leave."

The other supplemental benefit does not include paid sick days under California's Healthy Workplaces, Healthy Families Act of 2014, California's expired COVID-19 food sector supplemental paid sick leave law, or California's expired COVID-19 supplemental paid sick leave law.

Payment of Retroactive Benefits

The requirement to provide 2021 COVID-19 Supplemental Paid Sick Leave applies retroactively to January 1, 2021 for covered employees who took leave for one of the qualifying reasons listed above in the section entitled "Reasons for Taking Leave."

If a covered employee makes an oral or written request on or after March 29, 2021 for retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits, and the leave taken by the employee between January 1, 2021 and March 28, 2021 for a qualifying reason was:

- unpaid, the employer must provide the employee with retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits to cover the leave.
- covered by another supplemental benefit (as discussed under the above section entitled "Coordination with Other Paid Leave") that did not compensate the covered employee in an amount equal to or greater than the amount of compensation for 2021 COVID-19 Supplemental Paid Sick Leave that the employee is entitled to receive, the employer must provide the employee with a retroactive benefit that provides for such additional compensation.
- covered by the employee's regular paid sick or vacation days, the employer must provide the employee with retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits for those days and restore the used sick or vacation days to the employee's bank of available days.

The retroactive benefit must be paid on or before the pay date for the next full pay period after the covered employee's oral or written request. For any retroactive payment of benefits, the number of hours of leave corresponding to the amount of the retroactive benefit will count towards the total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that the employer is required to provide to the covered employee.

The 2021 FAQs provide the following example of a retroactive benefit payment: If a covered employee had to take two hours off for a vaccine appointment on February 15, 2021, the employee can make an oral or written request to the employer to be paid for that time off in February, because it is a qualifying reason for taking 2021 COVID-19 Supplemental Paid Sick Leave. The oral or written request must be made on or after March 29, 2021 (the date when SB 95 is effective for employers). A request made before March 29 does not count. After the employee makes the request, the employer will have until the payday for the next full pay period to pay the retroactive 2021 COVID-19 Supplemental Paid Sick Leave.

Administrative Tasks for Employers

Posted Notice

The California Labor Commissioner has published a model notice (linked below) that employers must post in a conspicuous location in the workplace. If an employer's covered employees do not frequent a workplace, the notice requirement may be satisfied by delivery through electronic means, such as by e-mail.

Notice of Available 2021 COVID-19 Supplemental Paid Sick Leave

The employer is required to provide each employee with written notice of the amount of 2021 COVID-19 Supplemental Paid Sick Leave available to the employee either on the employee's itemized wage statement or in a separate writing on each payday, beginning with the next full pay period following March 29, 2021. The amount of available 2021 COVID-19 Supplemental Paid Sick Leave must be listed separately from the amount of other paid sick days or paid time off available to the employee.

San Francisco HCSO 2020 Reporting Delayed

Published: March 31, 2021

The San Francisco Office of Labor Standards Enforcement (OLSE) has postponed the requirement for employers to submit the 2020 Annual Reporting Form for the San Francisco Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance (FCO) for a minimum of six months, at least until October 31, 2021. This form would otherwise have been due by April 30, 2021.

The San Francisco Board of Supervisors is currently considering proposed legislation that would cancel the 2020 employer reporting requirement altogether (as it did last year for the 2019 employer reporting requirement), due to the on-going COVID-19 public health crisis.

All other requirements of the HCSO remain in effect. Covered employers must continue to make health care expenditures on behalf of their covered employees, generally within 30 days of the end of each quarter. The deadline for expenditures in the first quarter of 2021 is April 30, 2021.

As a reminder, the official HCSO Notice should be posted in a conspicuous place at any workplace or job site where covered employees work. The updated 2021 Notice is available in 6 languages at:
https://sfgov.org/olse//sites/default/files/Document/HCSO%20Files/2021%20HCSO%20Poster%20Final.pdf

2021 State-Based Compliance: Quarter One

Arkansas

Virginia

Washington

Arkansas PBM Law Upheld

On December 10, 2020, the U.S. Supreme Court unanimously held in Rutledge v. Pharmaceutical Care Management that federal ERISA law does not preempt a state law that regulates the price at which pharmacy benefit managers ("PBMs") reimburse pharmacies for the cost of drugs.

Background

PBMs act as intermediaries between pharmacies and prescription drug plans (both self-funded and insured). When a participant goes to fill a prescription, the pharmacy checks with the PBM to determine that person's coverage and copayment information. After the participant leaves with his or her prescription, the PBM reimburses the pharmacy for the prescription, less the amount of the participant's copayment.

The amount a PBM reimburses a pharmacy for a drug is not necessarily tied to how much the pharmacy paid to purchase that drug. Instead, PBM contracts with pharmacies typically set reimbursement rates according to a list specifying the maximum allowable cost ("MAC") for each drug. PBMs normally develop and administer their own unique MAC lists. Similarly, the amount that prescription drug plans pay PBMs for a drug is a matter of contract between a given plan and a PBM. A plan's payment to a PBM often differs from and exceeds the amount of the PBM's reimbursement to the pharmacy. That difference generates a profit for PBMs.

In Arkansas, the pharmacy reimbursement rates set by PBMs were often too low to cover pharmacies' costs, and many pharmacies – particularly rural and independent ones – were at risk of losing money and closing. So, in 2015, Arkansas passed Act 900, which effectively requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than the pharmacy's wholesale cost.

Supreme Court Case

The Pharmaceutical Care Management Association ("PCMA"), a national trade association representing the 11 largest PBMs in the country, filed a lawsuit against Arkansas, claiming that Act 900 is preempted by federal ERISA law.

ERISA generally preempts state laws that relate to employee benefit plans. The U.S. District Court and the U.S. Court of Appeals both concluded earlier that Act 900 relates to employee benefit plans and is therefore preempted by ERISA. However, the U.S. Supreme Court reached a different conclusion on the case.

The Court held that Act 900 had neither an impermissible connection with nor reference to ERISA and was therefore not preempted by ERISA, noting that Act 900:

- is merely a form of cost regulation that does not force plans to adopt any particular scheme of substantive coverage.
- does not refer to ERISA or apply exclusively to ERISA plans.
- does not interfere with central matters of plan administration as the responsibility for offering the pharmacy a "below-acquisition reimbursement" lies first with the PBM.
- fails to cause any "operational inefficiencies" that are sufficient to trigger ERISA preemption.

Employer Considerations

The Rutledge decision gives pharmacies more leverage to obtain higher reimbursements from PBMs for drugs purchased by participants in an employer-sponsored group health plan. PBMs have the choice of absorbing these additional costs or passing them along to the employer plan. It is not clear whether PBMs can require plans to pay these higher amounts unilaterally, or whether PBMs will need to negotiate new contracts with employer plans to obtain higher payments from the plans.

Because of the Rutledge decision, employers and plan participants can expect to pay more for prescription drugs. This financial effect will be felt across the entire country (not just in Arkansas) as more states adopt laws similar to Act 900.

Virginia Requires Maternity Benefits in Short-Term Disability Coverage

Beginning July 1, 2021, any policy delivered or issued in Virginia which provides for short-term disability ("STD") coverage will be required to include minimum benefits for childbirth.

The new regulations, signed into law on April 9, 2020, include the following:

- STD policies must provide a minimum maternity benefit of at least 12 weeks duration immediately following the birth of a child.
- Covered policies may not use an elimination period to reduce the required payable benefit of 12 weeks.
- If the policy imposes a maximum benefit per policy period, an insured may exhaust benefits prior to a childbirth and not be eligible for a full 12 months of payable benefits for a new child. However, where a policy imposes a maximum benefit period per disability, then the policy must provide the required 12 weeks of payable benefit for a childbirth.

The new requirements will only apply to new policies providing STD benefits issued or delivered on or after July 1, 2021. Policies providing long-term disability coverage are not covered by the new requirements.

This update is based upon interim guidelines from the Virginia Bureau of Insurance. Final guidelines are expected in the future.

Update on the Washington Long Term Care Program

In 2019, the State of Washington enacted H.B. 1087 (amended by S.S.B. 6267) to establish the Long-Term Services and Supports Trust Program ("LTC Program") that creates a state-run long-term care benefit for certain qualified individuals. The LTC Program will be funded by a new premium assessment on employee wages that takes effect January 1, 2022.

Rulemaking associated with the LTC Program is underway. Recently, Washington's Employment Security Department ("ESD") issued proposed and draft rules offering the first guidance on these new requirements. ESD also released a timeline for implementation.

In the 2021 legislative session, the House passed S.H.B. 1323 proposing changes to the LTC Program, including when an employee must obtain a long-term care insurance policy to qualify for an exemption from the payroll deduction for the premium assessment. Currently the bill is in the Senate awaiting a vote. All indications are that the bill is likely to pass.

This article summarizes the LTC Program, including some changes proposed by S.H.B. 1323. The following is subject to change as guidance develops.

Premium Assessment

Beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the LTC program. All wages are subject to the premium assessment; there is no cap.

What are wages?

The law defines wages as "all remuneration paid by an employer to an employee." According to the draft rules, examples of wages include:

- Salary or hourly wages;
- Cash value of goods or services given in the place of money;
- Commissions or piecework;
- Bonuses;
- Cash value of gifts or prizes;
- Cash value of meals and lodging when given as compensation;
- Holiday pay;
- Paid time off, including vacation leave and sick leave, as well as associated cash outs, (but not supplemental benefit payments provided by the employer);
- Separation pay including, but not limited to, severance pay, termination pay, and wages in lieu of notice;
- Value of stocks at the time of transfer to the employee if given as part of a compensation package;
- Compensation for use of specialty equipment, performance of special duties, or working particular shifts; and
- Stipends/per diems unless provided to cover a past or future cost incurred by the employee as a result of the performance of the employee's expected job function.

Do all employees working in Washington pay the premium assessment?

Yes. While the guidance has not specifically addressed this issue, it appears that all employees who work in Washington will be subject to the premium assessment unless an exception applies. The following individuals are exempt from the premium assessment:

- Employees who qualify for an exemption.
- Self-employed individuals (opt-in available).
- Employees of a federally recognized tribe (under S.H.B. 1323 an opt-in may be available).
- Employees of the federal government.

Note that while employees working in Washington must pay into the LTC program, only eligible Washington residents will be able to access benefits when available.

Special rules for parties to a collective bargaining agreement in existence on October 19, 2017

Parties to a collective bargaining agreement in existence on October 19, 2017, are not subject to the LTC program requirements (including premium assessments) until the existing agreement is reopened or renegotiated by the parties or expires. Employers must inform ESD immediately upon the reopening, renegotiation, or expiration of a collective bargaining agreement that was in effect prior to October 19, 2017.

Parties to a collective bargaining agreement in existence on October 19, 2017, that has not been reopened or renegotiated by the parties or expired may elect to be subject to the LTC program (including premium assessments) prior to the expiration, reopening or renegotiation of the agreement. Parties seeking to do so must submit to the department a memorandum of understanding, letter of agreement, or a similar document signed by all parties.

Reporting and Paying the Premium Assessment

Employers will be required to collect the premium assessment from Washington employees via after-tax payroll contributions and remit the premiums to ESD. This includes employers located outside of Washington with Washington employees. Employers are not required to contribute to the LTC Program. Employers will submit quarterly reports to ESD and make quarterly premium payments by the last day of the month following the end of the calendar quarter being reported. More guidance on premium payments and reporting is expected in future rulemaking.

Exempt Employees

An employee who is at least 18 years of age, has long term care insurance and attests to this may apply to ESD for an exemption from the premium assessment. The employee must apply for the exemption between October 1, 2021 and December 31, 2022. Applications for exemption will be available on ESD website or in another approved format. If approved, the exemption is effective the quarter immediately following approval. Exempt employees are not entitled to a refund of any premium deductions made before the effective date of an approved exemption.

An employee with an approved exemption must notify any current or future employer of their exempt status by providing a copy of their approval letter to the employer. If the employee fails to notify the employer of the exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification was provided.

If an employer deducts premiums after the employee provides notification of the employee's exempt status, the employer must refund the deducted premiums to the employee. An employer is not entitled to a refund for any premiums remitted to ESD that were deducted from exempt employees.

The employer must maintain a copy of the approval letter provided by the employee.

What is long term care insurance for purposes of the exemption?

To qualify for an exemption, the employee must attest to having long-term care insurance. The proposed rules define long term care insurance for this purpose as defined under RCW 48.83.020. Employees looking to claim the exemption should discuss with their carrier whether their long-term care insurance policy meets this definition.

If enacted, what is the effect of S.H.B. 1323 on the exemption?

S.H.B. 1323 proposes a significant change that will limit those employees who may qualify for an exemption. Only employees who purchased long term care insurance before the effective date of S.H.B. 1323 would be eligible for an exemption.

Note that under the current law, the employee must have long term care insurance and attest to that fact when applying for an exemption (between October 1, 2021 – December 31, 2022). S.H.B. 1323 requires such coverage to be in place by a certain date.

If enacted, the effective date would likely be July 24, 2021. Employees looking to claim an exemption would need to purchase coverage before the effective date.

Will there be opportunities to qualify for an exemption later?

As currently written, the only window to qualify for an exemption is between October 1, 2021 – December 31, 2022. Once an employee is exempt, the employee is permanently ineligible for coverage through the LTC Program.

Benefits

Benefits become available January 1, 2025 to qualified individuals. Qualified individual means:

- Washington resident at least 18 years of age;
- Has paid into the Program for the equivalent of either:
  - A total of 10 years without interruption of 5 or more consecutive years, or
  - 3 years within the previous 6 years (S.H.B. 1323 would add “from the date of application” after 6 years).
- Has worked at least 580 hours during each of the 10 years or each of the 3 years.
- Determined by the Department of Social and Health Services to require assistance with at least 3 activities of daily living (e.g., eating, bathing, dressing)

The available benefit is $100/day with a lifetime maximum of $36,500. An exempt employee may never be a qualified individual for this purpose.

Employer Action

Employers should:

- Coordinate with payroll to address the upcoming tax, reporting and filing requirements.
- Set up a process to accept notice of employee exemptions and maintain records accordingly.
- Await further guidance later this year.

Washington State Considers a Covered Lives Assessment

The Washington State legislature is considering a bill that would create a new Covered Lives Assessment ("CLA") on health insurers and third-party administrators providing coverage to individuals residing in the state. Funds generated from this assessment would serve to strengthen the public health system.

As proposed:

- Beginning March 1, 2022, and annually thereafter, each health carrier, Medicaid managed care organization (MCO) and third-party administrator (TPA) must file a statement of covered lives with the Office of the Insurance Commissioner (OIC).

- For Fiscal Year (FY) 2023, the OIC will assess carriers, MCOs, and TPAs a per member per month (PMPM) CLA of $3.25.

- Beginning FY 2024, health carriers, MCOs, and TPA's must pay a pro rata share of the total CLA based on the number of covered lives reported to the state.
  - For FY 2024, the total CLA will be $143M (or, as projected, $2.27 PMPM).
  - FY 2025 (and each FY thereafter) the total CLA will be $200M (or, as projected, $3.18 PMPM).

- Covered lives for purposes of the CLA means all persons residing in Washington state who are:
  - Covered under an individual or group health plan that is issued or delivered in Washington state or an individual or group health plan that otherwise provides health benefits to Washington residents;
  - Covered under a self-funded multiple employer welfare arrangement (MEWA); or
  - Enrolled in a group health plan administered by a TPA.

- Annually, before July 1, the OIC will calculate and bill the amount of CLA due from each entity. The assessment is payable by July 15. Penalties may apply to entities for failure to pay the CLA.

- TPAs will be required to register with the OIC by December 31, 2021. TPAs failing to register or renew their registration (or providing incorrect, incomplete, or misleading information) may be fined up to $5,000/violation.

As proposed, the CLA applies to health insurance carriers and TPAs. While employers sponsoring group health plans will not be directly responsible for the CLA, carriers and TPAs are likely to pass the cost on to employers through increased premiums and administrative costs.

The bill was introduced January 12, 2021 and will go through the lengthy process toward enactment. It will have to be approved by both the state House and Senate and then signed into law by the Governor. We are monitoring the legislation and will keep you apprised.

2021 Compliance Bulletins: Quarter Two

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Guidance Issued on the 2021 COBRA Subsidy

Published: April 9, 2021

On April 7, 2021, the Department of Labor ("DOL") issued FAQs regarding implementation of the 2021 COBRA premium assistance (or "COBRA subsidy"). The 2021 COBRA subsidy was included as part of the American Rescue Plan Act ("ARP").

Background

The COBRA subsidy is available to assistance eligible individuals ("AEIs") who are COBRA qualified beneficiaries ("QBs") because of an involuntary termination of employment or a reduction in hours receive a 100% COBRA subsidy for the period of April 1, 2021 – September 30, 2021. The subsidy expires the earlier of:

- the first date that the AEI is eligible for other group health plan coverage or Medicare;
- the end of the maximum COBRA period; or
- September 30, 2021.

Employers are eligible to recoup the cost of the subsidy as a payroll tax credit. It is anticipated that more information on the payroll tax credit is expected in future IRS guidance. New notifications are required with the first compliance date of May 31, 2021.

Guidance

The latest guidance includes a series of FAQs as well as model notices that can be used for compliance with the 2021 COBRA subsidy. The guidance provides some helpful direction, but unfortunately, it does not answer all the questions related to the 2021 COBRA subsidy. Prior guidance related to the 2009 COBRA subsidy may be helpful; however, it should be noted that the DOL and IRS may not use the same interpretation of these issues as it relates to the 2021 subsidy. We anticipate further guidance will be forthcoming.

General Information

Which plans does the COBRA premium assistance apply to?

- All group health plans sponsored by private-sector employers or employee organizations (unions) subject to COBRA under ERISA.
- Group health plans sponsored by state and local governments subject to the continuation of coverage provisions under the Public Health Service Act.
- Group health insurance required under state "mini-COBRA" laws.

COBRA does not apply to plans sponsored by the federal government or by churches and certain church-related organizations (however, an insured group health plan sponsored by a church may be subject to state "mini COBRA" and therefore could be eligible for premium assistance).

The FAQ simply states that the subsidy applies to "all group health plans" and does not specifically address which types of group health plan coverage. Based on the 2009 COBRA subsidy, it would appear the subsidy would be available for the following coverage:

- major medical
- dental
- vision
- health reimbursement accounts ("HRAs")

Likely, the subsidy will not apply to health flexible spending arrangements ("FSAs"). It is not clear whether the subsidy would be available for employee assistance plans ("EAPs"), onsite clinics that provide more than just first aid or telemedicine. Further guidance is necessary.

Who is eligible to receive the COBRA premium assistance?

An AEI is a COBRA qualified beneficiary who meets the following requirements during the period from April 1, 2021 through September 30, 2021:

- eligible for COBRA continuation coverage by reason of a qualifying event that is a reduction in hours or an involuntary termination of employment (not including a voluntary termination); and
- elects COBRA continuation coverage.

The FAQ clarifies that a reduction in hours for this purpose includes reduced hours due to change in a business's hours of operations, a change from full-time to part-time status, taking a temporary leave of absence, or an individual's participation in a lawful labor strike, as long as the individual remains an employee at the time that hours are reduced.

It should be noted that the FAQ does not provide a definition for "involuntary termination." Based on 2009 guidance, it would appear an involuntary termination may include:

- the employer's failure to renew a contract at the time the contract expires, if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services.
- an employee-initiated termination from employment if the termination from employment constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.
- a layoff period with a right of recall or temporary furlough period.
- an employer's action to end an individual's employment while the individual is absent from work due to illness or disability.
- termination for cause (except for gross misconduct).

An individual will not be eligible for premium assistance if eligible for:

- other group health coverage, such as through a new employer's plan or a spouse's plan (not including

excepted benefits, a qualified small employer health reimbursement arrangement (QSEHRA), or a health FSA); or

- Medicare.

Note however, an individual may qualify for premium assistance if the individual has coverage through the Marketplace or Medicaid. However, by enrolling in subsidized COBRA continuation coverage, the individual will lose eligibility for premium tax credits with respect to individual coverage in the Marketplace.

How long does the subsidy last?

The COBRA subsidy can last from April 1, 2021 through September 30, 2021. However, it will end earlier if the AEI:

- becomes eligible for another group health plan, such as a plan sponsored by a new employer or a spouse's employer (not including excepted benefits, a QSEHRA, or a health FSA), or Medicare; or

- reaches the end of the maximum COBRA continuation coverage period.

AEIs must notify the plan if they become eligible for coverage under another group health plan or for Medicare. Failure to do so can result in a tax penalty of $250 (or if the failure is fraudulent, the greater of $250 or 110% of the premium assistance provided after termination of eligibility). No penalties apply if the failure is due to reasonable cause and not due to willful neglect.

The FAQ does not clarify what "eligible for other group health plan coverage" means but the Summary of COBRA Premium Assistance Provisions (set forth under Model Notices located at www.dol.gov/cobra-subsidy) states that "eligibility for other coverage is determined regardless of whether you take or decline the other coverage. However, eligibility for coverage does not include any time spent in a waiting period." Based on the 2009 guidance, this would generally mean the individual was eligible for and able to enroll in the other group health plan coverage. Further guidance is necessary including how this interacts with the Outbreak Period extensions and special enrollment rights.

Who is eligible for a "second chance" for COBRA continuation of coverage?

A COBRA QB whose qualifying event was a reduction in hours or an involuntary termination of employment prior to April 1, 2021 may have an additional enrollment opportunity (as a "second chance AEI") when the individual:

- did not elect COBRA continuation of coverage when it was first offered prior to that date, or

- elected COBRA but is no longer enrolled (for example, an individual dropped COBRA because he or she could not continue to pay premiums).

These "second chance AEIs" must receive a notice of extended COBRA election period informing them of this opportunity. This notice must be provided by May 31, 2021 and individuals have 60 days after the notice is provided to elect COBRA.

It is important to note that the additional election period 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, or under the extended election rule, 18 months measured from the date of the loss of coverage associated with the qualifying event).

COBRA continuation coverage with premium assistance elected in this additional election period begins with the first period of coverage beginning on or after April 1, 2021. Individuals can begin their coverage prospectively from the date of their election, or, if an individual has a qualifying event on or before April 1st, choose to start their coverage as of April 1st, even if the individual receives an election notice and makes such election at a later date. In either case, the subsidy is only available for periods of coverage from April 1, 2021 – September 30, 2021.

The FAQ clarifies that the extended deadline relief related to the Outbreak Period does not apply to the 60-day notice or election periods related to the COBRA subsidy. The Outbreak Period began March 1, 2020 and ends 60 days after the announced end of the National Emergency. The relief effectively delays due dates and timeframes

associated with certain benefit plan requirements, including the 60-day COBRA initial election period. The relief is measured on a participant-by-participant basis and is the earlier of (1) one-year from the date the relief first applied or (2) the end of the Outbreak Period. Since this relief does not apply with respect to the COBRA subsidy, AEIs should elect COBRA within the timeframes required under ARP. For example, an AEI who receives the required election notice on May 31, 2021 must elect coverage by July 30, 2021.

What happens if a state has a "mini-COBRA" continuation requirement?

ARP does not change any requirement of a state "mini-COBRA" program. ARP only allows AEIs who elect continuation coverage under state insurance law to receive premium assistance from April 1, 2021 through September 30, 2021. It also allows AEIs to switch to other coverage offered to similarly situated active employees if the plan allows it, provided that the new coverage is no more expensive than the prior coverage.

Premiums

Do AEIs need to apply for the premium assistance?

Employers should provide AEIs with the required notice of eligibility to elect COBRA continuation of coverage and receive the COBRA subsidy. This notice includes all forms necessary for enrollment, including forms to indicate that the individual(s) qualify as an AEI. These forms should be timely remitted to the employer.

How do AEIs receive the COBRA subsidy?

The premium assistance is not paid to AEIs. Rather, AEIs do not pay any of the COBRA premium for the period of coverage from April 1, 2021 – September 30, 2021.

Employers will receive reimbursement through the COBRA premium assistance tax credit (further guidance expected on this). For premium assistance provided through state "mini COBRA," the carrier will receive reimbursement.

Can an individual requested to be treated as an AEI?

Yes. Employers may receive a "Request for Treatment as an Assistance Eligible Individual" from an individual who believes he or she may be an AEI but has not received a notice from the employer. This form is attached to the Summary of COBRA Premium Assistance Provisions. If an individual makes such a request, plans should not collect premium payments from AEIs and subsequently ask them to seek reimbursement for periods of coverage beginning on or after April 1, 2021 and preceding the date on which an employer sends an election notice if an individual has made an appropriate request for such treatment.

If an AEI has been enrolled in COBRA since December 2020, must his or her paid premiums be refunded?

No. The COBRA subsidy only applies to premiums for coverage periods from April 1, 2021 – September 30, 2021. There is no subsidy available for the period from December 2020 – March 2021.

If, however, the AEI paid in full for a period of COBRA beginning on or after April 1, 2021 through September 30, 2021 the employer will need to either provide a credit or refund. Employers should take care not to collect premiums for AEIs during the subsidized period.

Can an AEI be charged an "administrative fee?"

No. AEIs cannot be required to pay any part of what they would otherwise pay for their COBRA continuation coverage, including any administration fee that would otherwise be charged.

Notices

What are the notice requirements for employers?

The DOL released model notices to meet this requirement, which can be found at www.dol.gov/cobra-subsidy.

- Updated General Notice for qualifying events from April 1, 2021 – September 30, 2021. A general notice 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. This notice may be provided separately or with the COBRA election notice following a COBRA qualifying event. To use this notice properly, the plan administrator must fill in the blanks with the appropriate plan information. When distributing the model notice, the plan administrator should include the attachment Summary of COBRA Premium Assistance Provisions (found under Model Notices). The Summary contains information on ARP and forms to elect or discontinue the premium assistance in order to satisfy the notice requirements of ARP.

- Notice of extended COBRA election period to all AEIs who had a qualifying event before April 1, 2021. A notice of the extended COBRA election period must be furnished 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, if COBRA had been elected or not discontinued, would have ended before April 1, 2021 (generally, those with applicable qualifying events before October 1, 2019). This notice must be provided by May 31, 2021. To use this notice properly, the plan administrator must fill in the blanks with the appropriate plan information. When distributing the model notice, the plan administrator should include the attachment Summary of COBRA Premium Assistance Provisions.

- Notice of expiration of the COBRA subsidy. AEIs must be provided with a notice of expiration of periods of premium assistance explaining that the premium assistance for the individual will expire soon, the date of the expiration, and that the individual may be eligible for coverage without any premium assistance through COBRA continuation coverage or coverage under a group health plan. Coverage may also be available through Medicaid or the Health Insurance Marketplace. This notice must be provided 15-45 days before the individual's premium assistance expires. It appears this notice must be provided when the premium subsidy is set to expire due to the end of the maximum COBRA coverage period or the end of the premium assistance period (Sept. 30, 2021).

While employers are not required to use the Model Notices, it is usually a best practice as, when appropriately modified, the DOL considers their use to be in good faith compliance with the content requirements for COBRA and ARP.

Failure to satisfy the COBRA continuation of coverage requirements may result in an excise tax of $100/qualified beneficiary/day for each day in violation of COBRA (but not more than $200/family/day).

It is important to note that the extended deadline relief related to the Outbreak Period does not apply to the notices or the election periods related to COBRA premium assistance available under ARP. Therefore, plans and issuers must provide the notices according to the timeframes specified in ARP.

The DOL issued an Alternative Model Notice for use by insured coverage subject to state "mini-COBRA" requirements.

Changing Coverage

Can an AEI change his or her COBRA coverage option from the coverage in place at the time of the qualifying event?

In general, COBRA continuation coverage provides the same coverage that the individual had at the time of the qualifying event. However, under ARP, an employer may (but is not required to) offer AEIs the option of choosing other coverage. Changing coverage will not cause an individual to be ineligible for the COBRA 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.

If the plan permits AEIs to change coverage options, the plan must provide notice of their opportunity to do so (included in the model notices). Individuals have 90 days to elect to change their coverage after the notice is provided.

Can an AEI add additional family members who were originally eligible for COBRA, but declined to enroll?

Each COBRA QB may independently elect COBRA continuation coverage. If a family member did not elect COBRA continuation coverage when first eligible and that individual would be an AEI, that individual has an additional opportunity to enroll and qualify for the premium assistance. However, this extended election period does not extend the maximum period of COBRA continuation coverage.

If an AEI is currently enrolled in Marketplace coverage, can he or she cancel individual coverage in order to receive the COBRA subsidy?

Yes. If AEIs want to end the coverage they are currently receiving through the Marketplace (such as through Healthcare.gov) to enroll in COBRA continuation coverage with premium assistance, they can do so, but only on a prospective basis.

Employer Action

Employers should:

- identify eligible AEIs by looking back to individuals who would have been COBRA eligible beginning on or after Nov. 1, 2019 as a result of a reduction in hours or involuntary termination of employment.

- work with COBRA vendors, if applicable, to coordinate a plan.
  - The first deadline is May 31, 2021. The Notice of Extended COBRA Election Period must be issued to all AEIs with a qualifying event prior to April 1, 2021 by this date. Make sure to include the Summary of COBRA Premium Assistance Provisions under ARP.
  - Update COBRA election notices to reflect the subsidy language included in the Model Notice for new COBRA events between April 1, 2021 through September 30, 2021. Make sure to include the Summary of COBRA Premium Assistance Provisions under ARP.
  - Ensure the vendors are prepared to issue subsidy expiration notices.
  - Discuss what to do if COBRA premiums are received from AEIs for the months April – September 2021 and whether a refund or credit may be necessary.
  - Prepare how to respond in the event you (or the COBRA vendor) receive a "Request for Treatment as an Assistance Eligible Individual."

- Discuss tax credits with payroll departments and tax advisors.

- Await further guidance and consider reviewing the 2009 guidance for direction.

It is expected that the IRS will also issue guidance, including information for employers to claim the payroll tax credit associated with the COBRA subsidy.

COVID-19 PPE Now a Qualified Medical Expense

Published: April 12, 2021

On March 26, 2021, the IRS issued IRS Announcement 2021-7, which clarifies that amounts paid for certain personal protective equipment ("COVID-19 PPE") used to prevent the spread of COVID-19, including masks, hand sanitizer and sanitizing wipes can be treated as amounts paid for medical care under § 213(d) of the Internal Revenue Code.

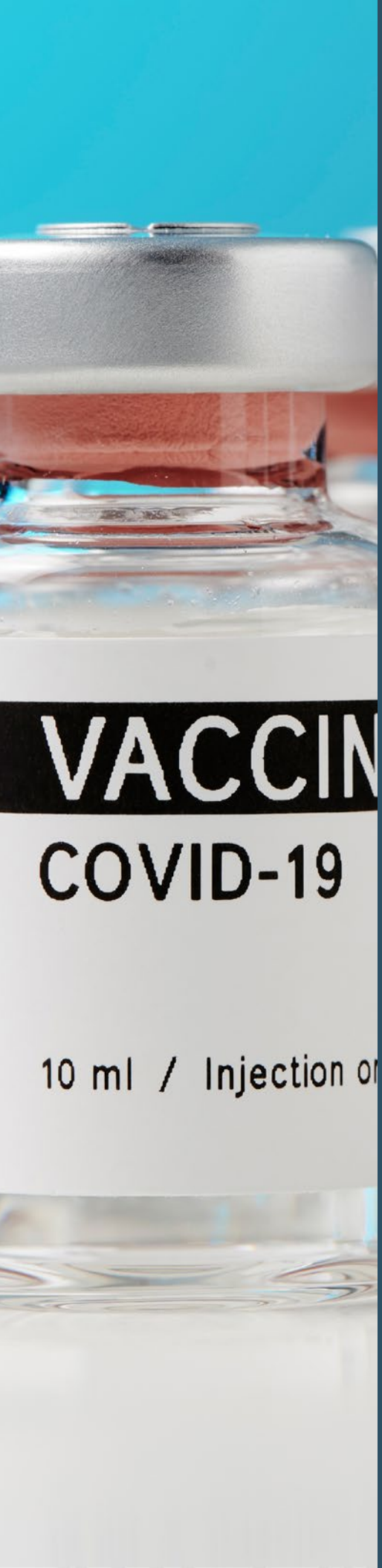
Accordingly, because these amounts are expenses for medical care under § 213(d) of the Internal Revenue Code, these amounts can also be eligible expenses under a health flexible spending account (health FSA), health savings accounts (HSAs), health reimbursement arrangements (HRAs) and Archer medical savings accounts (Archer MSAs). Note, that if the amount is paid or reimbursed under one of these accounts, it is not deductible under § 213.

The IRS announcement also provides relief for group health plans, including health FSAs and HRAs, to amend their plans pursuant to provide for reimbursements of expenses for COVID-19 PPE incurred for any period on or after January 1, 2020.

Consistent with prior guidance, group health plans may amend their plans by the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective. No amendment with retroactive affect can be adopted after December 31, 2022. Further, the plan must operate consistently with the terms of the amendment, including during the period beginning on the effective date of the amendment through the date in which the amendment is adopted.

Employer Action

Employers should review their plan documents. For plans that use a broad definition under 213(d) for eligible medical expenses, an amendment is not necessary. However, for plans with a narrower definition of 213(d), the definition of eligible medical expenses may need to be amended.



Update on COVID-19 Vaccine and Vaccine Administration Cost

Published: April 23, 2021

Medicare has increased and simplified its payment rate for administration of the COVID-19 vaccine to $40 per dose. This change may impact group health plans with respect to their payment rate to providers.

Background

Non-grandfathered group health plans are required to cover, without cost sharing, the COVID-19 vaccine. This obligation extended to coverage associated with administering the vaccine. The federal government continues to pay for the vaccine itself through funding authorized by the CARES Act.

For vaccines administered in-network, plans will pay the rate negotiated with in-network providers, and that continues to be true. For vaccines administered out-of-network, however, group health plans must reimburse providers an amount that is reasonable, determined in comparison to prevailing market rates for such service. Guidance provides that the amount that would be paid under Medicare is considered reasonable.

Initially, Medicare established a Medicare payment rate for a single-dose vaccine or for the final dose in a series, at $28.39. For a COVID-19 vaccine requiring a series of two or more doses, the payment rate was $16.94 for the initial dose(s) in the series and $28.39 for the final dose in the series. Medicare allowed for the rates to be geographically adjusted. It appears many fully insured plan carriers, and many self-insured plans had been reimbursing at these Medicare rates for both in-network and out-of-network providers, regardless of whether the cost was treated as a pharmacy benefit or a medical benefit.

What's New?

Medicare recognized updated information about the costs involved in administering the COVID-19 vaccine for different types of providers and suppliers, and the additional resources necessary to ensure the vaccine is administered safely and appropriately. Thus, for vaccine administration services provided on or after March 15, 2021, Medicare's payment rate increased to approximately $40 per dose, regardless of whether a single dose or a dose in a series of doses. That rate is subject to geographic adjustment.

This change in the Medicare vaccine administration payment rate is expected to be adopted by most providers administering the COVID-19 vaccine, increasing the full cost for double-dose vaccine administration by approximately $35, or about 78%, and for single-dose vaccine administration by approximately $23, or about 81%.

Employer Action

Employers may be notified by carriers, third party administrators ("TPAs"), and/or pharmacy benefit managers ("PBMs") regarding this development, or they may simply notice higher claims costs related to the vaccine administration. A self-insured plan may be given a choice to opt-out of the higher payment by their TPA or PBM, but the employer would have to find another solution for providing vaccine administration at no cost. For this reason, opting out is likely to be impractical.

Guidance Issued on MHPAEA Comparative Analysis Requirement

Published: April 26, 2021

As previously reported, the Consolidated Appropriations Act, 2021 ("CAA") amends the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to require group health plans and health insurers to conduct a comparative analysis of non-quantitative treatment limitations ("NQTLs") imposed on mental health/substance use disorder ("MH/SUD") benefits as compared to medical and surgical benefits. NQTLs are limits on the scope or duration of treatment that are not expressed numerically.

On April 2, 2021, the Departments of Labor, the Treasury and Health and Human Services (collectively, "the Departments") issued FAQ 45, providing the first guidance on this new requirement.

Briefly, the FAQ:

- Clarifies that plans and carriers should now be prepared to make a comparative analysis available upon request.
- Includes a list of elements that should be included in a comparative analysis to meet the Department's requirements and describes the types of documents that plans should be prepared to make available in support of the analysis.
- Describes circumstances where a comparative analysis will not be sufficient, including when it:
  - consists of conclusory or generalized statements without specific supporting evidence and detailed explanations; or
  - is a mere production of a large volume of documents without a clear explanation of how and why each document is relevant.
- Outlines the correction and enforcement action the Departments may take in the event the plan has not provided sufficient information to review the comparative analysis or where the Departments determine the plan is not in compliance with MHPAEA.
- Allows participants, beneficiaries and their authorized representatives in an ERISA-covered plan to receive a copy of the comparative analysis upon request.

- Highlights that near-term enforcement efforts will be focused on the following NQTLs:
  - Prior authorization requirements for inpatient services;
  - Concurrent review for inpatient and outpatient services;
  - Standards for provider admission to participate in-network, including reimbursement rates; and
  - Out-of-network reimbursement rates (plan methods for determining usual, customary and reasonable ("UCR") charges.

Below you will find additional details on the guidance.

Background

Mental Health Parity and Addition Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") applies to:

- employers with at least 51 employees offering a group health plans that provides for any MH/SUD benefits, and

- fully insured group health plans in the small market, generally employers with 50 or fewer employees (small market in California and New York are employers with fewer than 100 employees) , that are required to provide all essential health benefits, including MH/SUD benefits.

The MHPAEA:

- Provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

- Prohibits separate treatment limitations that apply only to MH/SUD benefits.

- Provides that NQTLs may not be imposed on MH/SUD benefits in any classification unless, the processes, strategies, evidentiary standards, and other factors are comparable and applied no more stringently for MH/SUD benefits than for medical/surgical benefits under the terms of the plan (or health insurance coverage) as written and in operation.

- Imposes certain disclosure requirements.

With respect to NQTLs, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity.

The Consolidated Appropriations Act, 2021

The CAA amends MHPAEA to expressly require a group health plan that imposes NQTLs on MH/SUD benefits to perform and document a comparative analysis of the design and application of NQTLs. Beginning February 10, 2021, plans (and health insurance carriers) must make a comparative analysis available to the Departments or applicable state authorities upon request.

What's New?

When must the NQTL comparative analysis be available?

As the requirement applies beginning February 10, 2021, plan and issuers should now be prepared to make their comparative analysis available upon request.

Note the CAA expressly requires that plans and carriers conduct and document the comparative analysis of the design and application of NQTLs. It is no longer a best practice. The carrier is responsible for compliance for fully insured plans subject to the MHPAEA. For self-funded plans subject to MHPAEA, the employer is ultimately responsible for compliance. Employers should coordinate with third-party administrators ("TPAs") or other vendors to assist in performing this analysis.

What documentation must be made available?

The FAQ provides additional clarification, including minimum requirements for a comparative analysis to be sufficient under the law. The analysis must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue and include the bases for the plan's or carrier's conclusion that the NQTLs comply with MHPAEA. The report developed by the plan must include comparative analysis specific to each NQTL imposed on a MH/SUD benefit.

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 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 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 conclusions as to the comparability of the processes, strategies, and factors, within each affected classification, and their relative restrictiveness, 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.

A general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors will not be sufficient to meet this statutory requirement.

The guidance suggests that plans should utilize the DOL's own self-compliance tool to determine their compliance with MHPAEA. The tool can be accessed at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

Plans should be prepared to make available all documents that support the analysis and conclusions of their comparative analysis. The FAQ and the DOL's self-compliance tool include a list of the types of documents that should be available to support a NQTL analysis.

Examples of insufficient documentation

The guidance provides examples of practices and procedures plans should avoid in responding to a request for comparative analysis as they are insufficient, including:

- Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanation.
- Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.
- An analysis that is outdated due to time, change in plan structure or other reason.

Requests from state regulating agencies and participants and beneficiaries

In addition to the Departments, state regulators, participants, beneficiaries and/or enrollees (or their authorized beneficiary) can also request a NQTL analysis. As with other requests, plans must be prepared to make this information available upon request. The guidance also makes clear that any NQTL analysis must also be provided, free of charge, upon request as part of an adverse determination appeal under a non-grandfathered group health plan.

Near-term enforcement priorities

The Departments will focus their enforcement efforts on any NQTL that is brought to their attention through a complaint or violation. In the absence of such a complaint, the Departments will focus their enforcement efforts on the following NQTLs:

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

If a request for a comparative analysis references a specific NQTL, plans should also be prepared to make available a list of all other NQTLs that they have performed a comparative analysis on. It is possible that plans may be required to submit analyses for these additional NQTLs.

Penalties

If the Departments conclude, after review of the analyses, that the plan has provided insufficient information, the Departments can specify the information necessary for the plan to comply with the request. If the Departments conclude that the plan is not in compliance with MHPAEA, the plan will be required to specify what actions they will take to bring the plan into compliance. The Act imposes a 45-day corrective action period where the plan will be required to submit new analyses showing that they have now come into compliance with MHPAEA. If the plan is still noncompliant after the corrective action period, the plan, within 7 days of receipt of the Departments' determination of noncompliance, must notify all individuals enrolled in the plan or coverage that the coverage has been determined to be out of compliance with MHPAEA.

Employer Action

Carriers of fully insured plans should be responsible for compliance with this new requirement. Self-funded plans should coordinate with their third-party administrators or carrier partners to determine if they are able to conduct the analysis for the plan. Plans should be prepared to apply pressure on their TPAs or carrier partners if they initially refuse to conduct the analyses. The carriers and TPAs are in the best position to complete these NQTL analyses. However, if after repeated requests these vendors are still unwilling to provides the analyses, plans must be prepared to complete the analyses themselves.

HHS Extends Public Health Emergency until July 20, 2021

Published: May 7, 2021

The COVID-19 pandemic Public Health Emergency, scheduled to expire on April 21, 2021, was renewed. This will once again extend the period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Notably, in a letter sent to state governors, HHS indicated that the agency expects that the Public Health Emergency will likely remain in place for all of 2021. While not formal agency action, it appears that HHS intends to continue to renew the Public Health Emergency through, at least, the end of 2021.

Important Definitions

Emergency Period
HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire July 20, 2021 (unless further extended or shortened by HHS).

Outbreak Period
The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief and 2) 60 days after the announced end of the National Emergency. The Departments are expected to announce the end date; at this time, no end date has been announced.

While there are other temporary benefit plan provisions and changes that are allowed due to the public health emergency, summarized below are only those provisions directly impacted by the Emergency Period extension.

Benefit Plan Changes in Effect Through the End of the Emergency Period

- **COVID-19 Testing.** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

- **Excepted Benefits and COVID-19 Testing.** An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.

- **Expanded Telehealth and Remote Care Services.** Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.

- **Summary of Benefits and Coverage ("SBC") Changes.** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.

- **Grandfathered plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g. added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

Benefit Plan Changes in Effect Through the End of the Outbreak Period

On an individual basis, group health plans, disability, and other employee welfare benefit plans will disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.

- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth adoption, or placement for adoption.

- **ERISA Claims Deadlines.** Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request.
  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

- **Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans.** A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 coverage and other required plan notifications. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements

Employers Encouraged to Provide PTO for Vaccinations

Published: May 10, 2021

On April 21, 2021, President Biden issued an announcement to encourage all employers to offer paid time off for employees to schedule vaccinations and recover from any side effects. This announcement highlights and reinforces the provisions of the American Rescue Plan Act ("ARPA") and includes:

- A Tax Credit for Small- and Medium-sized Businesses (under 500 employees) to Fully Offset the Cost of Emergency Paid Sick Leave (EPSL) for Employees to Get Vaccinated and Recover from Any Side Effects of Vaccination.
  - This tax credit is voluntary. Employers that voluntarily choose to allow employees to take EPSL on and after April 1, 2021, can obtain reimbursement through a tax credit.
  - This tax credit is part of the FFCRA expansion and extension that occurred under ARPA and is available through September 30, 2021.
  - The credit for EPSL is for up to 80 hours (i.e., 10 workdays) of EPSL per employee and up to $511 per day of EPSL provided between April 1 and September 30, 2021.
  - EPSL may be taken for, among other specific COVID-19 related reasons, an employee's need for leave to receive COVID–19 vaccinations and/or to recover from any side effects of vaccination.
  - If an employer chooses to continue offering EPSL on and after April 1, 2021, EPSL taken by an employee prior to April 1, 2021, will not count towards the 80 hours of EPSL employees can take on and after April 1, 2021.
  - Employers can also choose to continue offering emergency paid FMLA (EFMLA) on and after April 1, 2021, through September 1, 2021, to employees who are not able to work or telework because their children's school or daycare is closed for COVID-19-related reasons. Employers that choose to do so can obtain reimbursement through a tax credit.

- A Call for Employers – Large and Small – to Take Additional Steps to Help Get Their Employees and Communities Vaccinated.
  - The President is encouraging all employers to use their unique resources to educate, encourage and incentivize their employees to get vaccinated. The announcement suggests employers could include discounts for vaccinated individuals or offer product giveaways.

- Employers who have decided not to offer EPSL on and after April 1, 2021, can still choose to provide their employees with additional PTO in order to get vaccinated. It is unclear at this time whether or not an employer that offers additional PTO for vaccination only and not for the other reasons specified under EPSL will be eligible for the tax credit.

Tax Credits Under the American Rescue Plan

Along with this announcement, the IRS released a Fact Sheet explaining how small and medium-sized employers that voluntarily provide EPSL may claim the tax credit that is an offset against the employer's share of the Medicare tax.

- The tax credit for paid sick leave wages is equal to the EPSL paid for COVID-19 related reasons for up to two weeks (80 hours), limited to $511 per day and $5,110 in the aggregate, at 100 percent of the employee's regular rate of pay.

- The tax credit for paid family leave wages is equal to the family leave wages paid for up to twelve weeks, limited to $200 per day and $12,000 in the aggregate, at 2/3rds of the employee's regular rate of pay.

In anticipation of claiming the credits on the Form 941, Employer's Quarterly Federal Tax Return, eligible employers can keep the federal employment taxes that they otherwise would have deposited, including federal income tax withheld from employees, the employees' share of social security and Medicare taxes and the eligible employer's share of social security and Medicare taxes with respect to all employees up to the amount of credit for which they are eligible. The Form 941 instructions explain how to reflect the reduced liabilities for the quarter related to the deposit schedule. If an eligible employer does not have enough federal employment taxes set aside to cover amounts provided as EPSL or EFMLA, the employer may request an advance of the credits using Form 7200, Advance Payment of Employer Credits Due to COVID-19.

Employer Action

Employers with less than 500 employees who were not voluntarily offering an extension of EPSL may wish to reconsider their position to help encourage employee vaccination.

Employers should work with counsel and tax advisors to determine appropriate leave policies and to effectively claim any tax credits available.

Annual Out-of-Pocket Maximum Adjustments Announced for 2022

Published: May 11, 2021

On April 30, 2021, the Department of Health and Human Services ("HHS") published its Annual Notice of Benefit and Payment Parameters for 2022. This guidance is a final rule that addresses certain provisions of the Affordable Care Act ("ACA"). For purposes of employer-sponsored health plans, the final rule includes:

- Caps on out-of-pocket dollar limits for non-grandfathered group health plans with plan years that begin in 2022.
- A policy to codify that individuals with COBRA coverage may qualify for a special enrollment period to enroll in individual health insurance coverage based on the cessation of employer contributions or government subsidies (such as those provided for under the American Rescue Plan Act of 2021) to COBRA continuation coverage.

Change to the Out-of-Pocket Maximums

Under the final rule, non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2022 as follows:

- $8,700 for self-only coverage; and
- $17,400 for coverage other than self-only.

Note that different out-of-pocket limits apply to high-deductible health plans, for purposes of making contributions to a health savings account ("HSA"). The 2022 HSA thresholds will likely be announced in June 2021.

Special Enrollment Period for Individual Coverage

The final rules create a special enrollment opportunity to access the individual coverage market upon the loss of all employer (or government) contributions toward COBRA coverage.

Specifically, when an individual or their dependent is enrolled in COBRA continuation of coverage (or state "mini-COBRA") and the employer (or the

government) contributes toward the cost of that coverage, the individual will have a special enrollment opportunity into individual coverage when those employer contributions (or government subsidies) completely cease. It should be noted that this relief is limited to the individual coverage marketplace and does not extend to HIPAA special enrollment rights for purposes of enrollment in group health plan coverage. In other words, an individual with COBRA coverage that is subsidized by an employer (or government) generally will not have a special enrollment opportunity in an employer sponsored group health plan when those contributions cease.

This relief applies market-wide to individual health insurance coverage, including coverage purchased outside of the Exchange, directly from carriers or through insurance agents, as well as coverage acquired from state Exchanges.

The triggering event for this special enrollment period is the last day of the period for which COBRA continuation coverage was paid for or subsidized, in whole or in part, by an employer or a government entity.

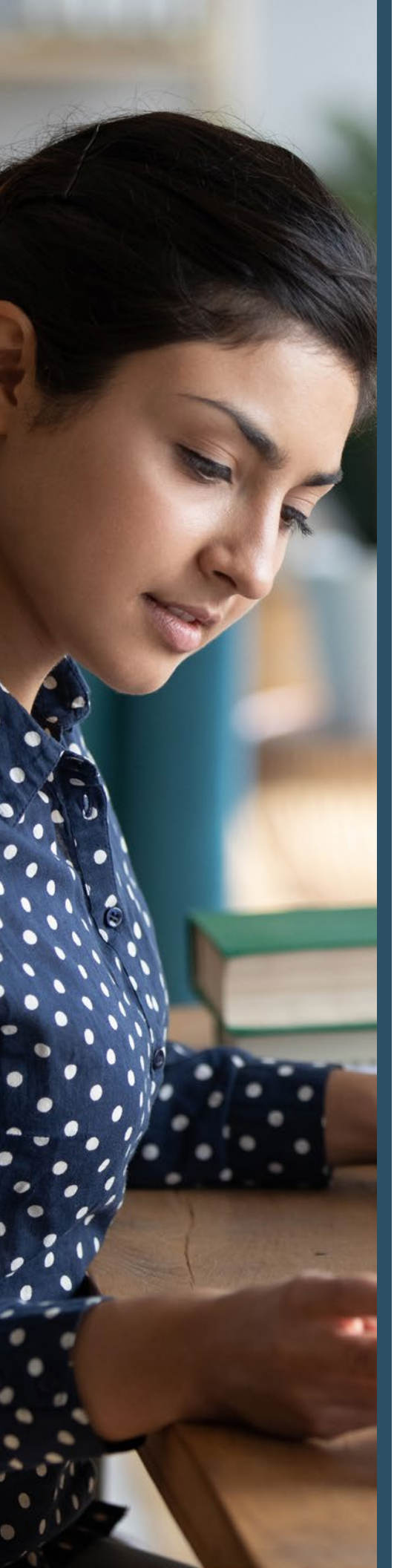
An individual eligible for this special enrollment period would have 60 days before and after the triggering event (in this case, the last day for which the qualified individual or dependent has COBRA continuation coverage to which an employer or governmental entity is contributing) to select an individual market plan through this special enrollment period.

These changes take effect on July 6, 2021.

Employer Action

- Update out-of-pocket limits for plan years beginning on or after January 1, 2022.

- Understand and communicate (as needed) that cessation of all employer (or government) contributions toward COBRA continuation of coverage may trigger a special enrollment opportunity for individual market coverage.



San Francisco HCSO 2020 Reporting Cancelled

Published: May 20, 2021

Due to the ongoing COVID-19 public health crisis, the requirement for employers to submit the 2020 Annual Reporting Form for the San Francisco Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance (FCO) has been cancelled.

The 2020 Annual Reporting Form would normally have been due by April 30, 2021. As reported in March 2021, the San Francisco Office of Labor Standards Enforcement (OLSE) announced that this deadline would be postponed until at least October 31, 2021, while the San Francisco Board of Supervisors considered relevant proposed legislation. On April 20, 2021, the Board of Supervisors passed legislation to cancel the 2020 employer reporting requirement altogether, and it was signed into law by San Francisco Mayor London Breed on April 30, 2021.

It is important to note that all other requirements of the HCSO remain in effect. Covered employers must continue to make health care expenditures on behalf of their covered employees, generally within 30 days of the end of each quarter. For example, the deadline for expenditures in the first quarter of 2021 is April 30, 2021.

As a reminder, the official HCSO Notice should be posted in a conspicuous place at any workplace or job site where covered employees work. The updated 2021 Notice is available in 6 languages at: https://sfgov.org/olse//sites/default/files/Document/HCSO%20Files/2021%20HCSO%20Poster%20Final.pdf.

2022 Inflation Adjusted Amounts for HSAs

Published: May 21, 2021

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2022, and the maximum amount that may be made newly available for excepted benefit health reimbursement arrangements (HRAs). Most limits increased from 2021 amounts.

Annual Contribution Limitation

For calendar year 2022, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $3,650. For calendar year 2022, the limitation on deductions for an individual with family coverage under a high deductible health plan is $7,300.

High Deductible Health Plan

For calendar year 2022, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage (unchanged from 2021), and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,050 for self-only coverage or $14,100 for family coverage.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Excepted Benefit HRA Adjustment

For plan years beginning in 2022, the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $1,800.

IRS Provides Additional Guidance on the COBRA Subsidy

Published: May 24, 2021

On May 18, 2021, the IRS issued 86 FAQs regarding implementation of the 2021 COBRA premium assistance (or "COBRA subsidy") and corresponding tax credit under the American Rescue Plan Act ("ARPA"). The FAQs provide helpful guidance explaining employer obligations regarding the COBRA subsidy for Assistance Eligible Individuals ("AEI").

In addition, the guidance provides some helpful clarification with respect to the Emergency Relief Notices which requires plans to disregard certain periods beginning March 1, 2020 until 60 days after the announced end of the National Emergency (the "Outbreak Period"). This Emergency Relief runs until the earlier of:

- One year from the date the applicable person was first eligible for the relief; or
- 60 days after the announced end of the National Emergency (this date has not been announced).

The following provides highlights from the FAQs and is not an exhaustive summary. Employers should carefully review this guidance in full to understand their obligations.

Eligibility for COBRA Premium Assistance

ARPA provides a temporary 100% COBRA Subsidy to AEIs between April 1, 2021 and September 30, 2021. An AEI is:

- A COBRA qualified beneficiary ("QB") as a result of a reduction in hours or the involuntary termination of a covered employee's employment other than by reason of an employee's gross misconduct;
- Eligible for COBRA for some or all of the period beginning April 1, 2021, through September 30, 2021; and
- Elects COBRA continuation coverage.

This includes QBs who are the spouse or dependent child of the employee who had the reduction in hours or involuntary termination of employment resulting in a loss of coverage, as well as the employee.

Other notable eligibility provisions include:

- An individual can become an AEI more than once.
- Employers may require AEIs to self-certify or attest to their status as an AEI as a result of an involuntary termination of employment or reduction in hours or with respect to their eligibility status for other group health plan coverage or Medicare. Employers must retain records of self-certification, attestation or other documentation that the individual was eligible for the COBRA subsidy to substantiate the tax credit. An employer may rely on an individual's attestation unless the employer has actual knowledge that such attestation is incorrect.
- COBRA subsidy is available to an AEI until the individual is permitted to enroll in other group health plan coverage (including during a waiting period for other group health coverage). COBRA coverage is not considered other group health plan coverage.
  - Outbreak period relief, which extends the timeframes to request special enrollment in a spouse's group health plan coverage, may provide an enrollment opportunity in other group health plan coverage that will eliminate COBRA subsidy eligibility.
- An individual currently enrolled in Medicare who is a COBRA QB as a result of an involuntary termination of employment or reduction in hours is not eligible for the COBRA subsidy.
- A reduction in hours or involuntary termination of employment that follows an earlier qualifying event (e.g., divorce) does not make the QB from the first qualifying event an AEI.

If the original qualifying event was a reduction in hours or an involuntary termination of employment, the COBRA subsidy is available to AEIs who have elected and remained on COBRA for an extended period due to a disability determination, second qualifying event, or an extension under state mini-COBRA, to the extent the additional periods of coverage fall between April 1, 2021, and September 30, 2021. This does not apply with respect to "second chance" COBRA elections.

  - This is a notable clarification from the IRS. Employers will need to carefully review the original COBRA qualifying event ("QE") for all individuals with a current COBRA election who are in a disability extension or have extended COBRA due to a second QE to determine whether the original QE was a reduction in hours or an involuntary termination of employment. If it was, then the subsidy may be available.

- An AEI is not eligible for the COBRA subsidy if the individual is offered retiree coverage under a separate group health plan that is not COBRA coverage.
- The subsidy is limited to premiums attributable to COBRA coverage for AEIs. For this purpose, a COBRA QB is the employee, the employee's spouse or dependent child of the employee who was covered by the plan on the day before the QE. If an individual does not meet the definition of a federal COBRA QB, the individual's coverage is not eligible for premium assistance (even though the individual may continue to be eligible under the plan terms or as required under state law). For example, a domestic partner is not a COBRA QB and continuation of coverage for a domestic partner is not eligible for the subsidy.

Reduction in Hours

An AEI will qualify for COBRA subsidy:

- whether the reduction in hours is voluntary or involuntary,

- due to a furlough (defined as a temporary loss of employment or complete reduction in hours with a reasonable expectation of return to employment or resumption of hours) whether the employer initiated the furlough, or the individual participated in a furlough process analogous to a window program, or

- as the result of a lawful strike initiated by employees or their representatives or a lockout initiated by the employer, as long as at the time the work stoppage or the lawful strike commences the employer and employee intend to maintain the employment relationship.

Involuntary Termination of Employment

An involuntary termination of employment means a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. Whether a termination of employment is involuntary is based on the facts and circumstances.

According to the FAQs, an involuntary termination of employment includes:

- Employee-initiated termination for good reason due to employer action that results in a material negative change in the employment relationship (i.e., constructive discharge).

- An employer's decision not to renew an employee's contract if the employee was otherwise willing and able to continue the employment relationship and was willing either to execute a contract with terms similar to those of the expiring contract or to continue employment without a contract.

- An employer's action to end an individual's employment while the individual is absent from work due to illness or disability, if before the action there is a reasonable expectation that the employee will return to work after the illness or disability has subsided.

- An employee-initiated termination of employment due to an involuntary material reduction in hours or as a result of a material change in the geographic location of employment.

- Involuntary termination of employment for cause (but not gross misconduct).

An involuntary termination of employment does not include:

- Death of the employee.

- Voluntary retirement.

- The expiration of a contract when the parties understood at the time the expiring contract was entered into, and at all times when services were being performed, that the contract was for specified services over a set term and would not be renewed.

- A departure due to the personal circumstances of the employee unrelated to an action or inaction of the employer, such as a health condition of the employee or a family member, inability to locate daycare, or other similar issues.

- An employee's termination of employment due to general concerns about workplace safety.

Coverage Eligible for COBRA Premium Assistance

The FAQs clarify that the COBRA subsidy is available for any group health plan coverage except a health FSA offered under a cafeteria plan and a qualified small employer HRA ("QSEHRA"). This includes:

- Vision plans

- Dental plans; and

- HRAs, including individual coverage HRAs ("ICHRAs").

Other notable coverage provisions include:

- Retiree health coverage may be treated as COBRA continuation coverage for which COBRA premium subsidy is available, but only if the retiree coverage is offered under the same group health plan as the coverage made available to similarly situated active employees.

- If an employer no longer offers the health plan that previously covered the AEI, the individual must be offered the opportunity to elect the plan that a similarly situated active employee would have been offered that is most similar to the previous plan that covered the individual, even if the premium for the plan is greater than the premium for the previous plan. In this case, the other coverage elected by the individual is eligible for the COBRA subsidy, regardless of the premium for that coverage.

Beginning of COBRA Premium Assistance

AEIs are entitled to receive COBRA premium assistance as of the first applicable period beginning on or after April 1, 2021 depending on the period for which premiums would have been normally charged by the plan (e.g., monthly if charged monthly). COBRA subsidy is available from April 1, 2021 through September 30, 2021 even if the AEI elects COBRA after September 30, 2021 if the election is made within the 60-day election window.

- An AEI electing COBRA coverage under the second chance election period may waive COBRA for any period before electing to receive the COBRA subsidy.

  – For example, a "second chance" AEI is not required to elect COBRA subsidy for April and May to receive COBRA and the subsidy prospectively beginning June 2021.

- Employers that are no longer subject to COBRA (i.e., a small employer) may need to provide COBRA coverage under the second chance election if the qualifying event occurred when the employer was subject to COBRA. This is an important consideration for small employers (fewer than 20 employees) who may have been subject to COBRA for calendar year 2020 but are not subject to COBRA in 2021.

End of COBRA Premium Assistance Period

An AEI is eligible for the COBRA subsidy until the earlier of:

- The first date the AEI is eligible for other group health plan coverage or Medicare;

- The date the individual ceases to be eligible for COBRA; or

- The end of the last period of coverage beginning on or before September 30, 2021.

The FAQs clarify:

- Once subsidized COBRA coverage ends, COBRA continuation automatically continues with payment due according to the terms of the plan (taking into account Outbreak Period relief).

- An AEI that fails to provide notice that they are no longer eligible for COBRA subsidy may be subject to a tax penalty of $250.

– Greater of $250 or 110% of the subsidy if the failure to provide notice is fraudulent.

- The death of an employee/AEI who had a reduction in hours or involuntary termination of employment does not end subsidy eligibility of the spouse or dependents.

Extended Election Period

ARPA provides an extended election period (also referred to as a "second chance" election) for AEIs to enroll in COBRA coverage with the COBRA subsidy if they are still within the 18 months of COBRA coverage based on their loss of coverage date. This second chance election opportunity only applies to federal COBRA coverage (not state "mini-COBRA").

The FAQs clarify:

- An employee's spouse and/or dependents that did not elect COBRA coverage when the employee experienced an involuntary termination of employment or reduction in hours can elect COBRA under this second chance opportunity and are eligible for the COBRA subsidy.
- An AEI whose QE occurred before April 1, 2021 and has an open COBRA election period (including Outbreak Period relief) but has not yet elected COBRA may elect COBRA coverage retroactively to the loss of coverage, but their subsidy will not apply for coverage before April 1, 2021.
- An AEI that had been offered COBRA for medical, dental, and vision and elected only dental and vision must be offered the second chance election for medical coverage.

Extensions Under the Emergency Relief Notices

An AEI that is eligible to elect retroactive COBRA coverage prior to April 1, 2021 due to Outbreak Period relief must elect COBRA subsidized coverage (April 1, 2021 – September 30, 2021) within 60 days of receiving the second chance election notice and must also elect or decline retroactive COBRA coverage at this time.

Any AEI that elects COBRA coverage with subsidy but declines to elect retroactive COBRA coverage during their 60-day second chance election period may not elect retroactive COBRA coverage at a later date.

To simplify this, an AEI who is eligible to elect COBRA coverage for the period prior to April 1, 2021 under the Outbreak Period relief must do so in connection with their ARPA election. Failure to make the election for retroactive coverage at this time will preclude the AEI from a future election opportunity (even if the election window would otherwise be open under the Outbreak Period rules).

Additionally:

- The AEI may be required to pay for coverage prior to April 1, 2021.
- Outbreak Period relief applies to payments for retroactive coverage and employers may credit partial and/or late payments from a QB to the earliest period of COBRA coverage for which payment is due before April 1, 2021.

Comparable State Continuation Coverage

Continuation coverage under a state mini-COBRA law that provides a different maximum length of continuation coverage, has different QEs, different QBs, or different maximum premiums does not fail to provide comparable benefits solely for those reasons. Additionally, an employer may not claim the tax credit for subsidy for continuation coverage under a state mini-COBRA law that requires an insurer to provide the continuation coverage.

Calculation of COBRA Premium Assistance Credit

The amount of the COBRA subsidy credit is the premium that would have been charged to an AEI in the absence of the premium assistance and does not include any amount of contribution that the employer would have otherwise provided. If the COBRA premium actually charged to COBRA QBs is $400, then the tax credit will be $400 regardless of the actual cost of COBRA coverage. The FAQ includes examples of severance arrangements and how the tax credit may apply.

Additionally:

- If a plan increases the cost of COBRA premiums for similarly situated employees and QBs, the COBRA subsidy tax credit will apply to the increased amount.
  - This is true even if the employer provides a separate taxable payment to the AEI.

- The COBRA premium tax credit applies with respect to QBs as defined under federal COBRA rules. For example, a registered domestic partner may have COBRA rights under a state mini-COBRA law but is not an AEIs and no COBRA subsidy tax credit will be available for their coverage.

- The COBRA subsidy tax credit does not cover the incremental additional cost for COBRA coverage for individuals that are not AEIs.

  – If the cost of COBRA coverage for all AEIs and non-AEIs does not exceed the cost of COBRA coverage for AEIs alone (as under family coverage) then the COBRA subsidy tax credit is the full cost of COBRA coverage.

- The COBRA subsidy tax credit may increase if the AEI changes coverage from the benefit package the AEI had on the day before the qualifying event to a higher cost option during open enrollment (as allowed under normal COBRA rules).

- The COBRA premium subsidy tax credit for continuation coverage of an HRA is limited to 102% of the amount actually reimbursed to the AEI.

Claiming the COBRA Premium Assistance Credit

The Premium Payee is eligible to claim the COBRA subsidy tax credit. An employer subject to federal COBRA is the Premium Payee. This includes government employers. The carrier is the Premium Payee with respect to fully insured coverage subject to state mini-COBRA. The COBRA subsidy tax credit is claimed for any covered period for which the Premium Payee will pay after an AEI has elected coverage. A COBRA subsidy tax credit cannot be claimed before the coverage period begins.

To receive the credit, employers can reduce deposits of federal employment taxes, including withheld taxes, that they would otherwise be required to deposit, up to the amount of the anticipated credit. Depending on whether the entire credit is received by reducing deposits, employers may credit against Medicare payroll taxes to reimburse the cost for the COBRA subsidy:

- On their Quarterly Form 941; or

- By filing Form 7200, Advance Payment of Employer Credits Due to COVID-19.

  - If employer deposits are reduced to zero in anticipation of receiving the credit, the employer may request an advance of the amount of the anticipated credit that exceeds the federal employment tax deposits available for reduction.

A Premium Payee may not claim a COBRA subsidy tax credit for any amounts that were taken into account for credits as wages under the CARES Act or qualified health plan expenses under the FFCRA.

The guidance further clarifies:

- A Premium Payee is still entitled to the COBRA subsidy tax credit if an AEI fails to report that they are no longer eligible for the COBRA subsidy unless the Premium Payee learns that the AEI is no longer eligible for the COBRA subsidy.

- COBRA subsidy tax credits are included in Premium Payee gross income for the taxable year.

The FAQ includes additional details on how to claim the COBRA subsidy tax credit when using a third-party payer (e.g., a reporting agent, payroll service provider, PEO or CPEO). This summary does not detail these issues.

Employer Action

If you have not already done so, work with COBRA administrators to ensure the Notice in Connection with Extended Election Period and Summary of COBRA Premium Assistance Provisions are provided to AEIs by the May 31, 2021 deadline.

Employers may need to engage payroll or tax professionals for assistance with tax requirements related to reporting and claiming tax credits.

Verify proper election notice and payment procedures are in place for the subsidy period as well as for retroactive COBRA coverage under the second chance election opportunity.

Ensure certification or attestation of AEI eligibility is maintained as this can be relied upon for claiming COBRA subsidy tax credits.

Careful coordination with COBRA administrators and payroll vendors is important to ensure they understand requirements in this guidance and can implement and communicate this information to affected participants.

IRS Guidance Clarifies DCAP Relief

Published: May 25, 2021

The IRS released Notice 2021-26 to address taxation of Dependent Care Assistance Programs ("DCAPs") as it relates to the relief afforded under Section 214 of the Consolidated Appropriations Act, 2021 ("CAA") and the increased DCAP limit for calendar year 2021 under the American Rescue Plan Act of 2021 ("ARPA").

Briefly, the guidance confirms that:

- With respect to the carryover or extended grace period available under the CAA, if the dependent care benefits would have been excluded from income if used during taxable year 2020 (or 2021, if applicable), these benefits will remain excludible from gross income and are not considered wages of the employee for 2021 and 2022;

- With respect to the increased DCAP limit under ARPA ($10,500), for a non-calendar year plan the increased exclusion amount does not apply to reimbursement of expenses incurred during the portion of the plan year that falls in 2022. In other words, a non-calendar year DCAP generally cannot exclude more than $5,000 in 2022.

Background

As previously reported, Notice 2021-15 provides guidance regarding the implementation of the temporary (and optional) ability under the CAA to allow unused DCAP benefits remaining at the end of a plan year to reimburse dependent care expenses incurred in the next plan year, either due to a carryover or an extended grace period for incurring claims. Briefly, under the CAA, DCAPs may either:

- Carry over any unused DCAP amounts from plan years ending in 2020 to a plan year ending in 2021 (and from a plan year ending in 2021 to a plan year ending in 2022).

- Extend the claims period for plan years ending in 2020 (or 2021) for up to 12 months after the end of the plan year for unused DCAP benefits (extended grace period).

In addition, the American Rescue Plan Act of 2021 ("ARPA") increases the DCAP limit to $10,500 (or $5,250 in the case of a married individual filing separately) for the 2021 calendar year (not the plan year). Unless extended by future legislation, the increased amounts go back to $5,000 (or $2,500) for calendar year 2022.

Treatment of Unused Benefits Made Available in 2021 or 2022

Notice 2021-26:

- Clarifies that DCAP benefits that would have been excluded from income if used during the taxable year ending in 2020 or 2021, as applicable, remain eligible for exclusion from the participant's gross income and are disregarded for purposes of application of the limits for the subsequent taxable years of the employee when they are carried over from a plan year ending in 2020 or 2021 or permitted to be used pursuant to an extended claims period.

- Explains that in the case of a DCAP in a non-calendar year Section 125 cafeteria plan beginning in 2021 and ending in 2022, the increased exclusion available under ARPA does not apply to reimbursement amounts incurred during the 2022 portion of the plan year. Thus, a reimbursement of more than $5,000 from the DCAP in 2022 may result in a portion of the employee's contribution becoming taxable upon reimbursement.

- Provides examples illustrating this guidance, including possible tax consequences of electing $10,500 in DCAP benefits for a plan year that begins in 2021 but ends in 2022 (a non-calendar year plan).

The guidance includes helpful examples:

Calendar Year (Jan 1 - Dec. 31) DCAP Plan
An employee is covered by a calendar year Section 125 cafeteria plan that offers a DCAP benefit. The employee elects to contribute $5,000 for DCAP benefits for the 2020 plan year but incurs no dependent care expenses during the plan year. The Section 125 plan permits the employee to carry over the unused $5,000 of DCAP benefits to the 2021 plan year. The employee elects to contribute $10,500 for DCAP benefits for the 2021 plan year. The employee incurs $15,500 in dependent care expenses in 2021 and is reimbursed $15,500 by the DCAP.
The $15,500 is excluded from the employee's gross income and wages because $10,500 is excluded as 2021 benefits under ARPA increased exclusion and the remaining $5,000 is attributable to a carryover permitted under the CAA.

Non-Calendar Year (July 1 – June 30) DCAP Plan
An employee is covered by a calendar year Section 125 cafeteria plan that offers a DCAP benefit. The employee elects no DCAP benefits for the plan year beginning July 1, 2020, and there are no unused amounts from prior plan years available. For the plan year beginning July 1, 2021, the employee elects to contribute $10,500 for DCAP benefits. The employee incurs $5,000 in dependent care expenses during the period from July 1, 2021, to December 31, 2021, and receives $5,000 in reimbursements during 2021. The $5,000 is excluded from the employee's gross income and wages. The employee has $5,500 of DCAP benefits available as of January 1, 2022 and incurs $5,500 in dependent care expenses during the period from January 1, 2022, through June 30, 2022 (the end of the plan year). Employee is reimbursed $5,500 by the DCAP. For the plan year that begins July 1, 2022, the employee elects to contribute $5,000 for DCAP benefits. The employee incurs $2,500 in dependent care expenses during the period from July 1, 2022, to December 31, 2022, and is reimbursed $2,500 by the DCAP.
For calendar year 2022, the employee receives a total of $8,000 in reimbursements for DCAP benefits ($5,500 + $2,500). Of the $8,000 received in the 2022 taxable year, $5,000 is excluded from the employee's gross income and wages under the exclusion for DCAP benefits. The remaining $3,000 received by the employee is included in the employee's gross income and wages.

The guidance also includes an example that tackles a non-calendar year plan with the increased DCAP limit plus a CAA carryover.

Employer Action

Employers with non-calendar plans should consider whether to increase the DCAP limit as it relates to calendar year 2021 given the potential tax implications of this design. In addition, be mindful that the increased DCAP limit may cause additional problems for purposes of nondiscrimination testing.

Careful coordination with third-party administrators is important to ensure they understand requirements in Notice 2021-26 and can implement and communicate this information to affected participants. Plan amendments may be required to align contribution and benefit reimbursement maximums with this guidance.

HHS Expands Interpretation of Sex Discrimination under 1557

Published: May 26, 2021

On May 10, 2021, the Department of Health and Human Services ("HHS") announced that it will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include discrimination on the basis of (1) sexual orientation and (2) gender identity. HHS also stated its Office of Civil Rights ("OCR") will comply with the Religious Freedom Restoration Act and all other legal requirements in enforcing Section 1557.

Background

Section 1557 of the Affordable Care Act ("ACA") prohibits hospitals, doctors' offices, insurance carriers and other entities that receive financial assistance from the federal government relating to a health program or activity (such as Medicare or Medicaid) from discriminating on the basis of sex and other factors set forth in Title IX of the Civil Rights Act. Final regulations issued in 2020 attempted to narrow the interpretation of discrimination on the basis of sex to exclude sexual orientation and gender identity.

On June 15, 2020, the U.S. Supreme Court decided in the case of Bostock v. Clayton County that termination of an employee because of the employee's sexual orientation or gender identity is a form of sex discrimination under Title VII of the Civil Rights Act.

On August 17, 2020, the U.S. District Court for the Eastern District of New York blocked enforcement of the 2020 regulations, holding they were inconsistent with the Supreme Court's definition of sex discrimination in the Bostock Case.

Interpretation Announcement

Since the Supreme Court's decision in Bostock, two federal circuits have concluded that the prohibition of discrimination on the basis of sex in Title IX must be read to include sexual orientation and gender identity. In response to these rulings, HHS announced on May 10, 2021, that consistent with the Supreme Court's decision in Bostock and Title IX, OCR will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include discrimination on the basis of sexual orientation and gender identity.

The OCR enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act ("HIPAA") Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule. Individuals who believe they have been victims of prohibited discrimination may request OCR to investigate.

HHS further states that this enforcement interpretation will guide OCR in processing complaints and conducting investigations.

Employer Action

Hospitals, doctors' offices, insurance carriers, and other entities that are subject to the ACA section 1557 nondiscrimination requirements should consider removing exclusions or limitations in health benefit programs (or other employee benefit plans) based on sexual orientation or gender identity. Employers should consult with legal counsel if they have implemented plan designs or eligibility rules based on sexual orientation or gender identity and work with TPAs to determine how to modify their plan design to fit within the HHS interpretation.

It is important to note that employers sponsoring group health plans that are not subject to Sec. 1557 remain subject to other federal employment laws, including Title VII of the Civil Rights Act which prohibits discrimination on the basis of sex (including sexual orientation or gender identity). Employers should consult with legal counsel and proceed with caution if implementing plan designs or eligibility rules based on sexual orientation or gender identity.

Additionally, state insurance and employment laws may also prohibit such discrimination.

2021 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 15, 2021

The Patient-Centered Outcomes Research (PCOR) fee filing deadline is August 2, 2021, for all self-funded medical plans and HRAs for plan years ending in 2020. The IRS issued Notice 2020-84 announcing the adjusted fee amount for this year as well as limited transition relief.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2019 – January 31, 2020	$2.54/covered life/year	August 2, 2021
March 1, 2019 – February 28, 2020	$2.54/covered life/year	August 2, 2021
April 1, 2019 – March 31, 2020	$2.54/covered life/year	August 2, 2021
May 1, 2019 – April 30, 2020	$2.54/covered life/year	August 2, 2021
June 1, 2019 – May 31, 2020	$2.54/covered life/year	August 2, 2021
July 1, 2019 – June 30, 2020	$2.54/covered life/year	August 2, 2021
August 1, 2019 – July 31, 2020	$2.54/covered life/year	August 2, 2021
September 1, 2019 – August 31, 2020	$2.54/covered life/year	August 2, 2021
October 1, 2019 – September 30, 2020	$2.54/covered life/year	August 2, 2021
November 1, 2019 – October 31, 2020	**$2.66/covered life/year**	August 2, 2021
December 1, 2019 – November 30, 2020	**$2.66/covered life/year**	August 2, 2021
January 1, 2020 – December 31, 2020	**$2.66/covered life/year**	August 2, 2021

Employers with self-funded health plans ending in 2020 should use the 2nd quarter Form 720 to file and pay the PCOR fee by August 2, 2021. The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

Temporary Transition Relief

Generally, there are three established methods a self-funded group health plan may use to determine the average number of covered lives for purposes of calculating the PCOR fee:

- The Actual Count Method,
- The Snapshot Method, and
- The Form 5500 method.

For plan years that end on or after October 1, 2019 and before October 1, 2020, in addition to the established counting methods, a plan may use any reasonable method for calculating the average number of covered lives. This relief has not been extended.

New Mandatory Preventive Items and Services

2021 Updates

Published: June 21, 2021

Most plans will be required to cover new preventive items and services beginning later this year, or in 2022 or 2023 (depending on the plan year), including ones related to Hepatitis B virus infection screenings and colon cancer screenings.

Background

Non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services.

Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF") are considered to be "preventive." The USPSTF recommendations can change, and those changes generally apply for plan years that begin on or after the date that is one year after the date the new recommendation or guideline is considered to be issued.

Topic	USPSTF Recommendation	Effective for Plan Years Beginning On or After:
Unhealthy drug use screening: adults age 18 years or older	Screening by asking questions about unhealthy drug use in adults age 18 years or older when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred	July 1, 2021
Sexually transmitted infections behavioral counseling: sexually active adolescents and adults at increased risk	Behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections	September 1, 2021
Healthy diet and physical activity behavioral counseling intervention for cardiovascular disease prevention: adults 18 years or older with cardiovascular disease risk factors	Offering or referring adults age 18 years or older with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity	December 1, 2021
Hepatitis B virus infection screening: adolescents and adults at increased risk for infection	Screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection	January 1, 2022
Tobacco smoking cessation and behavioral interventions: all adults	For non-pregnant adults, it is recommended that clinicians ask about tobacco use, advise cessation of use, and provide behavioral interventions and U.S. FDA-approved pharmacotherapy for cessation	December 1, 2021
For pregnant persons, it is recommended that clinicians ask about tobacco use, advise cessation of use, and provide behavioral intervention for cessation	February 1, 2022	December 1, 2021
Lung cancer screening: adults age 50 to 80 years who have a 20 pack-year history and currently smoke or have quit within the past 15 years	Annual screening for lung cancer with low-dose computed tomography (LDCT) in adults age 50 to 80 years old who have a history of smoking at least 20 packs of cigarettes per year and who currently smoke or have quit smoking within the past 15 years	April 1, 2022
Hypertension screening: adults age 18 years or older without known hypertension	Hypertension screening in adults 18 years or older with office blood pressure measurement, and blood pressure measurement outside of the clinical setting for diagnostic confirmation before starting treatment	May 1, 2022
Colorectal cancer screening: adults age 45 to 75 years old	Colorectal cancer screening for all adults age 45 to 75 years old	June 1, 2022
Healthy weight and weight gain in pregnancy behavioral counseling interventions: pregnant persons	Clinicians offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy	June 1, 2022

Employer Action

Employers sponsoring non-grandfathered group health plans should review the various preventive care requirements effective for their upcoming plan years. Such coverage must be provided in-network, without cost-sharing.

For fully insured health plans, carriers are generally responsible for compliance and should include these benefits as applicable. Self-funded health plans should discuss with TPAs to ensure coverage is in effect for plan years that begin on or after the applicable effective dates.

For a complete list of preventive items and services, visit: https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics

Supreme Court Dismisses Latest Challenge to the ACA

Published: June 15, 2021

Background

The “individual mandate” provision of the ACA as originally enacted in 2010 required most U.S. residents to obtain minimum essential health insurance coverage or pay a monetary penalty. The individual mandate penalty withstood a legal challenge in 2012 when the Supreme Court ruled it was a valid exercise of Congress’ taxing power. However, Congress effectively eliminated the individual mandate penalty by reducing it to zero effective January 1, 2019.

As a result, Texas (along with other states and two individuals) filed a lawsuit against federal officials. The plaintiffs alleged that the ACA’s individual mandate to obtain health insurance was unconstitutional without the tax penalty; that the individual mandate provision was not severable from the rest of the ACA; and therefore, that no provision of the ACA was enforceable.

After a tumultuous, see-saw litigation trail in the U.S. District Court for the Northern District of Texas and U.S. Court of Appeals for the Fifth Circuit, the Supreme Court agreed to review the case.

Court Decision

On June 17, 2021, the Supreme Court issued its 7-2 decision dismissing the case on the grounds that the individual and state plaintiffs did not have standing to bring the lawsuit because they had not incurred nor were expected to incur any financial injury that was “fairly traceable” to the ACA’s individual mandate.

The Court was not persuaded by the individual plaintiffs’ claims of monetary harm due to the costs of purchasing health insurance, because there was no penalty or other consequence to plaintiffs for failing to obtain such health insurance under the individual mandate. Similarly, the Court held that the states failed to demonstrate how their increased costs (allegedly due to an influx of individuals participating in state-operated insurance programs, such as Medicaid, and administrative expenses related to other ACA provisions) were attributable to the “unenforceable” individual mandate.

Interestingly, by dismissing the case on the threshold issue of standing, the Court did not address the questions of whether the individual mandate without a penalty is unconstitutional, and if so, whether this one provision can be separated from the ACA without striking down the entire Act. Therefore, those issues remain unresolved.

Employer Action

There is no impact to employer-sponsored health plans or other requirements under the ACA. We will continue to monitor litigation in this area and provide updates of further developments.

2021 State-Based Compliance: Quarter Two

Massachusetts

Navada

New Mexico

Oregon

Texas

Washington

Reminder: Massachusetts PFML Fully Available Beginning July 2021

Massachusetts Paid Family and Medical Leave ("PFML") has provided protected leave and wage replacement benefits to eligible employees for certain qualifying reasons. Beginning July 1, 2021, in addition to the leave reasons that have been effective since the beginning of 2021, employees may take up to 12 weeks of family leave per year to care for a family member with a serious health condition. With this phase in, all leave reasons will be effective.

Background

Beginning January 1, 2021, PFML benefits have been available to eligible employees for up to:

- 12 weeks to bond with a child during the first 12 months after the child's birth, adoption or foster care placement or due to a qualifying exigency arising out of family member being on or called for active duty;
- 20 weeks for an employee's own serious health condition; and
- 26 weeks to care for a family member who is a covered servicemember.

There is a 7-day waiting period before benefits may begin. No more than 26 weeks may be taken in a year.

Family Leave to Care for a Family Member

Beginning July 1, 2021, up to 12 weeks of family leave may be taken per year to care for a family member with a serious health condition.

Family members, for the purpose of Massachusetts PFML benefits, include: the employee's spouse, domestic partner, child, parent, grandchild, grandparent or sibling; the parent of employee's spouse or domestic partner; and guardians who legally acted as a parent when the employee was a minor. Where an employee's family member lives does not affect their eligibility. An employee can take paid family leave to care for a family member with a serious health condition no matter where they are located.

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves receiving care in a hospital, hospice, or residential medical facility, or continuing treatment by a health care provider.

Employer Action

When applying for family leave to care for a family member with a serious health condition under the public option, both the employee who is applying for leave and a health care provider must complete a portion of the "Certification of a Serious Health Condition" form as part of the employee's application.

Employers with a private plan exemption will need to verify with their carriers the documents necessary for applying for this type of leave.

Additionally, employers should review their leave policies and procedures to make sure they are compliant when benefits to care for a family member with a serious health condition becomes available beginning July 1, 2021.

Massachusetts Establishes COVID-19 Emergency Paid Sick Leave

On May 28, 2021, Governor Baker signed legislation implementing COVID-19 emergency paid sick leave ("EPSL") for Massachusetts employees. Employers are required to provide up to 40 hours of EPSL to employees when they are unable to work for certain qualifying reasons related to the COVID-19 pandemic. Employees may use EPSL beginning June 7, 2021 through September 30, 2021, or until the state's EPSL fund is exhausted, whichever first occurs.

Who Must Comply?

All Massachusetts employers (private and public) are subject to EPSL. A state fund will be created to reimburse employers for EPSL benefits paid to employees.

Qualifying Reasons For Leave

Employers are mandated to provide EPSL to an employee for the following reasons related to the COVID-19 pandemic:

1. An employee's need to:
   - self-isolate and care for oneself because of the employee's COVID-19 diagnosis;
   - seek or obtain medical diagnosis, care or treatment for COVID-19 symptoms; or
   - obtain immunization related to COVID-19 or the employee is recovering from an injury, disability, illness or condition related to such immunization;

2. An employee's need to care for a family member who:
   - is self-isolating due to a COVID-19 diagnosis; or
   - needs medical diagnosis, care or treatment for COVID-19 symptoms;

3. A quarantine order, or other determination by a local, state or federal public official, a health authority having jurisdiction, the employee's employer or a health care provider that the employee's presence on the job or in the community would jeopardize the health of others because of the employee's exposure to COVID-19 or exhibiting of symptoms, regardless of whether the employee has been diagnosed with COVID-19;

4. An employee's need to care for a family member due to a quarantine order, or other determination by a local, state or federal public official, a health authority having jurisdiction, the family member's employer or a health care provider that the family member's presence on the job or in the community would jeopardize the health of others because of the family member's exposure to COVID-19, regardless of whether the family member has been diagnosed with COVID-19; or

5. An employee's inability to telework because the employee has been diagnosed with COVID-19 and the symptoms inhibit the ability of the employee to telework.

Amount of Benefits Available

An employer must provide the following amount of leave for an employee who takes EPSL as follows:

- 40 hours for an employee who works 40 hours or more per week;

- The number of hours an employee works per week on average over a 14-day period of a regular schedule when the employee works less than a 40-hour workweek but maintains a regular schedule with

consistent hours per week, or

- for an employee whose schedule and weekly hours worked vary from week to week, the employee will be provided EPSL that:
  - is equal to the average number of hours that the employee was scheduled to work per week over the 6-month period immediately preceding the date on which the employee takes the EPSL, including hours for which the employee took leave of any type; or
  - if the employee did not work over a 6-month period, is equal to the reasonable expectation of the employee at the time of hiring of the average number of hours per week that the employee would normally be scheduled to work.

An employee may use EPSL on an intermittent basis and in hourly increments.

Limits on Benefits Available

Employees are eligible for up to $850 per week of EPSL. The benefit amount provided by an employer may be reduced by the amount of wages or wage replacement that an employee receives for that period under any government program or law (i.e., unemployment benefits).

EPSL may be reduced if the aggregate amount an employee would receive would exceed the employee's average weekly wage.

Employer Reimbursement

An employer who pays an employee EPSL will be reimbursed by the state within 30 business days after submitting an application (the form is not yet available) to the state. However, any qualified sick leave wages paid by an employer that are eligible for the tax credit for paid sick and paid family and medical leave under the Families First Coronavirus Response Act, or subsequent extensions, including the Consolidated Appropriations Act, 2021 and the American Rescue Plan Act of 2021, will not be eligible for reimbursement from the EPSL fund.

Benefits and Other Protections Available

EPSL is in addition to all job protected time off, paid and unpaid, that the employer is required provide to employees:

- under Massachusetts Earned Sick Time;
- under any existing policy or program of the employer;
- pursuant to a collective bargaining agreement; or
- under federal law, to the extent permitted by that federal law.

However, any employer with a separate COVID-19 sick leave policy who makes available an amount of COVID-19 sick leave sufficient to meet the requirements of EPSL, that may be used for the same purposes and under the same conditions as EPSL, is not required to provide additional COVID-19 emergency paid sick leave under EPSL.

While employees are receiving EPSL, employers must maintain all employment benefits provided or made available to an employee by the employer including, but not limited to, health insurance, group life insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

An employer may not require an employee to use other paid leave provided by the employer to the employee before the employee uses the EPSL, unless federal law requires otherwise.

It is unlawful for any employer to interfere with, restrain or deny an employee's ability to take EPSL.

Notices

Employees

An employee must provide notice to the employer of the need for EPSL as soon as practicable or foreseeable. After the first workday an employee receives EPSL, an employer may require the employee to follow reasonable notice procedures in order to continue receiving EPSL. An

employer may not require, as a condition of an employee's taking EPSL, that the employee search for or find a replacement worker to cover the hours during which the employee is using EPSL.

Employers

The state will be providing model notices in English and other languages for employers to use. Employers must post this notice in a conspicuous location accessible to employees in every establishment where employees work and must provide a copy to their employees. However, in cases where the employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based platform, notification must be sent via electronic communication or a conspicuous posting in the web-based platform.

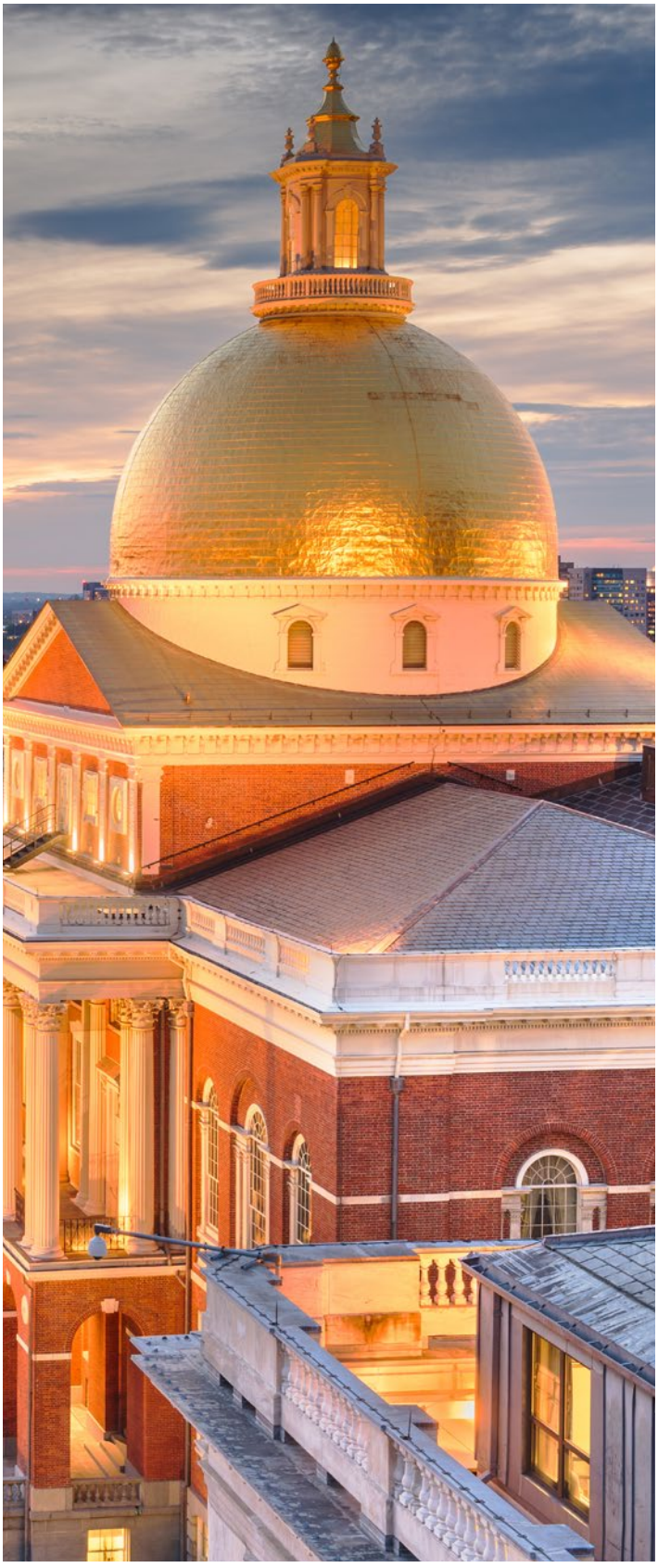
Health Information Protected

Health information related to EPSL possessed by an employer regarding an employee or employee's family member must:

- be maintained on a separate form and in a separate file from other personnel information;
- be treated as confidential medical records;
- not be disclosed except to the affected employee or with the express permission of the affected employee; and
- be kept confidential in accordance with any other state or federal law.

Employer Action

As the state releases the various notice and reimbursement forms, employers should work with their employment counsel and leave absence management vendors to ensure compliance. Employers should be aware that the EPSL law also allows for the state to promulgate regulations necessary for its implementation. We will continue to monitor any developments related to EPSL.



Nevada Paid Leave for COVID-19 Vaccination and Family Care

Recently, Nevada enacted laws requiring certain employers to provide paid leave to employees to get COVID-19 vaccinations and to help employees' family members with medical needs.

Paid Leave for Vaccination and Other Medical Reasons

Effective immediately through December 31, 2023, SB 209 amends the existing mandatory paid leave law to require private employers with 50 or more employees in Nevada to provide employees with paid time off for COVID-19 vaccination as follows:

- two consecutive hours of paid leave if the vaccination requires only one dose; or
- four hours of paid leave in two allotments of two consecutive hours each if the vaccination requires two separate doses on two separate occasions.

Other considerations are as follows:

- The employee must provide at least 12 hours of notice to the employer.
- An employer may not:
  1. deny an employee the right to use such paid leave;
  2. penalize the employee for using such paid leave;
  3. retaliate against the employee for using such paid leave; or
  4. require the employee to find a replacement worker as a condition of using the paid leave.
- Such paid leave cannot be used in calculating the number of hours for which an employee is entitled to be compensated for overtime.
- An employer must maintain a record of the receipt or accrual and use of this paid leave for each employee for a one-year period.

Exceptions are available for:

- An employer who provides an on-premises vaccination clinic; and
- An employer during its first 2 years of operation.

Note that, as opposed to the existing paid leave law, SB 209 does not exempt seasonal, on-call, or temporary employees from coverage.

While the existing mandatory paid leave law indicates that employees can use mandatory paid leave "without providing a reason," this new law specifies that the reasons may include:

- Treatment of a mental or physical illness, injury, or health condition;
- Receiving a medical diagnosis or medical care;
- Receiving or participating in preventative care;
- Participating in caregiving; or
- Addressing other personal needs related to the health of the employee.

"Kin Care" Law

Effective October 1, 2021, AB 190 will require employers offering sick leave to allow an employee to use accrued sick leave for an absence due to an illness, injury, medical appointment or other authorized medical need of a member of the employee's immediate family to the same extent and under the same conditions that apply to the employee when taking such leave. "Immediate family" means:

- The child, foster child, spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent or stepparent of an employee; or
- Any person for whom the employee is the legal guardian.

Other considerations are as follows:

- An employer may limit the amount of this sick leave to an amount which is equal to the amount of sick leave that the employee accrues during a six-month period.
- An employer may not deny employees the right to use kin care leave nor may employers retaliate against employees who exercise their right to use kin care leave.
- An exception is available as to any employee covered under a valid collective bargaining agreement.

Violations of this kin care law may be subject to an administrative penalty of up to $5,000 for each violation.

Posting Requirement

Both laws direct the Office of the Nevada Labor Commissioner to prepare a bulletin concerning the laws' respective provisions which must be posted in a conspicuous location in each workplace.

New Mexico's New Sick Leave Law

On April 8, 2021, Governor Michelle Lujan Grisham signed House Bill 20, enacting the Healthy Workplaces Act ("HWA"). The HWA requires private employers to provide paid sick leave to all New Mexico employees, effective July 1, 2022. The following provides additional detail.

Applicability

A covered employee is any individual employed by an employer, including a part-time, seasonal, or temporary employee. A covered employer is an individual, partnership, association, corporation, business trust, legal representative, or any organized group of persons employing 1 or more employees, but excludes the federal government, the state, and any political subdivision of the state.

Accrual

Employees accrue a minimum of 1 hour of earned sick leave for every 30 hours worked, capped at 64 hours per 12-month period. Employers may be more generous as follows:

- employers may choose a higher accrual rate;
- employers may choose a higher limit; and
- employers may instead elect to front load, granting employees the full 64 hours of earned sick leave for the upcoming year on January 1 of each year or, for employees whose employment begins after January 1 of a given year, a pro rata portion of the 64 hours for use in the remainder of that year.

The accrual works as follows:

- earned sick leave begins to accrue upon the commencement of the employee's employment or July 1, 2022, whichever is later, and may be used immediately;
- employees who are exempt from overtime requirements are assumed to work 40 hours in each work week for the purposes of earned sick leave accrual unless their normal work week is less than 40 hours, in which case earned sick leave accrues based on their normal work week; and
- accrued unused earned sick leave must carry over from year to year, but an employer is not required to permit an employee to use more than 64 hours in a 12-month period.

Changes in Employment

When a different employer succeeds or takes the place of an existing employer, all employees of the original employer who remain employed by the successor employer are entitled to all earned sick leave previously accrued. If an employee is transferred to a separate division, entity, or location of the same employer, the employee is entitled to all previously accrued sick leave. When there is a termination of employment, previously accrued earned sick leave that has not been used must be reinstated if the employee is rehired within 12 months. Employees do not have to be paid out for any accrued, unused sick leave upon their termination of employment.

Use of Sick Leave

An employee may use earned sick leave:

- for the employee's or the employee's family members': (a) mental or physical illness, injury, or health condition; (b) medical diagnosis, care or treatment of a mental or physical illness, injury, or health condition; or (c) preventive medical care;
- for meetings at the employee's child's school or place of care related to the child's health or disability; or
- for absence necessary due to domestic abuse, sexual assault, or stalking suffered by the employee or a family member of the employee; provided that the leave is for the employee to: (a) obtain medical or psychological treatment or other counseling; (b) relocate; (c) prepare for or participate in legal proceedings; or (d) obtain services or assist a family member of the employee with any of these activities.

An employer may not require, as a condition of an employee's taking earned sick leave, that the employee search for or find a replacement worker to cover the hours during which the employee is using earned sick leave.

Earned sick leave may be used in the smallest increment that the employer's payroll system uses to account for absences or use of other time, not to exceed 1 hour.

Coordination of Leave

An employer cannot require an employee to use other paid leave before the employee uses sick leave under the HWA.

An employer with a paid time off policy that makes available an amount of earned sick leave sufficient to meet the accrual requirements and is available for the same purposes and under the same terms and conditions of the HWA is compliant. However, on the effective date of the HWA, the sick leave required by the HWA must be in addition to any paid time off provided by an employer pursuant to a collective bargaining agreement unless that paid time off provided may be used for the same purposes and under the same terms and conditions as the HWA.

Documentation

Documentation is not required for sick leave; however, an employer may require reasonable documentation that sick leave has been used for a covered purpose if the employee uses 2 or more consecutive workdays of sick leave.

Types of Documentation

The following must be accepted as reasonable documentation:

- Documentation signed by a health care professional indicating the amount of earned sick leave necessary.
- In cases of domestic abuse, sexual assault, or stalking: a police report; a court-issued document; or a signed statement from a victim services organization, clergy member, attorney, advocate, the employee, a family member of the employee, or other person affirming that the sick leave was taken for one of the available purposes.

A signed statement may be written in the employee's native language and cannot be required to be in a particular format or notarized. An employer may not require the documentation to explain the nature of any medical condition or the details of the domestic abuse, sexual assault, or stalking.

Timing

An employee must provide documentation upon request to the employer in a timely manner. The employer must not delay the commencement of earned sick leave on the basis that the employer has not yet received documentation.

Confidentiality

All information an employer obtains related to an employee's reasons for taking sick leave must be treated as confidential and not disclosed except with the permission of the employee or as necessary for validation purposes

for insurance disability claims, accommodations consistent with the Americans with Disabilities Act, as required by the HWA, or by court order.

Retention

Employers must retain records documenting hours worked by employees and earned sick leave taken by employees for 4 years.

Employer Notice

Earned sick leave is provided upon the oral or written request of an employee or an individual acting on the employee's behalf. When possible, the request must include the expected duration of the sick leave absence. When the use of earned sick leave is foreseeable, the employee must make a reasonable effort to provide oral or written notice of the need for such sick leave to the employer in advance of the use of the earned sick leave and must make a reasonable effort to schedule the use of earned sick leave in a manner that does not unduly disrupt the operations of the employer. When the use of earned sick leave

Employer Notice

An employer must give written or electronic notice to an employee at the commencement of employment of the following:

- the employee's right to earned sick leave;
- the manner in which sick leave is accrued and calculated;
- the terms of the use of earned sick leave as guaranteed by the HWA;
- that retaliation against employees for the use of sick leave is prohibited;
- the employee's right to file a complaint with the Division if earned sick leave, as required pursuant to the HWA, is denied by the employer or if the employee is retaliated against; and
- all means of enforcing violations of the HWA.

Employers must also display a poster in a conspicuous and accessible place in each establishment where employees are employed. This notice and poster must be provided in English, Spanish, or any language that is the first language spoken by at least 10% of the employer's workforce, as requested by the employee. The Division will create and make available this notice and poster.

Retaliation

An employer cannot take or threaten any adverse action whatsoever against an employee:

- that is reasonably likely to deter such employee from exercising or attempting to exercise a right granted pursuant to the HWA; or
- because the employee: (a) has exercised or attempted to exercise such rights; (b) has reasonably alleged violations of the HWA; or (c) has raised a concern about violations of the HWA to the employer, the employer's agent, other employees, a government agency or to the public through print, online, social or any other media.

An employer cannot attempt to require an employee to sign a contract or other agreement that would limit or prevent the employee from asserting rights provided for in the HWA or to otherwise establish a workplace policy that would limit or prevent the exercise of such rights. In addition, an employer cannot count use of sick leave in a way that will lead to discipline, discharge, demotion, non-promotion, less favorable scheduling, reduction of hours, suspension or any other adverse action.

Enforcement

The Division will:

- establish a system to receive complaints and review those complaints;
- establish a process for investigating and resolving complaints in a timely manner and keeping complainants notified regarding the status of the investigation of their complaint; and
- audit employers.

The identity of any complainant is kept confidential unless disclosure of such complainant's identity is necessary for resolution of the investigation or otherwise required by law. The Division, the office of the attorney general, or a person or entity that has a member who has been affected by a violation of the HWA may bring a civil action for a violation of the HWA. A civil action may be filed in a court of competent jurisdiction for a violation of the HWA within 3 years from the date the alleged violation occurred; provided that the time limit to file a civil action established by this subsection must be tolled during an investigation by the Division of the violation or related violations by the same employer. A lack of an investigation by the Division must not act as a bar to a civil action brought by a complainant pursuant to the HWA.

Penalties

An employer that violates the HWA must be liable to the affected employee:

- for an instance of sick leave taken by an employee but unlawfully not compensated, in an amount equal to 3 times the wages that should have been paid or $500, whichever is greater;
- for an instance of sick leave requested by an employee but unlawfully denied by the employer and not taken by the employee or unlawfully conditioned on searching for or finding a replacement worker, in an amount equal to actual damages or $500, whichever is greater;
- for each instance of retaliation prohibited by the HWA excepting discharge from employment, in an amount equal to actual damages, including back pay, wages or benefits lost, an additional amount of $250 and equitable relief such as rescission of disciplinary measures taken by the employer or other relief as determined by a court of law;
- for each instance of prohibited discharge from employment, in an amount equal to actual damages, including back pay, wages or benefits lost, an additional amount of $500 and reinstatement or other equitable relief as determined by a court of law;
- for each willful notice or recordkeeping violation, $250; and
- for each misclassification of an employee as an independent contractor, actual damages or $500, whichever is greater.

A plaintiff prevailing in a legal action brought pursuant to the HWA must recover all appropriate legal or equitable relief, the costs and expenses of suit and reasonable attorney fees. In an action brought by the Division or the attorney general, any damages recovered must be payable to the individual employees who experienced the violation.

No Preemption

The HWA provides minimum requirements pertaining to earned sick leave and must not be construed to preempt, limit or otherwise affect the applicability of any other law, regulation, requirement, policy or standard, including collective bargaining agreements, that provides for greater accrual or use by employees of earned sick leave, whether paid or unpaid, or that extends other protections to employees. This includes paid leave in Bernalillo County.

Employer Action

Employers should:

- review any existing sick leave policies to determine whether they meet the HWA's requirements and should otherwise develop such sick leave policies to be in compliance by July 1, 2022; and
- regularly monitor the New Mexico Department of Workforce Solutions website for any guidance, rules, or regulations regarding HWA leave and for sample notices.

New Mexico Vaccine Purchase Act Reporting Reminder

This article serves to remind employers with employees and/or dependents in New Mexico of a unique vaccine program and associated payment and reporting obligations in light of New Mexico's recent communications to some of them.

Since the 1990s, the state of New Mexico has had a Vaccines for Children (VFC) program. As part of that program, the state has been the sole purchaser of pediatric vaccines for children in New Mexico, whether provided through private insurance or VFC. Then in 2015, New Mexico passed a law requiring all insurers and group health plans doing business in the state to pay their fair share of the pediatric vaccine cost.

The entities that are subject to the payment include carriers as to insured medical coverage and employers as to self-insured medical coverage. Even if sitused out of state, reimbursement for the cost of vaccines is required for any covered children in the state of New Mexico.

As part of the law, covered entities must annually report the number of insured children under the age of 19 on the last calendar day of the previous year (even if that number is zero) by June 30 each year. It should be worked out between employers of self-funded plans and their TPAs as to whom will complete the required payment and reporting. Any employer with an insured medical plan can notify the Immunization Program (vpa.fund@state.nm.us) that the plan is insured, providing the name of the carrier, and will be taken out of the invoicing database.

A group health plan that fails to file a report is liable to pay a late filing fee of $500 per day from the date the report was due. A similar penalty is due for each day any required payment is late.

Oregon Considers Delaying Paid Family and Medical Leave

The Oregon legislature is considering a bill (HB 3398) that would delay the effective date of the Oregon Paid Family and Medical Leave law.

In June 2019, Oregon enacted HB 2005 that created the Paid Family and Medical Leave Insurance Fund to provide wage replacement benefits to eligible employees for approved family and medical leave. Under the existing law, premium payments are set to begin in 2022 with benefits becoming available in early 2023.

As proposed, HB 3398 would delay:

- premium payments funded by both employers and employees via payroll deductions from January 1, 2022 until January 1, 2023.

- the availability of benefits under the program from January 1, 2023 until September 1, 2023.

Additionally, the bill would delay rulemaking, notice requirements, and general funding from the state.

The bill was introduced May 4, 2021; it will go through a lengthy process before enactment. If approved by the House, it must also be approved by the Senate, and then signed into law by the Governor. We are monitoring the legislation and will provide additional updates.

Dallas Paid Sick Leave Ordinance Invalidated by Federal Court

There is no longer uncertainty surrounding the state of sick leave ordinances in at least one of Texas' biggest cities, as a federal court has permanently enjoined the City of Dallas from enforcing its paid sick leave ordinance, consistent with other sick leave movements in Texas.

Background

As reported previously, paid sick leave ordinances have passed in Austin, San Antonio, and Dallas. Despite support from both sides of the aisle, the Texas legislature failed to pass legislation that would have preempted city sick leave ordinances in the state of Texas. Enforcement of Austin's sick leave ordinance was stayed while the Texas Supreme Court decided whether to find such ordinances unconstitutional as a violation of the state's minimum wage act. On July 24, 2019, a district court delayed the implementation of the San Antonio ordinance until December 1, 2019 in connection with a lawsuit filed by a business coalition challenging the constitutionality of the ordinance. The Dallas ordinance went into effect August 1, 2019 until March 30, 2020, when a federal court preliminarily enjoined the city from enforcing it during the litigation. On June 5, 2020, the Supreme Court of Texas declined to hear the City of Austin's petition for review, leaving the future of such ordinances uncertain.

New Developments

Effective March 31, 2021, the U.S. District Court for the Eastern District of Texas permanently enjoined the Dallas ordinance requiring all private for-profit and non-profit employers to provide paid sick leave to their employees working in the City of Dallas. The court held that the ordinance is preempted by the Texas Minimum Wage Act and therefore violates the Texas Constitution.

While the federal decision enjoining the Dallas ordinance does not dispose of the cases in Austin and San Antonio, it may offer some insight into the future of those ordinances.

Further, the Texas Senate recently passed Senate Bill 14 which, if signed into law, would legislatively prevent a municipality or county from adopting or enforcing an ordinance requiring any terms of employment that exceed or conflict with federal or state law relating to any form of employment leave, hiring practices, employment benefits, scheduling practices, or other terms of employment. The bill has been sent to the House for consideration.

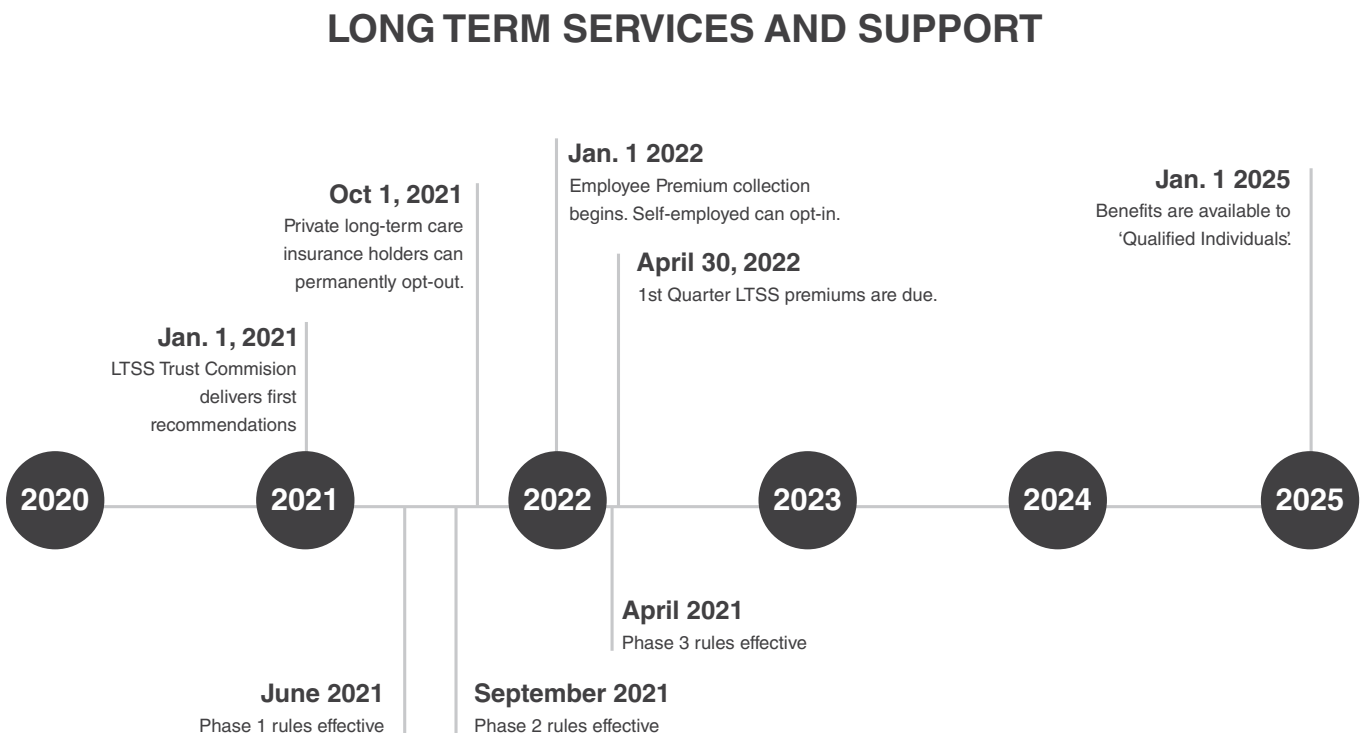
Employer Action

Although all three Texas paid sick leave ordinances are currently enjoined, we encourage employers in Austin and San Antonio to continue tracking developments related to the ordinances, in the event of unanticipated court action that would allow those ordinances to go into effect. Additionally, employers should monitor the status of Senate Bill 14.

Washington Long-Term Care Program Signed into Law

In 2019, the State of Washington enacted H.B. 1087 (amended by S.S.B. 6267 and S.H.B. 1323) to establish the Long-Term Services and Supports Trust Program ("LTSS Trust Program") that creates a state-run long-term care benefit for certain qualified individuals. The LTSS Trust Program will be funded by a new premium assessment on employee wages that takes effect January 1, 2022. It appears this program will be called the "WA Cares Fund" and a website (www.wacaresfund.wa.gov/) has been established.

The Employment Security Department ("ESD") has started the rulemaking process and released a timeline for implementation.



In the 2021 legislative session, the legislature passed S.H.B. 1323 proposing changes to the LTSS Trust Program, including when an employee must obtain a long-term care insurance policy to qualify for an exemption the premium assessment. S.H.B. 1323 was signed into law on April 21, 2021, and takes effect July 25, 2021.

This article summarizes the LTSS Trust Program. The following is subject to change as guidance develops.

Premium Assessment

Beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the LTSS Trust Program. All wages are subject to the premium assessment; there is no cap.[1]

What are wages?

The law defines wages as "all remuneration paid by an employer to an employee." According to the draft rules, examples of wages include:

- Salary or hourly wages;
- Cash value of goods or services given in the place of money;
- Commissions or piecework;
- Bonuses;
- Cash value of gifts or prizes;
- Cash value of meals and lodging when given as compensation;
- Holiday pay;
- Paid time off, including vacation leave and sick leave, as well as associated cash outs, (but not supplemental benefit payments provided by the employer);
- Separation pay including, but not limited to, severance pay, termination pay, and wages in lieu of notice;
- Value of stocks at the time of transfer to the employee if given as part of a compensation package;
- Compensation for use of specialty equipment, performance of special duties, or working particular shifts; and
- Stipends/per diems unless provided to cover a past or future cost incurred by the employee as a result of the performance of the employee's expected job function.

Do all employees working in Washington pay the premium assessment?

Yes. While the guidance has not specifically addressed this issue, it appears that all employees who work in Washington will be subject to the premium assessment unless an exception applies.[2]

The following individuals are exempt from the premium assessment:

- Employees who qualify for an exemption.
- Self-employed individuals (opt-in available).[3]
- Employees of a federally recognized tribe (opt-in available).
- Employees of the federal government.

Footnotes

1. This is different from Washington Paid Family and Medical Leave premium assessments, which are capped at the Social Security limit.
2. Employment for this purpose has the same meaning as 50A.05.010 (RCW 50B.040.010(9)). This is the same meaning as Washington Paid Family and Medical Leave Insurance premium assessments. Presumably, if an employee is subject to a PFML premium assessment, the employee will also be subject to the LTSS Trust Program premium assessment.
   RCW 50A.05.010(8)(a): "Employment" means personal service, of whatever nature, unlimited by the relationship of master and servant as known to the common law or any other legal relationship performed for wages or under any contract calling for the performance of personal services, written or oral, express or implied. The term "employment" includes an individual's entire service performed within or without or both within and without this state, if: (i) The service is localized in this state; or (ii) The service is not localized in any state, but some of the service is performed in this state; and (A) The base of operations of the employee is in the state, or if there is no base of operations, then the place from which such service is directed or controlled is in this state; or (B) The base of operations or place from which such service is directed or controlled is not in any state in which some part of the service is performed, but the individual's residence is in this state.
3. Under draft rules, a self-employed person is:
   - A sole proprietor;
   - A joint venturer or a member of a partnership that carries on a trade or business, contributes money, property, labor or skill and shares in the profits or losses of the business;
   - A member of a limited liability company;
   - An independent contractor who works as described in RCW 50A.05.010; or
   - Otherwise in business for oneself as indicated by the facts and circumstances of the situation, including a part-time business.
   - A corporate officer is an employee and not self-employed.

Note. While employees working in Washington must pay into the LTSS Trust Program, only eligible Washington residents will be able to access benefits when available.

Special rules for parties to a collective bargaining agreement in existence on October 19, 2017

Parties to a collective bargaining agreement in existence on October 19, 2017, are not subject to the LTSS Trust Program requirements (including premium assessments) until the existing agreement is reopened or renegotiated by the parties or expires.

Employers must inform ESD immediately upon the reopening, renegotiation, or expiration of a collective bargaining agreement that was in effect prior to October 19, 2017.

Parties to a collective bargaining agreement in existence on October 19, 2017, that has not been reopened or renegotiated by the parties or expired may elect to be subject to the LTSS Trust Program (including premium assessments) prior to the expiration, reopening or renegotiation of the agreement. Parties seeking to do so must submit to the department a memorandum of understanding, letter of agreement, or a similar document signed by all parties.

Reporting And Paying The Premium Assessment

Employers will be required to collect the premium assessment from Washington employees via after-tax payroll contributions and remit the premiums to ESD. This includes employers located outside of Washington with Washington employees. Employers are not required to contribute to the LTSS Trust Program.

Employers will submit quarterly reports to ESD and make quarterly premium payments by the last day of the month following the end of the calendar quarter being reported.

More guidance on premium payments and reporting is expected in future rulemaking.

Exempt Employees

An employee may apply to ESD for an exemption from the LTSS Program (and the associated premium assessment). To qualify for the exemption, the employee must:

- Be at least 18 years of age on the date of application (and provide identification that verifies their age at time of application), and
- Attest to having long term care insurance purchased before November 1, 2021.

The employee must apply for the exemption between October 1, 2021 and December 31, 2022. Applications for exemption will be available on the ESD website or in another approved format. ESD may verify an employee's long-term care insurance coverage and may request additional information from the employee as part of the application process.

If approved, the exemption is effective the quarter immediately following approval. Exempt employees are not entitled to a refund of any premium deductions made before the effective date of an approved exemption.

An employee with an approved exemption must notify any current or future employer of their exempt status by providing a copy of their approval letter to the employer. If the employee fails to notify the employer of the exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification was provided.

If an employer deducts premiums after the employee provides notification of the employee's exempt status, the employer must refund the deducted premiums to the employee. An employer is not entitled to a refund for any premiums remitted to ESD that were deducted from exempt employees.

The employer must maintain a copy of the approval letter provided by the employee.

What is long term care insurance for purposes of the exemption?

To qualify for an exemption, the employee must attest to having long-term care insurance purchased before November 1, 2021.

The rules define long-term care insurance for this purpose under RCW 48.83.020.

Briefly, under this definition:

"Long-term care insurance" means an insurance policy, contract, or rider that is advertised, marketed, offered, or designed to provide coverage for at least twelve consecutive months for a covered person. Long-term care insurance may be on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes any policy, contract, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance includes:

- Group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance.
- Qualified long-term care insurance contracts (generally defined under Code Section 7702B). [4]

Long-term care insurance does not include:

- Life insurance policies that:
  - Accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement;
  - provide the option of a lump sum payment for those benefits; and
  - do not condition the benefits or the eligibility for the benefits upon the receipt of long-term care.
- Any insurance policy, contract, or rider that is offered primarily to provide coverage for basic Medicare supplement, basic hospital expense, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, related income, asset protection, accident only, specified disease, specified accident, or limited benefit health.

Employees looking to claim the exemption should discuss with their carrier whether their long-term care insurance policy meets this definition. Additional information about the policies that meet the definition of long-term care insurance for this purpose is expected on the WA Cares Fund website.

Will there be opportunities to qualify for an exemption later?

As currently written, the only window to qualify for an exemption is between October 1, 2021 – December 31, 2022.

Once an employee is exempt, the employee is permanently ineligible for coverage through the LTSS Trust Program.

When is long-term care insurance considered "purchased"?

While not defined in the statute, ESD considers a policy "purchased" (for purposes of the exemption) at the time the purchaser and insurer agree to terms on a policy and a transaction occurs.

Footnotes

4. RCW 48.83.020(8)
   - (8) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:
     a. An individual or group insurance contract that meets the requirements of section 7702B(b) of the internal revenue code of 1986, as amended; or
     b. The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (e) of the internal revenue code of 1986, as amended.

How long must the employee retain the long-term care insurance policy after receiving an approved exemption from ESD?

The statute does not require a person to keep the private long-term care policy for a specified period after the exemption is granted. ESD may ask for additional information or verify that the person held long-term care insurance at the time of application.

Can the employer apply for the exemption on behalf of employees?

No. Only the employee can apply for the exemption.

Benefits

Benefits become available January 1, 2025, to qualified individuals.

Qualified individual means:

- Washington resident at least 18 years of age;
- Has paid into the Program for the equivalent of either:
  - A total of 10 years without interruption of 5 or more consecutive years, or
  - 3 years within the previous 6 years from the date of application for benefits.
- Has worked at least 500 hours during each of the 10 years or each of the 3 years.
- Determined by the Department of Social and Health Services to require assistance with at least 3 activities of daily living (e.g., eating, bathing, dressing).

The available benefit is $100/day with a lifetime maximum of $36,500.

An exempt employee may never be a qualified individual for this purpose.

Employer Next Steps

- Coordinate with payroll to address the upcoming tax, reporting and filing requirements.
- Set up a process to accept notice of employee exemptions and maintain records accordingly.
- Await further guidance later this year.

Resources

- RCW 50B.04 Long term services and supports trust program https://app.leg.wa.gov/RCW/default.aspx?cite=50B
- ESD website with rulemaking https://esd.wa.gov/newsroom/rulemaking/ltss
- S.H.B. 1323, as passed by the legislature, http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/House%20Passed%20Legislature/1323-S.PL.pdf#page=1

WA Cares Fund website, http://www.wacaresfund.wa.gov/

Washington LTSS Exemption Rule Finalized, New Website Available

The Long-Term Services and Supports Trust Program ("LTSS Trust Program") is a state-run long-term care benefit for certain qualified individuals. Beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the Program. Employers will be required to collect the premium from an employee's wages and remit payment to the state on a quarterly basis.

An employee may apply for an exemption of the LTSS Program (and the associated premium assessment). To qualify for the exemption, the employee must:

- Be at least 18 years of age on the date of application (and provide identification that verifies their age at time of application), and
- Attest to having long-term care insurance purchased before November 1, 2021.

The employee must apply for the exemption between October 1, 2021 and December 31, 2022. As of May 18, 2021, the exemption application is not yet finalized.

The following summarizes recent developments.

Final Exemption Rules Adopted

The Employment Security Department ("ESD") finalized rules on the exemption process (WAC 192-905). These rules generally follow the proposed rules with little change. The final rule continues to define long-term care insurance for purposes of qualifying for an exemption under RCW 48.83.020.

Informal Comments Answer Some Outstanding Questions

In its Concise Explanatory Statement (May 2021), ESD provides some helpful informal comments:

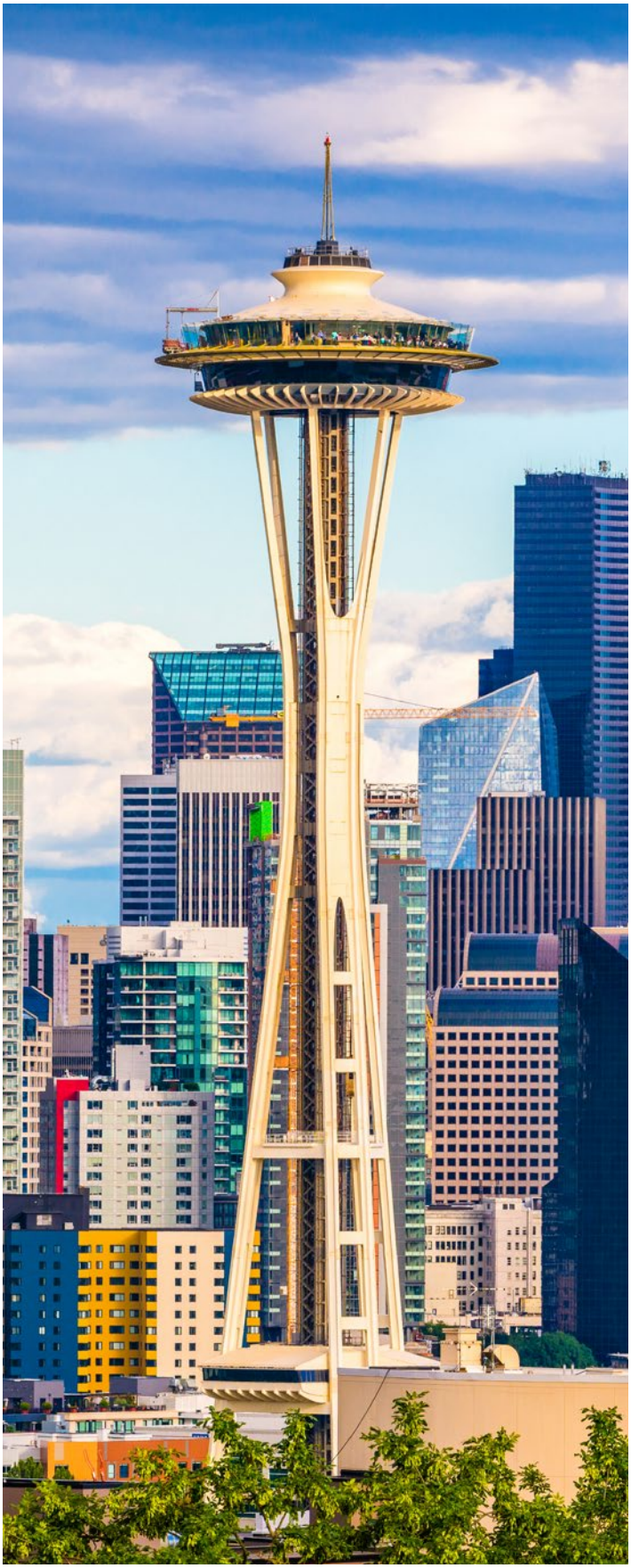
- **Timeframe to apply for an exemption.** Applications for an exemption will only be accepted from October 1, 2021 – December 31, 2022 under the statute. The statute does not authorize additional opportunities to qualify for an exemption.
- **When is a long-term care insurance policy considered "purchased"?** While not defined in the statute, ESD considers a policy "purchased" (for purposes of the exemption) at the time the purchaser and insurer agree to terms on a policy and a transaction occurs.
- **Attestation and policy retention.** An employee will only need to attest once for an exemption if it is granted by ESD. An exempt person is permanently ineligible for coverage in the Program. ESD may ask for additional information or verify that the person held long-term care insurance at the time of application. The statute does not require a person to keep the private long-term care policy for a specified period after the exemption is granted.
- **Only an employee may apply for an exemption.** An employer cannot apply for an exemption on an employee's behalf.
- **When does the approved exemption take effect?** Exemptions take effect the quarter following the approval.

New Website for More Information

It now appears the LTSS Program will be called the "WA Cares Fund." The state established a website, www.wacaresfund.wa.gov, that provides information to employers, employees and qualified individuals about the Program. The website includes some helpful information:

- **Exemptions.** It appears this website will soon include information on how to apply for an exemption. In the future, it may include additional information about the policies that meet the definition of long-term care insurance.

- **Employer Information.** There is a section dedicated to employer information, including a toolkit and newsletter signup.



Washington Modifies Workplace Protections for High-Risk Employees

On April 8, 2021, Washington Governor Jay Inslee issued Proclamation 20-46.3 ("Proclamation") modifying the additional workplace protections for employees at high risk for COVID-19. The modifications are effective April 23, 2021 and include additional flexibility for employers to require medical verification from workers regarding their status as high-risk and allow employers to discontinue health insurance coverage with proper notice.

Background

On April 13, 2020, Governor Inslee issued a proclamation providing additional workplace protections for high-risk workers to safeguard them from exposure to COVID-19 without jeopardizing their employment. The protections were extended to high-risk employees as defined by the Centers for Disease Control and Prevention ("CDC"). Employers are:

- Required to provide more flexibility to high-risk employees to exhaust all available options for alternative work assignments such as telework, reassignment, and distancing
- Required to provide more flexibility for high-risk employees to use any available employer-granted accrued leave or unemployment insurance in any sequence at the discretion of the employee if workplace flexibility and accommodations are not feasible
- Prohibited from retaliating against employees that exercise their rights under the Proclamation
- Prohibited from enforcing any provisions of their collective bargaining agreements that are contrary to the protections afforded by the proclamation

Employers were also required to maintain employer related health insurance benefits for the duration of time an employee was unable to work after they had exhausted all available paid leave.

Modifications

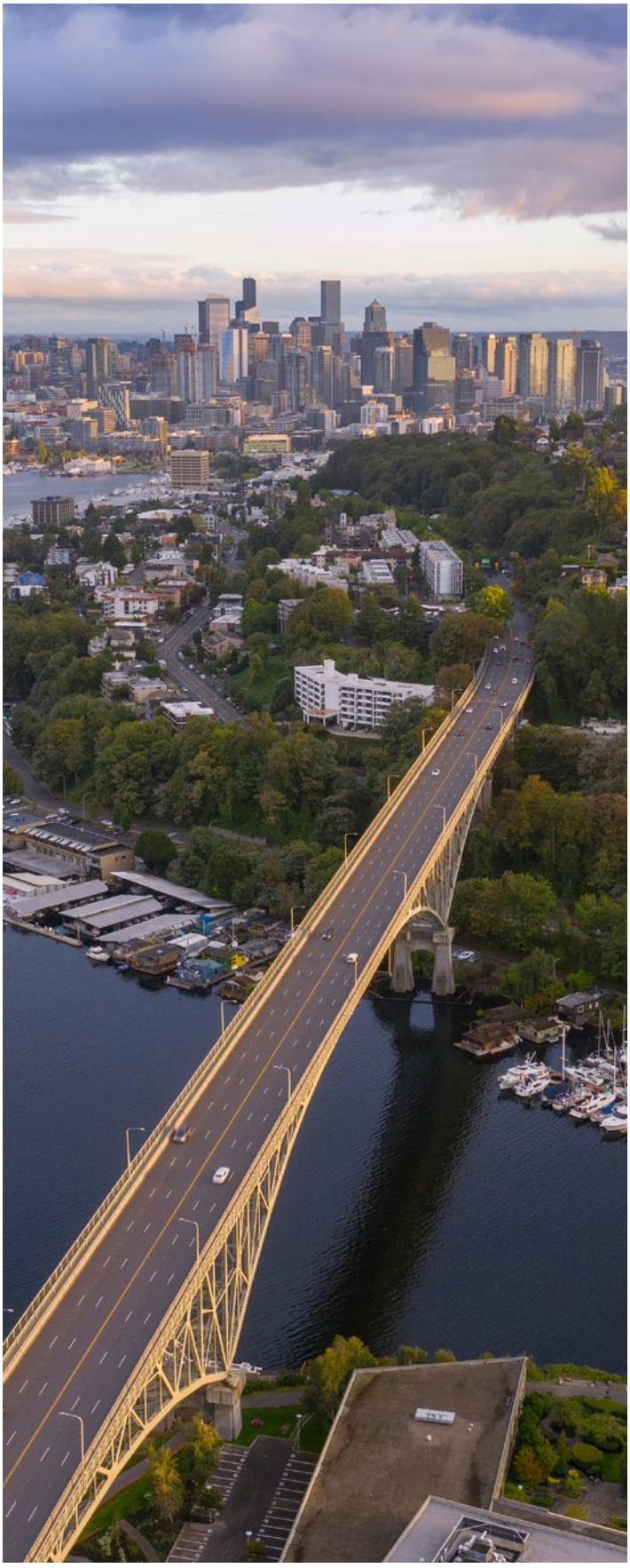
The Proclamation modifies certain requirements to the expanded workplace protections. Effective April 23, 2021, employers may

- Require medical verification from any employee availing themselves of the protections of the Proclamation as long as they do so according to the required interactive process required by state and federal disability laws.
- Discontinue employer-provided health coverage for high-risk employees electing not to return to work. An employer must provide 14 days advance notice and must ensure that coverage continues through the remainder of the month in which the advanced notice period lapses. This will likely trigger COBRA rights for individuals losing coverage. Keep in mind, individuals protected under FMLA or other state law may still have the right to continue coverage.

Employers may also continue to require employees that do not report to work to give up to five days advance notice to the employer of any decision to return to work. Violations of the proclamation may be subject to criminal penalties.

Employer Action

Employers with employees in Washington will want to carefully review current accommodations for high-risk employees to determine whether medical verifications or changes to benefits protections are warranted. With respect to group health plan coverage, employers should review existing practices. If looking to discontinue benefits employers will need to provide appropriate notice at least 14 days in advance. If group health plan benefits are lost, it is likely to trigger a COBRA event (due to a loss of coverage as a result of a reduction in hours) in which case the individual may be eligible for a COBRA subsidy.



Washington PAL Assessment Begins July 1, 2021

In 2020, the Washington state legislature passed a bill directing the Health Care Authority ("HCA") to collect a covered lives-based assessment from certain health insurance providers to keep the Partnership Access Lines ("PAL") program services up and running. Specifically, the assessment funds the Partnership Access Line and Psychiatric Consultant Line. Briefly, these programs assist providers with managing patient psychiatric needs and helps connect adults and children to care.

Beginning July 1, 2021, this covered lives-based assessment goes into effect.

The assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provide health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

There is an argument that such an assessment may be preempted for self-funded employers subject to ERISA. To date, it is unclear whether an employer has challenged this assessment and whether such challenge would be successful.

A "covered life" for this purpose means a Washington resident who is covered by an assessed entity. This appears to include all covered Washington "belly buttons" of the assessed entity.

The assessed entity will need to register with the HCA (or its designated entity). At this point, there is no guidance as to how to register, but presumably a website will be made available.

Beginning July 1, 2021, no later than the end of the 45 calendar days after the end of each quarter, an assessed entity must submit to HCA (or its designated entity) the total number of Washington resident covered lives for each calendar month of the prior quarter. Presumably, the first reporting period would be July 1, 2021 – September 30, 2021, with a filing due by November 14, 2021.

Each assessed entity will receive a quarterly invoice for its share of the total amount of program costs that are for the proportion of the entity's covered lives and will need to submit timely payment. At this point there is no guidance as to what the per member/per month assessment will be. These invoices are likely to be issued at some point after the covered lives reports are filed.

Employer Action

Employers with a fully insured plan: no action needed. Carriers are responsible for this assessment. Carriers are likely to pass this fee along through premium increases.

Employers with a self-insured group health plan: the employer (or perhaps the TPA on behalf of the employer) will need to register with the state and submit covered lives reports and assessment payments on a quarterly basis. Absent guidance, it appears the first report is due mid-November. At this time, there is no guidance as to how much the assessment will be and the process for submitting reports and paying the assessment. Further guidance is needed.

2021 Compliance Bulletins: Quarter Three

July

August

September

Guidance Issued on the 2021 COBRA Subsidy

Published: July 28, 2021

The Consolidated Appropriations Act, 2021 ("CAA") imposes new reporting requirements related to pharmacy benefits and prescription drug costs that apply to group health plans and health insurance issuers. On June 21, 2021, the Departments of Labor, the Treasury and Health and Human Services (collectively, "the Departments") issued a request for information ("RFI") regarding this new requirement. The RFI will help the Departments formulate rulemaking to implement this new requirement.

While there are no action items for employers related to the RFI, it does lay out some initial questions related to this new requirement and provides some insight as to the Departments' thinking.

Background

As previously reported, by December 27, 2021, and not later than June 1 of each year thereafter, the CAA requires group health plans and health insurance carriers offering group or individual health insurance coverage to submit a report to the Departments with respect to certain health plan and prescription drug information based on the previous plan year.

Specifically, the report will include:

- beginning and end dates of the plan year;
- the number of participants, beneficiaries, or enrollees, as applicable;
- each state in which the plan or coverage is offered;
- the 50 most frequently dispensed brand prescription drug and the total number of paid claims for each such drug;
- the 50 most costly prescription drugs by total annual spending and the annual amount spent by the plan or coverage for each such drug;

- the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year;

- total spending by the plan or coverage broken down by the type of health care services;

- spending on prescription drugs by the plan or coverage as well as by participants, beneficiaries, and enrollees, as applicable;

- the average monthly premiums paid (broken out by employer and employee contributions);

- rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year; and

- any reduction in premiums and out-of-pocket costs associated with these rebates, fees, or other remuneration.

Eighteen months after the date this information is submitted and biannually thereafter, the Departments will issue a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, aggregated so that no drug or plan specific information is made public.

Request For Comments

The RFI asks 41 questions related to this new reporting requirements (with some containing multiple sub-questions). Responses will be used to help formulate future guidance.

Some of the questions are summarized as follows:

- General implementation concerns. This includes:
  - What challenges do plans and issuers anticipate facing in meeting the statutory reporting obligations? For example, do plans or issuers currently have access to all the information they are required to report?
  - How much time will plans and issuers need to prepare their data and submit it to the Departments? What data sources are readily available and which data may take longer to compile?
  - Among group health plans, are there different considerations for reporting by fully insured versus self-funded plans, or for insured plans with small group versus large group coverage?

- Entities that must report. Will self-insured plans contract with third-party administrators to submit this information on behalf of the plan? What role will Pharmacy Benefits Managers ("PBMs") play in furnishing necessary information to plans and will PBMs conduct some or all of the reporting?

- Information required to be reported. This includes:
  - How will the plan determine the 50 prescription drugs that are most frequently dispensed and the 50 drugs with the greatest increase in expenditures?
  - How will the plan determine the 25 drugs with the highest amount of rebates from drug manufacturers during the plan year?

- Compliance costs. What costs or other impacts do plans anticipate from implementing this new reporting requirement?

Employer Action

As this is just an RFI, there are no action items at this time. However, this information is helpful to understand the complexities of this upcoming reporting requirement. It is likely the Departments will issue regulations at a later date.

ARPA Subsidy

New Notice Required for Small New Jersey Employers

Published: August 2, 2021

The New Jersey Department of Banking and Insurance recently issued Bulletin No. 21-08, which establishes a new notice requirement for small employers of fully insured group health plans subject to New Jersey State Continuation. The Bulletin provides that employees that were otherwise furloughed or work reduced hours can now have access to coverage under the American Rescue Plan Act ("ARPA") of 2021.

Background

ARPA was signed into law in March 2021 and provides temporary premium assistance for COBRA continuation coverage. In order to qualify for this premium assistance, an individual has to be an Assistance Eligible Individual ("AEI"). In order to be an AEI, the individual must:

- Be eligible for COBRA or NJ state continuation due to a reduction in hours or due to involuntary termination for a reason other than gross misconduct;
- Elect COBRA or NJ state continuation; and
- Not be eligible for other group health coverage or Medicare.

Bulletin No. 20-12 relaxed the full-time requirement so that employees whose hours were reduced did not have to elect COBRA or NJ continuation; rather, furloughed employees or temporarily laid off employees could remain covered under the employer's group health plan.

Bulletin 21-08

Small employers that continued to cover employees under small employer plans using the relaxed full time requirement or while the employee were furloughed or temporarily laid off are required to comply with new notice requirements in order for those employees to receive premium assistance as AEIs under ARPA.

Employer Action

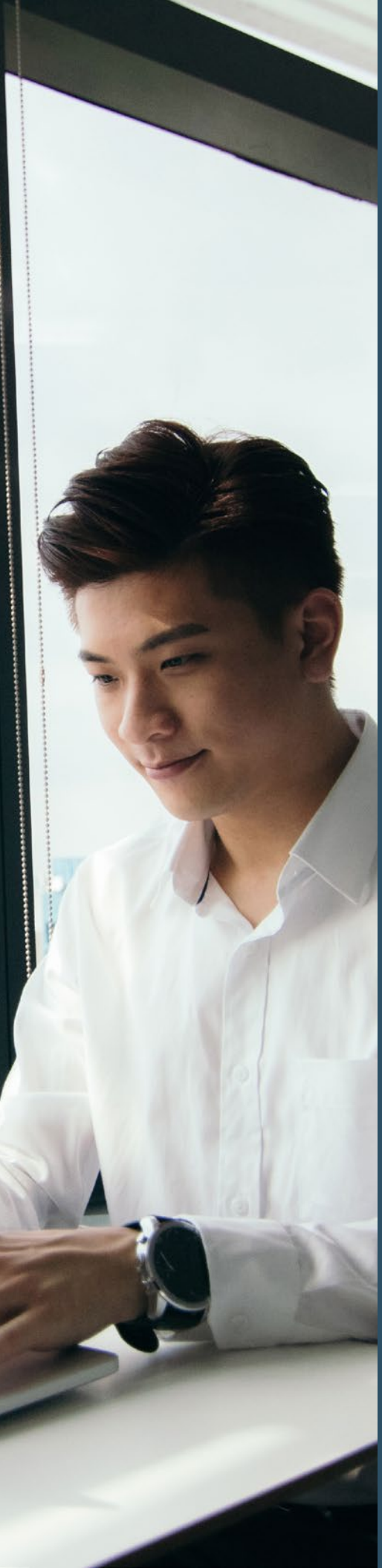
Small employers currently covering employees whose hours were reduced below 25 hours per week or who are on furlough or layoff status should provide notice that coverage ended as of April 1, 2021 and that continuation coverage under COBRA or New Jersey continuation is available. The qualifying event was April 1, 2021. For New Jersey continuation, employers should use the Alternative Notice of ARP Continuation Coverage Election Notice that has been modified for use with New Jersey continuation. This notice may be found at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/cobra/premium-subsidy/model-alternative-election-notice.pdf.

For COBRA continuation use the model notice provided at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

Action to Provide an Extended Election Period

Small employers whose employees had the opportunity to elect continuation due to reduced hours, furlough or layoff, but who did not elect continuation or who elected continuation but later terminated it, must be given the opportunity for an extended election period. The Department gave very little notice to comply with the original dates set forth in the Bulletin: employers must provide notice of the extended election period no later than May 31, 2021 with respect to COBRA continuation and no later than 5 business days following July 21, 2021 for State continuation. Employers should provide this notice as soon as possible, if they haven't already.

We will continue to keep you updated.



First Guidance on Surprise Medical Billing Issued

Published: August 5, 2021

On July 13, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") jointly published an interim final rule implementing provisions of the No Surprises Act ("NSA"). This is the first set of regulations to address the NSA ("Part I Regulations"); additional rules are forthcoming, including guidance on the Independent Dispute Resolution ("IDR") process.

Briefly, as it relates to group health plans, the regulations:

- Include protections to limit out-of-network ("OON") cost-sharing and "balance billing" as they relate to emergency services, OON providers of air ambulance services, and non-emergency services performed by OON providers at in-network facilities (with limited exceptions).
- Prescribe a formula to determine a participant's cost-sharing for these services and how much the plan will pay to the provider for these services. Generally, this will be the lesser of a Qualified Payment Amount ("QPA") or the provider's billed charge, unless a state law or the All-Payer Model Agreement applies.
- Describe new notification obligations, including posting information about the surprise medical bill protections on the plan's website as well as including such information in the Explanations of Benefits ("EOBs") issued with respect to these services.

These rules take effect for plan years beginning on or after January 1, 2022, and apply to all group health plans (including grandfathered plans), except:

- Excepted benefits (e.g., dental and vision plans);
- Short-term limited duration insurance;
- HRAs and other account-based plans; and
- Retiree plans (plans with fewer than 2 participants who are current employees).

For fully insured group health plans, the carrier will be responsible for compliance.

For self-funded group health plans, the plan sponsor is responsible and will need to work closely with third-party administrators ("TPAs") to comply with these rules. TPAs will likely need to update plan documents to reflect the changes required under the NSA and could pass additional administrative costs on to plan sponsors.

The following highlights some of the additional details from these rules. It will be important to discuss implementation and compliance with TPAs. The Departments request comments on numerous aspects of the rule by September 7, 2021.

Background

As previously reported, with respect to group health plans (and health insurance carriers), the NSA provides protection as it relates to OON cost-sharing and "balance billing" with respect to:

- Emergency services;
- Non-emergency services delivered by OON providers at in-network facilities, and
- OON air ambulance services.

"Balance billing" refers to the practice of an OON provider billing a patient the difference between (1) the provider's billed charges and (2) the amount collected from the plan (or carrier) plus any amounts previously collected from the patient (e.g., copays, coinsurance, or amounts paid toward the deductible).

The law also establishes a pathway for resolving payer-provider payment disputes using negotiation and arbitration. If entities are unable to come to an agreement, the IDR process requires each party to submit a final payment offer and the arbiter will select one of these offers as the final payment amount. The arbitrator's decision is final and generally may not be appealed.

Generally, the requirements of the NSA apply to the items and services described above unless the state has an "All-Payer Model Agreement" ("APMA") (used by Maryland, Pennsylvania and Vermont) or state balance billing law (including Delaware, Massachusetts and Pennsylvania that applies.

In general, self-funded ERISA group health plans will be subject to the requirements of the NSA (versus state law or APMA). However, where state law allows, a plan sponsor may voluntarily "opt-in" to a state's balance billing protections that provide a method for determining the cost-sharing amount or total amount payable under such a plan (versus the NSA). Currently four states – Nevada, New Jersey, Virginia and Washington – provide such an option. A plan that opts in to such a state law must do so for all items and services to which the state law applies.

Self-funded plans that opt-in to the state law must prominently display in their plan materials describing the coverage of OON items and services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the items and services provided by OON facilities and providers that are covered by the specified state law.

Interim Final Rules

General Requirements

With respect to OON emergency services, non-emergency services furnished by an OON provider in an in-network facility and OON air ambulance services, the NSA requires the services be provided:

- without cost-sharing requirements that are greater than those that would apply if the services were provided in-network;
- by calculating cost-sharing requirements as if the total amount that would have been charged for the services were equal to the "recognized amount" for such services; and
- by counting any cost-sharing payments toward any in-network deductible or out-of-pocket maximum ("OOPM") (including the annual limit on cost-sharing).

Emergency Services

If a group health plan provides coverage for emergency services in a hospital's emergency department (or an independent free-standing emergency department), the coverage must be provided:

- without any prior authorization;
- regardless of whether the provider furnishing the emergency services is an in-network provider (or facility);
- without limiting what constitutes an emergency medical condition solely based on diagnosis codes; and
- without regard to any other term or condition of coverage, other than:
  - an exclusion or coordination of benefit;
  - a waiting period; or
  - applicable cost-sharing.

The Departments are concerned that some plans (and carriers) currently deny coverage of certain services provided in the hospital's emergency department by determining whether the care involves an emergency medical condition based solely on the final diagnosis code. The interim final rules clarify that all pertinent documentation must be considered and should focus on the presenting symptoms and not final diagnosis when evaluating claims for emergency services.

The regulations further clarify that:

- Post-stabilization services are considered emergency services subject to the NSA unless certain conditions are satisfied.
- A plan that covers emergency services is prohibited from denying benefits to a participant with an emergency medical condition that receives emergency services based on a general plan exclusion.

Notice & Consent Exception for Non-Ancillary Services

In the case of non-emergency, non-ancillary services performed by an OON provider at certain in-network facilities, an exception to the prohibition on surprise medical billing may be permissible when the provider gives the patient advance oral and written notification and receives the patient's signed consent. The rules provide the specific content, method and timing of the notice and consent communications and provides substantial detail on each of these components.

This exception does not apply to ancillary services. For this purpose, ancillary services include items and services:

- related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services;
- that are diagnostic, including radiology and laboratory services; and
- provided by an OON provider, only if there is no in-network provider who can furnish such item or service at such facility.

In addition, the exception does not apply for items or services furnished because of unforeseen, urgent medical needs that arise at the time a service is furnished for which an OON provider otherwise satisfied the notice and consent requirements.

Cost-Sharing Calculations

Cost-sharing is what the participant or beneficiary must pay for a covered item or service under the terms of the group health plan (e.g., copayments, coinsurance, and amounts paid towards deductibles). Generally, cost-sharing does not include premium payments, balance billing by OON providers, or the cost of items or services that are not covered under the plan.

The participant's cost-sharing for OON emergency services and for non-emergency services furnished by an OON provider in an in-network facility is calculated based on the "recognized amount" for such services. Unless the APMA or a state law applies, the recognized amount is the lesser of the "Qualified Payment Amount" ("QPA"), or the amount billed by the provider or facility. If the APMA or state law applies, the recognized amount is determined by the APMA or specified state law.

With respect to OON air ambulance providers, APMA and state laws generally do not apply. Cost-sharing is determined based on the lesser of the QPA or the billed amount.

Qualified Payment Amount

The QPA is the median of the contracted rates for a particular item or service plus an inflation adjustment. The rules around calculating the QPA are complicated and described in much detail in the regulations, including various special rules that apply (e.g., related to anesthesiology, new plans, and limited data). Briefly, the QPA is determined by:

1. Calculating a median contracted rate by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number.
2. Adding an inflation adjustment (to be announced by the Departments annually).

Notably, for self-funded plans, the regulations define the "insurance market" as all self-insured group health plans of the plan sponsor or, at the option of the plan sponsor, all self-insured group health plans administered by the same entity that is responsible for calculating the QPA on behalf of the plan (in most cases, the TPA).

Plan/Provider Payment Process

The plan will determine whether the services are covered by the plan. Within 30 days of receipt of a "clean claim,"[1] the plan must send the provider an initial payment or notice of denial of the payment. The total amount paid by a plan for items and services is referred to as the "OON Rate." Assuming APMA and state laws do not apply, the plan must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee:

- if the plan and the provider or facility have agreed on a payment amount, the agreed-on amount; or

- if the parties (plan and provider) enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

If the APMA or state law applies, then the OON rates is determined by the APMA or specified state law.

If the payment is disputed, an IDR process will begin after a 30-day window for open negotiation. The regulations addressing the IDR process and IDR entities will be issued in later rulemaking.

Group Health Plan Disclosures

Group health plans (and health insurance carriers) must make publicly available, post on a public website of the plan or issuer and include on each EOB for an item or service with respect to which the NSA applies a notice of the protections under the NSA. If a state balance billing law applies, this must be included in the notice. A model notice may be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

Employer Action

Employers should review these requirements with their carriers and TPAs for compliance effective with the first plan year that begins on or after January 1, 2022. As most of these requirements are functions of claim payment and adjudication, it will be important that vendors can support the changes required by the NSA. Self-funded health plans will want to ensure TPAs can meet these new requirements.

We expect additional guidance on the NSA, including the IDR process.

1. For this purpose, a "clean claim" means the plan received the information necessary to adjudicate a claim for payment for such services.

COBRA Subsidy Termination Notice Reminder

Published: August 9, 2021

The American Rescue Plan Act of 2021 included COBRA premium assistance (a 100% COBRA subsidy) for certain assistance eligible individuals ("AEIs") who lose group health plan coverage as the result of an involuntary termination of employment or a reduction of hours. The COBRA subsidy is available to AEIs for the period between April 1, 2021 and September 30, 2021. Among other requirements, employers (and their COBRA vendors) must issue notice prior to the expiration of the subsidy.

Specifically, with respect to the September 30, 2021 expiration date, AEIs must be provided with a notice of expiration of the COBRA subsidy between August 16 and September 15, 2021. The notice must explain the date that the premium assistance will expire and that the individual may be eligible for coverage without any premium assistance through COBRA, a group health plan, the Marketplace, or Medicare/Medicaid.

The Departments have issued a Model Notice of Expiration of Period of Premium Assistance. While employers are not required to use the Model Notice, doing so is considered a best practice. The model notice may be found under Model Notices at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy-for-employers-and-advisers.

Employer Action

With respect to the September 30, 2021 subsidy expiration date, employers should work with their COBRA vendors to provide AEIs with this notice between August 16 and September 15, 2021. Employers will need to confirm each AEI's date for the end of the maximum COBRA period and the premium to continue COBRA coverage when the subsidy expires.

Additional Guidance Issued on the 2021 COBRA Subsidy

Published: August 10, 2021

On July 26, 2021, the IRS released Notice 2021-46 providing additional guidance on the 2021 COBRA premium assistance (or "COBRA subsidy"). The 2021 COBRA subsidy was included as part of the American Rescue Plan Act ("ARP"). This IRS guidance is coming relatively late, with only two months remaining in the COBRA subsidy period.

Background

Assistance eligible individuals ("AEIs") who are COBRA qualified beneficiaries ("QBs") because of an involuntary termination of employment or a reduction in hours receive a 100% COBRA subsidy for the period of April 1, 2021 through September 30, 2021.

The subsidy expires the earlier of:

- The first date that the AEI is eligible for other group health plan coverage or Medicare;
- The end of the maximum COBRA period; or
- September 30, 2021.

Employers are eligible to recoup the cost of the subsidy as a payroll tax credit.

Employers and their COBRA administrators must issue notices with respect to the subsidy.

This latest guidance from the IRS includes a series of FAQs that provides additional information to employers, health insurers, and plan administrators on the COBRA subsidy. While the guidance does not answer all outstanding questions related to the COBRA subsidy, it does provide helpful clarification on the availability of the COBRA subsidy for extended coverage periods, loss of the COBRA subsidy for dental and vision coverage, and which entity may claim the COBRA subsidy tax credit.

Eligibility for COBRA Premium Assistance – Extended Coverage Options

Q: Is the COBRA subsidy available for an AEI eligible for an extended period of COBRA continuation coverage due to a disability determination, second qualifying event, or state mini-COBRA?

Yes. The IRS confirmed that for those AEIs who are eligible to continue COBRA coverage beyond 18 months due to a disability determination, second qualifying event, or an extension under state mini-COBRA, such individuals will also be considered AEIs (absent eligibility for other group coverage or Medicare) to the extent the additional coverage period falls between April 1, 2021 and September 30, 2021.

End of the COBRA Subsidy – Dental and Vision Coverage

Q: If an AEI elects COBRA continuation coverage for only dental and/or vision coverage and receives a COBRA subsidy, does the AEI cease to be eligible for the COBRA subsidy if they subsequently become eligible for other group health plan coverage or Medicare that does not provide dental or vision benefits?

Yes. The AEI's COBRA subsidy for all plans ends when the individual becomes eligible for coverage under any other disqualifying group health plan or Medicare. As a result, an AEI that becomes eligible for Medicare will lose eligibility for the COBRA subsidies for medal, vision, and dental coverage despite most Medicare plans' limited coverage of dental or vision benefits. The same holds true for an AEI that becomes eligible for other group medical coverage where the AEI's new plan sponsor does not offer vision or dental benefits, or if the benefits provide less coverage than the COBRA plans in which the AEI is currently enrolled.

It is important to note that the subsidy requirements terminate once an AEI becomes eligible for a form of disqualifying coverage. The AEI does not need to enroll in the coverage to lose the subsidy.

Claiming the COBRA Subsidy Payroll Tax Credit

As described in ARP and subsequent guidance, the funding to offset the additional expense of subsidized COBRA coverage for AEIs comes in the form of a payroll tax credit. With respect to federal COBRA, the common law employer sponsoring the plan will generally receive the payroll tax credit. Carriers claim the credit with respect to fully insured plans that are not subject to federal COBRA but are subject to a state mini-COBRA law.

In Notice 2021-46, the IRS provides additional clarification on the entity that may claim these credits and specifies certain situations where the right to claim the COBRA subsidy payroll tax credit falls to any entity other than the common law employer of the AEI.

Q: Who is the common law employer maintaining the plan?

The common law employer maintaining the plan is the current common law employer for an AEI whose hours have been reduced or the former common law employer for those AEIs who have been involuntarily terminated from employment.

Q: Who may claim the COBRA payroll tax credit when the group health plan is subject to both federal COBRA and the state mini-COBRA coverage?

The common law employer maintaining the plan is entitled to claim the payroll tax credit when the state mini-COBRA coverage is comparable to federal COBRA and the group health plan is subject to both laws. Therefore, even if the state mini-COBRA coverage would otherwise require the AEI to pay the premiums directly to the insurer during the period of state-mandated coverage after federal COBRA coverage ends, the insurer is not entitled to claim the COBRA subsidy payroll tax credit.

Q: Which entity is entitled to claim the COBRA subsidy payroll tax credit when a group health plan subject to federal COBRA covers employees of different common law employers who are members of the same controlled group?

When a plan subject to federal COBRA covers employees of two or more members of a controlled group, each common law employer that is a member of the controlled group is entitled to claim the payroll tax credit with respect to its employees or former employees who are AEIs. While all members of a controlled group are treated as a single employer for employee benefit purposes, each member is a separate common law employer for employment tax purposes.

Q: In the event of business reorganizations, which entity is entitled to claim the COBRA payroll tax credit for AEIs who are merger and acquisition qualified beneficiaries ("M&A QBs") if the selling group remains obligated to provide COBRA constitution coverage?

When the selling group remains obligated to provide COBRA continuation coverage to M&A QBs after a business reorganization, the entity in the selling group that maintains the group health plan is entitled to claim the COBRA subsidy payroll tax credit.

The FAQs above highlight some of the information contained in Notice 2021-46. The guidance also provides clarification as it relates to who claims the payroll tax credit in a Multiple Employer Welfare Plan ("MEWA") and Professional Employer Organizations ("PEOs"), certain government plans and small market group plans purchased through the Small Business Health Options Program ("SHOP"). Review the guidance for further details.

Employer Action

Employers should continue to work with their COBRA administrators to ensure compliance with the ARP COBRA subsidy. Employers may need to engage payroll or tax professionals for assistance in claiming the tax credits.

HHS Extends Public Health Emergency until October 18, 2021

Published: August 11, 2021

On July 19, 2021, the Secretary of Health and Human Services ("HHS"), announced that the administration will renew the COVID-19 pandemic Public Health Emergency, scheduled to expire on July 20, 2021. This will once again extend the period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

As previously noted, in a letter sent to state governors, HHS indicated that the agency expects that the Public Health Emergency will likely remain in place for all of 2021. While not formal agency action, it appears that HHS intends to continue to renew the Public Health Emergency through, at least, the end of 2021.

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire October 18, 2021 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief and 2) 60 days after the announced end of the National Emergency. The Departments are expected to announce the end date; at this time, no end date has been announced.

While there are other temporary benefit plan provisions and changes that are allowed due to the public health emergency, summarized below are only those provisions directly impacted by the Emergency Period extension.

Benefit Plan Changes in Effect Through the End of the Emergency Period

- **COVID-19 Testing.** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

- **Excepted Benefits and COVID-19 Testing.** An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.

- **Expanded Telehealth and Remote Care Services.** Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.

- **Summary of Benefits and Coverage ("SBC") Changes.** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.

- **Grandfathered plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g. added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

Benefit Plan Changes in Effect Through the End of the Outbreak Period

On an individual basis, group health plans, disability, and other employee welfare benefit plans will disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.

- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth adoption, or placement for adoption.

- **ERISA Claims Deadlines.** Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request.
  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

- **Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans.** A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 coverage and other required plan notifications. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements.

More Employers May Be Required to Electronically File Some IRS Forms

Published: August 26, 2021

On July 23, 2021, the IRS issued proposed rules that would significantly expand the number of employers required to electronically file information returns with the IRS. Among others things, this change would impact filing of Forms 1094-C/1095-C. If finalized "as is," this change would take effect for filings due in 2022 (e.g., calendar year 2021 Forms 1094-C/1095-C due to be filed with the IRS by March 31, 2022). It should be noted that this article is limited to the impact the proposed rule may have on Forms 1094-C and Forms 1095-C; however, Forms 1094/1095-B are also affected (e.g., employers with fewer than 50 full-time employees who have a self-funded health plan may use these forms to comply with health coverage reporting). In addition, other forms are affected by this proposed rule but are not addressed in this article, including Forms W-2, 1099 and 5330. Review the proposed regulations for more information.

Under the current rules, employers are required to file Forms 1094-C and 1095-C electronically when filing 250 or more returns. When determining whether the 250 threshold is satisfied, each type of return is considered separately. In addition, corrected returns are generally counted separately from the original information filing and each corrected return is counted separately to determine whether electronic filing is required.

These proposed rules would change those parameters as follows:

- Lower the filing threshold. For filings due in 2022, the proposed regulations require electronic filing when 100 or more returns are filed (as opposed to 250). For filings due in 2023 and beyond, the threshold is further reduced to 10. It is important to note that employers with 50 or more full-time employees are generally required to file Forms 1094/1095-C to comply with the employer shared responsibility mandate. If finalized "as is" the 10-filing threshold will effectively require electronic filing for all Forms 1094/1095-C by 2023.

- Require aggregation. To determine whether an employer must file forms electronically, the proposed rules require all returns to be counted together. For example, under these proposed rules, an employer who files 300 Forms W-2 and 75 Forms 1095-C in 2022 would be required to file Form 1094-C and all Forms 1095-C electronically because, when aggregated, the employer files at least 100 returns (300 W-2s + 75 Forms 1095-C).

- Corrected returns. A corrected information return would be required to be filed in the same manner as the original form.

Employer Action

Although these are only proposed rules, given the potential 2022 effective date, employers should monitor this situation as electronic filing could be required as early as January 2022 for employers who were previously exempt.

Guidance on Preventive Care Services and PrEP Coverage

Published: August 30, 2021

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") have jointly released a new FAQ regarding preventive care services and coverage for pre-exposure prophylaxis ("PrEP").

As background, non-grandfathered group health plans must cover certain preventive care items and services without cost-sharing. On June 11, 2019, the USPSTF released a recommendation with an "A" rating that clinicians offer PrEP with "effective antiretroviral therapy to persons who are at high risk of human immunodeficiency virus ("HIV") acquisition." Non-grandfathered group health plans must cover PrEP consistent with the USPSTF recommendations and without cost-sharing effective for plan years beginning on or after June 30, 2020.

This FAQ 47 clarifies:

- Plans must cover, without cost-sharing, items and services that USPSTF recommends should be received prior to being prescribed PrEP as part of the determination of whether such medication is appropriate for the individual and for ongoing follow-up and monitoring. The Q/A-1 provides additional detail of baseline and monitoring services.

- Plans are also required to cover, without cost-sharing, office visits associated with each recommended preventive service for the individual when:
  - the service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and
  - the primary purpose of the office visit is the delivery of the recommended preventive service.

- Plans may not use reasonable medical management techniques to restrict the frequency of benefits for services specified in the USPSTF recommendation for PrEP, such as HIV and STI screening.
  - When PrEP is medically appropriate for an individual specified in the USPSTF recommendation, as determined by the individual's health care provider, it would not be reasonable to restrict the number of times the individual may start PrEP.

- Reasonable medical management techniques with respect to coverage of PrEP may be used to encourage individuals prescribed PrEP to use specific items and services, to the extent the frequency, method, treatment, or setting is not specified in the USPSTF recommendation.
    - For example, since the branded version of PrEP is not specified in the USPSTF recommendation, plans may cover a generic version of PrEP without cost-sharing and impose cost-sharing on an equivalent branded version (subject to an accommodation when the generic is not medically appropriate for a particular individual).
- As described in earlier guidance, plans utilizing reasonable medical management techniques must have an easily accessible, transparent, and sufficiently expedient exceptions process.
    - For example, one that allows prescribing and accessing PrEP medications on the same day that an individual receives a negative HIV test or decides to start taking PrEP. Such process cannot be unduly burdensome on the individual or provider.

As plans may not have understood that the regulatory coverage requirements apply to all support services of the USPSTF's recommendation for PrEP, the Departments will not take enforcement action against a plan for failing to provide coverage of such services until September 17, 2021 (the period ending 60 days after publication of these FAQs), and encourage states to take a similar enforcement approach.

Some Transparency in Coverage and CAA Deadlines Delayed

Published: September 2, 2021

On August 20, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively called "the Departments") jointly issued an FAQ which implements parts of the Consolidated Appropriations Act ("CAA") that was passed at the end of 2020 and the Transparency in Coverage ("TiC") final regulations that were issued in November of 2020. The requirements under the CAA apply to all group health plans, including grandfathered plans.

The FAQ defers enforcement of certain provisions of the CAA and TiC regulations, including:

- TiC – Machine Readable Files:
  - For files associated with in-network rates and out-of-network allowed amounts and billed charges, delayed until July 1, 2022.
  - For prescription drug files, delayed pending future guidance.

- CAA Price Comparison Tools: Delayed until the first plan year that begins on or after January 1, 2023 (to align with TiC requirements).

- Good Faith Estimate ("GFE") and Advance Explanation of Benefits ("EOBs"):
  - Delayed pending future rulemaking.

- Reporting on Pharmacy Benefits and Drug Costs:
  - Delayed pending future rulemaking – compliance expected by December 27, 2022.

Other provisions of the CAA will continue to take effect as described under the statute, but with good faith relief available pending future guidance or rulemaking. The following describes each requirement and any available relief.

Transparency in Coverage – Machine Readable Files

Requirement: Group health plans and health insurance carriers must make public three machine-readable files disclosing:

1. in-network rates,
2. out-of-network ("OON") allowed amounts and billed charges, and
3. negotiated rates and historical net prices for covered prescription drugs.

Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief: FAQ 49 provides the following relief with respect to publishing machine readable files:

- The requirement to make public in-network rates and OON allowed amounts and billed charges (1 and 2 above) is delayed until July 1, 2022.
  - For plan years that begin between January 1, 2022 and July 1, 2022, the files must be posted by July 1, 2022.
  - For plan years that begin after July 1, 2022, the files must be posted in the month in which the plan year begins.
- The requirement to make public negotiated rates and historical net prices for covered prescription drug (3 above) has been delayed pending further rulemaking.

Transparency in Coverage – Price Comparison Tools (Including CAA Requirements)

Requirement: Under the TiC requirements, group health plans and carriers must provide for the disclosure of cost sharing information in advance of receiving care. Such disclosure is required to be made through an internet-based self-service tool and in paper form. This requirement takes effect for plan years beginning on or after January 1, 2023, with respect to 500 identified items and services. Full compliance is required for plan years beginning on or after January 1, 2024.

The CAA includes price transparency and cost information requirements that are similar to (if not duplicative of) what is required by the TiC. Under the statute, the CAA requirements take effect for plan years beginning on or after January 1, 2022.

Enforcement Relief: The Departments will delay enforcement of the CAA's price comparison requirement to align with the TiC effective date (plan years beginning on or after January 1, 2023). In addition, the Departments will undertake rulemaking to determine whether the requirements from the TiC final rules also satisfy the requirements of the CAA. Notably, future guidance will require that cost sharing information be available via telephone (as well as through the internet and in paper form). Plans with existing tools should continue to make them available.

While the TiC requirements do not apply to grandfathered plans, to the extent they are duplicative of requirements under the CAA, grandfathered plans will likely need to comply.

Insurance ID Cards

Requirement: The CAA requires plans and carriers to include on any physical or electronic ID cards information about deductibles, out-of-pocket maximums, and a telephone number and website address for individuals to seek consumer assistance. Group health plans must comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: While regulations are expected to implement the ID card requirements, they will not be issued until after January 1, 2022. Plans should continue to implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

Good Faith Estimate and Advance Explanation of Benefits

Requirement: The GFE and Advance EOB requirements under the CAA go hand in hand. Upon the scheduling of items or services (or upon patient request) providers are required to:

- inquire whether the individual has health insurance coverage, and
- provide a GFE of the expected charges for furnishing those items and services to the group health plan.

Upon receiving a GFE, the group health plan must send the participant or beneficiary an Advance EOB that includes certain prescribed information. Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief

The Departments are delaying enforcement until future guidance is issued. Any future guidance will include a prospective applicability date to provide additional time for compliance.

Prohibition on Gag Clauses on Price and Quality Data

Requirement: Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from:

- furnishing provider-specific cost or quality of care information or data;
- electronically accessing de-identified claims and encounter data for each participant or beneficiary; and
- sharing such information, consistent with applicable privacy regulations.

Plans and carriers must submit an attestation of compliance.

This requirement was effective December 27, 2020.

Good Faith Relief: Plans should implement this requirement using a good faith, reasonable interpretation of the statute. Future guidance is expected as to how plans will complete and submit the required attestation. This attestation process is expected to begin in 2022.

Provider Directories

Requirement: Group health plans must update and verify the accuracy of provider directory information (every 90 days) and establish a protocol for responding to requests by telephone and email from a member about a provider's network participation status.

If a participant or beneficiary is furnished an item or service by a non-participating provider (or facility) and the individual was provided inaccurate directory information that stated the provider was "in-network", the plan must generally treat the item or service as provided in-network.

Group health plans should comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

The Departments have stated that plans will not be out of compliance if they do not impose more than in-network cost-sharing and count any cost-sharing toward the in-network deductible and out-of-pocket maximum in situations where the participant is provided information stating that a provider is in-network.

Balance Billing Disclosure

Requirement: The CAA requires plans and carriers to make certain disclosures regarding balance billing protections to participants and beneficiaries. This notice requirement is effective for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Plans will not be out of compliance when using the model notice (as appropriately modified).

Requirement: For plan years beginning on or after January 1, 2022, a patient in a course of treatment with an in-network provider/facility that becomes OON must be notified and given an opportunity to receive coverage on the same terms for up to 90 days.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Any future rulemaking will apply prospectively allowing plans and carriers a reasonable time to comply.

Reporting on Pharmacy Benefits and Drug Costs

Requirement: Group health plans and carriers must submit a report to the Departments with respect to certain health plan and prescription drug information based on the previous plan year. Notably, the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs.

Enforcement Relief: Recognizing the significant operational challenges with this requirement, the Departments will defer enforcement for both the first and second deadlines (December 27, 2021 and July 1, 2022, respectively) pending the issuance of regulations or further guidance.

Plans should work to ensure they are able to comply with 2020 and 2021 information reporting by December 27, 2022.

Employer Action

As many of these provisions are a function of plan administration, it will be important to consult carriers and TPAs (and PBMs with respect to pharmacy reporting) to understand their capabilities to assist in compliance with these new requirements. While the delayed timeframes are helpful, it will be important to understand the provisions and timeframe for when the requirements apply to your group health plan.

New York Paid Family Leave 2022 Contributions and Benefits

Published: September 7, 2021

The New York State Department of Financial Services has announced the contribution rate and benefit schedule under the New York Paid Family Leave ("PFL") law effective January 1, 2022 as follows:

- The contribution rate remains at 0.511% of weekly wages, up to a maximum annual contribution of $423.71.
- The maximum weekly benefit increases to 67% of average weekly wages payable for 12 weeks and will be capped at $1,068.36.

Additional details are provided below.

Contributions

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the annualized New York State Average Weekly Wage ("AWW"). For 2022, the contribution percentage has been set at 0.511% (includes a 0.005% risk adjustment for COVID-19 quarantine claims) and the New York State AWW in effect will be $1,594.57. A comparison to the 2021 contribution amounts is as follows:

	2021	2022	Percentage change
Contribution Percentage	0.511%	0.511%	0%
NYS Average Weekly Wage	$1,450.17	$1,594.57	10%
Annualized NYS Average Weekly Wage	$75,408,84	$82,917.64	10%
Maximum Annual Contribution	$385.34	$423.71	10%

Benefits

Beginning January 1, 2022, the PFL benefit had increased to the final phased-in maximum 67% of an employee's Average Weekly Wage (up to the New York State AWW) payable for 12 weeks. The maximum weekly benefit for 2022 will be $1,068.36 (the maximum annual benefit in 2022 increases to $12,820.32). A comparison to the 2021 benefit levels is as follows:

	2021	2022	Percentage change
Benefit Percentage	67%	67%	0%
Weeks Payable	12	12	0.0%
Maximum Weekly Benefit	$971.61	$1,068.36	10%
Maximum Annual Benefit	$11,659.32	$12,820.32	10%

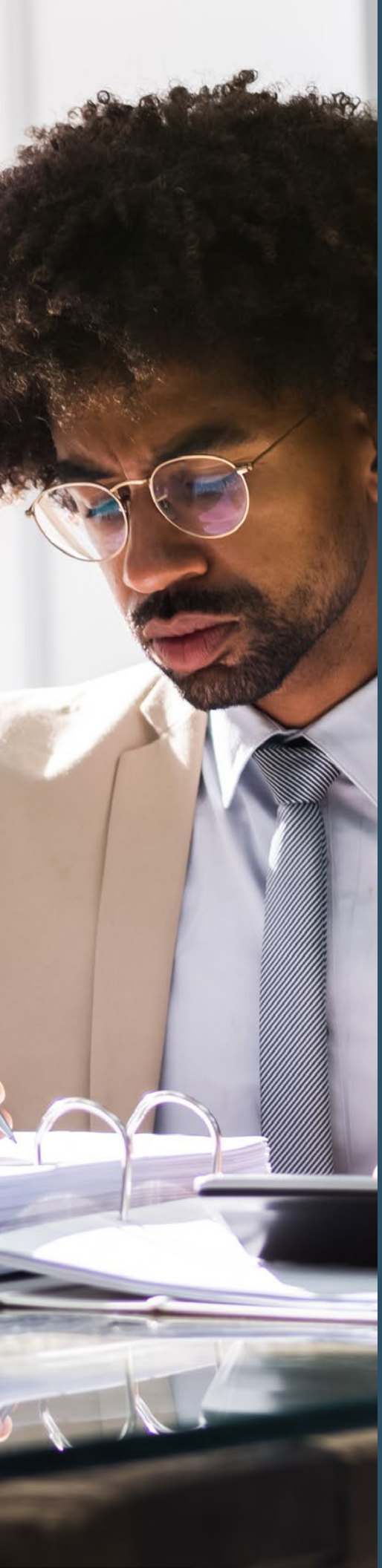
The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a 52-consecutive week period is limited to 26 weeks.

- The Superintendent of the NYS Department of Financial Services has the discretion to delay the scheduled PFL benefit increase if it is determined the increase may negatively impact employees, employers, insurers and the overall economic climate. For 2021, the Superintendent has determined the 2021 PFL benefit increase is appropriate and therefore, will be implemented as scheduled and noted above.

Employer Action

Employers should prepare for the 2022 New York PFL contribution and benefit increases that begin in January. Paid Family Leave coverage will typically be added as a rider on an employer's existing disability insurance policy although benefits can be provided through a self-funded plan approved by the state Workers' Compensation Board.



IRS Announces 2022 ACA Affordability Indexed Amount

Published: September 10, 2021

The IRS recently announced in Revenue Procedure 2021-36 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.61% for plan years that begin in 2022. This is a decrease from the 2021 percentage amount (9.83%).

Background

Rev. Proc. 2021-36 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2022

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2022 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

The W-2 safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.61% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

Rate of pay safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.61% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

Federal Poverty Level (FPL) safe harbor.

Coverage is affordable if it does not exceed 9.61% of the FPL.

For a 2022 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $103.14 (48 contiguous states), $128.85 (Alaska), or $118.68 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2022 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

President Biden Announces Plan to Increase Number of Vaccinated Americans

Published: September 10, 2021

On September 9, 2021, President Biden announced a "Path out of the Pandemic," indicating that he will use regulatory powers and other actions to increase the number of vaccinated Americans. In short, his plan provides the following:

- Employers with at least 100 employees must require their employees to be vaccinated or require unvaccinated employees to produce a negative test at least weekly before coming to work
- Federal workers and federal contractors must be vaccinated
- Booster shots should be available soon at no cost
- Health care workers at Medicare and Medicaid participating hospitals and other health care settings must be vaccinated
- Employers with more than 100 employees must provide paid time off to their employees to get vaccinated
- Large entertainment venues are requested to require proof of vaccination or testing for entry
- There are increased school safety measures
- Additional economic recovery is available

The plan includes a multi-pronged, comprehensive national strategy, discussed below. While the action plan lays out the administration's next steps, it also raises several questions that will hopefully be addressed in the rulemaking process.

Vaccination or Weekly Testing

The Department of Labor's Occupational Safety and Health Administration (OSHA) is developing a rule that will require all employers with 100 or more employees to ensure their workforce is fully vaccinated or require any unvaccinated workers to produce a negative test result on at least a weekly basis before coming to work. OSHA will issue an Emergency Temporary Standard

(ETS) to implement this requirement. While penalties for non-compliance are not outlined in the President's plan, the maximum penalty amount under existing OSHA enforcement protocols is $13,653 per violation. There will likely be challenges to this requirement based on overreach of OSHA's authority.

We are hopeful that future guidance will answer the numerous unanswered questions we are left with including:

- Whether the employer will need to be involved in facilitating the weekly testing option for unvaccinated workers and what (if any) of the expense the employer must cover.
- Under current guidance, group health plans are not required to cover COVID-19 testing as it relates to an employment requirement. Will the Departments revisit this guidance in light of this new directive by the President?
- How does the mandate apply to a remote workforce who do not "come into work"?
- While the mandate applies to employers with 100 or more employees, are there any steps employers with fewer than 100 employees should consider?
- Will the availability of a booster shot affect what it means to be "vaccinated" for this purpose (i.e., do you need the two-shot series or two shots plus the booster to be considered vaccinated)?
- How will the new availability of free tests at pharmacies affect this mandate?

Subsequent to the President's announcement, the IRS issued a reminder that the cost of home testing for COVID-19 is an eligible medical expense that can be paid or reimbursed under health flexible spending arrangements (health FSAs), health savings accounts (HSAs), or health reimbursement arrangements (HRAs). Additionally, costs of personal protective equipment (PPE) such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 are eligible medical expenses that can be paid or reimbursed through these accounts.

Vaccinations for all Federal Workers and Federal Contractors

All federal executive branch workers must be vaccinated. The President also signed an Executive Order requiring employees of contractors that do business with the federal government to be vaccinated.

Vaccinations for Providers who Accept Medicare or Medicaid

The Centers for Medicare & Medicaid Services (CMS) is taking action to require COVID-19 vaccinations for workers in most health care settings that receive Medicare or Medicaid reimbursement, including but not limited to hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies. This action builds on the vaccination requirement for nursing facilities recently announced by CMS, and will apply to nursing home staff as well as staff in hospitals and other CMS-regulated settings, including clinical staff, individuals providing services under arrangements, volunteers, and staff who are not involved in direct patient, resident, or client care.

Paid Time Off

OSHA is developing a rule that will require employers with more than 100 employees to provide paid time off for the time it takes for workers to get vaccinated or to recover if they are under the weather post-vaccination. This requirement will be implemented through the ETS.

Easy Access to Booster Shots

The Biden Administration is preparing for boosters to start as early as the week of September 20, subject to authorization or approval by the FDA and a recommendation from the Advisory Committee on Immunization Practices. Booster shots will be free and widely available across 80,000 locations – from pharmacies to doctors' offices to health centers.

Individuals will be able to find a vaccination site at Vaccines.gov, including what vaccines are available at each site and, for many sites, what appointments are open. A toll-free number, 1-800-232-0233, will also be available in over 150

languages. Americans who have already utilized the text code 438829 or WhatsApp to get vaccine information will automatically receive a text with information on boosters, if and when recommended.

Large Entertainment Venues-Proof

The President's plan calls on entertainment venues like sports arenas, large concert halls, and other venues where large groups of people gather to require that their patrons be vaccinated or show a negative test for entry.

School Safety

School safety measures include:

- Requiring staff in head start programs, Department of Defense schools, and Bureau of Indian Education-operated schools to be vaccinated
- Calling on all states to adopt vaccine requirements for all school employees
- Providing additional funding to school districts for safe school reopening
- Using the Department of Education's legal authority to protect students' access to in-person instruction
- Getting students and school staff tested regularly
- Providing every resource to the FDA to support timely review of vaccines for individuals under the age of 12

Increasing Safety and Care

Increased prevention and treatment efforts include:

- Mobilizing industry to expand easy-to-use testing production
- Making at-home tests more affordable
- Sending free rapid, at-home tests to food banks and community health centers
- Expanding free pharmacy testing
- Continuing to require masking for interstate travel and double fines
- Continue to require masking on federal property
- Increasing support for COVID-burdened hospitals
- Getting monoclonal antibody treatment to those who need it and training health care professionals to provide this treatment

Additional Economic Recovery

Other reforms include:

- New loan support for small businesses impacted by COVID-19
- A streamlined Paycheck Protection Program (PPP) loan forgiveness process
- Launching a Community Navigator Program to connect small businesses to the help they need

Employer Action

Further rulemaking is expected to implement the President's vaccination mandate in the workplace. Employers should review this new information and prepare for compliance. In the meantime, employers may want to consult with legal counsel and think about crafting a vaccine policy that considers exemptions for employees with qualified disabilities as defined under the Americans with Disabilities Act, as well as employees with sincerely held religious beliefs, as defined under Title VII of the Civil Rights Act.

We will continue to monitor these issues and keep you updated as guidance develops.

Medicare Part D Notification Requirements

Published: September 20, 2021

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is "creditable" or "non-creditable." This notification must be provided prior to October 15th each year. Also, following the plan's annual renewal, the employer must notify the Centers for Medicare & Medicaid Services ("CMS") of the creditable status of the drug plan.

Employers should send these notices no later than October 15, 2021 if they haven't done so already.

Below you will find information that summarizes these requirements in more detail.

What are the Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters (notices last updated by CMS for use on or after April 1, 2011).

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

To Whom Should the Participant Notice Be Sent?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to (but no more than 12 months before) October 15th each year (or next working day);
- Prior to (but no more than 12 months before) an individual's Initial Enrollment Period for Part D (three months before the month of the person's 65th birthday);
- Prior to (but no more than 12 months before) the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable, or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should also provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice Be Sent?

Entities have flexibility in the form and manner in which they provide notices to participants.

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements in 29 CFR § 2520.104b-1(c)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

> If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
>
> Please see page xx for more details.

Personalized Notices

A personalized notice is only provided upon request of the beneficiary. If an individual requests a copy of a disclosure notice, CMS recommends that entities provide a personalized notice reflecting the individual's information.

For more information on the participant disclosure requirement, visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

CMS Notification

When and How Should Notification be Given to CMS?

Employers will also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (March 1, 2022 for a 2022 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

Notice must be submitted electronically by completion of a form found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

Additional guidance on completing the form, including screen shots, is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/2009-06-29_CCDisclosure2CMSUpdatedGuidance.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected total of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

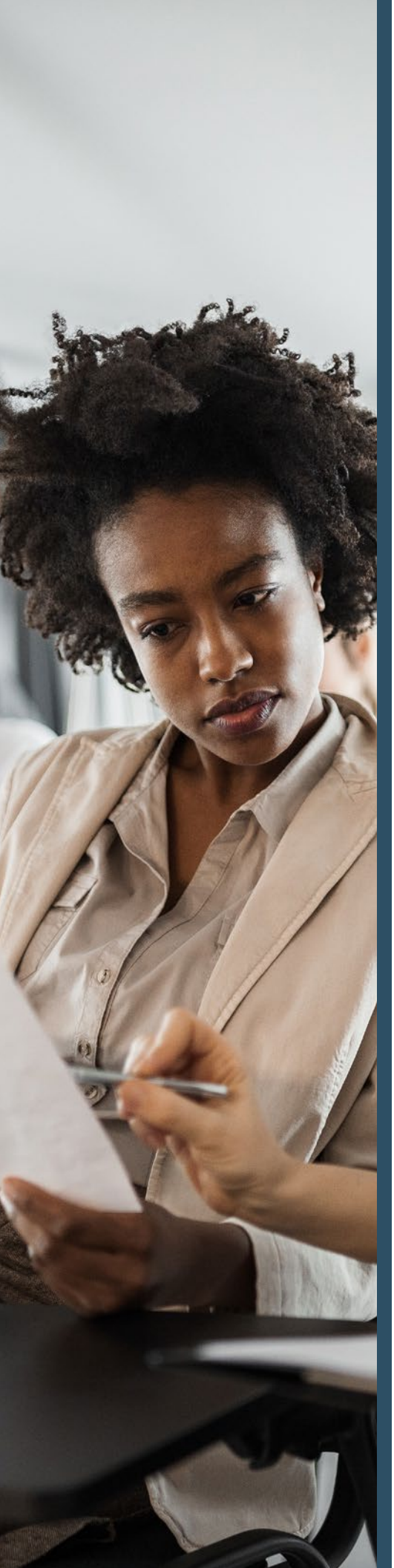
Some plans will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
  - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
  - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
  - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.



2021 MLR Rebate Checks Recently Issued to Fully Insured Plans

Published: September 21, 2021

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers were required to distribute MLR checks to employers by September 30, 2021.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What Do I Do with this MLR Rebate Check?

Insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to enrollees.

This does not apply to self-funded plans.

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and

- what, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the Rebate Amount Be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any Communication?

Yes.

For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [August ___] paychecks.

What will the Form of Rebate to the Employer be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will the Rebate be Issued?

Rebates must be paid by September 30 each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do Employers have to Give Some or All of the Rebate to Participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder

would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015 provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do Rebates Need to be Made to Participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the Form of Rebate to Participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants: This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants: This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants: This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the Federal Tax Implications to Employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.
- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

What are the Tax Implications for Employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When Employees Pay Premiums on a Pre-Tax Basis, does Reducing a Participant's Premiums Mid-Year Allow them to Make Election Changes?

Probably not.

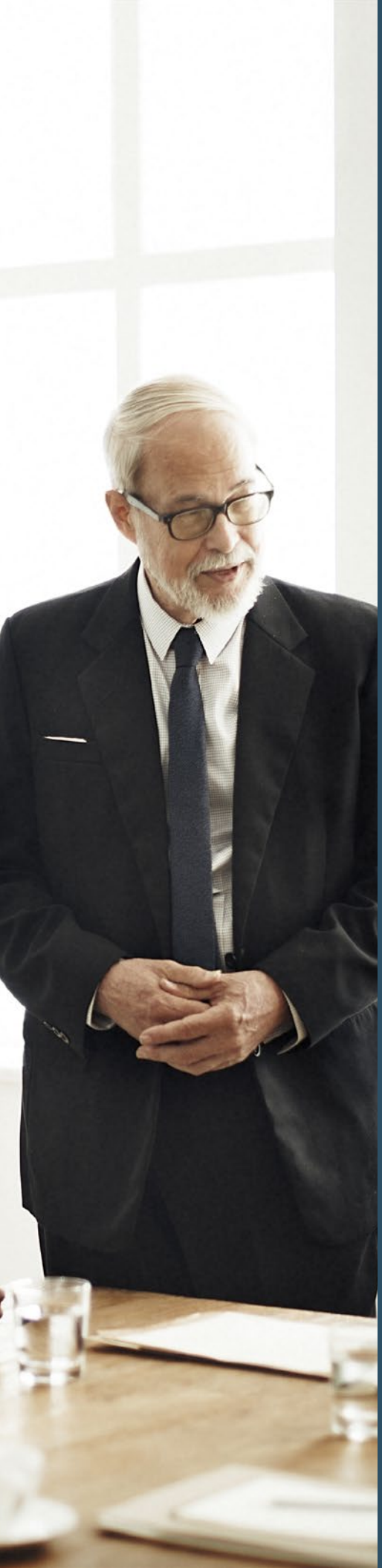
If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.

- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.



Proposed Requirements Address Air Ambulance Reporting Requirement

Published: September 27, 2021

On September 13, 2021, proposed regulations were issued that would implement certain provisions of the No Surprises Act, requiring group health plans to submit information related to air ambulance claims to the Department of Health and Human Services ("HHS") for 2022 and 2023.

Plans Subject to the Requirement

Major medical health plans (insured and self-insured, grandfathered and non-grandfathered) are subject to this requirement.

Data

The report must include the following data elements with respect to air ambulance services provided under a group health plan:

1. Identifying information for any group health plan, plan sponsor, or issuer, and any entity reporting on behalf of the plan or issuer, as applicable.

2. Market type for the plan or coverage (large group, small group, self- insured plans offered by small employers, and self-insured plans offered by large employers).

3. Date of service.

4. Billing NPI information.

5. Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code information.

6. Transport information (including aircraft type, loaded miles, pick-up (origin zip code) and drop-off (destination zip code) locations, whether the transport was emergent or non-emergent, whether the transport was an inter-facility transport, and, to the extent this information is available to the plan or issuer, the service delivery model of the provider (such as government-sponsored (federal, state, county, city/township, other municipal), public-private partnership, tribally-operated program in

Alaska, hospital-owned or sponsored program, hospital independent partnership (hybrid) program, independent).

7. Whether the provider had a contract with the group health plan or issuer of group or individual health insurance coverage, as applicable, to furnish air ambulance services under the plan or coverage, respectively.

8. Claim adjudication information, including whether the claim was paid, denied, appealed; denial reason; and appeal outcome.

9. Claim payment information, including submitted charges, amounts paid by each payor, and cost sharing amount, if applicable.

Confidentiality

As the requested information is claims-level data as opposed to aggregate data, HHS proposes to collect only that claims-level data that would be sufficient for producing the comprehensive report required by the No Surprises Act. HHS also intends to collect and maintain the information using information technology systems that are designed to meet all of the security standards protocols established under federal law or by HHS.

Timing

Plans must submit data regarding air ambulance services on a calendar year ("CY") basis for 2022 and 2023 within 90 days of the end of the calendar year.

- For CY 2022, by March 31, 2023, regardless of plan year.

- For CY 2023, by March 31, 2024 regardless of plan year.

Written Agreement

Insured plans

An employer with an insured plan satisfies the reporting requirements if it requires the health insurance issuer offering the coverage to report the required information pursuant to a written agreement. In this case, the issuer and not the plan is liable for any failure to file.

Self-funded plans

An employer with a self-funded plan may satisfy the reporting requirements by entering into a written agreement with the third-party administrator ("TPA"). The plan generally remains liable. However, nothing prevents a self-insured group health plan from including a clause in the written agreement for the TPA indemnifying the plan in the event the TPA fails to submit a complete or timely report.

Employer Action

Employers will not have the required data necessary to report. Therefore, employers should begin reaching out to carriers and TPAs handling their health programs during the calendar year 2022 and enter into written agreements with them, requiring issuers and TPAs to handle reporting. Employers with self-funded plans should consider adding indemnification provisions to their agreements in the event the TPA is not compliant.

2021 State-Based Compliance: Quarter Three

Connecticut

Illinois

New Hampshire

Oregon

Texas

Virginia

Washington

Connecticut Extends Dental and Vision Insurance to Age 26

Connecticut Governor Ned Lamont signed into law SB 1004, requiring fully insured health, dental and vision insurance policies to continue coverage for a child, stepchild, or other dependent child until the policy anniversary date on or after the date the child turns age 26, even if they are offered plans through their employer. The law is effective January 1, 2022.

Background

Currently, Connecticut insurance law follows the Affordable Care Act ("ACA") in which vision and dental coverage for children is considered an essential health benefit through age 19. The law allows dental and vision policies to terminate coverage for young adults before age 26 if they obtain coverage through their employer. To ease administration of benefits, Connecticut insurers will often quote vision and dental benefits to align with the ACA's requirement of medical coverage to age 26, but until now, this was not mandated by the state. Additionally, current health law does not recognize stepchildren and other dependent children.

Employer Action

Employers should work with their broker partners and fully insured carriers to ensure compliance when the new law becomes effective on January 1, 2022, including:

- Communicating the change in the law;
- Updating eligibility rules in all required documents; and
- Facilitating enrollment/reenrollment in plans.

Illinois Passes Consumer Coverage Disclosure Act

On August 27, 2021 Governor Pritzker signed into law the Consumer Coverage Disclosure Act ("the Act") requiring all businesses that sponsor a group health plan and employ individuals in Illinois to provide a new disclosure to all Illinois employees eligible for the coverage. This disclosure requirement applies to employers of any size that sponsor a self-funded or fully insured group health plan offering coverage to employees in Illinois (regardless of where the plan is situsted).

The law requires employers to provide a written list of the covered benefits included in the group coverage in a manner that easily compares the benefits under the group plan to the essential health benefits required in the individual marketplace in Illinois. While no additional details are available at this time, the Illinois Department of Labor ("IL DOL") will provide a template in the coming weeks that employers may use to meet the requirements.

Employers must distribute the list to those eligible for the group health plan upon request, at hire, and annually thereafter. The statute is silent as to timing beyond those general periods, so it is unclear how long employers will have to respond to a request or the timeframe they are allowed after an employee's hire for the initial distribution. Additional guidance is welcomed. Employers may meet the distribution requirements by providing the information via email to employees or providing the information on a website that an employee is able to regularly access. Employers must be able to demonstrate that each employee received the information and retain such records for a period of one year.

The IL DOL may penalize employers that do not comply with the requirements of the Act. The civil penalties vary depending upon whether the employer has fewer than 4 employees or 4 or more employees. It is unclear at this time whether all employees are counted or only those employed within the state of Illinois.

Fewer than 4 employees:

- 1st offense = not to exceed $500
- 2nd offense = not to exceed $1,000
- 3 or more offenses = not to exceed $3,000

4 or more employees:

- 1st offense = not to exceed $1,000
- 2nd offense = not to exceed $3,000
- 3 or more offenses = not to exceed $5,000

The amount of the penalty will also consider good faith efforts made by the employer to comply and the gravity of the violation.

Employer Action

Employers with employees located in Illinois should reach out to their insurer or TPA and ask whether they intend to assist employers with compliance with this requirement. We will monitor and provide an update when the Illinois Department of Insurance issues additional guidance, including a disclosure template.

New Hampshire Establishes Paid Family and Medical Leave Program

New Hampshire recently established the Granite State Paid Family Leave Plan as part of its state budget bill, a unique take on family and medical leave insurance ("FMLI") wage replacement benefits. Briefly, the state will provide up to six weeks of FMLI benefits for the roughly 10,000 New Hampshire state employees. Non-state employers and non-state employees can voluntarily opt-in to the program. The law was effective July 1, 2021, and FMLI coverage will become available for purchase by January 1, 2023.

Participation

State employees will automatically be covered under the program with the state paying the full cost to provide the benefit. The state will select an insurance carrier or carriers to provide the FMLI benefits through a process established by the state's Department of Administrative Services ("DAS"). The state employees will serve as the risk pool for the program.

All non-state public and private employers with more than 50 employees can opt-in to the program. These employers have the option of paying the entire premium or share the cost with employees.

Employees of these large employers who do not opt-in or do not offer an FMLI benefit that is at least equivalent to this coverage, or employees of employers with less than 50 employees may individually opt-in to the program. Coverage through the pool for these groups will include a 7-month waiting period, a one-week elimination period, and a 60-day annual open enrollment period as established by DAS.

Amount of Benefit

Eligible employees will receive 60 percent of their average weekly wage for up to six weeks of work per year. Wages used to determine the 60 percent FMLI coverage will be capped at the amount of the Social Security taxable wage maximum.

Qualifying Reasons for Leave

Employees can generally take FMLI for the same types of leave permitted under the federal Family Medical Leave Act ("FMLA") except certain restrictions apply pertaining to leave for an employee's own serious health condition:

- The birth, placement for adoption or foster care of an employee's child within one year of birth or placement;
- Serious health condition of a family member;
- Any qualifying exigency arising from foreign deployment with the armed forces, or to care for a service member with a serious injury or illness as permitted under the federal FMLA; or
- An employee's serious health condition that is not related to employment and their employer does not offer Short Term Disability insurance.

Cost of Benefit and Who Pays?

The benefit is free to state employees and will cost up to $5 per week for all other participants.

Employers with 50 or more employees (1) opting-in to the program, or (2) do not opt-in but their individual employees elect to participate in the FMLI program, will be required to withhold and remit premiums to the program through payroll deductions.

Employees of employers with fewer than 50 employees who opt-in to the program will be required to make premium payments directly to DAS. The law does not require employers with fewer than 50 employees to offer family medical leave or process payroll deductions on behalf employees choosing to participate in the program as individuals.

Business Tax Incentive

Employers that pay for FMLI benefits can deduct 50 percent of the amount they pay in premiums from their business taxes for the taxable period in which the premiums are paid.

Employee Protections

Employers with 50 or more employees that opt-in to the program must allow their employees to be restored to the position she or he held prior to such leave or to an equivalent position by her or his employer consistent with the job restoration provisions of the federal FMLA. These employers must continue to provide health insurance to employees during the leave. However, employees must remain responsible for any employee-shared costs associated with the health insurance benefits. These employers must not discriminate or retaliate against any employee for accessing FMLI benefits. Employers of employees participating in the program may require that paid leave taken under the program be taken concurrently or otherwise coordinated with leave allowed under the terms of a collective bargaining agreement or other established employer policy or the FMLA, as applicable.

Future Regulations

While the law contains few details regarding administration of the program, it does provide direction for state regulators. Information forthcoming includes:

- The base period by which the average weekly wage will be determined.
- The tenure requirement, expressed in terms of months of work, before an employee is eligible to be covered provided, however, that no tenure requirement will apply to an employee who has already met the requirement and then changes jobs.
- A waiting period or elimination period provided, however, that a waiting or elimination period will not be a required element of the benefit structure, and DAS will have authority to implement a plan with no such requirement.
- The minimum participation requirement.
- The parameters for open enrollment periods.
- Procedures for contributory plans, partially contributory plans, and non-contributory plans.
- Procedures for payroll deduction and premium remittance for employers with more than 50 employees.

Employer Action

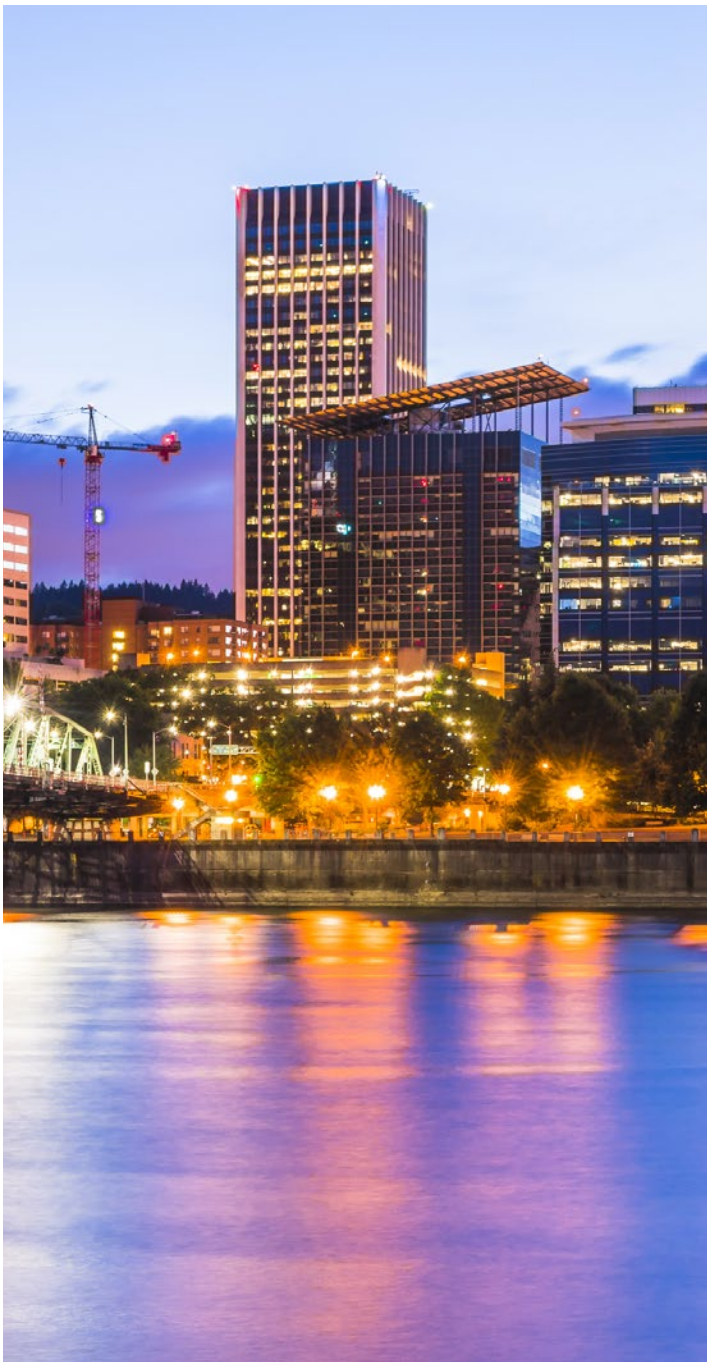
The implementation timeline of FMLI benefits is relatively aggressive. The law was effective July 1, 2021. The request for proposals for FMLI coverage by a carrier or carriers will be issued no later than March 31, 2022. The FMLI coverage will be in place for state government employees and available for purchase by other public and private employers with more than 50 employees and individuals by January 1, 2023. Employers should review their current leave programs and begin discussing with their employment and labor counsels, leave management vendors, payroll departments and payroll vendors how this law will impact their current programs so that they can make informed decisions regardless of whether they choose to opt-in to the program.

Oregon Delays Paid Family and Medical Leave

On July 27, 2021, Oregon Governor Kate Brown signed HB 3398, delaying the effective date of the Oregon Paid Family and Medical Leave law. HB 3398 will delay:

- premium payments funded by both employers and employees via payroll deductions from January 1, 2022 until January 1, 2023.
- the availability of benefits under the program from January 1, 2023 until September 1, 2023.

Additionally, the bill delays rulemaking, notice requirements, and general funding from the state.



Texas Heartbeat Act and the Possible Impact on Health Plans

Effective September 1, 2021, the Texas Heartbeat Act (the "Act," also known as Senate Bill 8) bans abortions after about six weeks of gestation except in the case of medical emergency. Additionally, the law includes a unique enforcement method, allowing private citizens to bring civil lawsuits against those who perform or are involved in the facilitation of a banned abortion.

Background

On May 19, 2021, Governor Greg Abbott signed the Act into law. The law was challenged from abortion providers and others that sought to block its enforcement before it went into effect. The Supreme Court declined to block the law preemptively by a vote of 5-4.

"Aiding and Abetting"

The law authorizes a private citizen to initiate a civil action against anyone who "knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise, if the abortion is performed or induced in violation of [the law]."

A court can award:

- injunctive relief sufficient to prevent the defendant from getting or aiding and abetting an abortion;
- statutory damages in an amount of not less than $10,000; and
- attorney 's fees.

In defining who can possibly be a defendant in a civil action under the Act, the list seems to be near limitless. Importantly, in the context of employee benefits, an employer whose plan covers abortion in violation of this law could be held liable. It could also potentially include employees at clinics; anyone who provides transportation for a patient to an abortion provider; those who donate funds for an abortion; and friends or family members who provide information to a patient about where to get an abortion.

Enforcement Challenges

Even though the Supreme Court declined to step in to stop the law from becoming effective, it is possible that the law will be found unenforceable under one or more of the following bases:

- **ERISA Preemption.** Under Section 514(a), ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." However, determining the meaning of "relate to" is often at issue in ERISA litigation.

- **General Federal Law Preemption.** The Act has been challenged by the Department of Justice on constitutional grounds as well as the supremacy clause.

- **Lack of Standing.** It is unclear whether a private citizen with no nexus to a pregnant woman can enforce the law.

- **Unauthorized Government Subcontracting.** The government is generally prohibited from being able to delegate its duties to private citizens to enforce criminal laws.

At the time of this article, BCBSTX, Cigna, and Aetna are in discussions of what changes, if any, they will make to their insured plans and communications to employers with self-funded plans but have not yet made any decisions. UHC has no plans to make any changes.

Employer Action

- Employers with self-funded plans covering abortion should decide whether they want to continue to do so.

- Employers should watch for further developments, as this law is already facing challenges.

Home Health Workers to Receive Paid Sick Leave in Virginia

Beginning July 1, 2021, all employers who employ home health workers in the Commonwealth of Virginia will be required to offer these employees paid sick leave.

Leave Accrual

As signed into law, the regulations require employees to accrue a minimum of one hour of paid sick leave for every thirty hours worked, up to a maximum of forty hours of paid sick leave in a year. The leave will begin to accrue upon commencement of employment.

Eligibility for Leave

Under the regulations, an employee is defined as a home health worker who works on average at least 20 hours per week or 90 hours per month.

The definition does not include an individual who:

- Is licensed, registered, or certified by a health regulatory board within the Virginia Department of Health Professions;
- Is employed by a hospital licensed by the Virginia Department of Health; and
- Works, on average, no more than 30 hours per month.

Reasons for Leave

Covered employees must be allowed to use accrued sick leave for any of the following reasons:

- An employee's mental or physical illness, injury, or health condition; an employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or an employee's need for preventive medical care; or
- For the care of a family member for the same reasons as stated for the employee.

Substitution of Other Leave

An employer that provides covered employees with other forms of leave, such as PTO, that meets the requirements of the law will not be required to provide additional paid sick leave.

Administration of Leave

- A covered employer is required to provide paid sick leave upon request by the employee. This request can be oral, written, electronic, or any other means acceptable to the employer.
- Although not expressly required, any such request by an employee should include an expected duration of the absence.
- Where the leave is foreseeable, the employee is required to make a good faith effort to provide the employer with notice of the need for leave in advance of the leave, as well as make reasonable efforts to schedule the leave in a manner that does not unduly disrupt the employer's operations.

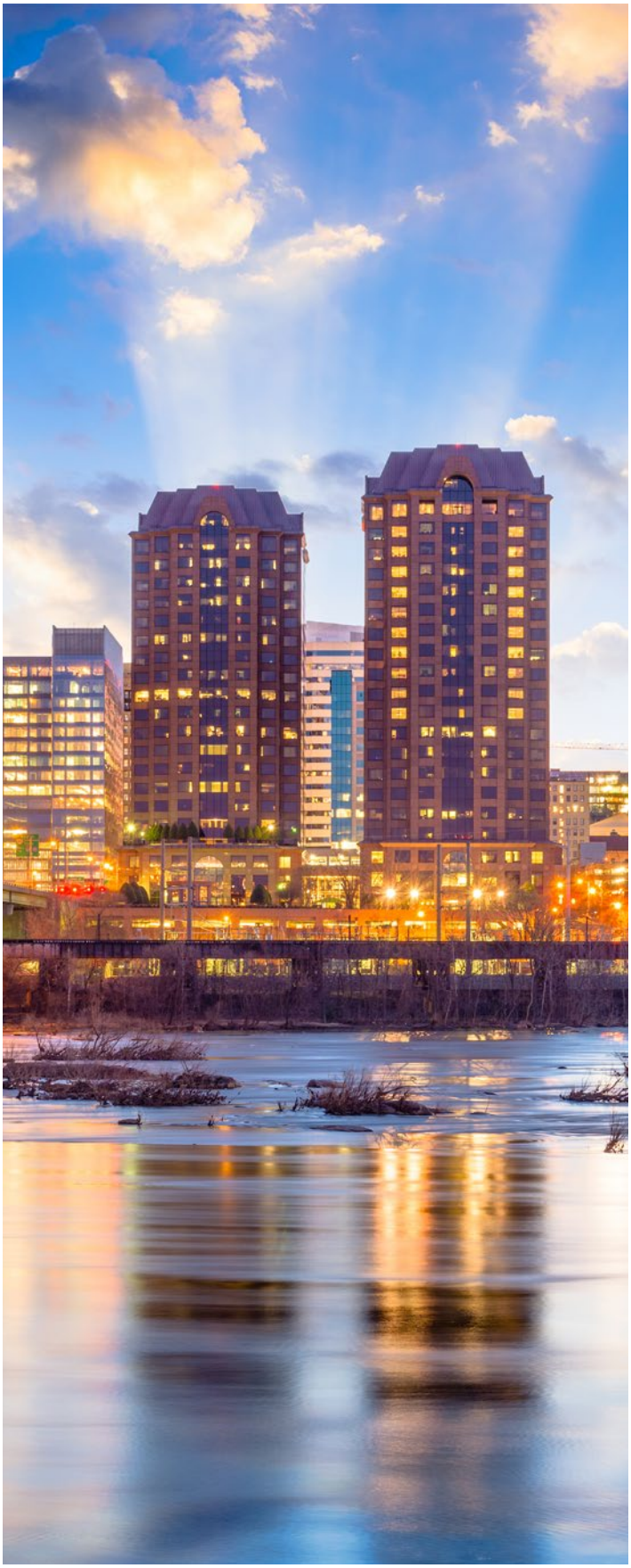
- If an employer requires notice from employees of the need to use leave, they must provide a written policy to employees which contains all applicable procedures. Failure to do so will prevent an employer from denying leave based on lack of notice received from an employee.

- An employer is permitted to require reasonable documentation that the leave was used in a permitted fashion for any paid sick leave of three or more consecutive workdays.

- Retaliation of any kind towards the exercise of these leave benefits by an employee is expressly prohibited.

Employer Action

Employers that employ home health workers should consult their existing leave policies to determine if they comply with the requirements of the statute. If not, they should work with independent employment counsel to formulate a compliant leave policy.



2022 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2022 health care expenditures required by the Improving Access to Medical Care Hotel Employees Ordinance, Seattle Municipal Code (SMC) 14.28.

Covered employers must make healthcare expenditures to or on behalf of covered employees (hourly employees who work an average of 80 hours or more per month for a covered employer) to improve their access to medical care. The amounts of the healthcare expenditure are adjusted each calendar year.

For the 2022 calendar year (January 1 to December 31, 2022), the adjusted rates are:

- $459 per month for an employee with no spouse, domestic partner, or dependents;
- $779 per month for an employee with only dependents;
- $916 per month for an employee with only a spouse or domestic partner;
- $1,375 per month for an employee with a spouse or domestic partner and one or more dependents.

For most covered employers, the Ordinance was effective July 1, 2020 or the next scheduled annual open enrollment period for health coverage (if offered) after July 1, 2020.

Employer Action

- Covered employers subject to the Ordinance should comply (or prepare to comply) with the law.
- If compliance is required with a plan year that begins in 2022 plan year, the adjusted rates should be used to determine appropriate expenditures.
- Include the adjusted rates of the expenditure as part of the annual notification required to covered employees.
- Monitor OLS FAQs and website for further information.

Washington State's PAL Assessment Update

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021. Washington's Health Care Authority ("HCA") is responsible for enforcement of this provision. The HCA contracted with KidsVax to administer the reporting and payment of the assessment. KidsVax has established a website at www.wapalfund.org to administer the reporting of covered lives and provide information to stakeholders and payers including self-funded plan sponsors.

The PAL assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provide health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

HCA updated its FAQs with the following additional information:

- Third-party vendor for administration of the WAPAL Fund assessment. HCA has contracted with KidsVax, who will act as the third-party administrator to calculate and administer the assessments. KidsVax will begin reaching out to assessed entities in summer 2021 with more information.
- Assessment applies to out-of-state employers. Out-of-state employers who insure Washington residents are subject to the assessment.
- Baseline reporting. Entities will be asked to complete a baseline-setting covered lives report to be submitted sometime in late August or early September. This baseline report will lead to a null, $0 assessment and is necessary for program implementation. It is not clear how assessed entities will be notified to submit the baseline reporting.
- First regular reporting and payment. The first regular covered lives report will be for the period of July 1 to September 30, 2021 and must be submitted within 45 calendar days after the end of the quarter (or by November 14, 2021). Invoices will be issued upon filing the covered lives report and are due upon receipt. However, entities will have a 30-day grace period to deliver payment
- Exception for self-funded tribal member-only plans. Self-funded tribal member-only plans are not subject to the PAL assessment. However, tribal governments may be subject to the assessment if they are not funded by contract health services or purchased/referred care (CHS/PRC) funds.

KidsVax has established a website, www.wapalfund.org, to provide important additional information to payers to facilitate paying the assessment, including:

- Overview of the program with FAQs
- Training webinar for payer registration and how to report covered lives
- PDF instructions for online account registration and covered lives report completion

- Page for submitting questions to KidsVax
- Registration page for email alerts

Employer Action

Employers sponsoring self-funded health plans covering Washington residents should be aware of this assessment. It appears that payers will need to register on the website and complete their first covered lives reports for the period of July 1, 2021 – September 30, 2021 as required. Payers will register by entering their federal Employer Identification Number, email address, and a password of their choice. The first covered lives report will generate a $0 (zero) assessment required for program implementation. Subsequent covered lives reports will generate assessments that can be paid by check via U.S. Mail or by ACH at the choice of the payer. It will be important to coordinate with TPAs to determine any assistance they may provide in handling the PAL assessment.

For fully insured health plans, the carrier is responsible for compliance with the PAL assessment.

2021 Compliance Bulletins: Quarter Four

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FAQs Address COVID-19 Vaccine Group Health Plan Incentives

Published: October 13, 2021

On October 4, 2021, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ Part 50 addressing several important issues concerning group health plans.

Notably, the guidance:

- Confirms incentives in a group health plan (such as premium discounts) are permissible under the HIPAA health-contingent wellness program rules provided the five criteria related to activity-only programs are met.
- Clarifies that group health plans are not permitted to deny eligibility for coverage or exclude coverage for otherwise covered items and services to treat COVID-19 based on an individual's vaccination status.
- Requires immediate coverage for COVID-19 vaccines and their administration according to the applicable scope of the Emergency Use Authorization ("EUA") or approval under a Biologics License Applications ("BLA").

Below you will find details on the guidance.

Group Health Plans and Vaccination Status

The FAQs confirm much of what we thought to be true as it relates to the use of incentives in a group health plan to encourage COVID-19 vaccinations.

A wellness program that conditions a premium discount on an individual obtaining a COVID-19 vaccine is considered an activity-only wellness program, a type of health-contingent program, which must meet the following five requirements:

1. Be reasonably designed to promote health or prevent disease.
2. Provide a reasonable alternative standard to qualify for the discount, at least for individuals for whom it is unreasonably difficult due to a medical condition or medically inadvisable to obtain the COVID-19 vaccination.

For example, an individual shows it is unreasonably difficult due to a medical condition or medically inadvisable to obtain the COVID-19 vaccination; the wellness program must offer the individual a reasonable alternative standard to qualify for the full reward, which may include offering the individual a waiver of obtaining the vaccination or the right to attest to following other COVID-19-related guidelines.

3. Provide notice of the availability of the reasonable alternative standard under the wellness program.

4. Limit the reward so it does not exceed 30% of the total cost of the group health plan coverage.

5. Give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

While the example specifically speaks to a "premium discount," a reward in this context may also include a penalty. Therefore, premium surcharges or change in cost-sharing (such as an increased deductible for unvaccinated employees) remain viable options so long as the plan otherwise meets the five HIPAA criteria for activity-only programs.

In addition:

- **Plan Design.** The guidance makes clear that under the HIPAA nondiscrimination rules, a group health plan may not discriminate in eligibility for benefits or coverage based on whether or not an individual obtains a COVID-19 vaccination beyond what is permissible under the voluntary wellness program rules described above. Thus, a group health plan may not condition eligibility for benefits or coverage for otherwise covered items or services to treat COVID-19 on a participant's or beneficiary's status as vaccinated.

- **Affordability.** An FAQ confirms that wellness incentives that relate to the receipt of a COVID-19 vaccination are treated as "not earned" when determining whether the coverage is affordable for purposes of the ACA's employer mandate. Therefore, affordability is determined based on the "unvaccinated" rate.

Finally, compliance with the HIPAA wellness rules is not determinative of compliance with any other law, including GINA, ADA, and state law. Importantly, these FAQs do not address incentives offered by employers as part of workplace policies and unrelated to their group health plan.

Timing and Scope of Coverage for COVID-19 Vaccines

According to the FAQs, effective as of January 5, 2021, non-grandfathered group health plans must cover COVID-19 vaccines and their administration, without cost sharing, immediately once the particular vaccine becomes authorized under an EUA or approved under a BLA and according to the scope of the applicable approval. This includes any EUA or BLA amendment, such as to allow for the administration of an additional dose to certain individuals, administration of booster doses, or the expansion of the age demographic for whom the vaccine is authorized or approved.

This is a change from the earlier rule which provided a 15-business day period after the approval of the Advisory Committee on Immunization Practices ("ACIP") before implementation. The Departments note in the FAQ that they are aware plans and carriers may not have understood this change and will only enforce the timing and coverage requirement prospectively, consistent with the scope of the particular EUA or BLA, to the extent additional coverage beyond what was articulated in previous guidance is required.

Employer Action

If considering COVID-19-related incentives in a group health plan, employers should carefully review this guidance and prepare to comply with the five criteria for health-contingent, activity-only wellness programs.

Employers should not deny eligibility for coverage or otherwise limit/restrict coverage for certain COVID-19 related items and services to unvaccinated participants and dependents.

- Prepare to comply immediately with coverage recommendations on COVID-19 related vaccines, as adopted by ACIP. This will include booster shots and any announced expansion in the age of the population approved for COVID-19 shots.

Attached to this Update is an appendix to highlight additional FAQs and considerations when implementing a COVID-19 vaccination program as part of a wellness program.

Surprise Medical Billing Guidance Clarifies IDR Process and Fees

Published: October 14, 2021

On September 30, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") jointly published additional interim final rules implementing provisions of the No Surprises Act ("NSA"). This is the second set of regulations to address the NSA ("Part II Regulations").

Briefly, as related to group health plans, previously-released "Part I Regulations" addressed, among other things, the following:

1. Protections for group health plan participants to limit out-of-network ("OON") cost-sharing and "balance billing" as they relate to emergency services, OON providers of air ambulance services, and non-emergency services performed by OON providers at in-network facilities (with limited exceptions).

2. A prescribed formula to determine a participant's cost-sharing for these services. In some cases, a state law or the "All-Payer Model Agreement" ("APMA") will determine a recognized amount on which participant cost-sharing amounts are based. Otherwise, participant payments will be based on a recognized amount that is generally the lesser of a qualified payment amount ("QPA") or the OON provider's billed charge.

3. A methodology for determining how much the plan will pay to the OON provider for these services. In some cases, a state law or the APMA will determine plan payment amounts. Otherwise, plan payments will be based generally an amount agreed upon between the plan and the OON provider, or an amount determined in a Federal Independent Dispute Resolution ("Federal IDR") process.

As anticipated, the new Part II Regulations primarily provide guidance on a Federal IDR process. Additional guidance, also issued on September 30, 2021, provides information on fees related to the Federal IDR process for calendar year 2022.

Further, the Part II Regulations address how the NSA interacts with the external review process mandated under the Affordable Care Act and related regulations. This includes expanding claims eligible for external review with respect to NSA-

related adverse benefit determinations, with examples, and directing the applicability of such determinations to grandfathered health plans.

Of particular note:

- The NSA rules take effect for plan years beginning on or after January 1, 2022, and apply to most group health plans (including grandfathered plans), with some exceptions.
- For fully insured group health plans, the carrier will be responsible for compliance.
- For self-funded group health plans, the plan sponsor is responsible and will need to work closely with third-party administrators ("TPAs") to comply with these rules, including implementation of an IDR process.

The Departments request comments on the Part II Regulations by December 6, 2021.

Part II Interim Final Rules

Plan/Provider Payment Process

As previously reported, the plan will determine whether the services are covered by the plan. Within 30 days of receipt of a "clean claim," the plan must send the provider an initial payment or notice of denial of the payment.

The total amount paid by a plan for items and services is referred to as the "OON Rate." Assuming state law and the APMA do not apply, the plan must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee:

- if the plan and the provider or facility have agreed on a payment amount, the agreed-on amount; or
- if the parties (plan and provider) enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

If the initial payment or denial of payment is disputed, the parties will commence an open negotiation period of 30 business days, beginning on the day the plan sends the provider an initial payment or notice of denial of the payment.

Federal IDR Process

Under the Part II Regulations, the steps to the Federal IDR Process are as follows:

1. Following a failed 30-day open negotiation period, either party may initiate the Federal IDR process.
2. The parties then may jointly select a certified IDR entity to resolve the dispute, and such entity cannot have any conflict of interest with either party.

3. If the parties cannot make a joint selection, or there is a conflict of interest with a selected certified IDR entity, the Departments will select a certified IDR entity.

4. The parties will submit their offers for payment along with supporting documentation, to the selected certified IDR entity.

5. Both parties must pay an administrative fee to the Departments – $50 each for 2022.

6. Up front, both parties must pay a certified IDR entity fee to the certified IDR entity, which should be within the range of $200 to $500, though ultimately the fee will only be paid once.

7. The parties may reach a settlement before the certified IDR entity makes a payment determination, in which case each party will receive back one-half the party's certified IDR entity fee, unless the parties agree to an alternate allocation.

8. Absent an earlier settlement, the certified IDR entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount.

9. The non-prevailing party is generally responsible for the certified IDR entity fee. Thus, the certified IDR entity will typically retain the fee paid by the non-prevailing party and return the fee paid by the prevailing party.

10. Note that a certified IDR entity must begin with the presumption that the QPA is the basis for the appropriate OON amount, and generally it must select the offer closest to the QPA. If a party submits additional permissible information, then the certified IDR entity must consider this information if it is credible. The IDR entity should deviate from the offer closest to the QPA only if submitted information clearly demonstrates that the value of the item or service is materially different from the QPA.

The table below provides further details on various deadlines in the Federal IDR process.

Open Negotiation and IDR Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified IDR entity selection	3 business days after the IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by parties	6 business days after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	10 business days after the date of certified IDR entity selection
Payment determination made	30 business days after the date of certified IDR entity selection
Payment submitted to the applicable party	30 business days after the payment determination

IDR Entity Certification Process

The rule includes details on how entities can become certified as independent IDR entities. To be certified by January 1, 2022, such entities should submit their applications by November 1, 2021. Such entities will be certified by the Departments on a rolling basis.

Certified IDR entities must meet monthly reporting requirements on payment determinations to ensure transparency in the IDR process.

Interaction of NSA with External Review Process

The Affordable Care Act, and accompanying regulations, require non-grandfathered group health plans to provide an external review process for disputing denied claims, which generally include the use of an "Independent Review Organization" (IRO). Such denied claims can occur, for example, when a plan administrator determines an item or service is not covered, is subject to restrictions on coverage, or is considered not medically necessary.

The Part II Regulations specifically provide that all plan coverage decisions pertaining to NSA protections in compliance with surprise billing and cost-sharing protections are eligible for external review. They also add several new examples to existing external review regulations, which address where external review would be available under various NSA-related plan determinations where higher cost-sharing was generally applied, including:

- Member's treatment did not involve emergency services
- Disregarding OON anesthesiology at in-network facility with no consideration of NSA applying
- Relying solely on a provider representation that member was in a condition to receive notice about NSA protections and gave informed consent to waive the protections
- No initial review of a proper medical code for certain services (routine post-natal versus neonatology), and possible error in applying informed consent to waive for ancillary services
- No review of in-surgery, OON anesthesiology services or possible error in applying informed consent to waive for ancillary services

The Part II Regulations also provide that grandfathered plans will be subject to external review requirements with respect for NSA-related coverage decisions.

Employer Action

Employers with self-funded group health plans should continue to review NSA requirements with their TPAs for compliance, effective with the first plan year that begins on or after January 1, 2022. That should include confirming that the TPA:

- Will be prepared to administer the Federal IDR process if and when necessary, and
- Can apply the plans' external review process, including working with an IRO, if and when there is a denied member claim relating to surprise billing and cost-sharing protections under the NSA. This includes grandfathered plans.

TPAs may pass costs associated with the IDR process on to plan sponsors.

Telehealth Relief for HDHPs Set to Expire

Published: October 19, 2021

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. Among other things, the CARES Act offered temporary relief related to telehealth and other remote care services when offered with a qualified high deductible health plan ("HDHP") and health savings account ("HSA").

Specifically, for plan years beginning on or before December 31, 2021, telehealth and other remote care services may be offered before satisfaction of the deductible without jeopardizing an individual's eligibility to contribute to an HSA.

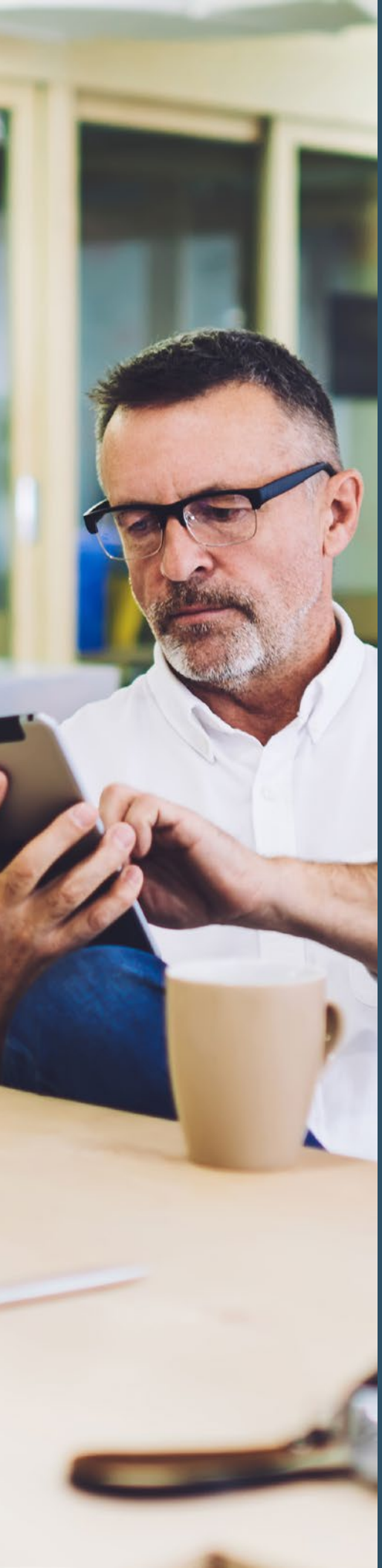
Unless further extended by legislation or regulation, this relief expires for plan years that begin on or after January 1, 2022. Employers that took advantage of this relief should now plan to charge a fair market value for telehealth or other remote care services for participants to retain HSA eligibility.

While there is support for further extending or making permanent this relief, to date there has been no legislative or regulatory action.

Employer Action

Employers with HDHPs that offered free (or reduced cost) telehealth or remote care services prior to satisfaction of the deductible should prepare to adjust their plan offerings and charge a fair market value for these services effective with the first plan year that begins on or after January 1, 2022.

We will continue to monitor developments in this area.



HHS Issues Guidance Addressing HIPAA and COVID-19 Vaccinations

Published: October 20, 2021

The Department of Health and Human Services ("HHS") issued guidance in the form of questions and answers addressing how the HIPAA Privacy Rule applies in regard to COVID-19 vaccinations. The guidance makes clear that HIPAA's privacy rules are not an obstacle to an employer that would like to establish a vaccination requirement for its employees and customers.

Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that establishes national standards to protect sensitive patient health information, commonly referred to as "protected health information" or "PHI," from being disclosed without the patient's consent or knowledge. HIPAA has three main components:

1. the Privacy Rule which provides that PHI cannot be used or disclosed without authorization unless it is for treatment, payment or health care operations;

2. the Security Rule which ensures confidentiality, integrity and availability of all electronic PHI that is created, received, maintained or transmitted; and

3. Breach Notification Rule which requires notice when PHI is acquired, accessed, used or disclosed in a manner not permitted under the Privacy rule.

Many employers questioned whether the HIPAA Privacy Rule would limit the ability of an employer to have a mandatory COVID-19 vaccination policy with respect to its employees. The guidance makes clear that HIPAA's Privacy Rule does not prevent an employer from putting forth such a policy.

The Guidance

The guidance restates an established HIPAA principle – that the Privacy Rule only applies to covered entities, including health plans, certain healthcare providers, healthcare clearinghouses and their business associates. While self-funded health plans generally operate through sponsoring employers, the guidance reiterates that the Privacy Rule does not apply to employers acting in their capacity as employers or employment records.

The HIPAA Privacy Rule does not prohibit any person (e.g., an individual or an entity such as a business), including HIPAA covered entities and business associates (which are functioning at such time in their role as an employer), from asking whether an individual has received a particular vaccine, including the COVID-19 vaccines.

HHS also explained that because HIPAA regulates the use and disclosure of PHI and not the ability to request information, the HIPAA Privacy Rule does not prohibit a covered entity from receiving COVID-19 vaccination information. However, after receipt of such information, an employer would likely have a duty to safeguard that information and keep it confidential.

The guidance also provides that an employer may require employees to disclose whether they have received a COVID-19 vaccine to the employer, clients or other parties. HHS observed that federal anti-discrimination laws do not prevent an employer from choosing to require that all employees physically entering the workplace be vaccinated against COVID-19 and provide documentation or other confirmation that they have met this requirement, subject to reasonable accommodation provisions, other equal employment opportunity considerations and conflicting state laws, as applicable. As stated before, once this information is collected, however, it must be kept confidential and stored separately from an employee's personnel file.

The HIPAA rules generally do not regulate what information can be requested from employees as part of the terms and conditions of employment. The following examples from HHS make clear that HIPAA does not prohibit a covered entity or business associate from requiring or requesting each workforce member to:

- Provide documentation of their COVID-19 or flu vaccination to their current or prospective employer.
- Sign a HIPAA authorization for a covered health care provider to disclose the workforce member's COVID-19 or varicella vaccination record to their employer.
- Wear a mask – while in the employer's facility, on the employer's property, or in the normal course of performing their duties at another location.
- Disclose whether they have received a COVID-19 vaccine in response to queries from current or prospective patients.

Finally, HHS provided that the HIPAA Privacy Rule generally does prohibit health care providers from disclosing an individual's PHI, including whether they have received a COVID-19 vaccine, to the individual's employer without consent from the individual, unless an exception applies. Exceptions could include disclosures made for treatment, payment or other health care operations.

Massachusetts Paid Family Leave 2022 Contributions and Benefits

Published: October 26, 2021

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2022. The DFML has also published (i) information regarding an employer's obligation for remitting retroactive contributions for employers moving from an approved private plan to the state plan and (ii) the FY2021 Annual Report for the PFML program.

Contributions

The 2022 contribution rate on eligible wages will be 0.68% (adjusted down from the 2021 rate of 0.75%). Individual contributions are capped by the Social Security income limit, which for 2021 is currently set at $142,800.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2022:

- Medical Leave Contribution: 0.56% of eligible wages allocated as follows:
  - Employer: At least 60% of the medical leave cost is paid by the employer (0.336%)
  - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.224%).

- Family Leave Contributions: 0.12% of eligible payroll deduction
  - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2022 contribution for medical and family leave benefits is .344% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- the portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- the portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2022:

- The MAAWW will be $1,694.24, an increase of 14% from the 2021 MAAWW of $1,487.78.
- The maximum weekly PFML benefit will be $1,084.31, an increase of 28% from the maximum weekly benefit of $850 in 2021.

Moving from a Private Plan to the State Plan

The DFML recently published information regarding an employer's obligation for remitting retroactive contributions to the state for employers with a private plan exemption initially effective prior to January 1, 2021. Employers with this exemption will need to go through one renewal cycle to not owe retroactive contributions. A renewal cycle means an initial term and one renewal term, with each term lasting a period of four completed quarters. An employer that terminates a private plan prior to the renewal cycle requirement will be responsible to remit retroactive contributions back to the effective date of the initial exemption for failure to renew.

An employer with an approved exemption that has renewed for one renewal cycle, and then attempts to terminate during that first renewal cycle (before the renewal cycle is complete), will also be responsible to remit retroactive contributions back to the effective date of the initial exemption for failure to renew.

If an employer has gone through one complete renewal cycle, at that time, an employer may terminate its private plan without owing retroactive contributions.

The DFML has created a table to demonstrate when an employer moving to the state plan would not be responsible for retroactive contributions.

Initial Exemption – Effective Date	First Date an Employer Can Move to State Plan Without Owing Retroactive Contributions
10/01/2019	10/01/2021
01/01/2020	01/01/2022
04/01/2020	04/01/2022
07/01/2020	07/01/2022
10/01/2020	10/01/2022
01/01/2021 or later	At any time. The effective date of the termination of a private plan is on the first day of the first quarter immediately following the date of the termination or nonrenewal.

The DFML notes that if the PFML exemption effective date is not aligned with the carrier policy effective date then the employer would be required to remain with the private plan until the PFML exemption end date to ensure no gaps in coverage and that they will not owe retroactive contributions and assessed penalties.

FY2021 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its first annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2021. Because the law required payments to begin on January 1, 2021, this report only contains information from January 1 to June 30, 2021. Subsequent reports will contain information from July 1 to June 30 (the Massachusetts Fiscal Year).

Employer Action

Employers should prepare for the 2022 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2022.

Reminder: Massachusetts HIRD Reporting Due December 15, 2021

Published: October 27, 2021

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure (HIRD) form through the MassTaxConnect (MTC) web portal. The HIRD reporting will be available to be filed starting November 15th **and must be completed by December 15th.**

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. Employers who currently have (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year) are required to complete the HIRD form.

- An individual is considered to be an employee if the employer included such individual in its quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. The employer is required to complete the HIRD form if it reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- For an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is considered to be an employee if he or she is hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs

Massachusetts Establishes COVID-19 Emergency Paid Sick Leave

Published: October 28, 2021

On May 28, 2021, Governor Baker signed legislation implementing COVID-19 emergency paid sick leave ("EPSL") for Massachusetts employees. Employers are required to provide up to 40 hours of EPSL to employees when they are unable to work for certain qualifying reasons related to the COVID-19 pandemic. Employees may use EPSL beginning June 7, 2021 through September 30, 2021, or until the state's EPSL fund is exhausted, whichever first occurs.

Who Must Comply?

All Massachusetts employers (private and public) are subject to EPSL. A state fund will be created to reimburse employers for EPSL benefits paid to employees.

Qualifying Reasons For Leave

Employers are mandated to provide EPSL to an employee for the following reasons related to the COVID-19 pandemic:

1. An employee's need to:
   - self-isolate and care for oneself because of the employee's COVID-19 diagnosis;
   - seek or obtain medical diagnosis, care or treatment for COVID-19 symptoms; or
   - obtain immunization related to COVID-19 or the employee is recovering from an injury, disability, illness or condition related to such immunization;

2. An employee's need to care for a family member who:
   - is self-isolating due to a COVID-19 diagnosis; or
   - needs medical diagnosis, care or treatment for COVID-19 symptoms;

3. A quarantine order, or other determination by a local, state or federal public official, a health authority having jurisdiction, the employee's employer or a health care provider that the employee's presence on the job or in the community would jeopardize the health of others because of the employee's exposure to COVID-19 or exhibiting of symptoms, regardless of whether the employee has been diagnosed with COVID-19;

4. An employee's need to care for a family member due to a quarantine order, or other determination by a local, state or federal public official, a health authority having jurisdiction, the family member's employer or a health care provider that the family member's presence on the job or in the community would jeopardize the health of others because of the family member's exposure to COVID-19, regardless of whether the family member has been diagnosed with COVID-19; or

5. An employee's inability to telework because the employee has been diagnosed with COVID-19 and the symptoms inhibit the ability of the employee to telework.

Amount of Benefits Available

An employer must provide the following amount of leave for an employee who takes EPSL as follows:

- 40 hours for an employee who works 40 hours or more per week;

- The number of hours an employee works per week on average over a 14-day period of a regular schedule when the employee works less than a 40-hour workweek but maintains a regular schedule with consistent hours per week, or

- for an employee whose schedule and weekly hours worked vary from week to week, the employee will be provided EPSL that:
  - is equal to the average number of hours that the employee was scheduled to work per week over the 6-month period immediately preceding the date on which the employee takes the EPSL, including hours for which the employee took leave of any type; or
  - if the employee did not work over a 6-month period, is equal to the reasonable expectation of the employee at the time of hiring of the average number of hours per week that the employee would normally be scheduled to work.

An employee may use EPSL on an intermittent basis and in hourly increments.

Limits on Benefits Available

Employees are eligible for up to $850 per week of EPSL. The benefit amount provided by an employer may be reduced by the amount of wages or wage replacement that an employee receives for that period under any government program or law (i.e., unemployment benefits).

EPSL may be reduced if the aggregate amount an employee would receive would exceed the employee's average weekly wage.

Employer Reimbursement

An employer who pays an employee EPSL will be reimbursed by the state within 30 business days after submitting an application (the form is not yet available) to the state. However, any qualified sick leave wages paid by an employer that are eligible for the tax credit for paid sick and paid family and medical leave under the Families First Coronavirus Response Act, or subsequent extensions, including the Consolidated Appropriations Act, 2021 and the American Rescue Plan Act of 2021, will not be eligible for reimbursement from the EPSL fund.

Benefits and Other Protections Available

EPSL is in addition to all job protected time off, paid and unpaid, that the employer is required provide to employees:

- under Massachusetts Earned Sick Time;
- under any existing policy or program of the employer;
- pursuant to a collective bargaining agreement; or
- under federal law, to the extent permitted by that federal law.

However, any employer with a separate COVID-19 sick leave policy who makes available an amount of COVID-19 sick leave sufficient to meet the requirements of EPSL, that may be used for the same purposes and under the same conditions as EPSL, is not required to provide additional COVID-19 emergency paid sick leave under EPSL.

While employees are receiving EPSL, employers must maintain all employment benefits provided or made available to an employee by the employer including, but not limited to, health insurance, group life insurance, disability insurance, sick leave, annual or vacation leave, educational benefits and pensions.

An employer may not require an employee to use other paid leave provided by the employer to the employee before the employee uses the EPSL, unless federal law requires otherwise.

It is unlawful for any employer to interfere with, restrain or deny an employee's ability to take EPSL.

Notices

Employees

An employee must provide notice to the employer of the need for EPSL as soon as practicable or foreseeable. After the first workday an employee receives EPSL, an employer may require the employee to follow reasonable notice procedures in order to continue receiving EPSL. An employer may not require, as a condition of an employee's taking EPSL, that the employee search for or find a replacement worker to cover the hours during which the employee is using EPSL.

Employers

The state will be providing model notices in English and other languages for employers to use. Employers must post this notice in a conspicuous location accessible to employees in every establishment where employees work and must provide a copy to their employees. However, in cases where the employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based platform, notification must be sent via electronic communication or a conspicuous posting in the web-based platform.

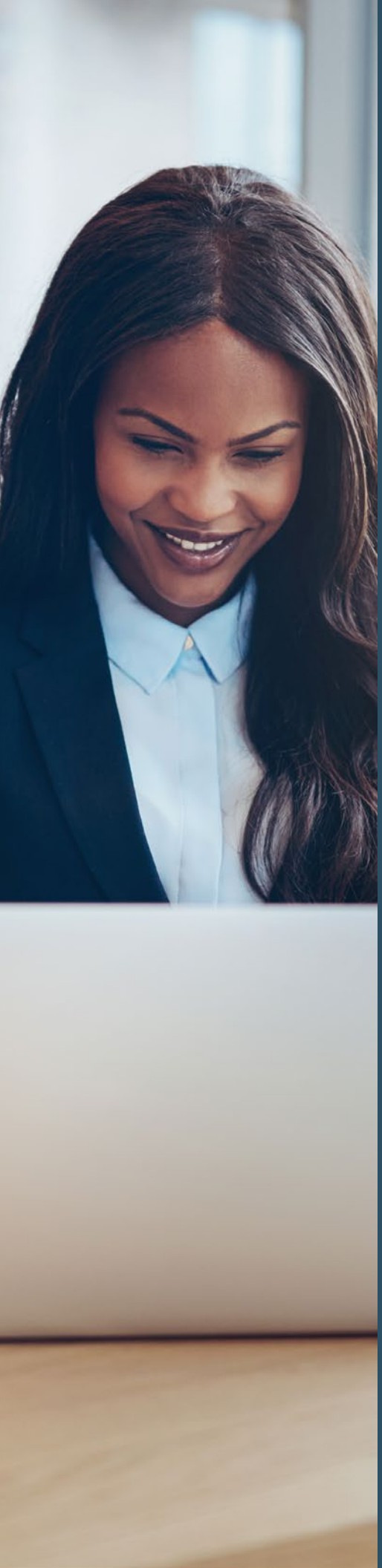
Health Information Protected

Health information related to EPSL possessed by an employer regarding an employee or employee's family member must:

- be maintained on a separate form and in a separate file from other personnel information;
- be treated as confidential medical records;
- not be disclosed except to the affected employee or with the express permission of the affected employee; and
- be kept confidential in accordance with any other state or federal law.

Employer Action

As the state releases the various notice and reimbursement forms, employers should work with their employment counsel and leave absence management vendors to ensure compliance. Employers should be aware that the EPSL law also allows for the state to promulgate regulations necessary for its implementation. We will continue to monitor any developments related to EPSL.



Guidance Clarifies Outbreak Period Rules for COBRA

Published: November 2, 2021

Recently, the Internal Revenue Service ("IRS"), in coordination with the Departments of Labor and Health and Human Services (collectively, "the Departments"), issued Notice 2021-58 which clarifies the deadlines for making COBRA elections and premium payments under the Outbreak Period rules.

Background

Briefly, in response to the COVID-19 pandemic, the Departments issued Emergency Relief Notices that established a disregarded period with respect to the following COBRA deadlines:

- 60-day period for individuals to elect COBRA.
- The due dates for making COBRA premium payments.
- The dates for individuals to inform plans of qualifying events or disability determinations.
- The date by which the plan (or sponsor/administrator) must furnish a COBRA election notice.

The disregarded period began on March 1, 2020, is measured on a participant-by-participant basis, and ends the earlier of:

- one year from the date that individuals and plans were first eligible for the relief, or
- 60 days after the end of the National Emergency (the end of the "Outbreak Period").

There has been a lot of confusion around the Outbreak Period relief and applicable deadlines related to COBRA. IRS Notice 2021-58 provides some welcome clarification.

New Guidance

The guidance clarifies that the disregarded period for electing COBRA and the disregarded period for making the initial or subsequent COBRA premium payments generally run concurrently. This means an individual who delays electing COBRA will have up to one year of total disregarded time to make the COBRA election and to make the initial COBRA payment (unless transition relief applies).

This guidance is helpful, as there was concern that an individual could have an additional year after electing COBRA to make the initial COBRA premium payment. This guidance confirms that the maximum one-year timeframes for the COBRA election and the initial COBRA premium payment run at the same time.

Therefore, individuals must make the initial COBRA election by the earlier of:

- one year and 60 days after the individual's receipt of a COBRA election notice, or
- the end of the Outbreak Period.

If an individual elected COBRA continuation coverage outside of the initial 60-day COBRA election timeframe, that individual generally will have one year and 105 days after the date the COBRA notice was provided to make the initial COBRA premium payment (60 days to make the initial COBRA election plus 45 days to make the initial COBRA premium payment = 105 days.)

If an individual elected COBRA continuation coverage within the initial 60-day COBRA election timeframe, that individual will have one year and 45 days after the date of the COBRA election to make the initial COBRA premium payment.

For each subsequent COBRA premium payment, the maximum time an individual has to make a payment while the Outbreak Period continues is one year from the date the payment originally would have been due, including the mandatory 30-day grace period.

Transition Relief for Premium Payments Due Before November 1

The guidance provides that an individual will not be required to make the initial premium payment before November 1, 2021, even if November 1, 2021 is more than one year and 105 days after the date the election notice was received, provided that the individual makes the initial premium payment within one year and 45 days after the date of the COBRA election.

This transition relief is available because there was some confusion as to whether the disregarded period for making the initial premium payment begins on the date of the COBRA election and individuals who made elections more than 60 days after receipt of the election notice may have less time than they anticipated to make the initial premium payment.

Interaction with COBRA Subsidy

As a reminder, the disregarded periods under the Emergency Relief Notices do not apply to the periods for providing required notices of the American Rescue Plan Act ("ARP") COBRA subsidy or electing subsidized COBRA coverage (the subsidy was available from April 1, 2021 through September 30, 2021).

However, the disregarded periods continue to apply to payments of COBRA premiums after the end of the subsidy period to the extent the individual is still eligible for COBRA and the Outbreak Period has not ended.

How the Relief Applies

The guidance provides 10 examples to better illustrate how the relief applies. A few of these examples are summarized below. The examples assume the Outbreak Period has not ended during the specified periods.

Example 1: COBRA election made more than 60 days after receipt of COBRA election notice.

Joe has a qualifying event triggering COBRA on August 1, 2020 and receives the COBRA election notice that same day. Joe elects COBRA on February 1, 2021, retroactive to August 1, 2020.

- Joe elected COBRA more than 60 days after receipt of the COBRA election notice.
- Joe has until November 14, 2021 (one year and 105 days after August 1, 2020) to make the initial COBRA payment.
- Initial COBRA premium payment would include the months of August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter.

Assume Joe makes his November 2020 payment timely (by December 1, 2021). However, Joe does not make a payment for December 2020 by December 31, 2021. What happens?

- Joe is not entitled to COBRA coverage for any month after November 2020 because he did not pay the December 2020 premium timely.
- The plan is not obligated to cover benefits or services for Joe that were incurred after November 30, 2020.

Example 2: COBRA election made within 60 days after receipt of COBRA election notice.

Mary has a qualifying event triggering COBRA on October 1, 2020 and receives her COBRA election notice that same day. Mary timely elects COBRA on October 15, 2020 (retroactive to October 1, 2020).

- Mary has until November 29, 2021 to make her initial COBRA premium payment (one year plus 45 days after October 15, 2020).
- Mary's initial COBRA premium payment would include only the monthly premium for October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020). Premium payments are due every month after that for the months Mary is eligible for COBRA coverage.

Example 3. Timeframe for electing COBRA.

Karen has a qualifying event triggering COBRA on August 1, 2020 and receives her COBRA election notice that same day.

- Karen has until September 30, 2021 to elect COBRA (one year plus 60 days after August 1, 2020).
- If Karen elects COBRA after September 30, 2020 (but before September 30, 2021), she has until November 14, 2021 to make the initial COBRA premium payment (one year plus 105 days after receipt of the Election Notice). The initial premium payment would include the monthly premiums for August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter.

Example 4. Applying transition relief to COBRA premium payments due before November 1, 2021.

Avery has a qualifying event triggering COBRA on April 1, 2020 and receives the COBRA election notice that same day. Avery elects COBRA on October 1, 2020 retroactive to April 1, 2020. As of July 15, 2021, Avery has not made the initial COBRA premium payment.

- Under the transition relief, Avery has until November 1, 2021 to make her initial COBRA premium payment. This is the case even though November 1, 2021 is more than one year and 105 days after April 1, 2020. This is because, under the transition relief, November 1, 2021 is less than one year and 45 days after Avery's COBRA election date of October 1, 2020.
    - The initial COBRA premium payment would include the monthly premium payments for April 2020 through October 2020.
    - The November 2020 premium is due by December 1, 2021 (one year and 30 days after the November 1, 2020), with premium payments due every month thereafter.

Example 5. Deadline to elect retroactive COBRA under the Emergency Relief Notices and not electing the COBRA subsidy.

Morgan had a qualifying event because he was involuntarily terminated from employment on August 1, 2020 and received a COBRA election notice that same day. As of September 1, 2021, he has not elected COBRA. Morgan also is an assistance eligible individual under ARP and received the required election notice on May 31, 2021. Morgan did not elect COBRA with premium assistance.

- Morgan had until September 30, 2021 to elect COBRA continuation coverage retroactive to August 1, 2020 (one year plus 60 days from August 1, 2020).
- If timely elected, Morgan has until November 14, 2021 to make the initial COBRA premium payment (one year plus 105 days after August 1, 2020).
- The initial COBRA premium payment would include the monthly premiums for August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter. Because Morgan did not elect the COBRA subsidy when offered, he is not eligible for subsidized COBRA premiums between April 1, 2021 – September 30, 2021.

Employer Action

Employers should:

- Work with their COBRA vendors to understand this new guidance and ensure administration is in accordance with the guidelines. Employers and COBRA administrators should review all the examples from the guidance to better understand these requirements.
- Understand that certain individuals may still elect retroactive COBRA coverage while the Outbreak Period is ongoing. Work with carriers (including stop loss) and TPAs to ensure appropriate coverage is available should an individual elect and pay for retroactive COBRA.
- Continue to monitor guidance and await further information as to when the Outbreak Period will officially expire.

For a copy of Notice 2021-58, visit https://www.irs.gov/pub/irs-drop/n-21-58.pdf.

HHS Extends Public Health Emergency until January 16, 2022

Published: November 8, 2021

On October 15, 2021, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective October 18, 2021. This will once again extend the Public Health Emergency period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire January 16, 2022 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, and 2) 60 days after the announced end of the National Emergency.

While there are other temporary benefit plan provisions and changes that are allowed due to the Public Health Emergency, summarized below are only those provisions directly impacted by the Emergency Period extension.

Benefit Plan Changes in Effect Through the End of the Emergency Period

- **COVID-19 Testing.** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

- **Excepted Benefits and COVID-19 Testing.** An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.

- **Expanded Telehealth and Remote Care Services.** Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.

- **Summary of Benefits and Coverage ("SBC") Changes.** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.

- **Grandfathered plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g. added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

Benefit Plan Changes in Effect Through the End of the Outbreak Period

On an individual basis, group health plans, disability, and other employee welfare benefit plans will disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.

- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth adoption, or placement for adoption.

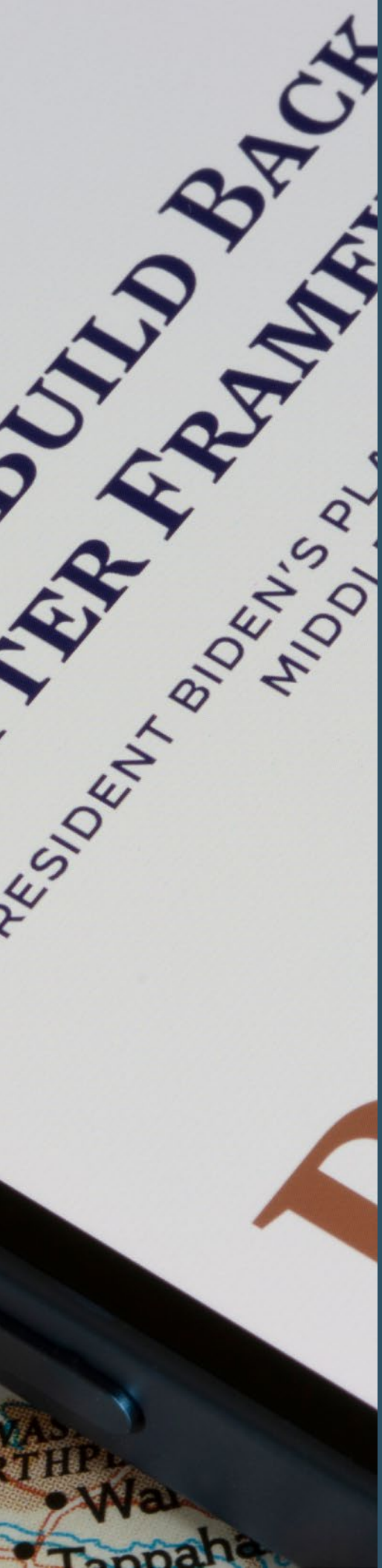
- **ERISA Claims Deadlines.** Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request.

    - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

- **Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans.** A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 testing and vaccinations and other required plan notifications. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements.



Build Back Better Legislation Includes Benefit Provisions

Published: November 9, 2021

During the last week of October 2021, the Biden administration announced a new framework for the budget reconciliation package, known as the Build Back Better Act (H.R. 5376). Subsequently, the U.S. House of Representatives released the legislative text and a section-by-section summary of the new framework. The legislation is still being negotiated, and the timing for when a vote is expected is uncertain.

If the proposed legislation is enacted into law in its current form, the following provisions would have notable impacts on employer-sponsored health and welfare benefit programs.

Increased employer contributions to avoid penalties under the ACA employer mandate

The 9.61% affordability percentage for 2022 would be reduced to **8.5%** (with no inflation adjustment) for 2022 to 2025, to determine whether employer-sponsored coverage is affordable under the Affordable Care Act's employer mandate. The lower affordability percentage means that for coverage to remain affordable, employee contributions toward self-only coverage in the lowest cost plan option offered by the employer would be reduced. This change would apply directly to all of the safe harbor calculations (W-2, Rate of Pay, and Federal Poverty Level ("FPL")) that employers generally use to avoid penalties under the ACA employer mandate.

For example, if enacted "as is," the FPL safe harbor for the lower 48 states for a plan year that begins January 1, 2022 would be $91.23 instead of $103.14 (which is based off of 9.61%, the announced threshold for 2022).

After 2025, the affordability percentage would revert to 9.5%, without any inflation adjustment thereafter.

Increased penalties under the Mental Health Parity and Addiction Equity Act

The legislation would authorize the U.S. Department of Labor to assess civil monetary penalties against plan sponsors and plan administrators for violations

of the Mental Health Parity and Addiction Equity Act ("MHPAEA") in an amount equal to the civil monetary penalties currently imposed under the Genetic Information Nondiscrimination Act ("GINA"). These changes would be effective one year after the date of enactment.

Reinstated and expanded bicycle commuting benefits

The exclusion for qualified bicycle commuting benefits would be reinstated, and the maximum benefit would increase from $20/month to 30% of the qualified parking benefit (i.e., $81/month, based on the 2021 qualified parking benefit of $270/month). In addition, the definition of qualified bicycle benefits would expand to include certain electric bicycles and the lease or rental of a bicycle (including a bikeshare). These changes would be effective for taxable years beginning after December 31, 2021.

Extended Marketplace subsidies

The legislation would extend the higher premium tax credits available in the Marketplace under the American Rescue Plan Act of 2021 ("ARPA") through 2025. In addition, the legislation would go further than ARPA by permitting employees with incomes below 138% of the Federal Poverty Level to obtain premium tax credits from 2022 to 2025 to purchase coverage in the Marketplace even if they have access to affordable healthcare coverage from their employer. The legislation appears to provide employers with relief from ACA penalties in this scenario, although the terms of that relief are uncertain.

In addition, the legislation allocates $195 million to the U.S. Department of Labor for enforcement activities relating to employer-sponsored benefit plans.

Notably, the legislation omits key priorities that were included in earlier versions of the bill, including:

- 12 weeks of federal paid family and medical leave.
- Negotiation of prescription drug prices by the federal government.
- Permanent increase in benefits limits under a dependent care flexible spending arrangement to $10,500.

Employer Action

Employers should continue to monitor the progress of the "Build Back Better" legislation.

Importantly, applicable large employers (i.e., those subject to the ACA employer mandate) should review their group health plan's contribution strategy to determine whether they will have budgetary problems in the event the 8.5% affordability threshold becomes law. They may be required to adjust the dollar amount of their employer premium contributions to preserve affordability and avoid potential exposure to ACA penalties.

OSHA's Emergency Temporary Standard: Guidance on Mandatory COVID-19 Vaccination/Testing

Published: November 9, 2021

On November 5, 2021, the Occupational Safety and Health Administration (OSHA) published its long-awaited Emergency Temporary Standard (ETS), which requires most U.S. employers with 100 or more employees to adopt a mandatory COVID-19 vaccination policy with an option to include an alternative weekly testing program.

The ETS is effective immediately and employers must begin their compliance efforts at once. Employers have until December 5, 2021, to comply with all of the requirements of the ETS, except for the weekly testing option for employees who have not been fully vaccinated. Employers have until January 4, 2022 to comply with the weekly testing option, though employers may begin complying earlier. OSHA anticipates the ETS will be in effect for six months from the date of publication in the Federal Register.

It is important to note that OSHA is seeking comments from the public on the ETS, and there is a possibility that the requirements may be expanded beyond their current parameters. In addition, multiple state attorneys general have filed lawsuits challenging the ETS. On November 6, 2021, a federal appellate court issued a temporary stay on enforcement of the ETS. The outcome of these legal challenge is unknown.

If the ETS survives legal challenge, its current provisions provide employers with a detailed roadmap of what compliance should look like. Notwithstanding the legal uncertainty, employers should take steps to prepare for compliance and monitor developments out of the courts.

Below you will find a summary of the important aspects of the ETS. The summary is not exhaustive and is not a substitute for legal advice.

Covered Employers

Private Sector - Private employers with 100 or more employees at any time during the effective period of the ETS, which begins on November 5, 2021, must comply. Employers must continue to comply for the entire duration of the ETS even if their employee count drops below 100.

Though employers with fewer than 100 employees on November 5, 2021 are not subject to the ETS, if their headcount reaches 100 employees at any time while the ETS is in effect, the employer must promptly comply. It should be noted that private employers with fewer than 100 employees may be required to comply if a state OSHA program requires compliance.

"Employees" include all employees on an employer's payroll including, but not limited to, temporary employees, part-time employees, remote employees and seasonal employees. Independent contractors are not counted as employees. Staffing agency employees are considered employees of the staffing agency and should be included in the staffing agency's headcount.

State and Local Governments - State and local governmental employers with 100 or more employees in states that have state-approved OSHA programs must comply. State and local governmental employers are not typically covered by federal OSHA requirements; however, in order for a state to receive approval to adopt its own State Plan, it must extend federal OSHA requirements to state and local governmental employers. State Plans must fully adopt the ETS by December 5, 2021; thus, their compliance date will be later than November 5, 2021. While State Plans must adopt programs that are "at least as effective as federal OSHA's requirements," states can adopt programs that are more expansive or stringent than the federal requirements. Thus, it is possible that some states may lower the compliance obligation below the 100-employee threshold.

Federal Government - The ETS does not apply to employees of federal agencies, except for those employed by the U.S. Postal Service.

States Prohibiting Mandatory Vaccinations, Testing or Face Coverings

OSHA intends for the ETS to preempt or override any attempts by states or localities to prevent vaccination or mask mandates and intends to invalidate any State or local requirements that ban or limit an employer's authority to require vaccinations, face coverings or testing.

Exempt Employees

Employees who work exclusively from home, who work exclusively outdoors, or who come into the workplace only when other employees (or customers) are not present are not covered by the ETS. However, if any such worker will be entering a covered workplace during times when other employees (or customers) are present, they must either be vaccinated or be able to present a negative test result obtained within seven days of entering the workplace.

Employees with medical conditions or sincerely held religious beliefs that prevent them from being vaccinated, undergoing weekly testing, and/or wearing a mask may be entitled to accommodations under Title VII of the Civil Rights Act or the Americans with Disabilities Act.

It is important to note that employees who have previously been diagnosed with COVID-19 are not exempt from compliance and must either be fully vaccinated or submit to weekly testing.

Full Vaccination

Employees are considered to be "fully vaccinated" two weeks after receiving a single Johnson & Johnson vaccine, or two weeks after receiving the second does of a two-dose vaccine series (i.e., Pfizer or Moderna). The ETS does not include booster shots and additional doses in the definition of fully vaccinated. The ETS provides a limited exception: employees who have completed the entire primary vaccination series by January 4, 2022 do not have to be tested even if they have not completed the two-week waiting period.

Testing

Employees who are not fully vaccinated must comply with the weekly testing requirements of the ETS. This includes unvaccinated employees, partially vaccinated employees and employees who are exempt from vaccination due to religious or disability-based restrictions. A COVID-19 test under the ETS is a test that is:

- cleared, approved or authorized, including in an Emergency Use Authorization (EUA), by the U.S. Food and Drug Administration (FDA) to detect current infection with the SARS-CoV-2 virus (e.g., a viral test);

administered in accordance with the authorized instructions; and

- not both self-administered and self-read unless observed by the employer or an authorized telehealth proctor.

Employees who fail to provide a weekly test result must be removed from the workplace until they can provide a negative test result.

Employers are not required to offer a testing option under the ETS. The ETS provides that employers that choose to adopt a mandatory vaccination-only policy may suspend or terminate employees who refuse to get vaccinated, unless their refusal is due to a medical condition or sincerely held religious belief that prevents them from being vaccinated, in which case reasonable Accommodations may have to be considered.

It is also important to note that the ETS does not require employers to pay for any costs associated with testing, although employers can choose to do so. Individual state or local laws may influence whether employers must cover the costs of testing. Group health plans are not required to cover COVID-19 testing for the purpose of the ETS.

Mask Requirements

Fully vaccinated employees are not required to wear masks. Any employee who is not fully vaccinated must wear a mask while in the workplace and when occupying a vehicle with another person for work purposes except:

- when the employee is alone in a room with floor to ceiling walls and a closed door.
- for a limited time while they are eating or drinking at the workplace, or for identification purposes in compliance with safety and security requirements.
- when the employee is wearing a respirator or facemask.
- where the employer can show that the use of face coverings in infeasible or creates a greater hazard that would excuse compliance (e.g., when it is important to see the employee's mouth for reasons related to their job duties, when the work require the use of the employee's uncovered mouth, or when the use of a face covering presents a risk of serious injury or death to the employee).

The ETS provides that a "face covering" means a covering that:

- completely covers the nose and mouth;
- is made with two or more layers of a breathable fabric that is tightly woven (i.e., fabrics that do not let light pass through when held up to a light source);
- is secured to the head with ties, ear loops or elastic bands that go behind the head. If gaiters are worn, they should have two layers of fabric or be folded to make two layers;
- fits snugly over the nose, mouth and chin with no large gaps on the outside of the face; and
- is a solid piece of material without slits, exhalation valves, visible holes, puncture or other openings.

Employer Support for Vaccination

Employers are required to provide employees with up to four hours of paid time off (PTO) from work for each required dose for a primary vaccination. Booster shots are not considered part of the primary vaccination series. Employees cannot be required to use sick, vacation or PTO time to cover these four hours.

Employers are required to provide "reasonable time and paid sick leave" to employees who suffer side effects from receiving a vaccination and need time off to recover. Employees may use available PTO or paid sick time to cover these absences, but if employees don't have enough accrued time to cover their absence, employers will have to pay for the remaining time off, and cannot advance PTO or sick leave which would result in the employee having a negative balance. The ETS does not require employers to provide PTO in connection with weekly testing, positive test results or quarantining or isolation. It should be noted that state or local laws may impose pay obligations under some of these scenarios.

Information to Provide to Employees

Employers must inform employees, in a language and at a literacy level the employee understands, about the key components of their compliance plan including, but not limited to:

- requirements for COVID-19 vaccination
- applicable exclusions from the written policy (e.g., reasonable accommodations for workers with disabilities or sincerely held religious beliefs)
- information on determining an employee's vaccination status and how this information will be collected
- paid time and sick leave for vaccination purposes and recovery from side effects
- employee obligations to provide prompt notification of positive COVID-19 tests and the employer's removal practices when notified of a positive test result of COVID-19-positive employees from the workplace
- testing and masking requirements
- disciplinary consequences for employees who do not abide by the policy
- vaccine efficacy, safety and the benefits of being vaccinated (by providing the Centers for Disease Control and Prevention (CDC) document "Key Things to Know About COVID-19 Vaccines")
- protections against retaliation and discrimination
- OSHA's prohibitions that impose criminal penalties for knowingly supplying false statements or documentation

Recordkeeping Requirements

Employers are required to keep a list of employee vaccination status that clearly indicates for each employee whether they are:

- fully vaccinated
- partially vaccinated
- not fully vaccinated because of a medical or religious accommodation
- not fully vaccinated because they have not provided acceptable proof of their vaccination status (includes employees who have chosen not to get vaccinated and have opted for weekly testing instead)

The following documents are considered acceptable for proof of vaccination:

- the record immunization from a healthcare provider or pharmacy
- a copy of the U.S. COVID-19 Vaccination Record Card
- a copy of medical records documenting the vaccination
- a copy of immunization records from a public health, state, or tribal immunization information system
- a copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) administering the vaccine(s).

Employers who have adopted a weekly testing option must maintain a record of each weekly test result for every employee subject to testing for the duration of the ETS. Test results are considered medical records under both the ETS and the Americans with Disabilities Act.

Employers must provide employees access to and copies of their individual test records upon request. In addition, upon request, employers must provide employees or employee representatives (such as union representatives) with the aggregate number of fully vaccinated employees at the workplace by the end of the next business day after the request. There is no limit on the number of times these requests can be made. Employers are also required to respond to requests from OSHA for certain records.

Positive Test of Employee/Close Contact with Positive Case

An employee who has tested positive must immediately be removed from the workplace until they either:

- receive a negative result on a COVID-19 NAAT test following a positive result on a COVID-19 antigen test (NAAT tests are less likely to provide false positives);
- meet the return-to-work criteria in the CDC's isolation guidance; or
- receive a recommendation to return to work from a licensed healthcare provider.

Employees who have tested positive for COVID-19 and returned to the workplace should be not subjected to weekly testing for 90 days following the date of their positive test.

The ETS does not require employees who have been exposed to someone diagnosed with COVID-19 to be quarantined; however, the CDC continues to recommend that unvaccinated employees be quarantined after close, prolonged contact with a COVID-positive person, and OSHA encourages employers to consider a quarantine protocol.

Employers are not required to contact trace under the ETS; however, the CDC continues to recommend contact tracing. Some state/local laws may also require contact tracing.

Employers must report each work-related COVID-19 fatality to OSHA within eight hours of learning of the fatality and each work-related COVID-19 in-patient hospitalization within 24 hours. OSHA has prepared a fact sheet explaining these reporting requirements.

Penalties

Employers that do not timely comply with the ETS may face penalties of $13,653 per violation for 2021 (2022 amounts not yet available). Willful or repeated violations can result in penalties of $136,532 per violation. States that operate their own OSHA plans must adopt maximum penalty levels that are at least as effective as federal OSHA.

Employer Action

Employers should prepare to comply and monitor developments out of the courts. If the ETS survives legal challenge, covered employers must have the following in place by December 5, 2021:

- establish a vaccination policy. OSHA has a sample mandatory vaccination policy and a sample vaccination or testing/face covering policy which may be found at https://www.osha.gov/coronavirus/ets2
- determine vaccination status of each employee, obtain acceptable proof of vaccination and maintain records and a roster of vaccination status
- provide support for employee vaccination
- require employees to promptly provide notice of positive COVID-19 test or COVID-19 diagnosis
- ensure employees who are not fully vaccinated wear face coverings when indoors or when occupying a vehicle with another person for work purposes
- provide each employee information about the ETS; workplace policies and procedures; vaccination efficacy, safety and benefits; protections against retaliation and discrimination; and laws that provide for criminal penalties for knowingly supplying false documentation
- report work-related COVID-19 fatalities to OSHA within eight hours and work-related COVID-19 in-patient hospitalizations within 24 hours
- make certain records available

By January 2, 2022, employers must ensure employees who are not fully vaccinated are tested for COVID-19 at least weekly (if in the workplace at least once per week) or within seven days before returning to work (if away from the workplace for a week or longer).

2022 Cost of Living Adjustments

Published: November 15, 2021

The IRS recently released cost of living adjustments for 2022 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual Contribution Limitation

For plan years beginning in 2022, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $2,750 to $2,850.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Annual Maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins in 2022 that can be carried over to the following plan year is $570.

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a maximum of $500 to 20% of the currently indexed health FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2022, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased to $280.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $130,000 to $135,000 for 2022.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2022 increased from $185,000 to $200,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

Non-Grandfathered Plan Out-Of-Pocket Cost-Sharing Limits

The 2022 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $8,700 for self-only coverage and $17,400 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2022, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $5,450 ($11,050 for family coverage) (increased from 2021).

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2022, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Code Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $1,800 (unchanged from 2021).

Health Savings Accounts

As announced in May 2021, the inflation adjustments for health savings accounts (HSAs) for 2022 were provided by the IRS in Rev. Proc. 2021-25.

Annual contribution limitation

For calendar year 2022, the limitation on HSA contributions for an individual with self-only coverage under a high deductible health plan is $3,650. For calendar year 2022, the limitation on HSA contributions for an individual with family coverage under a qualifying high deductible health plan is $7,300.

Qualifying high deductible health plan

For calendar year 2022, a "qualifying high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage (unchanged from 2021), and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,000 for self-only coverage or $14,100 for family coverage.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution

Individuals who are age 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

New Jersey Releases 2022 Disability and Family Leave Amounts

Published: December 1, 2021

New Jersey has announced the 2022 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs as follows:

Maximum TDI and FLI Weekly Benefit	$993
Alternative Earnings Test Amount for TDI and FLI	$12,000
Base Week Amount for TDI and FLI	$240
Taxable Wage Base (employers) for TDI	$39,800
Taxable Wage Base (employees) for TDI and FLI	$151,900
Employee Contribution Rate for TDI	0.14%
Employee Contribution Rate for FLI	0.14%

Temporary Disability Insurance 2022

Temporary Disability Insurance provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons. To be eligible for TDI, employees must have worked 20 weeks earning at least $240 per week ("Base Week Amount") or have earned a combined total of $12,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $993. TDI may be payable for up to 26 weeks in a 52-week period.

Employees and employers contribute to TDI. Employees contribute 0.14% of wages up to the 2022 Taxable Wage Base (Employee) of $151,900 equal to $212.66.

Employers contribute based on TDI experience anywhere from 0.10% and 0.75% of an employee's wages up to the 2022 Taxable Wage Base (Employer) of $39,800. The maximum annual contribution will range between $39.80 and 298.50.

Family Leave Insurance 2022

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member. Similar to TDI, to be eligible for FLI employees must have worked 20 weeks earning at least $240 per week ("Base Week Amount") or have earned a combined total of $12,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $993. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.14% of wages up to the 2022 Taxable Wage Base (Employee) of $151,900 equal to $212.66.

Comparison to 2021

	2022	2021	Percentage Change
Maximum TDI/FLI Weekly Benefit	$993	$903	10.0%
TDI Employee Contribution Rate	0.14%	0.47%	(70.2)%
TDI Maximum Annual Employee Contribution	$212.66	$649.54	(67.2)%
TDI Maximum Annual Employer Contribution	$39.80 to $298.50	$36.20 to $271.50	10.0%
FLI Employee Contribution Rate	0.14%	0.28%	(59.0)%
FLI Maximum Annual Employee Contribution	$212.66	$386.96	(67.2)%

New York State Modifies Paid Family Leave

Published: December 2, 2021

On November 1, 2021 Governor Kathy Hochel signed legislation to expand the definition of a family member to include siblings under New York Paid Family Leave ("NYPFL").

- Effective January 1, 2023 eligible employees will be able to take job-protected NYPFL to care for a sibling.
- The legislation defines a sibling as a biological or adopted sibling, a half-sibling or step-sibling.
- A family member continues to include a child, parent, grandparent, grandchild, spouse, or domestic partner for whom NYPFL may be taken.

NYPFL is currently available to most eligible employees who work for private New York State employers to bond with a new child through birth, adoption or foster care placement, care for a family member with a serious health condition, or assist loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service.

As a reminder, eligible employees may receive up to 12 weeks of partial pay (67% of average weekly wages) to the state maximum weekly benefit. For 2022, the state maximum weekly benefit has been set at $1,068.36.

IRS Releases Proposed Regulations on ACA Reporting and Other Issues

Published: December 6, 2021

On November 22, 2021, the Internal Revenue Service ("IRS") released proposed regulations that provide some relief with respect to ACA reporting requirements.

The proposed rule:

- Makes permanent an automatic extension of 30 days to furnish IRS Forms 1095-C (and 1095-B) to individuals. Effectively, this moves the due date for furnishing these forms to full-time employees and other individuals from January 31 to March 2 each year (or, if March 2nd falls on a weekend or holiday, the next business day).

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.

- Creates an alternative method for furnishing individuals with IRS Form 1095-B (and, in some cases, IRS Form 1095-C) as proof of minimum essential coverage (MEC).

Therefore, with respect to Forms 1095-C for calendar 2021, applicable large employers ("ALEs") have until March 2, 2022 (rather than January 31, 2022) to furnish these forms to full-time employees and other individuals.

It is important to note that the proposed rule does not extend the deadline to file completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) with the IRS. The due date remains March 31, 2022 (or February 28, 2022 for paper filing if filing fewer than 250 forms).

Please note, while the 2021 Forms 1094-C and 1095-C have been finalized, the instructions are not yet available. Once published, the instructions should be available on this website: https://www.irs.gov/forms-pubs/about-form-1095-c.

Below you will find additional details.

Automatic Extension of Time for Furnishing ACA Statements

Under the ACA, January 31 is the deadline to furnish IRS Forms 1095-C and 1095-B to certain individuals (such as full-time employees, in the case of IRS Form 1095-C) with respect to the preceding calendar year. The proposed regulations grant an automatic extension of 30 days in which to furnish these statements to individuals. The extension is automatic; employers or other reporting entities are not required to file a request with IRS, or to demonstrate reasonable cause to justify the extension.

Employers may rely on this relief for calendar year 2021 filings. This means Wednesday March 2, 2022 is the deadline to furnish individuals with a 2021 Form 1095-C or 1095-B.

While the IRS has provided the automatic extension of time to furnish the Form 1095-C (or Form 1095-B), if operating in a state with an individual mandate the timing to furnish proof of coverage to covered residents may be different.

Elimination of Transitional Good Faith Relief

Since 2015, the IRS provided reporting entities with relief from penalties if those entities could show they made good faith efforts to comply with the information reporting requirements. This relief has been extended each year, with the IRS announcing that 2020 would be the last year that transitional good faith relief would be available.

The proposed rule confirms that the good faith relief from penalties for reporting incorrect or incomplete information on Forms 1094-C, 1095-C, 1094-B and 1095-B is no longer available after 2020. For 2021, penalties for incorrect or incomplete forms furnished to individuals can be $280/return. Additionally, incomplete or incorrect forms filed with the IRS may trigger a $280/return penalty.

While the reasonable cause exception remains available and may provide relief from penalties for entities that can show a reasonable cause for failing to timely or accurately complete their reporting requirements, with the elimination of the good faith relief employers will want to take steps to ensure the accuracy of their forms and filings.

Alternative Method for Furnishing ACA Statements

Under the ACA, IRS Forms 1095-C and 1095-B must be sent by first class mail to the last known permanent address of the individual. If no permanent address is known, the statement must be sent by first class mail to the individual's temporary address. The statement may also be furnished electronically if certain requirements are met.

The proposed regulations would make permanent an alternative method for furnishing IRS Forms 1095-B (and, in some limited cases, IRS Forms 1095-C) to individuals, for as long as penalties under the ACA's individual shared responsibility rules remain zero. The alternative method would be available to the following reporting entities:

- Health insurance carriers and plan sponsors (other than ALEs) that are using IRS Form 1095-B to provide proof of MEC
- ALEs with a self-funded group medical plan that are using IRS Form 1095-B or 1095-C to provide proof of MEC to individuals who are not considered "full-time" under the ACA for any month of the calendar year (i.e., non-full-time employees and non-employees covered under the plan during the calendar year)
- Small employers (not ALEs) with a self-funded health plan that are using IRS Form 1095-B to provide proof of MEC

The alternative method is not available to ALEs that are furnishing IRS Form 1095-C to employees considered "full-time" under the ACA for one or more months of the calendar year. Further, the alternative method may not be available if operating in a state with an individual mandate where Forms 1095-C or 1095-B must be furnished to covered residents. Keep in mind, if the alternative method is used, the reporting entity must still file the Form 1095-B with the IRS.

The following steps must be followed by a reporting entity that elects to use the alternative method:

- A clear and conspicuous notice that meets certain technical requirements must appear on the reporting entity's website
- The notice must state that covered individuals may receive a copy of IRS Form 1095-B (and, in some cases, IRS Form 1095-C) upon request, and informs them how the request may be made
- The notice must appear in the same website location through October 15 (or the next business day) following the end of the calendar year
- IRS Form 1095-B (or, in some cases, IRS Form 1095-C) must be furnished to the requesting individual within 30 days after the request is received; the ACA statement may be furnished electronically if certain requirements are met.

If the proposed regulations are finalized without change, the alternative method would be available to reporting entities that are furnishing IRS Forms 1095-B (and, in some cases, IRS Forms 1095-C) for calendar year 2021, as well as for future calendar years.

Employer Action

Employers should continue to monitor the status of the proposed rule.

- With respect to furnishing Forms 1095-C for CY 2021, employers may rely on the proposed rule and must furnish these statements no later than March 2, 2022 (versus January 31, 2022).
- Employers should take extra care that Forms 1094-C and 1095-C are complete and accurate as the transitional good faith relief is no longer available with respect to calendar year 2021 filings (and thereafter).
- Determine whether your carriers will take advantage of the alternative furnishing method with respect to Forms 1095-B they issue.
- If operating in a state with an individual mandate (California, District of Columbia, Massachusetts. New Jersey, Rhode Island and Vermont), and required to furnish covered residents with proof of coverage during the calendar year, ensure you continue to comply with state rules.

Guidance on Prescription Drug Reporting

Published: December 7, 2021

On November 23, 2021, the Office of Personnel Management and the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") published interim final regulations under the Consolidated Appropriations Act, 2021 ("CAA") that require group health plans to submit an annual report to the federal government on prescription drugs and health care spending. The reports for calendar years 2020 and 2021 are due on December 27, 2022, and the reports for subsequent calendar years are due on the following June 1.

The annual reporting requirement generally applies to all group health plans. It does not apply to excepted benefit plans, short-term limited duration insurance, and health reimbursement arrangements and certain other account-based plans.

Fully insured group health plans can transfer the reporting obligation to the insurance carrier by entering into a written agreement that obligates the carrier to perform the reporting function. The carrier will then be liable for any reporting violation.

A self-funded group health plan can also enter into a written agreement with a third-party administrator ("TPA"), or a pharmacy benefit manager ("PBM") or other third party, to fulfill the reporting function, but the plan remains liable for any reporting violation.

According to the interim final regulations, the following information must be included in the annual report filed with the federal government:

- Total healthcare spending, broken down by type of cost (hospital care, primary care, specialty care, prescription drugs, and other medical costs, including wellness services)
- The 50 most frequently dispensed name-brand prescription drugs
- The 50 prescription drugs that generated the highest total annual spending
- The 50 prescription drugs with the greatest increase in total annual spending compared to the previous calendar year

- Prescription drug rebates, fees and other remuneration paid by drug manufacturers to the plan in each therapeutic class of drugs, as well as for each of the 25 drugs that generated the highest rebate amounts
- The impact of prescription drug rebates, fees and other remuneration on premiums and out-of-pocket costs

The interim final regulations contain standards and definitions that, for example, identify prescription drugs on a uniform basis regardless of dosage strength, package size, or mode of delivery.

Information in the report must be aggregated separately for each state in which coverage was provided under the plan, except as set forth in the following chart:

Type of Group Health Plan	Information Must Be Aggregated in the Report
Self-funded plan	For the state in which the plan sponsor has its principal place of business
Fully insured plan (other than a plan described below)	For the state where the insurance contract was issued
Health coverage provided through a group trust or multiple employer welfare arrangement ("MEWA")	• For the state where the employer has its principal place of business, if the plan is sponsored at the individual employer level; or • For the state where the association has its principal place of business, if the association qualifies as the employer under federal ERISA law; or • For the state where the association is incorporated, if the association has no principal place of business and qualifies as the employer under federal ERISA law
Individual health insurance sold through an association	For the issue state of the certificate of coverage

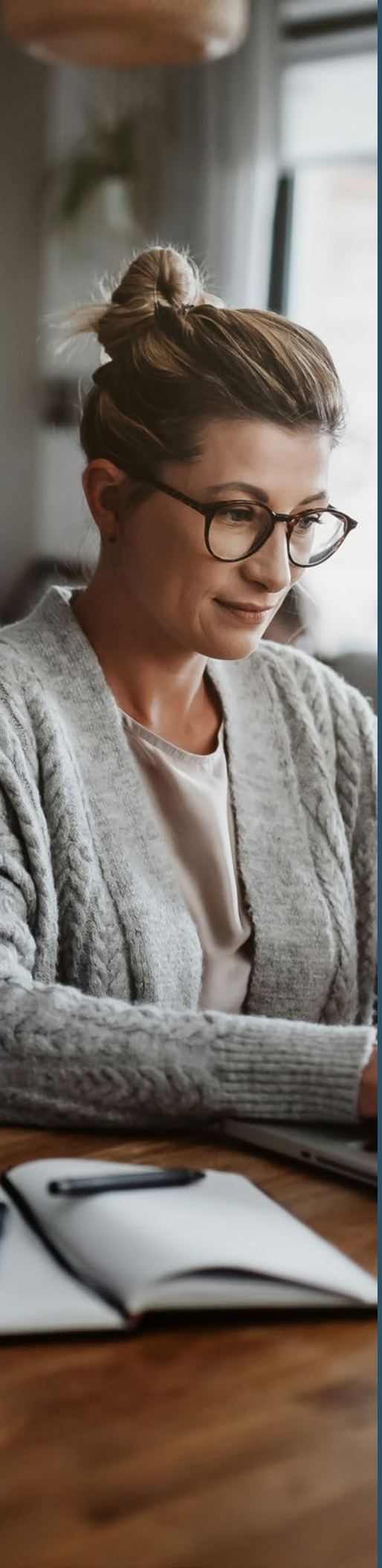
The Departments intend to compile and analyze the reports that it receives under the interim final regulations, and to publish its findings every two years to better understand prescription drug pricing trends and their effect on premiums and out-of-pocket costs.

Employer Action

While the deadline for calendar year 2020 and 2021 reporting is a year out (December 27, 2022), employers should start discussing next steps with brokers, carriers, TPAs and PBMs.

Fully insured plans. Employers should enter into written agreements with their insurance carriers and HMOs to transfer the reporting obligation and liability to the carrier.

Self-funded plans. Employers should enter into written agreements with TPAs, PBMs, or other third parties to ensure the vendor will provide the required reporting to the Departments. As the self-funded plan remains liable for reporting, employers should monitor the reporting efforts of the TPA or other third party to help minimize the exposure to liability for any reporting violation.



Winter Action Plan to Battle COVID-19

Published: December 10, 2021

On December 2, 2021, the Biden administration issued a nine-pronged plan to combat COVID-19 as the winter months approach and the new Omicron variant poses risk of new infections. The plan covers:

1. Boosters for adults
2. Vaccinations to protect children and keep schools open
3. Expanded free at-home testing
4. International travel protections
5. Workplace protections
6. Rapid response teams to battle rising cases
7. Supplying treatment pills to help prevent hospitalizations and death
8. Continued commitment to global vaccination efforts
9. Steps to ensure preparation for all scenarios

Aspects of this plan will affect employers and group health plans, as follows:

- **Expanded free at-home testing.** The Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") are directed to issue guidance by January 15, 2022, to clarify that individuals who purchase over-the-counter ("OTC") COVID-19 diagnostic tests can seek reimbursement from their group health plan or health insurance issuer to cover the cost of the OTC test during the public health emergency. The plan notes that, consistent with current guidance, group health plans are not required to cover testing for public health surveillance or employment purposes.

- **PTO for booster shots.** While all federal employees currently receive paid time off to get booster shots, employers are called upon to provide the same paid time off for their employees, if they are not doing so already, including paid time off for family members getting their first, second, or booster shots.

- **Targeting outreach to Medicare beneficiaries.** CMS is launching an initiative to get Medicare beneficiaries booster shots. CMS will be sending all Medicare beneficiaries a notice providing information on access to booster shots in their community as well as emails.

- **Protecting Workplaces to Keep Businesses Open.** The administration is calling on businesses to move forward with requiring their workers to get vaccinated or be tested weekly. No new guidelines or requirements are part of this provision. The emphasis on encouragement is likely in response to the ongoing legal challenges to the federal vaccine mandates. Currently, the courts have issued an enforcement stay with respect to the OSHA Emergency Temporary Standard ("ETS"), applicable to private employers, and a nationwide preliminary injunction with respect to both the CMS interim final rule applicable to health care workers and the federal contractor mandate.

Future guidance is expected to clarify and implement the provisions outlined in this plan. We are monitoring this information and will report on developments.

Final 2021 Instructions for Forms 1094-C and 1095-C Issued

Published: December 17, 2021

The IRS released final Instructions for Forms 1094-C and 1095-C for calendar year 2021 reporting.

Background

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2021 in preparation to complete, furnish and file these forms for 2021.

As previously reported, the IRS issued a proposed rule that:

- Makes permanent an automatic extension of 30 days to furnish IRS Forms 1095-C to individuals. Therefore, for calendar year 2021, the due date to furnish Form 1095-C to full-time employees and other individuals is March 2, 2022.

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.

The instructions generally reinforce what is set forth in the proposed rule, with some new information as it relates to an individual coverage health reimbursement arrangement ("ICHRA").

What's New?

Other than what was previously announced, the changes included in the 2021 instructions are minimal.

New Codes for ICHRAs

If an ALE offers an ICHRA for 2021, the Form 1095-C has been modified to add new codes 1T and 1U for ICHRAs offered to the employee and spouse but not dependents.

2021 Penalties

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. Good faith relief is no longer available. However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2021, the following penalties may apply:

- Failure to file a correct return is $280/statement (total calendar year penalty not to exceed $3,426,000).
- Failure to furnish a correct statement is $280/statement (total calendar year penalty not to exceed $3,426,000).

An employer that fails to both file and furnish a correct statement is subject to a combined penalty of $560/statement with a maximum penalty of $6,852,000.

Employer Action

Employers should begin preparing and ensure that statements are furnished to full-time employees and other individuals by March 2, 2022. If you are an employer with employees residing in a state with an individual mandate (e.g., California, the District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont) the deadlines may be different than what is required by the IRS. Many states are still reviewing their policies in light of the recently announced federal delay.

Employers should be certain the statements are complete and accurate since the good faith relief is no longer available.

OSHA's Emergency Temporary Standard

Guidance on Mandatory COVID-19 Vaccination/Testing

Published: December 21, 2021

UPDATE: On December 17, 2021, in a 2-1 decision, the 6th Circuit Court of Appeals allowed the Occupational Safety and Health Administration's ("OSHA") Vaccination and Testing Emergency Temporary Standard ("ETS") to move forward by lifting an earlier court's stay that had put the ETS on hold. In response to the court's decision, OSHA has initiated an aggressive implementation and enforcement schedule.

While OSHA expects covered employers to begin complying immediately, the agency has said it will delay enforcement of the vaccination requirements of the ETS until January 10, 2022, and will wait until February 9, 2022, to start enforcing the optional testing component of the ETS. Both of those dates are quickly approaching.

Although the ETS is moving forward for now, the litigation process continues, as the parties challenging the ETS immediately appealed the court's decision to the U.S. Supreme Court. While the Supreme Court will ultimately determine the ETS' fate, in the interim, OSHA has made it clear that it intends to move forward with full enforcement. As a result, covered employers will have to decide how best to re-start their compliance efforts.

Background

On November 5, 2021, OSHA published its long-awaited Emergency Temporary Standard (ETS), which requires most U.S. employers with 100 or more employees to adopt a mandatory COVID-19 vaccination policy with an option to include an alternative weekly testing program.

While the ETS was effective immediately, legal challenges and a nationwide stay halted OSHA's implementation and enforcement efforts. On December 17, 2021, the 6th Circuit Court of Appeals dissolved the stay, allowing the ETS to take effect. The states and businesses challenging the requirement have appealed the court's decision to the U.S. Supreme Court, who may have the final word on whether the ETS remains in effect.

With the ETS now in effect, employers should consider their compliance efforts. To account for the uncertainty created by the stay, OSHA is exercising enforcement discretion with respect to the compliance dates to provide employers with sufficient time to come into compliance.

OSHA will not issue citations for non-compliance with any of the requirements of the ETS before **January 10, 2022** and will not issue citations for non-compliance with the weekly testing requirements before **February 9, 2022** so long as the employer is exercising reasonable, good faith efforts to come into compliance with the standard. OSHA plans to work closely with the regulated community to provide compliance assistance.

This is a rapidly changing environment, but if the ETS survives legal challenge, its current provisions provide employers with a detailed roadmap of what compliance should look like. Even with the legal uncertainty, employers should take steps to prepare for compliance and monitor developments out of the courts.

Below you will find a summary of the important aspects of the ETS. The summary is not exhaustive and is not a substitute for legal advice.

Covered Employers

Private Sector

Private employers with 100 or more employees at any time during the effective period of the ETS, which begins on November 5, 2021, must comply. The definition of "employee" includes all employees on an employer's payroll, including temporary employees, part-time employees, remote employees, seasonal employees, etc. Independent contractors are not counted as employees. Staffing agency employees are considered employees of the staffing agency and are included in the staffing agency's headcount, not the host employer's headcount.

Employers with 100 or more employees on November 5, 2021 must continue to comply for the entire duration of the ETS even if their employee count subsequently drops below 100.

Employers with fewer than 100 employees on November 5, 2021 are not subject to the ETS; however, if headcount reaches the 100-employee threshold at any time while the ETS is in effect, then the employer must promptly comply.

State and Local Governments

State and local governmental employers with 100 or more employees in states that have state-approved OSHA programs must comply. State and local governmental employers are not typically covered by federal OSHA requirements. However, a condition for a state receiving approval to adopt its own State Plan is that it extends federal OSHA requirements to state and local governmental employers.

Employers not Covered

The following employers are not covered under the ETS:

- Workplaces covered by other federal mandates, such as the previously issued Healthcare ETS, or federal contractor employers covered by the Safer Federal Workforce Task Force COVID-19 Workplace Safety Guidance
- State and local governmental employers in states without approved state OSHA programs
- Private employers with fewer than 100 employees, unless a state OSHA program requires them to comply

States must adopt programs that are "at least as effective as federal OSHA's requirements;" however, OSHA allows states to adopt programs that are more expansive or stringent than the federal requirements, so it's possible that some states may lower the compliance obligation below the 100-employee threshold.

Some states, like Montana and Texas, have laws or executive orders that may prevent vaccine or mask mandates. OSHA believes it has the authority to preempt or override any attempts by states or localities to prevent vaccination or mask mandates. According to the guidance: "OSHA intends for the ETS to preempt and invalidate any

State or local requirements that ben or limit an employer's authority to require vaccination, face covering, or testing."

Exempt Employees

Employees who work exclusively from home, who work exclusively outdoors, or who come into the workplace only when other employees (or customers) are not present are not covered by the ETS. However, if any such worker will be entering a covered workplace during times when other employees (or customers) are present, they must either be vaccinated or be able to present a negative test result obtained within seven days of entering the workplace.

Employees with medical conditions or sincerely held religious beliefs that prevent them from 1) being vaccinated, 2) undergoing weekly testing, and/or 3) wearing a mask may be entitled to accommodations under Title VII of the Civil Rights Act or the Americans with Disabilities Act.

Employees who have previously been diagnosed with COVID-19 are not exempt from compliance and must either be fully vaccinated or submit to weekly testing.

Full Vaccination

Employees are considered to be "fully vaccinated" two weeks after receiving a single Johnson & Johnson vaccine, or two weeks after receiving the second does of a two-dose vaccine series (i.e., Pfizer or Moderna). Booster shots and additional doses are not included in the definition of fully vaccinated under the ETS.

Testing

Employers do not have to offer a testing option. The ETS states that employers must adopt a mandatory vaccination program, but that employers may also choose to adopt a weekly testing option. As OSHA puts it, for an employer that decides to adopt a weekly testing option, "that simply means that employees themselves may choose not to get vaccinated, in which case they must get tested and wear face coverings per the requirements of the standard."

According to the ETS, employers that choose to adopt a mandatory vaccination-only policy may suspend or terminate employees who refuse to get vaccinated, unless their refusal is due to a medical condition or sincerely held religious belief that prevents them from being vaccinated, in which case reasonable accommodations may have to be considered.

Covered employees who are not "fully vaccinated" must comply with the weekly testing requirements of the ETS. This includes unvaccinated employees, partially vaccinated employees and employees who are exempt from vaccination due to religious or disability-based restrictions.

Under the ETS, a COVID-19 test under the ETS is a test that is:

- cleared, approved or authorized, including in an Emergency Use Authorization (EUA), by the U.S. Food and Drug Administration (FDA) to detect current infection with the SARS-CoV-2 virus (e.g., a viral test);
- administered in accordance with the authorized instructions; and
- not both self-administered and self-read unless observed by the employer or an authorized telehealth proctor.

Acceptable tests include tests processed by a laboratory (whether collected at home or at a testing facility), tests witnessed or overseen by the employers or professionals (including telehealth), and tests where specimen collection and processing is either done or observe by an employer. Both Nucleic Acid Amplification Tests (NAAT) and antigen tests are acceptable, so long as they are not self-administered and self-read. However, antibody tests do not meet the definition of COVID-19 test for the purposes of the ETS.

The ETS does not require employers to pay for any costs associated with testing, although employers can choose to do so. Individual state or local laws may influence whether employers must cover the costs of testing. Group health plans are not required to cover COVID-19 testing for employment purposes.

Employees who fail to provide a weekly test result must be removed from the workplace until they can provide a negative test result.

Mask Requirements

Fully vaccinated employees are not required to wear masks. Any employee who is not fully vaccinated must wear a mask while in the workplace and when occupying a vehicle with another person for work purposes except under the following circumstances:

- when the employee is alone in a room with floor to ceiling walls and a closed door.
- for a limited time while they are eating or drinking at the workplace, or for identification purposes in compliance with safety and security requirements.
- when the employee is wearing a respirator or facemask.
- where the employer can show that the use of face coverings in infeasible or creates a greater hazard that would excuse compliance (e.g., when it is important to see the employee's mouth for reasons related to their job duties, when the work require the use of the employee's uncovered mouth, or when the use of a face covering presents a risk of serious injury or death to the employee).

Employer Support for Vaccination

Employers are required to provide employees with up to four hours of paid time off (PTO) from work for each required does for a primary vaccination. Booster shots are not considered part of the primary vaccination series. Employees cannot be required to use sick, vacation or PTO time to cover these four hours.

Employers are required to provide "reasonable time and paid sick leave" to employees who suffer side effects from receiving a vaccination and need time off to recover. Available PTO or paid sick time may be used to cover these absences, but if employees don't have enough accrued time to cover their absence, employers will have to pay for the remaining time off, and cannot advance PTO or sick leave which would result in the employee having a negative balance. The ETS does not require employers to provide PTO in connection with weekly testing, positive test results or quarantining or isolation. It should be noted that state or local laws may impose pay obligations under some of these scenarios.

Information to Provide to Employees

The ETS requires employers to adopt a robust compliance policy and inform employees, in a language and at a literacy level the employee understands, about the key components of their compliance plan including, but not limited to, the following:

- requirements for COVID-19 vaccination
- applicable exclusions from the written policy (e.g., reasonable accommodations for workers with disabilities or sincerely held religious beliefs)
- information on determining an employee's vaccination status and how this information will be collected
- paid time and sick leave for vaccination purposes and recovery from side effects
- employee obligations to provide prompt notification of positive COVID-19 tests and the employer's removal practices when notified of a positive test result of COVID-19-positive employees from the workplace
- testing and masking requirements
- disciplinary consequences for employees who do not abide by the policy
- vaccine efficacy, safety and the benefits of being vaccinated (by providing the Centers for Disease Control and Prevention (CDC) document "Key Things to Know About COVID-19 Vaccines")
- protections against retaliation and discrimination
- OSHA's prohibitions that impose criminal penalties for knowingly supplying false statements or documentation

Recordkeeping Requirements

Employers are required to keep a list of employee vaccination status that clearly indicates for each employee whether they are:

- fully vaccinated
- partially vaccinated
- not fully vaccinated because of a medical or religious accommodation
- not fully vaccinated because they have not provided acceptable proof of their vaccination status (includes employees who have chosen not to get vaccinated and have opted for weekly testing instead)

The following documents are considered acceptable for proof of vaccination:

- the record immunization from a healthcare provider or pharmacy
- a copy of the U.S. COVID-19 Vaccination Record Card
- a copy of medical records documenting the vaccination
- a copy of immunization records from a public health, state, or tribal immunization information system
- a copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) administering the vaccine(s).

Employers who have adopted a weekly testing option must maintain a record of each weekly test result for every employee subject to testing for the duration of the ETS. Test results are considered medical records under both the ETS and the Americans with Disabilities Act.

Employers must provide employees access to and copies of their individual test records upon request. In addition, upon request, employers must provide employees or employee representatives (such as union representatives) with the aggregate number of fully vaccinated employees at the workplace by the end of the next business day after the request. There is no limit on the number of times these requests can be made. Employers are also required to respond to requests from OSHA for certain records.

Positive Test of Employee/Close Contact with Positive Case

An employee who has tested positive must immediately be removed from the workplace until they either:

- receive a negative result on a COVID-19 NAAT test following a positive result on a COVID-19 antigen test (NAAT tests are less likely to provide false positives);
- meet the return-to-work criteria in the CDC's isolation guidance; or
- receive a recommendation to return to work from a licensed healthcare provider.

Employees who have tested positive for COVID-19 and returned to the workplace should be not subjected to weekly testing for 90 days following the date of their positive test.

The ETS does not require employees who have been exposed to someone diagnosed with COVID-19 to be quarantined; however, the CDC continues to recommend that unvaccinated employees be quarantined after close, prolonged contact with a COVID-positive person, and OSHA encourages employers to consider a quarantine protocol.

The ETS does not require contract tracing. However, the CDC continues to recommend contact tracing. Some state/local laws may also require contact tracing.

Employers must report each work-related COVID-19 fatality to OSHA within eight hours of learning of the fatality and each work-related COVID-19 in-patient hospitalization within 24 hours.

Penalties

Employers that do not timely comply with the OSHA ETS may face penalties of $13,653 per violation for 2021 (2022 amounts not yet available). Willful or repeated violations can result in penalties of $136,532 per violation. States that operate their own OSHA plans must adopt maximum penalty levels that are at least as effective as federal OSHA.

Employer Action

Though the outcome of the legal challenges remains uncertain, employers should prepare for compliance with the ETS. Employers should review their preparedness using the checklist below:

By January 10, 2022, covered employers must have the following in place:

- ❑ Determine whether you will adopt a vaccination only policy, or a vaccination plus testing policy.
- ❑ Establish a vaccination policy. OSHA provides a sample mandatory vaccination policy and a sample vaccination or testing/facing coverage policy at https://www.osha.gov/coronavirus/ets2
- ❑ Determine vaccination status of each employee, obtain acceptable proof of vaccination, maintain records and a roster of vaccination status.
- ❑ Provide support for employee vaccination.
- ❑ Require employees to promptly provide notice of positive COVID-19 test or COVID-19 diagnosis.
- ❑ Remove any employee from the workplace who received positive COVID-19 test or COVID-19 diagnosis.
- ❑ Ensure employees who are not fully vaccinated wear face coverings when indoors or when occupying a vehicle with another person for work purposes.
- ❑ Provide each employee information about the ETS; workplace policies and procedures; vaccination efficacy, safety and benefits; protections against retaliation and discrimination; and laws that provide for criminal penalties for knowingly supplying false documentation.
- ❑ Report work-related COVID-19 fatalities to OSHA within 8 hours and work-related COVID-19 in-patient hospitalizations within 24 hours.

By February 9, 2022:

- ❑ Ensure employees who are not fully vaccinated and who have indoor contact with others as part of their jobs are tested for COVID-19 at least weekly or within 7 days before returning to work if away from the workplace for a week or longer.

2021 State-Based Compliance: Quarter Four

Connecticut

District of Columbia

Washington

Reminder: Connecticut PFML Benefits Begin January 1, 2022

Beginning **December 1, 2021**, covered employees under the Connecticut Paid Family Medical Leave Act may begin to submit applications for paid leave benefits for future leaves with a benefit start date of **January 1, 2022** and beyond. Benefit payments for approved paid leave begin **January 1, 2022.**

As of January 1, 2021, employees began contributing through payroll deductions to Connecticut's Family Leave Insurance Program or to an approved private plan. Beginning January 1, 2022, employees will be eligible for up to 12 weeks of paid family and medical leave and an additional two weeks of leave if a health provider determines the individual requires more recovery time in the event of incapacity due to birth or pregnancy, for a total of 14 weeks. Eligible employees will receive partial pay, defined as 95% of 40 times up to the state minimum wage (threshold) and 60% on earnings above the threshold to a state maximum to bond with a new child, care for a seriously ill family member, care for an employee's own serious health condition, for a qualifying exigency arising out of family member being on active duty, or to serve as an organ or bone marrow donor.

Employers should continue working with employment counsel, payroll processors, and approved private plan vendors to ensure they are complying. We will continue to monitor this issue as well and will keep employers updated as applicable.

District of Columbia Expands Paid Leave Benefits

The Universal Paid Leave Emergency Amendment of 2021 ("PLEAA") was enacted by the District of Columbia ("D.C.") Council on August 23, 2021. Beginning October 1, 2021, covered employees will have expanded paid leave benefits under D.C.'s existing paid leave statutes.

Background

D.C. currently has existing legislation which provide various forms of paid and unpaid leave for covered employees. These laws are as follows:

- The Universal Paid Leave Amendment Act of 2016 ("UPL") – Provides paid leave for parental, family and medical leave. A covered employee is eligible for up to a maximum of eight weeks of parental leave, six weeks of family leave, and two weeks of medical leave in a calendar year period. These benefits are administered through the District's Paid Family Leave program ("PFL").

- Family and Medical Leave Act of 1990 – Requires covered employers to allow up to sixteen weeks of unpaid leave during a 24-month period for qualifying family and medical leave.

Expanded Paid Leave

The PLEAA has made several significant amendments to the existing paid leave requirements under the UPL and PFL for covered employees. These amendments include:

- Added a new and separate category of paid leave in the form of "Prenatal leave" and provides two weeks of paid prenatal leave benefits, which is in addition to the eight weeks already provided for parental leave.

The eligible reasons for taking prenatal leave include:
- routine and specialty appointments,
- exams and treatments associated with a pregnancy provided by a healthcare provider,
- prenatal check-ups,
- ultrasounds,
- treatment for pregnancy complications,
- bedrest that is required or prescribed by a health care provider, and
- prenatal physical therapy

- Medical leave duration has been increased to six weeks (previously it was two weeks) and the definition of "qualifying medical leave" has been updated to include:
  - Miscarriage, and
  - Stillbirth

- While the combined maximum duration for benefits received in a single 52-week period generally remains at eight weeks, a covered employee may receive maximum benefits for both prenatal and parental leave, which will result in a maximum duration of ten weeks total paid leave duration.

- The PFL's one-week waiting period has been temporarily suspended, meaning that covered employees will be eligible for benefits immediately. This will remain in effect from October 1, 2021 through one year following the end of D.C.'s public health emergency.

- Benefits under the PFL can now be applied retroactively so long as a claim is filed within 30 days.

Expiration

As an emergency Act, the PLEAA will expire after 90 days, unless renewed. However, it is important to recognize that the Fiscal Year 2022 Budget Support Act contains identical provisions, which would make the amendments to the UPL and PFL permanent if enacted. The Budget Support Act is currently awaiting Congressional review.

Employer Action

- Await further guidance from the Mayor's Office (which is required to be released by October 31, 2021). This guidance will include an updated PFL poster which must be posted pursuant to the existing rules governing this requirement.

- Ensure that all personnel dealing with leave requests are familiar with the new requirements concerning Prenatal leave and the expanded eligibility reasons for medical leave.

WA Cares Fund Exemption Applications Now Open

On October 1, 2021, the window to apply for a permanent exemption from the Washington long-term care program opened.

As background, beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund" or "WA Cares Coverage"). WA Cares Fund will provide long-term care benefits to eligible Washington residents (up to $36,500). All wages are subject to the premium assessment; there is no cap.

If eligible, employees may apply to the Employment Security Division ("ESD") for an exemption from the premium assessment. If approved, the employee is permanently excluded from the state's long-term care coverage and benefits.

To qualify for a permanent exemption, an individual must:

- Have purchased a qualifying private long-term care insurance plan before November 1, 2021;
- Be at least 18 years of age; and
- Submit an exemption application to ESD.

Applications will be accepted through December 31, 2022. After that date, the application window is permanently closed. It should be noted that employers cannot apply for the exemption on behalf of employees.

ESD will review applications and notify individuals who are eligible for an exemption. The exemption will take effect the quarter after the application is approved by ESD.

Employees will need to provide current (and future) employers with a copy of the exemption approval letter to avoid the premium assessment.

Exemption Application

Employees can go to the WA Cares Fund website and click the button labeled "Apply for an Exemption" to start the process.

Notably, the following steps must be completed:

- **Create a SAW Account.** An employee will need to create a SecureAccess Washington (SAW) account by going to secureaccess.wa.gov and clicking the "SIGN UP!" button. An employee may already have SAW account related to other agency services (e.g., Department of Licensing).

- **Add Paid Family and Medical Leave to the Account.** If not already included, the employee will need to add Paid Family and Medical Leave as a new service in the account.

- **Add WA Cares Exemption Account.** Once logged into the Paid Family and Medical Leave section, there is an option to create a WA Cares Exemption Account.

- **Apply for the Exemption.** Once the WA Cares Exemption Account is created, the employee will apply for an exemption. Employees will need to answer some questions and upload proof of identity (e.g., valid driver's license or passport).

- **Await Approval.** Upon completion and submission, ESD will review the application and notify the employee if approved for an exemption.

While the online system went live on October 1, it subsequently went down for maintenance. It is possible that the website will continue to experience delays or systems issues as ESD manages the volume of applications.

Washington's Implementation of Federal No Surprises Act

Washington state's Balance Billing Protection Act ("BBPA") prohibits balance billing for certain emergency and non-emergency services provided by out-of-network ("OON") facilities or providers. The BBPA applies to:

- Fully insured, regulated health insurance plans (including group health plans), except grandfathered plans; and
- Plans offered to public employees.

While self-funded ERISA group health plans are not subject to the BBPA, employers sponsoring such arrangements may opt-in to BBPA balance billing protections.

The federal No Surprises Act ("NSA") was enacted as part of the Consolidated Appropriations Act, 2021 ("CAA") and takes effect for plan years that begin on or after January 1, 2022. The NSA also prohibits balance billing in certain circumstances and provides additional consumer protections in group health plans.

The NSA applies to all group health plans (including grandfathered plans, fully insured and self-funded plans).

With both a state and federal law offering protections around balance billing, there is confusion as to how these two laws will interact when both may apply. On November 1, 2021, the Washington Office of Insurance Commissioner ("OIC") released Technical Assistance Advisory 2021-05 providing guidance on implementation of the NSA.

Background

The BBPA became effective on January 1, 2020 and prevents some balance billing of insured individuals when OON facilities or providers bill patients for unpaid amounts if the patient's insurer does not pay the full billed amount. The BBPA provides the following balance billing protections:

- Prohibits an OON provider or facility from balance billing a covered individual for:
  - emergency services, and
  - non-emergency health care services when provided at an in-network facility if the services are provided by an OON provider and involve surgical or ancillary services (e.g., pathology, anesthesiology).
- Creates a mechanism for the carrier and the OON provider or facility to resolve payments. The carrier will pay the OON provider or facility a "commercially reasonable" amount, based on payments for the same or similar service in a similar geographic area. If the carrier and provider or facility cannot agree on a price for the covered services, they can go to binding arbitration, but they cannot bill the covered individual for the amount in dispute.

A notice of consumer rights must be made available by the provider to individuals describing the protection afforded by the BBPA. Individuals may not be asked to consent to a balance bill or waive the protections of the BBPA.

The NSA becomes effective January 1, 2022 and prohibits balance billing for:

- Emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved;
- Non-emergency services performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers); and
- Air ambulance services provided by OON providers.

The NSA also contains consumer protection provisions relating to:

- Transparency in coverage
- Price comparison tools
- Additional consumer disclosures on insurance ID cards
- Continuity of care
- Provider network directory accuracy
- Air ambulance reporting
- Prescription benefit and drug cost reporting

BBPA and NSA

The NSA preempts state laws only when those laws are less restrictive than the NSA. Based on this, where the OIC has authority, it will enforce the provisions of the NSA that are broader (i.e., require more) than the BBPA. This includes the following:

- Balance billing prohibitions that are broader than the BBPA scope of services including emergency post-stabilization care
- Prohibition on balance billing for grandfathered health plans
- Requirements for in-network cost sharing for individuals that relied on a provider directory maintained by the insurer indicating a provider was in-network
- Prohibitions on balance billing for continuation of care patients for 90 days after a provider becomes OON
- Cost sharing calculations for individuals and dispute resolution for
  - coverage under grandfathered health plans
  - services covered by the NSA (but not BBPA) – for example, non-emergency neonatology and intensivists
- External review requirements to determine if balance billing protections are applicable
- Consumer disclosures on insurance ID cards
- Disclosure requirements to enrollees regarding balance billing protections

In some respects, the BBPA requires more than the NSA. Therefore, certain provisions of the BBPA (not found in the NSA) will remain in effect, including:

- Prohibitions on individual consent to waive balance billing protections
- Notice requirements regarding whether a health plan is subject to BBPA
- Notice requirements indicating whether a claim was processed in accordance with the BBPA
- Provider directory requirements
- BBPA methods for cost-sharing calculations and dispute resolution for OON provider payments
- Transparency tools for price and quality information
- Enrollee notification requirements upon provider termination by a health carrier

Deferred Enforcement

OIC authority extends over insurance carriers and fully insured group health plans as well as self-funded plans that opted into BBPA protections. Accordingly, OIC will defer enforcement against some entities and of some NSA provisions to align with enforcement deferrals announced by the Departments.

The entities against which OIC will not take enforcement action include:

- Air ambulance services
- Self-funded group health plans that did not opt-in to the BBPA (the Departments will be responsible for enforcement)
- Health services providers and facilities

The OIC will defer enforcement of the following NSA provisions:

- Price comparison tools availability requirements deferred until plan years beginning on or after January 1, 2023
- Advance EOB requirements pending additional regulations by the Departments

Model Notice

The OIC developed a revised standard template to serve as a single notice of consumer rights under both the BBPA and NSA. The notice should be provided to enrollees in any communication that authorizes non-emergency surgical or ancillary services at an in-network facility. Employers sponsoring fully insured group health plans or self-funded group health plans that opted-in to the BBPA should use the new notice beginning January 1, 2022.

Draft Legislation to Align BBPA and NSA Requirements

The OIC has also requested legislation to align the BBPA with the NSA to avoid unnecessary confusion from the overlapping provisions of the laws as well as reducing administrative costs for service providers and insurers. The implementation of the NSA described in Technical Advisory 2021-05 would be applicable until this draft legislation becomes law. It is expected that the legislature will take up this matter in the 2022 session.

The proposed legislation would:

- Add behavioral health emergency facilities as emergency services providers;
- Require coverage of behavioral health emergency services and crisis services at certain facilities without prior authorization;
- Expand the scope of BBPA balance billing protections to align with NSA including post stabilization and non-emergency, non-ancillary services at in-network facilities;
- Aligns dispute resolution process for fully insured and self-funded group health plans;
- Clarifies that OON payment provisions of BBPA and NSA will not satisfy OIC network adequacy standards;
- Clarifies OIC authority to enforce all provisions of the NSA and CAA; and
- Preserves prohibition of informed consent to waive balance billing protections.

Employer Next Steps

Employers sponsoring fully insured plans should be able to rely on their carriers for compliance with the balance billing protections of the BBPA and NSA but may need to confirm that other requirements, such as those related to consumer protections will be satisfied. For example, this may include confirming insurance ID card disclosures, continuity of care protections, and provider network accuracy provisions have been implemented.

Employers sponsoring a self-funded arrangement will be required to comply with the NSA effective for the first plan year that begins on or after January 1, 2022. Further, employers sponsoring ERISA self-funded plans that have opted into the BBPA should work with TPAs to confirm compliance with all aspects of the BBPA and NSA and that TPAs are monitoring for additional guidance as it becomes available.

We will continue to monitor for developments related to these requirements.

Washington Increases Paid Family and Medical Leave Premium

The Washington Employment Security Department ("ESD") announced an increase in the premium rate for Washington Paid Family and Medical Leave ("WA PFML"). The premium rate will increase to 0.6% of employee wages up from the current 0.4%. The increase is effective for the first quarter of 2022 and should be reflected in contributions and reporting for all pay dates on or after January 1, 2022.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family leave through the state insurance fund or an approved voluntary plan that may be insured or self-funded. On January 1, 2019, Washington began collecting premiums to fund the program. Premiums are funded by employee and employer contributions based on employee wage up to the social security cap ($142,800 in 2021). Employers have also been required to report employee wages and hours when premiums are remitted to ESD.

2022 Premium Changes

Effective for payrolls on or after January 1, 2022:

- the premium amount is increasing to 0.6% of employee wages.
- the wages subject to premiums are increasing to $147,000 to reflect the higher social security wage cap for 2022.
- the employer portion of the premium is being reduced to 26.78% and the employee portion is increasing to 73.22% to reflect actual usage of the available family and medical leave benefits.

Employers with fewer than 50 employees are not required to contribute the employer portion.

EXAMPLE of annual premium amount for an employee earning $75,000 in 2021 and 2022

- Total annual premium in 2021: $75,000 x 0.4% = $300.00
  - Employee cost: $189.99
  - Employer cost: $110.01
- Total annual premium in 2022: $75,000 x 0.6% = $450.00
  - Employee cost: $329.49
  - Employer cost: $120.51

Note – Beginning January 1, 2022, ESD will be updating the reporting system for paid leave and Washington Cares Fund so that employers can report and pay employee premiums for both WA PMFL and WA Cares Fund at the same time. The WA Cares Fund premiums are paid by employees via payroll deductions.

Employer Action

Employers should confirm their payroll systems are prepared to deduct the new rates from employee paychecks beginning on January 1, 2022. Employers that do not increase employee deductions to reflect the correct amount will not be able to recover any amounts from employees with catch-up deductions from later payrolls but will still be required to contribute the higher premiums.

Washington State PAL Assessment Initial Amount Released

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL Assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021.

On October 1, 2021, WAPAL Fund issued the 2022 WAPAL Fund monthly assessment rate. The monthly assessment rate is based on the number of covered lives each month and may be adjusted in the future depending on funding needs. The 2022 monthly assessment rate is $0.13 per covered life per month.

The PAL Assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provides health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services. The first covered lives report and payment deadline is November 15, 2021 for the months of July, August and September 2021.

Example. If a self-funded group health plan has 1,000 covered lives for the months of July, August and September 2021, the PAL assessment for the quarter is $390.

As a reminder, assessed entities are required to register on the WAPAL Fund website (www.wapalfund.org) to create an account to file covered lives reports. Covered lives reports are filed on a quarterly basis to receive an invoice for the quarterly assessment before the payment deadline. Generally, the payments are due 45 days after the end of the quarter as follows:

- March 31: payment due May 15
- September 30: payment due November 15
- June 30: payment due August 15
- December 31: payment due February 15

Carriers are responsible for this assessment for fully insured health plans. Employers sponsoring self-funded health plans are generally responsible for the assessment; however, third-party administrators ("TPAs") may provide assistance with reporting and paying the assessment.

Employer Action

No employer action required if health plan coverage is insured.

Employers sponsoring self-funded plans should work with their TPAs to confirm their plan is registered and prepared to file the covered lives report and pay the assessment. Once the invoice for the payment due has been received, payments can be made by check via U.S. Mail or by ACH at the choice of the payer.