2020: First Quarter

Compliance Digest

Compliance Bulletins Released January-March

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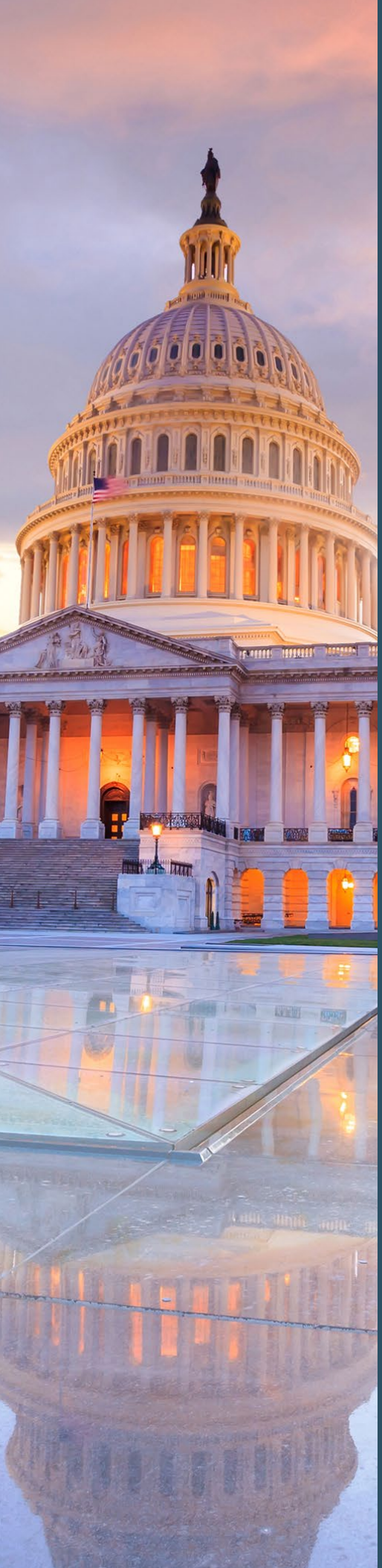
2020 Compliance Bulletins

January

February

March



Key ACA Taxes Repealed, but the PCOR Fee Is Back

Published: January 3, 2020

In a bipartisan effort, the U.S. Congress agreed on a spending package to fund the federal government which included important changes to federal laws affecting employer-sponsored group health and welfare benefit plans. The legislation was signed into law by the President on December 20, 2019.

The law repeals the following taxes under the Affordable Care Act ("ACA"):

- 40% tax on high cost health plans (a.k.a., the "Cadillac Plan Tax") after December 31, 2019.
- 2.3% medical device tax on sales after December 31, 2019.
- Annual Health Insurer Tax ("HIT") for calendar years beginning after December 31, 2020.

In an interesting turn of events, the new law reinstates the Patient-Centered Outcomes Research (PCOR) fee through September 30, 2029 for insured and self-funded health plans. Prior to enactment of this new law, many plans had paid their final PCOR fee as July 31, 2019 or were scheduled to pay their final assessment on July 31, 2020. With reinstatement of the fee, insured and self-funded plans will continue with these payments into 2029 and (in some cases) 2030. More guidance will be issued from the IRS as to future PCOR fee amounts and process.

The following chart illustrates the upcoming PCOR fee payments and deadlines.

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2018 – January 31, 2019	$2.45/covered life/year	July 31, 2020
March 1, 2018 – February 28, 2019	$2.45/covered life/year	July 31, 2020
April 1, 2018 – March 31, 2019	$2.45/covered life/year	July 31, 2020
May 1, 2018 – April 30, 2019	$2.45/covered life/year	July 31, 2020
June 1, 2018 – May 31, 2019	$2.45/covered life/year	July 31, 2020
July 1, 2018 – June 30, 2019	$2.45/covered life/year	July 31, 2020
August 1, 2018 – July 31, 2019	$2.45/covered life/year	July 31, 2020
September 1, 2018 – August 31, 2019	$2.45/covered life/year	July 31, 2020
October 1, 2018 – September 30, 2019	$2.45/covered life/year	July 31, 2020
November 1, 2018 – October 31, 2019	TBA/covered life/year	July 31, 2020
December 1, 2018 – November 30, 2019	TBA/covered life/year	July 31, 2020
January 1, 2019 – December 31, 2019	TBA/covered life/year	July 31, 2020

The new law does not address “surprise billing,” which can occur when healthcare services are provided by out-of-network doctors or specialists working at an in-network facility. The new law also does not address prescription drug pricing or health cost transparency. Congress may revisit these issues in 2020.

Employer Action

- Employers can breathe a sigh of relief as the Cadillac Plan Tax will no longer take effect on January 1, 2022. The repeal of the medical device tax and HIT tax will also provide some cost relief to employer sponsored plans.
- With the PCOR fee reinstated for ten more years, employers should continue to prepare for compliance. While insurance carriers will pay the fee for fully insured plans, employers are responsible for paying the PCOR fee for self-funded health plans, including health reimbursement arrangements (“HRAs”).
    - It is expected that employers sponsoring self-funded health plans (including HRAs) will continue to use IRS Form 720 to file and pay the PCOR fee with an expected due date of July 31 of the calendar year immediately following the last day of the plan year.
    - The IRS is expected to issue an inflation adjusted amount to use for the next reporting period.

Overtime Pay Consequences of Common Employee Benefits

Published: January 21, 2020

On December 16, 2019, the Wage and Hour Division of the U.S. Department of Labor (DOL) published final regulations on "regular rate of pay" for overtime pay purposes under the Fair Labor Standards Act ("FLSA"). The final regulations address common employer-provided benefits as well as other workplace practices, which were not specifically addressed in previous DOL guidance.

Common Employer-Provided Benefits Addressed in DOL Final Regulations

The following benefits are excluded from "regular rate of pay" for overtime pay purposes:

- Employer contributions to an employee's health savings account (HSA) with a custodian or trustee, when such contributions are communicated to employees.

- Employer contributions to a benefit plan, where the primary purpose of the plan is to provide payment of benefits to employees on account of:
  - death,
  - disability,
  - illness,
  - hospitalization,
  - accident, or
  - legal services.

- Employer's cost to provide parking benefits to employees (e.g., parking spaces near the business premises of the employer).

- Reimbursements to employees for the following expenses incurred for the employer's convenience or benefit:
  - cell phone,
  - non-mandatory credentialing exam fees, or
  - organization membership dues.

- Payments for occasional periods when no work is performed, including:
  - family medical leave,
  - military service,
  - voting,
  - attending child custody or adoption hearings,
  - attending funeral services, or
  - any other paid leave required under state or local law.

The following benefits are excluded from "regular rate of pay" for overtime pay purposes, provided employee eligibility for the benefit does not depend on hours worked, services rendered, job performance, or other criteria based on the quality or quantity of the employee's work:

- Benefits from a self-funded employee benefit plan, including a self-funded health reimbursement arrangement (HRA).

- Employer's cost for the following conveniences furnished to the employee:
  - on-the-job medical care,
  - on-site treatment provided by specialists such as chiropractors, massage therapists, physical therapists, or personal trainers, or
  - counselors or Employee Assistance Programs.

- Employer's cost for providing wellness programs, such as:
  - health risk assessments,
  - biometric screenings,
  - vaccination clinics (e.g., flu vaccination),
  - nutrition classes or weight loss programs,
  - smoking cessation programs,
  - stress reduction or mental health wellness programs,
  - exercise programs,
  - coaching to help employees meet health goals, or
  - financial wellness programs or financial counseling.

- Employer's cost of providing gym access, gym memberships, and fitness classes furnished as a convenience to the employee.

- Tuition benefits, whether paid to the employee, an education provider, or a student loan program.

- Adoption assistance, including financial assistance, legal services, and information and referral services.

- Emergency childcare services provided by the employer in the case of unforeseen circumstances (e.g., when schools or daycare centers are closed for bad weather).

- De minimis gifts or prizes (e.g., coffee mugs or t-shirts) provided to employees in connection with a contest or raffle.

The following benefits are included in "regular rate of pay" for overtime pay purposes:

- Cash payments to an employee made in-lieu of receiving health insurance provided through employer contributions to a section 125 cafeteria plan.
- Commuter subsidies paid by the employer (other than employer-provided parking spaces and parking benefits).
- Childcare services provided by the employer on a routine basis.
- Surrogacy assistance from the employer, which tends to consist solely of payment or reimbursement of medical expenses (typically outside of a medical plan).
- Employer's payment of an employee's accumulated educational debt.

The DOL final regulations also address other important employer practices, such as pay for forgoing holidays, compensation for bona fide meal periods, call-back pay, and discretionary bonuses. The DOL acknowledges in the final regulations that it is impossible to address all of the various compensation and benefits arrangements that may exist between employers and employees, both now and in the future. The above list is therefore not intended to be exhaustive.

Employer Action

Employers should review the DOL's final regulations on "regular rate of pay" for overtime pay purposes under the FLSA and review their common employer-provided benefits to ensure compliance with the final regulations. For further assistance in evaluating the effect of the final regulations on their overtime pay practices, employers should contact their employment-law attorney or resource.

Family and Medical Leave Tax Credit Extended

Published: January 22, 2020

In the spending bill passed into law on December 20, 2019, the employer tax credit for paid family and medical leave was extended for one additional year. This tax credit was created under the Tax Cuts and Jobs Act of 2017 and was initially available for 2018 and 2019 only. The credit is now available through the end of 2020.

Background

The tax credit is available to certain employers as to FMLA-qualifying circumstances (whether under FMLA or not) for employees earning $78,000 or less for whom paid family and medical leave is provided. Nothing in the rules requires the employer to be subject to FMLA to receive the tax credit. Thus, it is available to employers with less than 50 employees. Notably, paid leave must be provided to both full-time and part-time employees in order to claim the credit; if part-time employees are excluded from a paid leave policy, this credit is not available.

Frequently Asked Questions

The following frequently asked questions provide additional detail of the Paid Family and Medical Leave Tax Credit.

Q1. What is the amount of credit?

The credit is generally 12.5% of the amount of wages paid to qualifying employees (although it increases by .25% for every percentage point an employee's FMLA wages exceed 50% of their normal wages, capped at 25%).

The credit is also capped with respect to each employee to the normal hourly wage rate of such employee for each hour
(or fraction thereof) of actual services performed for the employer multiplied by the number of hours (or fraction thereof) for which family and medical leave is taken. In the case of any employee who is not paid on an hourly wage rate, the wages of such employee are prorated to an hourly wage rate under regulations to

be established by the Secretary of the Treasury.

Q2. What form does this credit take?

The credit is in the form of a general business credit.

Q3. Which employers are eligible for the credit?

To take the credit, an employer must have in place a written policy that provides not less than 50% of the wages normally paid to such employee and:

- in the case of a qualifying employee who is full-time (customarily employed for at least 30 hours per week), provides not less than 2 weeks of annual paid family and medical leave; and
- in the case of a qualifying employee who is a part-time employee (customarily employed less than 30 hours per week), provides an amount of annual paid family and medical leave that is not less than a prorated amount. Note that many existing programs do not offer paid leave to part-time employees and thus would not qualify for the credit (unless there is no part-time workforce).

If an otherwise eligible employer (whether or not subject to FMLA) provides paid family and medical leave outside of what is required under FMLA to an eligible employee, there are protections it must ensure in order to take advantage of the tax credit. In that case, the otherwise eligible employer must provide paid family and medical leave in compliance with a written policy which ensures that the employer:

- will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy; and
- will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy.

All entities in the same controlled group under Code Sec. 52(a) and (b) (more than 50% common ownership) are treated as a single employer.

Q4. Which employees qualify?

An employee for whom a credit is available is any employee who:

- has been employed for at least one year; and
- had compensation of no more than $78,000 for 2020.

Q5. What circumstances qualify?

"Family and medical leave" means leave for any one or more of the following purposes whether the leave is provided via FMLA or by a policy of the employer:

- because of the birth of a son or daughter of the employee and in order to care for such son or daughter.
- because of the placement of a son or daughter with the employee for adoption or foster care.
- in order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition.
- because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.
- because of any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- to care for a servicemember as to an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember.

Vacation leave, personal leave, and medical or sick leave for any other purpose is not counted.

The IRS has clarified that an employer may take credit for paid leave provided under its short-term disability program.

Any leave which is paid by a state or local government or required by state or local law is not considered in determining the amount of paid family and medical leave provided by the employer.

Q6. What is the maximum amount of leave?

The amount of family and medical leave that may be taken into account is up to 12 weeks.

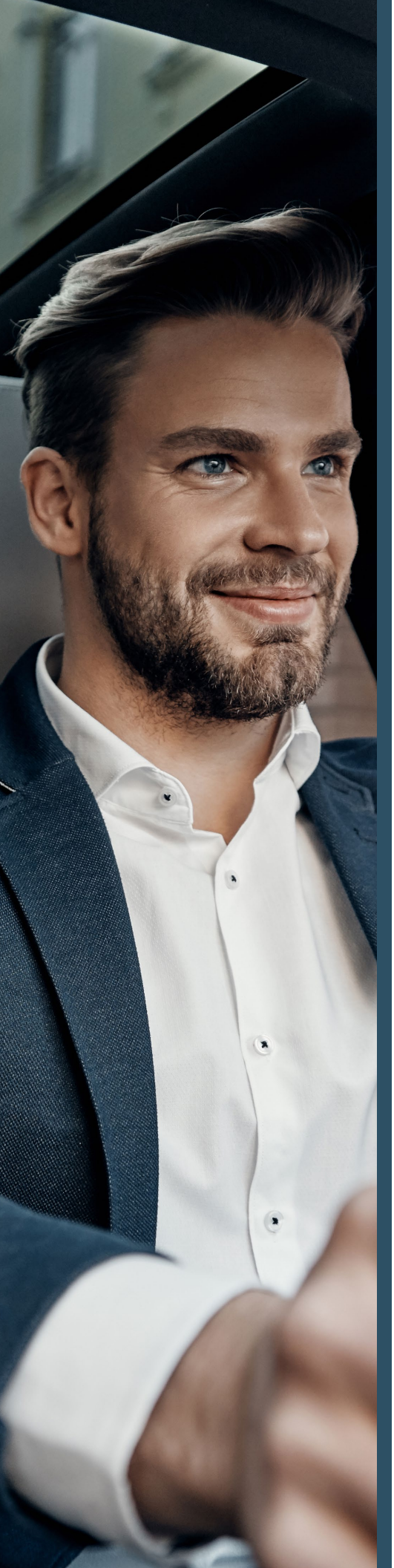
Q7. When is the effective date of the credit?

This credit was initially created for only 2018 and 2019 but has been extended through 2020.

A taxpayer may elect to have this section not apply for any taxable year.

Employer Action

Existing guidance for claiming the paid family and medical leave tax credit should carry forward through 2020.



Parking Tax Relief for Tax-Exempt Employers

Published: January 23, 2020

The Taxpayer Certainty and Disaster Tax Relief Act of 2019 was signed into law on December 20, 2019. The law repeals a provision under the Tax Cuts and Jobs Act that required tax-exempt organizations to include their costs for providing qualified transportation fringe benefits to employees in unrelated business income.

This relief is limited to non-profits. The elimination of the employer's deduction for qualified transportation fringe benefits for all other employers remains in effect.

California Individual Mandate, Penalty, and Reporting

Published: January 29, 2020

Beginning January 1, 2020, all California residents are required to have minimum essential coverage ("MEC") for every calendar month thereafter. A penalty applies to those residents who fail to comply with the individual mandate, unless they are considered exempt.

The new state law also requires employers (and other entities) that sponsor an employment-based health plan to file reports (similar to IRS Form 1095-C or 1095-B) with California's Franchise Tax Board on all California residents covered by the plan. These reports will enable covered employees and family members to avoid the individual mandate penalty. The initial deadline for filing reports with the Franchise Tax Board will be March 31, 2021, with respect to calendar year 2020.

The new reporting obligation for employers is subject to an important exception: if the group health plan is fully insured, and an insurance carrier is filing reports (similar to IRS Form 1095-B) with the Franchise Tax Board on covered employees and family members, then the employer does not have to file a report with the Franchise Tax Board on those same covered individuals.

California's Individual Mandate

The new state law creates a "minimum essential coverage individual mandate" under which California residents must be enrolled in and maintain MEC for each month beginning on or after January 1, 2020. The mandate does not apply, however, for any month in which an individual:

- Has a certificate of exemption for hardship or religious conscience issued by Covered California (which is California's insurance marketplace)
- Is a bona fide resident of another state or a U.S. possession
- Is an expatriate living outside of the U.S. who meets certain federal tax requirements
- Is a member of an Indian tribe

- Is not a citizen or national of the U.S., and is not lawfully present in the U.S.
- Is enrolled in limited or restricted scope coverage under the Medi-Cal program or another similar state program
- Is incarcerated (other than incarceration pending the disposition of charges)
- Is a member of a health care sharing ministry

For purposes of the mandate, MEC includes coverage under an employer-sponsored group health plan offered in connection with employment to an employee and related individuals (unless the plan is considered an "excepted benefit" such as limited scope dental or vision benefits that are offered separately). Other sources of MEC will also enable California residents to comply with the mandate.

California residents who fail to comply with the mandate for one or more months of the year will be liable for an "individual shared responsibility penalty" that is payable as part of their state income tax return. The penalty for the full year is equal to 2.5 percent of the individual's adjusted gross household income, but not less than $695 (adjusted for inflation), and not more than the state average premium for a bronze-level individual insurance policy from Covered California. California residents should contact their tax advisor for assistance in evaluating their personal situation, including whether they qualify to have the penalty waived if certain requirements are met.

Employer Reporting Obligation

The following entities providing MEC to a California resident during a calendar year are required to file a report (the "MEC report") with both the covered individuals and the Franchise Tax Board:

- An employer or other sponsor of an employment-based health plan
- An insurance carrier offering health coverage
- Covered California with respect to individual health insurance policies
- The State Department of Health Care Services and county welfare departments with respect to coverage under a state program
- Any other provider of MEC, including the University of California with respect to student health insurance coverage

Employers and other entities sponsoring an employment-based health plan are permitted under the new state law to enter into contracts with third-party service providers, including insurance carriers, to provide the required MEC reports.

The deadline for furnishing the MEC report to covered individuals residing in California is January 31 of the following year, while the deadline for filing the MEC report with the Franchise Tax Board is March 31 of the following year. MEC reports must be in a form to be specified by the Franchise Tax Board (but similar to IRS Form 1095-C or 1095-B).

Important exception: If an insurance carrier is filing a MEC report with the Franchise Tax Board on California residents covered under a group insurance policy, then the employer or other sponsor of the group health plan is not required to file a MEC report with the Franchise Tax Board on those same covered individuals.

Employers and other entities that fail to file the required MEC report with the Franchise Tax Board are subject to a penalty of $50 per covered individual.

Applicable Dates

- **January 1, 2020** – California's individual mandate becomes effective for state residents
- **January 31, 2021** – Deadline for providing MEC reports to individuals residing in California for calendar year 2020
- **March 31, 2021** – Deadline for filing MEC reports with the Franchise Tax Board for calendar year 2020

Employer Action

Employers that sponsor a group medical plan for employees and family members residing in California may want to include information about the California minimum essential coverage individual mandate and the individual shared responsibility penalty as part of its 2020 new-hire enrollment materials and annual open enrollment materials.

During late 2020 and each year thereafter, employers with a fully insured group medical plan covering employees and family members in California should confirm with their insurance carriers that the carriers are filing MEC reports with the Franchise Tax Board. If they are, then the employer is not required to file its own MEC reports with the Franchise Tax Board on those same covered individuals.

During late 2020 and each year thereafter, employers with a self-insured group medical plan should make arrangements to file MEC reports with the Franchise Tax Board either directly or with the assistance of a third-party vendor.

Additional guidance on MEC reporting is expected.

New Jersey Legislative Updates

Published: February 11, 2020

New Jersey Update Summary

New Jersey Issues Final Earned Sick Leave Law Regulations.

On January 6, 2020, the New Jersey Department of Labor & Workforce Development issued regulations regarding the enforcement of New Jersey's Earned Sick Leave Law (which took effect in October 2018). The regulations include many comments and responses that provide insight into the law's interpretation.

New Jersey Clarifies 2019 Individual Mandate Reporting.

The State of New Jersey has again updated the information related to employer reporting beginning in 2020 under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Employers (including out-of-state employers) who provided health coverage to New Jersey residents enrolled in self-funded group health plans must issue participant statements by March 2, 2020 and remit to the state by March 31, 2020 the same Forms 1095-C provided to the IRS for calendar year 2019. Employers with fully insured plans may generally rely on the insurance carrier to issue statements and file required information with the state. New Jersey has established the statement issuance date and filing deadline to coincide with recent IRS guidance for ACA reporting compliance.

New Jersey Amends the NJ WARN Act.

On January 21, 2020, New Jersey Governor Murphy signed legislation that greatly expands the reach and enhances the benefits under the Milville-Dallas Airmotive Plant Job Loss Notification Act (the NJ WARN Act). The law becomes effective July 19, 2020. Employers with employees in New Jersey should consult with employment counsel to ensure compliance with the Act when considering layoffs, closing a facility or transferring employees to a new location.

New Jersey Issues Final Earned Sick Leave Law Regulations

Late in October 2018, New Jersey's Earned Sick Leave Law (ESLL) took effect. Under the ESLL, employees can accrue one (1) hour of earned sick leave for every 30 hours worked, up to 40 hours a year. In November 2018, the State held a public hearing at which it discussed some proposed rules to help employers and employees better understand the provisions set forth in the ESLL.

Finally, on January 6, 2020, the New Jersey Department of Labor & Workforce Development (the "Department") issued regulations regarding the enforcement of the ESLL, including 118 separate comments and responses Although the final regulations contain minimal changes, the Department's responses to the public's concerns provide insight into how the Department interprets the law.

Please review our Compliance Update "New Jersey Enacts Paid Sick Leave" issued May 8, 2018 for a summary of the ESLL:

https://emersonreid.dmplocal.com/dsc/collateral/021120_P_ERC_New_Jersey_Enacts_Paid_Sick_Leave_Law_GEN.pdf

The following will discuss the final regulations issued this year.

Substantive Change: Benefit Year

In the final regulations, the Department clarified that an employer can establish multiple "benefit years" for employees rather than require each employer to establish a single benefit year for all employees. A benefit year is now defined as "the period of 12 consecutive months established by an employer in which an employee shall accrue and use earned sick leave." In the comments, the Department explains that an employer may utilize an employee's anniversary year as the benefit year for purposes of the ESLL.

Issues Addressed in Comments

In the Department's 118 comments and responses, a few clarifications were made on certain provisions of the ESLL. Below is a high-level overview of a few of these comments and is not intended to be an exhaustive analysis.

Collective Bargaining Agreements (Comments 1, 7, 73, 80, 94, 99)

The Department clarifies that employees represented by a union may accept earned sick leave benefits greater than or less than those provided in the ESLL or waive those rights as part of the collective bargaining process. The Department also interprets the ESLL as applying to the parties of an expired collective bargaining agreement immediately if not replaced by a new collective bargaining agreement.

Paid Time Off Policies (Comments 8, 9, 12, 65, 68, 72, 92)

When an employer is using a PTO policy to satisfy the ESLL's requirements, the Department explains that to comply with the law, an employer's PTO policy must: (a) permit an employee to use all of the PTO for reasons covered by the ESLL; (b) provide for accrual or advancement in accordance with the SLL's requirements; (c) allow employees to use the time off in accordance with the ESLL; (d) provide for payment of sick time in accordance with ESLL; and (e) provide for payout or carryover in compliance with the ESLL. Employers using the PTO policy to satisfy the ESLL must also comply with all ESLL Requirements for all PTO hours including documentation, notice provisions, and prohibitions against retaliation.

FMLA (Comment 10)

The Department explains that the terms of the federal Family and Medical Leave Act (FMLA) do not conflict with ESLL. The ESLL prohibits an employer from requiring an employee to use available earned sick leave.

New Jersey Issues Final Earned Sick Leave Law Regulations

Non-Discretionary Bonuses (Comment 5, 67)

The Department states that non-discretionary bonuses must be included in the calculation of ESLL compensation. The Department did not explain how employers can include these bonuses in calculating the rate of pay for the ESLL.

Temporary Staffing Firms (Comments 54, 83)

The final regulations clarify that in the case of a temporary staffing agency placing an employee with client firms, earned sick leave shall accrue based on the total time worked on assignment with the temporary agency, not separately for each client firm to which the employee is assigned.

120-Day Waiting Period (Comment 2)

The final regulations confirm that an employee, shall not be eligible to use earned sick leave until the 120th calendar day after the employment commences.

40 Hour Maximum (Comment 7)

The Department clarified that an employer shall not be required to permit an employee to use more than 40 hours of earned sick leave in any benefit year, regardless of how many hours have been carried over.

Employer Action

The final regulations and guidance do cover many other specific topics; therefore, it is advisable to review the comments and responses in their entirety. Employers should evaluate their ESLL and PTO policies with labor counsel to ensure compliance.

New Jersey Clarifies 2019 Individual Mandate Reporting

The State of New Jersey has again updated the information related to employer reporting beginning in 2020 under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Employers (including out-of-state employers) who provided health coverage to New Jersey residents enrolled in self-funded group health plans must issue participant statements by March 2, 2020 and remit to the state by March 31, 2020 the same Forms 1095-C provided to the Internal Revenue Service (IRS) for calendar year 2019. Employers with fully insured plans may generally rely on the insurance carrier to issue statements and file required information with the state. New Jersey has established the statement issuance date and filing deadline to coincide with recent IRS guidance for Affordable Care Act ("ACA") reporting compliance.

Background

The New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance, starting January 1, 2019. Failure to do so, absent an exemption, will result in an individual penalty imposed by the state when a person files his or her 2019 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.

Who Must Issue and File Required Forms

Forms are required to be issued to all primary enrollees no later than March 2, 2020 and filed with the state no later than March 31, 2020 on behalf of all part-year and full-year New Jersey residents for 2019. A part-year resident is an individual who lives in the state for at least 15 days in any month in 2019.

Certain employers and other providers of minimum essential health insurance coverage such as insurance carriers, multiemployer plans, government entities, etc. must file the forms with the New Jersey Division of Taxation no later than March 31, 2020. Currently, there is no plan to offer an extension. Filers or their representative must register and use MFT Secure Transport Services, the same system used to file Forms W-2, as the state will not accept mailed paper forms. Employers should only send Forms 1095-C to the state for individuals subject to NJ'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 sending sensitive information.

What Forms are Required by Whom

- Employers with Fully Insured Coverage: The insurance carrier will be required to file form 1095-B with the state for each covered member of the plan. Employers are not required to file with the state. The carrier should furnish Form 1095-B to NJ residents.

- Employers with Self-Insured Coverage: Employers should furnish Form 1095-C to covered members who are New Jersey residents. This likely overlaps with the federal requirement to furnish these Forms. Employers will file with the state Form 1095-C and must complete Parts I and III. The employer may file a Form 1095-B for any plan member who was not an employee during all of 2019. Small employers (less than 50 employees) will report coverage using form 1095-B.

- Employers Participating in a Multiemployer Arrangement: The plan sponsor will file Form 1095-B (or 1095-C) for each covered employee.

New Jersey Clarifies 2019 Individual Mandate Reporting

Employer Action

- Employers with fully insured plans should confirm that the insurer will issue Forms 1095-B to New Jersey primary enrollees by March 2, 2020. It's important to note that the IRS 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 should confirm that the insurer will file the Forms 1095-B with the state no later than March 31, 2020.

- 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 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. It is unclear at this time whether these adult children will need to submit proof of coverage when filing their New Jersey state tax returns in order to prove minimum essential coverage.

New Jersey Amends the NJ WARN Act

On January 21, 2020, New Jersey Governor Murphy signed legislation that greatly expands the reach and enhances the benefits under the Milville-Dallas Airmotive Plant Job Loss Notification Act (the "NJ WARN Act" or "Act"). The law becomes effective July 19, 2020. Employers with employees in New Jersey should consult with employment counsel to ensure compliance with the Act when considering layoffs, closing a facility or transferring employees to a new location.

Background

The NJ WARN Act requires private NJ employers generally in business for three or more years with 100 or more full-time employees (including out-of-state employees) to provide a notice at least 60 days in advance of a mass layoff, temporary or permanent facility closing (except in certain circumstances), or transfer of employees to another location.

Under the existing law, full-time employees are entitled to severance pay equal to one week of pay for each full year of employment when an employer fails to provide the requisite NJ WARN Act notice in a timely fashion.

Changes to the NJ Warn Act

The following are key changes to the NJ WARN Act effective July 19, 2020:

- The Act no longer distinguishes between full-time and part-time employees when determining the size of an employer subject to the Act and to whom a notice and severance benefits must be provided.

- Severance benefits of one week of pay for each full year of employment must be paid to each affected employee even when an employer issues the NJ WARN Act notice within the required timeframe.

- Notice must be issued to each affected employee at least 90 days in advance of a mass layoff, facility closing or transfer of employees to another location. Employers will be required to pay an additional four weeks of pay if they fail to provide employees with the full 90-day notice.

- The definition of a "mass layoff" changes and will consist of 50 or more qualifying terminations. All the employer's facilities/locations are considered when determining the number of employees who may be affected.

- Employees covered by a Collective Bargaining Agreement ("CBA") will receive the greater of any CBA severance benefit, or the benefit as required under the NJ WARN Act.

- The law provides certain protections for NJ workers upon a change of ownership or filing for bankruptcy protection.

- The definition of employer now includes a person who is involved in the decision-making process responsible for the employment action that gives rise to a mass layoff subject to notification, which could subject certain individuals to personal liability for NJ WARN Act failures.

Employer Action

New Jersey employers should review their internal policies and severance practices with counsel to understand the changes and ensure compliance with the NJ WARN Act.

Medicare Part D
CMS Notification Reminder

Published: February 18, 2020

Employers sponsoring a group health plan need to report information on the 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 the 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.

An employer with a calendar year plan (January 1 – December 31, 2020) must complete this reporting no later than Saturday, February 29, 2020.

Additional guidance on completing the form, including screen shots, is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

Deadline Extended for 2019 Forms 1095-C

Published: February 19, 2020

On December 2, 2019, the IRS issued Notice 2019-63, which provides:

- An extension of time, until **March 2, 2020**, for employers to provide Forms 1095-C to their full-time employees and other individuals; and
- An extension of relief from penalties for the 2019 reporting year for employers and other entities that make good-faith efforts to comply with the reporting requirements.

Notice 2019-63 does not, however, extend the deadline to provide completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) to the IRS (as described in Q/A-2 below). Nor does it provide any relief from providing Forms 1095-C to full-time employees ("FTEs"). This means that all Applicable Large Employers ("ALEs") must continue to provide Form 1095-C to any employee that was full time for any month of 2019.

However, the Notice provides an alternative furnishing method for Form 1095-B (and in some cases Form 1095-C), with relief from the 2019 Section 6055 reporting penalty, for:

- Insurance carriers that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019;
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019; and
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-C to covered individuals who were not full-time employees in any month of calendar year 2019.

Briefly, the alternative furnishing method allows carriers (and in some cases employers) to avoid 2019 Section 6055 penalties associated with a failure to furnish the applicable form to covered individuals by posting information to a website and timely providing the completed applicable Form upon request.

The following FAQs provide additional details.

Q1: What Was Extended?

2019 Forms 1095-C must be furnished to FTEs and other individuals by Monday, **March 2, 2020** (rather than by January 31, 2020).

This extension of time also applies to insurance carriers providing 2019 Forms 1095-B to individuals covered under an insured plan, and to employers providing 2019 Forms 1095-B to individuals covered under a self-funded health plan (but see Q/A-3).

The Notice states that the new deadline of March 2, 2020, will not be further extended by the IRS.

Q2: Were The Deadlines For Reporting To The Irs Extended?

No, the 2019 Form 1094-C and all supporting Forms 1095-C (and the 2019 Form 1094-B and all supporting Forms 1095-B) must be filed with the IRS by Tuesday, March 31, 2020, if filing electronically (or by Friday, February 28, 2020, if filing by paper). These deadlines **were not extended** as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C with the IRS must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: With The Indiviudal Mandate Reduced To Zero After December 31, 2018, Is There Any Relief When Furnishing A Form 1095-B?

Yes, but it is generally limited to Forms 1095-B (except as described in Q/A-4 below).

Because the individual shared responsibility penalty is reduced to zero for 2019, an individual does not need the information on Form 1095-B in order to compute his or her federal tax liability or file an income tax return with the IRS. (But see Q/A-7 below regarding individual healthcare mandates in certain states.)

The IRS will not assess a 2019 Section 6055 reporting penalty against reporting entities for failing to furnish Form 1095-B to covered individuals in cases where the following two conditions are met (Alternative Furnishing Method):

1. **Website posting.** The reporting entity posts a notice prominently on its website stating that responsible individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that they can use to contact the reporting entity with any questions.

2. **Provide form within 30 days.** The reporting entity furnishes a 2019 Form 1095-B to any responsible individual upon request within 30 days of the date the request is received.

Insurance carriers (and employers with self-funded plans) that take advantage of this relief must still provide the 2019 Form 1094-B and all 2019 Forms 1095-B to the IRS by the required deadline. In other words, while the carrier (or employer) will not be penalized by the IRS for not supplying covered individuals with Forms 1095-B with respect to their coverage (subject to the two conditions set forth above), the carrier (or employer) must still create Forms 1095-B and provide them to the IRS by the required deadline.

There is no relief from the penalties associated with a failure to file completed forms with the IRS.

Q4: Will The Alternative Furnishing Method Apply To Ales With A Self-Funded Health Plan?

No, except in one situation.

ALEs are still required to provide Forms 1095-C to employees who were full-time for any month of calendar year 2019. Nothing has changed with respect to this requirement, aside from extending the deadline to March 2, 2020. ALEs offering self-funded group health plan coverage must continue to furnish Forms 1095-C to their FTEs, with all applicable parts (I, II and III) of Form 1095-C completed.

Some ALEs who offer self-insured health plan coverage to individuals who are not FTEs (e.g., part-time employees) may consider using the alternative furnishing method with respect to Form 1095-C.

Furnishing Form 1095-C to Individuals Who Were NOT Full-Time Employees

The Notice does provide relief to ALEs required to furnish 2019 Forms 1095-C to individuals covered under a self-funded group health plan **who were not FTEs for any month of calendar year 2019.** In this limited instance, ALEs may use the alternative furnishing method and will not face 2019 Section 6055 penalties, provided the ALE meets two conditions (outlined in Q/A-3):

- Post a prominent notice on website stating the Form 1095-C (or 1095-B) is available by request; and
- Provide the Form 1095-C (or Form 1095-B) within 30 days of a request.

In most cases, the individuals targeted for this relief are those who receive Form 1095-C with Code 1G in line 14 of Part II. Examples of covered individuals who are not full-time employees for any month of the calendar year, but who may receive coverage under the employer's self-funded group health plan, include:

- Part-time employees covered under the plan.
- A spouse or child receiving COBRA coverage.
- A former employee receiving COBRA coverage who had a COBRA qualifying event in 2018 or earlier.
- Individuals covered under a self-funded retiree medical plan who retired in 2018 or earlier.

Even if an ALE takes advantage of this alternative furnishing method with respect to an individual covered by the self-insured group health plan who was not a full-time employee in any month of 2019, the employer must still submit completed Forms 1094-C and 1095-C to the IRS by the required deadline.

Q5: Is The Good Faith Penalty Relief Extended?

Yes, penalty relief is extended for employers and other reporting entities that report incorrect or incomplete information on Form 1094-C or Forms 1095-C, when these entities can show that they made good-faith efforts to comply with the information reporting requirements for 2019. This relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

Q6: What If The Submissions Are Late?

Employers that do not comply with the due dates for providing a return or statement to an individual or the IRS are subject to penalties (except as described in Q/A-3 and Q/A-4). Employers and other reporting entities should still furnish and file the forms, and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q7: Our Employees Reside In States With An Individual Healthcare Mandate. Are There Other Things To Consider?

A handful of states (including the District of Columbia) have enacted individual healthcare mandates that apply to residents. As part of this requirement, carriers and employers must provide statements to residents and reporting to the states to demonstrate minimum essential coverage and enable covered employees and other individuals to avoid state

penalties. States have either adopted (or are expected to adopt) the federal forms, 1095-B and 1095-C, to satisfy this requirement. While there may be limited federal relief with respect to furnishing these forms, carriers and employers may want to continue to provide these forms to covered employees and other individuals who are subject to a state mandate.

The following is a list of states (including the District of Columbia) with an individual healthcare mandate and effective dates for compliance.

State or Jurisdiction	Effective Date of Individual Healthcare Mandate	Employer Reporting Begins in 2020	Employer Reporting Begins in 2021
California	January 1, 2020		X
New Jersey	January 1, 2019	X	
Rhode Island	January 1, 2020		X
Vermont	January 1, 2020		X (however, employers may not be required to report coverage to the state)
Washington, DC	January 1, 2019	X	

Massachusetts established an individual mandate in 2007. Reporting to individuals is provided via Form 1099-HC. Employers with at least 6 employees who are residents of the state must file an HIRD. As the Massachusetts requirement predates these recent healthcare mandates and uses different reporting forms, it is not included on this list.

Q8: What About Future Relief?

The Notice asks for comments as to whether an extension of the due date to furnish Forms 1095-C (and Forms 1095-B) and continued extension of the good faith relief will be necessary for future years and why. There is information in the Notice on how taxpayers may submit comments.

Q9: Have Revised Forms 1094/1095-C And 1094-1095-B Been Released For 2019?

Yes. The IRS recently released draft Forms 1094/1095-C and 1094/1095-B information returns and instructions for calendar year 2019, but they have very few changes from the prior year's versions. Since they were released so late, there was much that there might be significant modifications to the forms and reporting requirements, perhaps related to the fact that beginning January 1, 2019, the penalty for an individual not maintaining MEC was reduced to zero. However, at least based on the 2019 draft forms and instructions, this is not the case. There were relatively few changes made from the prior year, as detailed below.

- **Draft 2019 Form 1094-C:** No changes.
- **Draft 2019 Form 1095-C:** No changes to the form itself.

  Identifying the "Plan Start Month" in Part II remains optional for 2019, although it may become mandatory for 2020.

The Instructions for Recipient on the back of the form had a few changes to reflect the elimination of the individual mandate penalty, and to underscore that information reported on the form is relevant to determining if an individual qualifies for subsidies through the Marketplace/Exchange. Changes include:

- deleting a statement that the information is reported on the form "to assist you in completing your income tax return"
- adding a statement that "[i]f you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit"Draft

2019 Instructions for Forms 1094-C and 1095-C:

In addition to routine updates to the furnishing and filing deadlines, and the dates used in examples, the following changes were made:

- deleting a reference that individuals reported to have MEC under a self-insured plan "are not liable for the individual shared responsibility payment for the months that they are covered under the plan"
- adding a statement that "[e]ligibility for certain types of minimum essential coverage can affect a taxpayer's eligibility for the premium tax credit"
- updating the calendar year penalty caps for the failure of an ALE to (1) file correct information returns, or (2) provide correct payee statements, to $3,339,000 each (from $3,275,500 in 2018)
- updating the applicable percentage for affordability safe harbors and the Qualifying Offer Method to 9.86% for plan years beginning in 2019 (from 9.56% in 2018)

Changes to the draft 2019 Forms 1094-B, 1095-B, and applicable instructions are similar to the changes described above.

Q10: What Should Employers Do Next?

Employers should consider the following:

- Employers should take note of the extended deadline, March 2, 2020, to furnish 2019 Forms 1095-C to full-time employees and other individuals.
- Final versions of the 2019 Forms 1094-C and 1095-C, along with relevant instructions, should be released soon. Hopefully, the final versions include additional guidance on the relief announced in this Notice.
- ALEs should complete Form 1095-C (including all relevant parts) and timely furnish the statements to full-time employees. ALEs should also timely transmit form 1094-C along with all Forms 1095-C to the IRS.
- Employers with fully insured plans should be aware that their carriers may not issue Forms 1095-B directly to covered employees for 2019. Individuals asking for a copy should be directed to the carrier. Employers should anticipate that covered employees residing in a state with an individual healthcare mandate may need to contact the carrier to obtain a Form 1095-B before filing a state income tax return.
- ALEs with self-funded health plans that extend coverage to individuals other than full-time employees should decide whether to continue to furnish Forms 1095-C as done in prior years, or to take advantage of the new alternative furnishing method with respect to those covered individuals, USI has identified a few administrative reasons why ALEs may be reluctant to adopt this new furnishing method for 2019:
  - While the Notice offers limited relief with respect to furnishing a Form 1095-C to covered individuals who were not full-time employees for any month of calendar year 2019, the ALE must ensure that Form 1095-C (including Part III) is completed and submitted to the IRS on behalf of these individuals. As the information must be included in the final submission, it is unclear whether taking advantage of the Section 6055 penalty relief makes any practical or administrative sense.

- Employers looking to take advantage of this relief will need to post the required notice on a website and provide the completed Form 1095-C within 30 days of a request. Failure to do so could subject to the employer to associated penalties.

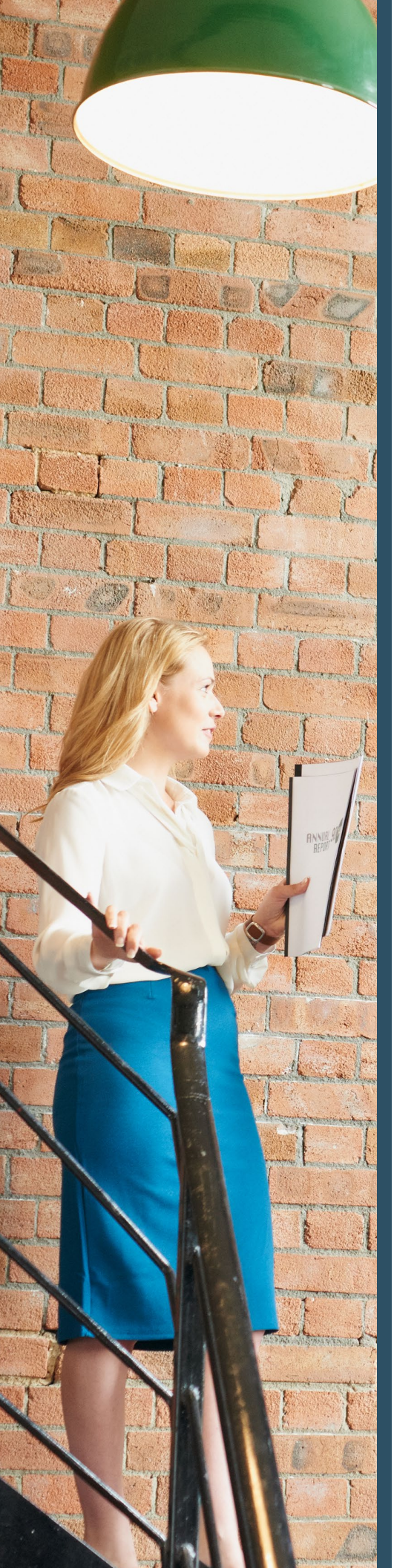
- Given the timing of Notice 2019-63, vendors or other third parties that assist in preparation and distribution of 2019 Forms 1094-C and 1095-C may not be able to accommodate this new process.

- Employers with employees who reside in states with an individual healthcare mandate will want to work with vendors to ensure forms are provided and reported to the state in a timely and complete manner.

- While good faith penalty relief was extended under the Notice, be aware that the IRS is actively assessing fines associated with failures to file Forms 1094-C and 1095-C with the IRS by the deadline (as described in Q/A-2 above). Timely reporting remains an area of active IRS enforcement.

For reference, please review our December __, 2019 Bulletin with additional information on the reporting requirement:

https://emersonreid.dmplocal.com/dsc/collateral/120919_P_ERC_Deadline_Extended_for_2019_Forms_1095_C_GEN(1).pdf



2020 Federal Poverty Guidelines Announced

Published: February 25, 2020

HHS recently announced the 2020 Federal Poverty Level (FPL) guidelines which, among other things, establish the FPL safe harbor for purposes of the Affordable Care Act (ACA) employer mandate. For 2020, the FPL safe harbor is $103.99/month in the lower 48 states, $129.99/month for Alaska, and $119.64/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of affordability. As the FPL guidelines were announced after the start of the calendar year, plans beginning on January 1, 2020 use $101.79/month for the lower 48 states ($127.14 Alaska and $117.19 Hawaii), which is 9.78% of the applicable 2019 FPL. The increased threshold applies to plan years beginning on or after February 1, 2020.

Background

Large employers may be subject to the employer penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Marketplace. The FPL is relevant to this penalty in two ways:

1. Affordability Safe Harbor

For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. Subsidy Eligibility

An individual is only eligible for a subsidy in the Marketplace if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

Indexed Amounts

The following are the 2020 HHS poverty guidelines:

2020 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/ household	Poverty guideline
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120
For families/households with more than 8 persons, add $4,480 for each additional person.	

2020 Poverty Guidelines for Alaska	
Persons in family/ household	Poverty guideline
1	$15,950
2	$21,550
3	$27,150
4	$32,750
5	$38,350
6	$43,950
7	$49,550
8	$55,150
For families/households with more than 8 persons, add $5,600 for each additional person.	

2020 Poverty Guidelines for Hawaii	
Persons in family/ household	Poverty guideline
1	$14,680
2	$19,830
3	$24,980
4	$30,130
5	$35,280
6	$40,430
7	$45,580
8	$50,730
For families/households with more than 8 persons, add $5,150 for each additional person.	

Affordability Safe Harbor and Subsidy Eligibility 2019 Results

Based on new 2020 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $12,760 for a single individual for every state (and Washington D.C.) except Alaska or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is $103.99 (9.78% of $12,760/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is $12,760 – $51,040 for a single individual and $26,200 – $104,800 for a family of four for every state (and Washington D.C.), except Alaska or Hawaii.

DOL Penalties Increase for 2020

Published: February 26, 2020

The Department of Labor (DOL) published the annual adjustments for 2020 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2020

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

Description	2019 Penalty	2020 Penalty
Failure to file Form 5500	Up to $2,194 per day	Up to $2,233 per day
Failure of a MEWA to file reports	Up to $1,597 per day	Up to $1,625 per day
Failure to provide CHIP Notice	Up to $117 per day per employee	Up to $119 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$117 per day per violation (per participant/beneficiary)	$119 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,156 per failure	Up to $1,176 per failure
Failure to furnish plan documents (including SPDs/SMMs)	$156 per day $1,566 cap per request	$159 per day $1,594 cap per request
Genetic information failures	$117 per day (per participant/beneficiary)	$119 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$2,919 minimum	$2,970 minimum
Failure to meet genetic information requirements – not de minimis failures	$17,515 minimum	$17,824 minimum
Cap on unintentional failures to meet genetic information requirements	$583,830 maximum	$594,129 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.

Coronavirus: Health Coverage and Employee Leaves of Absence

Published: March 11, 2020

As the new coronavirus disease 2019 ("COVID-19") continues to spread, many employees are wondering whether there is coverage under their medical plan and whether they can take a leave of absence. The following provides some high-level information intended to address these inquiries. This information is up to date as of March 9, 2020, is general in nature, and subject to change.

Health Coverage

According to the CDC, individuals who feel sick with fever, cough, or difficulty breathing, and have been in close contact with a person known to have COVID-19, or live in or have recently traveled from an area with ongoing spread of COVID-19 should call their healthcare professional. The healthcare professional will work with the state's public health department and CDC to determine if the individual needs to be tested for COVID-19. Keep in mind that tests associated with COVID-19 have not been readily available to date.

Is the Test Covered?

1. **General Coverage.** In most traditional group health plan arrangements, testing for COVID-19 should be covered like other diagnostic tests (e.g., the flu test or rapid strep test) when medically necessary.Non-traditional group health plans (e.g., skinny plans (preventive care only), some reference-based pricing arrangements, and short-term limited duration insurance) may not provide coverage.

   The plan document terms should be consulted.

2. **State Law.** Some states, including Alaska, California, New York, Oregon, and Washington, have issued statements and/or emergency rules requiring (among other things) insurance carriers to cover services associated with testing for the COVID-19 without cost-sharing. It is likely that other states have adopted (or will adopt) similar rules after this article was set for publication. This includes Colorado, Florida, Georgia, Hawaii, Maryland, Pennsylvania, and Utah.

These rules generally apply to fully insured health plans, including small and large group plans.

Self-funded group health plans subject to ERISA are not required to comply with state mandates. Employers with self-funded group health plans should work with their benefits consultants and third-party administrators to determine whether to adopt plan changes to align with the state action. In some situations, the carrier (or TPA) is asking employers with self-funded health plans to "opt-in to" (or to "opt-out of") of the enhanced benefit options.

3. **HSA-compatible QHDHPs.** A qualified high deductible health plan ("QHDHP"), in part, is a health plan with a minimum deductible ($1,400 for self-only coverage and $2,800 for coverage other than self-only for 2020). An individual with a QHDHP and no other disqualifying coverage may be eligible to establish and contribute to a health savings account ("HSA").

   Generally, a QHDHP may not provide benefits for any year until the individual meets the deductible for that year. However, there is a safe harbor that permits coverage for preventive care prior to meeting the deductible. The definition of preventive care is limited and includes:

   - ACA mandated preventive items and services;
   - periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations);
   - routine prenatal and well-child care;
   - immunizations for adults and children;
   - tobacco cessation and obesity weight-loss programs;
   - certain screening devices as listed in IRS Notice -2004-23; and
   - items and services associated with certain chronic conditions as identified in IRS Notice 2019-45.

   However, except as it relates to certain identified chronic conditions, preventive care does not include any service or benefit intended to treat an existing illness, injury or condition.

   At this point, it is not clear whether testing and treatment for COVID-19 is considered preventive care and therefore not subject to the deductible. Absent guidance from the IRS, QHDHPs should consider applying the deductible toward expenses associated with COVID-19 to preserve HSA-eligibility. Further guidance from the IRS would be helpful.

Other Benefits and Protections

1. **Disability benefits. Will a COVID-19 diagnosis trigger a short-term disability benefit?** Per the CDC, reported illnesses associated with COVID-19 range from mild symptoms to severe illness. Therefore, each employee will need to be evaluated on a case-by-case basis, depending on the individual's condition and the definition of disability under the terms of the plan. For example, someone who is asymptomatic but asked to stay home may not be eligible for disability benefits while someone who is hospitalized would be eligible.

   Employees in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico have access to state mandated disability leave.

2. **Leave**. Employers should evaluate whether employees with COVID-19 qualify for paid leave. Arizona, California, Connecticut, Washington D.C., Maryland, Massachusetts, Michigan, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington have different forms of paid leave laws (sick, family, and/or medical). In addition, paid leave may be available under a city law, employer policies, collective bargaining agreements, etc.

   Employers should also evaluate whether employees with COVID-19 qualify for unpaid FMLA leave due to the employee's own serious health condition. Further, an employee may qualify for unpaid FMLA leave due to a family member's serious health condition.

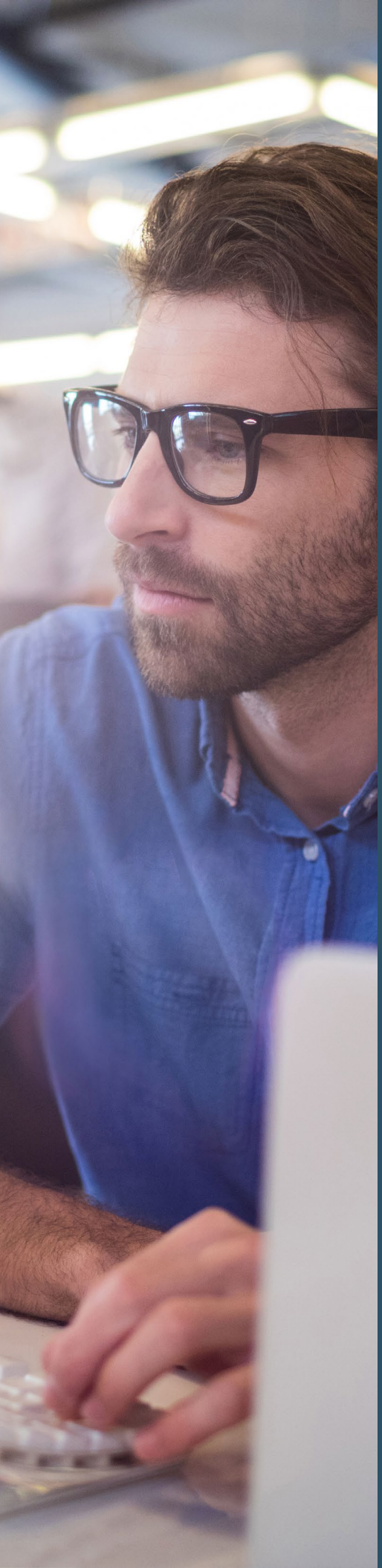
   Whether an employee on a non-FMLA leave is eligible to continue benefits will depend on the benefit plan and applicable law.

Employer Action

We can help with benefit related inquiries, but COVID-19 raises many other issues such as employment-related issues in which case employers should reach out to counsel.

For more information on COVID-19:

CDC dedicated website,
https://www.cdc.gov/coronavirus/2019-ncov/index.html



COVID-19 Federal Guidance and Proposed Legislation

Published: March 18, 2020

Treatment of expenses with Qualified High Deductible Health Plans

Since many states and health insurance carriers have implemented rules and policies to cover COVID-19 treatment and testing without cost-sharing, there has been concern that such first-dollar coverage would adversely impact individuals covered by qualified high deductible health plans (QHDHPs) with health savings accounts (HSAs). The IRS has issued guidance that provides relief in this situation. The guidance allows QHDHPs to provide medical care services and items associated with testing for and treatment of COVID-19 without a deductible or with a deductible below the minimum statutory threshold ($1,400 for self-only coverage and $2,800 for family coverage). The guidance also clarifies that where a QHDHP provides reimbursement for such expenses before the minimum statutory deductible is satisfied, individuals covered under the QHDHP will not be disqualified from HSA eligibility. This relief provided by the IRS does not change prior guidance regarding QHDHP requirements other than regarding testing and treatment of COVID-19 and does not expand the definition of preventive care. Should a vaccine for COVID-19 become available, it would be considered preventive care for QHDHP purposes because the guidance reminds us that vaccinations continue to be considered preventive care for the purpose of determining whether a health plan is a QHDHP.

COVID-19: Proposed Federal Legislation

The House passed legislation, called the Families First Coronavirus Response Act (the CRA), on March 14, 2020 that, if passed, would mandate testing for COVID-19, make changes to the Family and Medical Leave Act and make changes to paid sick leave policies. These provisions, if enacted, would only be temporary; taking effect within 15 days of enactment and continue through the end of 2020. The legislation will now move on to the Senate and the Senate Majority Leader has indicated that Republicans may support the House bill without further amendments. President Trump has also indicated he will sign this legislation.

With respect to testing, the CRA requires all employer-sponsored health plans to provide coverage for testing and other services that relate to COVID-19 without cost sharing, prior authorization and other medical management requirements.

The CRA provides that the tests and services include FDA cleared or authorized in vitro COVID-19 diagnostic tests, as well as items and services provided to an individual during health care provider office visits, urgent care center visits and emergency room visits that result in ordering or administering an in vitro diagnostic product.

With respect to employees taking leave, the CRA expands the FMLA requirements for leave and creates a federal paid sick leave law for U.S. employers with less than 500 employees ("Covered Employers"). The CRA provides refundable payroll tax credits for employers providing these leaves under the CRA due to COVID-19 through the end of 2020.

The CRA does not require an employee to meet the usual FMLA requirements, including working for 12 months, working for 1.250 hours or working in a location with at least 50 employees in a 75-mile radius. The CRA requires Covered Employers to temporarily expand FMLA protections and benefits to employees employed at least 30 calendar days that need leave because of reasons relating to COVID-19. The reasons for the leave are set forth as follows:

1. Where a public health official or health care provider recommends or orders leave for the employee because the employee's presence on the job would jeopardize the health of others; because of the exposure of the employee to COVID-19 or the employee exhibits symptoms of COVID-19 where the employee cannot perform their job and comply with the recommendation or order.

2. To care for a family member of the employee where a public health official or health care provider determines the family member's presence in the community would jeopardize the health of other individuals in the community because of the family member's exposure to COVID-19 or the family member's symptoms of COVID-19.

3. To care for the employee's child under the age of 18 if school or the child's place of care has been closed, or the childcare provider of such child is unavailable because of COVID-19.

The CRA also provides for paid leave for affected employees, requiring Covered Employers to pay the employee at two-thirds of the employee's regular rate of pay. The CRA does not require the first two weeks of leave be paid; employees can substitute PTO or other accrued leave for unpaid or partially paid periods, but Covered Employers cannot require this. The CRA does, however, provide for the possibility of regulations that could limit employers that the expanded FMLA provisions would apply to. These regulations could exclude certain health care providers and emergency responders from the definition of eligible employee; and could exempt businesses with under 50 employees if the CRA might jeopardize the viability of the business. With respect to job protection, the CRA does not require all Covered Employers to give such protection to all affected employees. A Covered Employer with less than 25 employees does not have to restore an affected employee to his or her position if the position ceases to exist, but such Covered Employer would be subject to other requirements such as including reinstatement to an equivalent position if one becomes available within a one year period.

The CRA would also require all Covered Employers (including those with less than 25 employees) to provide paid sick leave to all employees, even if employed less than 30 days. Covered Employers would be required to provide 80 hours of sick leave to full-time employees; and provide part-time employees with the number of hours averaged over a 2-week period. Such sick leave must be in addition to the sick leave the Covered Employer already provides. The CRA also includes a posted notice requirement regarding paid sick leave. Employees who would be eligible for the paid sick leave include those who need time off to:

a. self-isolate because the employee was diagnosed with COVID-19;
b. obtain a diagnosis or care if the employee is experiencing symptoms of COVID-19;
c. comply with an official order or recommendation because the employee was exposed to COVID-19 or has symptoms, or to care for or assist a family member in connection with (a) or (b) above; or

d. care for a child whose school or pace of care closes or whose childcare provider is unavailable.

New York Responses to COVID-19

Published: March 19, 2020

Emergency Sick Leave Legislation

On March 18, 2020 Governor Cuomo signed legislation (the "Act") that implements emergency sick leave benefits and job protection to employees who are subject to a mandatory or precautionary order of quarantine or isolation issued by a governmental entity ("Quarantine Period"). The Act is effective immediately.

In order for benefits under the Act to apply, an employee must (1) exhibit symptoms, or (2) have been diagnosed with a medical condition and be unable to work, even remotely, during the Quarantine Period. Benefits under this Act may not be payable if an employee returns from a country the Centers for Disease Control and Prevention issued a level two or three travel health notice and the travel was not business related. In that case, employees may use employer-provided accrued sick time or unpaid leave.

Generally speaking, the benefits under the Act are based on the size of the employer as of January 1, 2020. Employers with 1-10 employees and a net income of less than $1 million in the prior tax year are only required to provide unpaid sick leave during the Quarantine Period. The minimum requirements are as follows:

Employer Size	Minimum Sick Leave Requirements
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

Employers with up to 100 employees must allow employees to be eligible for NY Paid Family Leave and NYS Disability benefits after they have exhausted their paid sick leave under the Act. The Act expands the definitions of "disability" and "family leave" under NYPFL and NYS DBL to allow for disabilities and leaves due to a Quarantine Period.

The leave provided under the Act may not be credited against an employee's prior accrued leave and, upon returning to work after a leave taken pursuant to the Act, employees must be restored to their positions. Benefits may be payable concurrently upon the first full day of an unpaid Quarantine Period; however, the maximum weekly benefit an employee may receive is $840.70 for paid family leave benefits and $2,043.92 for disability benefits.

The federal government passed legislation including sick leave provisions which will need to be coordinated with benefits under the Act.

Employer Action

Employers should carefully review the Act's provisions, work closely with counsel and communicate with employees to ensure they receive any benefits under the Act to which they may be entitled. Employers subject to the New York City Paid Sick and Safe Leave Act must also ensure requirements of that ordinance are also being met. Employers subject to the NYC Paid Sick and Safe Leave Act must continue to comply with its requirements.

Although included in the Act, this summary does not include the Governor's comprehensive paid sick leave proposal contained in his executive budget, as it will not become effective until January 1, 2021. Further details will be provided at a later date.

Insurance Response

On March 2, 2020, Governor Cuomo issued a directive to New York health insurance carriers to take certain actions related to the COVID-19 outbreak and to remind insurers of their responsibilities under current law. The directive, issued in a Circular Letter by the Department of Financial Services, impacts fully insured plans in the small and large group markets and does not apply to self-insured plans.

At the time of this writing, the major insurance carriers have indicated that testing and other services related to COVID-19 will be covered with no member cost-sharing for insured plans. Employers should review the carrier's guidance with respect to their plans. Although the directive does not apply to self-insured plans, employers with self-insured plans can work with carriers and their third-party administrators and stop-loss carriers to implement similar actions.

Below are key points from the directive, many of which are simply reminders to carriers of what is already in place. It should be noted that the insurance industry and state and federal reactions to the outbreak continue to evolve and are subject to change.

- Carriers should devote resources to informing insureds of available COVID-19 benefits, including updating websites and staffing nurse helplines to handle the increased volume. All inquiries should be responded to in a timely fashion.

- Laboratory tests for COVID-19 are an essential health benefit and must be covered for small group health plans and will typically be available for large group health plans. Carriers are advised to waive any cost-sharing for COVID-19 laboratory tests received at an in-network provider office visit, urgent care center or for any emergency room visit. If in-network providers are unable to conduct testing, carriers must cover testing out-of-network.

- Carriers are reminded that New York laws prohibits carriers from excluding a service that is otherwise covered under a health insurance policy because the service is delivered via telehealth. Carriers are directed to ensure that their telehealth programs with participating providers are robust and will be able to meet any increased demand, as patients may be encouraged to seek treatment using telehealth services in lieu of office visits, due to the contagious nature of COVID-19.

- Carriers are directed to verify their provider networks are adequate to handle the increase in need for health services in the event more COVID-19 cases are diagnosed in New York, or to provide access to out-of-network providers at in-network cost-sharing rates.

- Utilization review decisions must be made in the timeframes required by law. Carriers should not use preauthorization requirements as a barrier to access necessary treatment for COVID-19 and should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate.

- If a vaccine become available, carriers should cover the immunization immediately with no patient cost-sharing.

- New York insurance law requires carriers that cover prescription drugs must provide access to non-formulary prescription drugs through a standard and expedited review process when the insured is suffering from a health condition that may seriously jeopardize the individual's health.

- Inpatient hospital services cannot be subject to an annual or lifetime limit since it is considered an essential health benefit.

- Pre-hospital emergency medical services are to be covered for the treatment of an emergency condition when such services are provided by an ambulance service.

- Carriers must hold harmless insureds who receive surprise medical bills for services related to testing and treatment of COVID-19.

We will continue to monitor developments around COVID-19 and will continue to update you.

California Insurance Response to COVID-19

Published: March 19, 2020

On March 5, 2020, the California Department of Insurance and California Department of Managed Health Care each issued guidance stating that commercial health insurance carriers and health maintenance organizations (HMOs) are immediately required to reduce cost-sharing (including copays, deductibles and coinsurance) to zero for all medically necessary screening and testing for coronavirus disease 2019 (COVID-19) (the "Guidance"). The Departments want to ensure that cost does not affect consumers' access to medically necessary screening and testing for COVID-19.

The Guidance applies to all commercial health insurance carriers and HMOs in California. It is not clear whether the Guidance applies to health insurance policies issued or delivered outside of California, but covering California residents. Self-insured group health plans are not required to comply directly with the Guidance.

Below are highlights from the Guidance of the requirements imposed on the carriers and HMOs as well as reminders about existing state laws:

- Immediately reduce cost-sharing to zero for all medically necessary screening and testing for COVID-19, including hospital, emergency department, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19.
- Notify all contracted providers about the waiver of cost-sharing for medically necessary COVID-19 screening and testing.
- Ensure the advice nurse line and customer service representatives clearly communicate this information to covered individuals who contact them about COVID-19 screening or testing.
- Prominently display a statement on their public website that cost-sharing is waived for medically necessary COVID-19 screening and testing, as well as guidance on how to access care.

- With respect to the carriers, inform the call center staff to advise covered individuals to call their provider's office or advice nurse line for instructions about how best to access care for COVID-19 screening and testing, prior to any in-person visit to a clinic or emergency department.

- All medically necessary emergency care must be covered without prior authorization, whether the care is provided by an in-network or out-of-network provider.

- Utilization review timeframes for approving requests for urgent and non-urgent services must be complied with. Insurance carriers and HMOs are strongly encouraged to waive prior authorization requests for services related to COVID-19 or, at a minimum, to respond to those requests quicker than the normal required timeframes.

- As more COVID-19 cases develop on California, ensure provider networks are adequate to handle an increased need for health care services, including offering access to out-of-network services where appropriate.

- Ensure covered individuals are not liable for unlawful balance billing from providers, including balance bills related to COVID-19 screening and testing.

- Work with providers to use telehealth services to deliver care when medically appropriate, to limit a covered individual's exposure to others who may be infected with COVID-19.

- Increase the capacity of contracted providers and facilities.

- In the event of a shortage of a particular prescription drug, waive prior authorization and step therapy requirements if the provider recommends a different drug to treat the condition.

We will continue to monitor developments around COVID-19 and will continue to update you.

Families First Coronavirus Response Act:
Signed into Law

Published: March 20, 2020

We recently advised you of proposed federal legislation responding to the COVID-19 pandemic. On March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act (the "CRA"). Subsequent to our March 18, 2020 Bulletin, the House made several technical corrections, narrowing some aspects of the original version of the bill, which is the version ultimately signed by President Trump.

As enacted, the legislation:

- Mandates all employer-sponsored health plans cover COVID-19 testing.

- For U.S. private employers with less than 500 employees and all public agency employers with 1 or more employees ("Covered Employers"), the Act:
  - Provides up to 12 weeks of leave under FMLA for eligible employees who have been employed for at least 30 days and unable to work (or telework) due to a need to care for a son or daughter under 18 years of age when their school or place of care has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID-19.
  - Creates a federal paid sick leave law providing for employer-paid leave of up to 80 hours to employees for COVID-19 issues.

The CRA does provide for the possibility of regulations that could limit employers to which the expanded FMLA provisions would apply. Such regulations may provide for the possible exclusion of certain health care providers and emergency responders from the definition of eligible employee or an exemption for businesses with under 50 employees if compliance might jeopardize the viability of the business.

The CRA's provisions mandating group health plan coverage for COVID-19 testing is effective immediately. The FMLA changes and paid sick leave take effect no later than April 2, 2020 and remain in place until the end of 2020.

Below are some important highlights from the final legislation.

Testing

The CRA requires all **employer-sponsored health plans** to provide coverage for testing and other services related to COVID-19 without cost sharing, prior authorization or other medical management requirements. The tests and services include FDA cleared or authorized in vitro COVID-19 diagnostic tests as well as items and services provided to an individual during health care provider office visits, urgent care center visits and emergency room visits that result in ordering or administering an in vitro diagnostic product.

Expanded FMLA

The CRA requires Covered Employers to temporarily expand (April 2, 2020 through December 31, 2020) FMLA protections and benefits to employees who have been employed 30 calendar days and need leave as a result of a school closure or closure of a childcare provider due to the public health emergency related to COVID-19. Employees are not required to meet the usual FMLA requirements, including working for 12 months, working for 1.250 hours or working in a location with at least 50 employees in a 75-mile radius. The final legislation narrowed the available leave and removed leave protections associated with an employee's own exposure or symptoms related to COVID-19 or that of a family member. Note, however, that traditional FMLA remains available, so employees can still take unpaid leave for their own serious health condition or that of a family member.

This new expanded FMLA leave includes both unpaid and employer paid leave. The first 10 days of the COVID-19 FMLA leave are unpaid (this is a change from the proposed legislation which allowed 14 days of unpaid leave). During this period of unpaid leave, an employee may elect to substitute any accrued vacation leave, personal leave, or medical or sick leave. After the 10-day unpaid leave period, Covered Employers must pay employees at two-thirds of the employee's regular rate of pay. The final legislation provides that the amount of such paid leave should not exceed $200 per day and $10,000 in the aggregate.

The final legislation includes a special rule that permits Covered Employers of employees who are health care providers or emergency responders to elect to exclude such employees from the application of these requirements.

While the job restoration provisions of FMLA generally apply with respect to this new COVID-19-related leave, there is relief afforded to Covered Employers with fewer than 25 employees. Specifically, such employers need not restore an affected employee to his or her position if the position ceases to exist, though such an employer will be subject to other requirements, including reinstatement to an equivalent position if one becomes available within a one--year period.

Paid Sick Leave

Covered Employers must also provide paid sick leave in connection with COVID-19. The CRA's paid sick leave provisions apply to all employees, even those employed less than 30 days, and apply to all Covered Employers. Under the final legislation, an employer may (but is not required to) exclude employees who are health care providers or emergency responders from the sick leave requirement.

An employee is eligible for paid sick leave under the CRA to the extent that the employee is unable to work (or telework) due to a need for leave because:

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

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

c. the employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

d. the employee is caring for an individual who is subject to an order as described in (a) or has been advised as described in (2).

e. The employee is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID-19 precautions.

f. The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Covered Employers are required to provide 80 hours of sick leave to full-time employees, and provide part-time employees with the number of hours averaged over a 2-week period. The sick leave must be provided in addition to the sick leave the Covered Employer already provides.

The amount an employee is paid during this sick leave is based on the employee's required compensation and the employees' number of hours normally scheduled to work (with a special calculating rule for employees with varying hours). Generally, this means paid sick time is paid at the employee's regular rate of pay (or minimum wage, whichever is greater). However, the final legislation added a special rule permitting employers to use two-thirds of the employee's required compensation with respect to sick leave associated with family members ((d)-(e) above).

Further, the final bill includes a maximum amount of paid leave as follows:

- $511/day ($5,110 in the aggregate) for sick leave associated with (a), (b) or (c) above (generally the employee's own care).

- $200/day ($2,000 aggregate) for sick leave associated with (d), (e) or (f) above (care for a family member or other designated illness).

The CRA also includes a posted notice requirement related to paid sick leave. A model notice should be made available within 7 days of enactment (by March 23, 2020).

Potential Tax Credits

Beginning on a date to be determined between now and April 2, 2020 and ending on December 31, 2020, the CRA provides refundable payroll tax credits for employers providing paid family leave or paid sick leave wages required under the CRA due to COVID-19. The final rule includes credit for an employer's qualified health plan expenses allocable to wages associated with the respective leaves.

A refundable payroll tax credit is allowed for 100% of wage payments made under expanded FMLA, which, subject to further guidance, may include "qualified health plan expenses" allocable to such wages. However, for each employee, the credit is capped at $200 per day and $10,000 in the aggregate (or 50-day total limit).

A refundable payroll tax credit is also allowed for private employers for 100% of payments made for qualified paid sick leave wages, which, subject to further guidance, may include "qualified health plan expenses" allocable to such wages. However, this credit is limited in several ways:

- Wages taken into account are generally capped at $511 per day per employee.

- Wages taken into account are capped at $200 per day per employee for employees caring for a family member or for a child whose school or place of care has been closed.

- Only 10 days, in aggregate, may be taken into account.

Employer Action

- Testing: all employers should contact their carriers or TPAs to immediately implement coverage of COVID-19 testing with no cost-sharing, no prior authorization requirement, and no medical management requirements. Employers should also evaluate the extent to which plans must cover other items and services furnished in connection with the COVID-19 testing.

- Expanded FMLA: Covered Employers should review FMLA documentation and modify to reflect temporary COVID-19 requirements under the CRA. They should consider working with (if not already) an FMLA administration vendor to coordinate compliance with the CRA. Communications should be provided to employees explaining the new FMLA benefits for COVID-19 related leaves. They should also work with their payroll department or vendor to establish procedures for calculating and paying out for paid leave after first 2 weeks.

- Paid Sick Leave: Covered Employers should consider working with (if not already) a leave administration vendor to coordinate compliance with the CRA. They should post the DOL model notice (available March 23) and distribute an explanation on eligibility for paid sick leave. They should also work with their payroll department or vendor to establish procedures for calculating and paying out for paid sick leave.

- Tax Credits: Covered Employers should work with their payroll department or vendor to track payments under expanded FMLA or paid sick leave and work with them on how to calculate and claim tax credits through payroll tax filings.

We will continue to monitor developments and provide you with updates.

Benefit Considerations in Light of Employee Terminations/Layoffs

Published: March 20, 2020

Due to the COVID-19 pandemic, many employers are being forced to terminate, lay-off and/or reduce hours for employees. While this brings up a host of employment law issues that should be discussed with counsel, it also brings up various issues related to employers' benefit programs. Below is an overview of benefit-related issues that require attention.

Plan Eligibility

Most benefit programs require employees to be actively at work and/or to maintain a certain number of hours in order to be eligible for coverage. The terms of eligibility should be set forth in the plan's Summary Plan Description ("SPD"). If an employee does not maintain the required number of hours to be eligible for benefits, or is not actively at work, generally, a loss of benefits coverage results unless the employee is under protected leave, such as the Family Medical Leave Act. In some cases, plans and policies may include language that allows an employee to continue benefits as an active employee even when the employee is not meeting eligibility criteria on a short-term basis, such as during a layoff or unpaid non-FMLA leave. This type of continuation may be mandated by state law or through designed plan terms.

It is not advisable for an employer to simply leave an employee on its benefit plan if the employee is not actively at work or not meeting the hours requirement. The terms of the plan document govern the benefit plan and employers must follow these written terms to avoid ERISA fiduciary liability. It is also important to note that insurance carriers, including stop-loss carriers, may not cover claims incurred by individuals who were not satisfying the eligibility rules of the plan.

Employers should carefully review the termination provisions for each benefit program sponsored to understand when there is a loss of coverage as a result of a reduction in hours or layoff. Employers may also reach out to carriers to discuss and get approval for more generous coverage if appropriate.

COBRA

Employers that offer health plan coverage who have at least 20 employees are required to offer COBRA continuation coverage when there is a loss of coverage as a result of a termination of employment or a reduction in hours. COBRA applies to both fully and self-insured medical plans, dental plans, vision plans, EAPs, telehealth, many onsite clinics, health reimbursement arrangements (HRAs)and health flexible spending arrangements (FSAs) where the account is underspent (more contributions are made than reimbursements issued). Most of the time, the qualifying event (i.e., termination or reduction of hours) occurs and coverage will terminate at the end of the month in which the qualifying event occurred. Sometimes, plans may terminate coverage at the time of the qualifying event. If the qualifying event is termination of employment or reduction in hours, COBRA coverage extends for 18 months. States may have continuation coverage laws that lengthen this period of coverage (e.g., California and New York). COBRA coverage must be extended to all qualified beneficiaries (i.e., employee, spouse, children) who had health plan coverage on the day before the qualifying event. Employers should take note of notification obligations, payment and timing rules for COBRA.

Employers are permitted to charge a premium of 102% of the cost of coverage for COBRA, however they may charge less at their discretion. Employers should be careful, however, not to discriminate in setting the premiums. Employers can even subsidize some or all of the premium associated with COBRA coverage and may even want to consult a benefits attorney to help set up a repayment plan with employees upon return to work. Employers should be careful where premium payments favor highly compensated individuals with a self-insured plan, as there could be potential discrimination issues which would cause the payment of the COBRA premiums to be treated as taxable income to those highly compensated individuals. Additionally, it is important to note that an individual has the opportunity to enroll in other coverage upon a loss of coverage such as a spouse's group plan or the Marketplace or other individual coverage. If the employer subsidizes the COBRA coverage for an employee for a few months, at the end of those months, there would be no opportunity to drop the COBRA coverage and enroll in another plan. The employee could, of course, choose not to pay COBRA premiums at that time, which would terminate the COBRA coverage, but it will not result in a special enrollment event for the employee.

Premium Payments

If employees continue to stay on an employer's benefits plan while not actively at work, collecting premiums can be difficult. If an employee fails to pay, coverage can be terminated. There are several ways an employee may pay premiums while on a leave. Employers should review their SPDs and Employee Handbooks for policies and procedures. Generally speaking, employers can allow employees to catch up on their premium payments once they return to work, but state laws should be reviewed for limits of what can be deducted from pay. Of course, if the employee never returns to work, it may be difficult for the employer to recoup payments. Employers can also have employees pre-pay premiums before the start of the leave, but employers must be careful not to collect for too long of a period because they could violate the cafeteria plan regulations that prohibit deferred compensation. Finally, employers can require employees to pay their portion of premiums during their leave. In this case, these payments would be on an after-tax basis. If an employee is on paid leave, employers can collect premium amounts as they usually do through payroll deductions.

Full-Time Employees under the ACA

Applicable Large Employers, ALEs, (at least 50 employees) must identify their full-time employees (FTEs) for purposes of the Employer Mandate using either the monthly measurement method or look-back measurement method. Generally speaking, an individual with at least 130 hours of service in a month is considered an FTE. Whether an individual is considered an FTE or not is important for both penalty exposure and annual Forms 1094-C and 1095-C reporting. When an employer uses the look-back measurement method and employees are terminated and rehired, or when their hours are reduced, special rules come into play.

Termination and Rehire

When an employee is terminated and later rehired, the employee may be considered a new employee if the employee did not have any hours of service with the employer (including any commonly owned entities) for a period of at least 13 consecutive week (26 consecutive weeks for educational organizations). If the employee is treated as a new employee, upon rehire, the employer would not be subject to a penalty for the first three months of employment for the rehired FTE as long as affordable and minimum value coverage is offered at the end of the 3-month period.

If an employer is using the look-back measurement method and, under these rehire rules, the employee is a new variable hour, seasonal or part-time employee, the employer may impose a new initial measurement period to determine FTE status. If an employer is using the monthly measurement method and the employee is not a new hire under these rules, the employee is treated as a continuing employee. The employer has to offer coverage to an FTE who is a continuing employee by the later of the first day the employee is credited with an hour or service, or the first day of the calendar month following resumption of service. With the look-back measurement method, a continuing employee retains the status s/he had with respect to the applicable stability period. This status is reinstated upon the employee's resumption of services under the timeframes described above. Failure to offer a continuing FTE coverage within this timeframe could result in a penalty.

Reduction in Hours

A reduction in hours will affect FTE determinations differently depending on which measurement method an employer uses. Using the monthly measurement method, FTEs are determined by counting the employee's hours of service for each calendar month. If the employee averages at least 30 hours of service per week or 130 hours of service per month, the employee is an FTE for that month. Using the look-back measurement method, employees identified in the Standard Measurement Period as FTEs earn that status for a subsequent Stability Period regardless of what happens to their hours in the Stability Period as long as the employee remains the employee of the employer. If an employee has a reduction in hours in the Stability Period (usually during the plan year), it does not affect his or her status as an FTE.

When terminating employees, laying them off or reducing their hours, employers should keep good records and be aware of how it will affect their 2020 ACA reporting. Employers should also review SPD provisions regarding waiting periods when making decisions whether to waive those waiting periods when employees return to work.

California's Additional Response to COVID-19

Published: March 26, 2020

California has announced several more developments with respect to health insurance carriers and health maintenance organizations in California in addition to those we provided to you in our March 19, 2020 Bulletin. Below is a summary of these additional responses.

Payments of Insurance Premiums – Possible Relief

Recognizing that insureds may not be able to pay insurance premiums due to circumstances beyond their control, the California Department of Insurance has requested that all insurance carriers provide their insureds with at least a 60-day grace period to pay insurance premiums, to avoid cancellation of policies. This is not an order, rather it is a request that is directed to all admitted and non-admitted insurance carriers that provide any insurance coverage in California, including life, health, auto, property, casualty, and other types of insurance.

New Special Enrollment Period in Covered California

The California Department of Insurance and the California Department of Managed Health Care have ordered California's state marketplace, Covered California, to create a special enrollment period through June 30, 2020, for eligible uninsured individuals to obtain individual health insurance coverage. This same special enrollment period also applies to individual health insurance policies purchased outside of Covered California. As a reminder, individuals who qualify for Medicare or Medi-Cal are not eligible for individual health policies.

Coverage during this special enrollment period will be effective on the first day of the month following the date the premium payment is postmarked or delivered to the plan, whichever is earlier. For example, if an individual pays his/her premium on March 25, 2020, the effective date of coverage would be April 1, 2020.

The special enrollment period provides relief for employees who were not eligible for or chose not to enroll in their employer's group health plan, by enabling them to obtain insurance for healthcare expenses incurred in treating COVID-19 (as well as other healthcare services), as long as they reside in California and otherwise qualify for an individual insurance policy.

The order from the California Department of Insurance also applies to "health plans and health insurers offering coverage outside the health insurance benefits exchange." It is not entirely clear whether the order extends to employer-sponsored group plans and are hopeful the Department of Insurance will provide further guidance.

Filing Requirement for Insurance Carriers for Medically Necessary Treatment of COVID-19

The California Department of Insurance is requiring all health insurers operating in California to submit a notification describing how they are communicating with potentially impacted insured and summarizing the actions the insurer has taken (or is taking) to ensure the health care needs of insureds are met. This requirement does not apply with respect to self-insured group health plans. The notification must include information that demonstrates the insureds have access to medically necessary health care during the COVID-19 outbreak, including, but not limited to:

- Relaxing limits on waiting periods between refills so that insureds can maintain at least a 30-day supply of medication on hand (with the exception of refills for certain drug classes such as opioids, benzodiazepines and stimulants).
- Permitting conversion of 30-day prescriptions with multiple refills into one larger prescription (for example, allowing a prescription written as a 30-day supply with 2 refills to be filed as a single 90-day supply).
- Relaxing fill or refill supply limits imposed by the insurer, where the provider has indicated that a larger fill or refill is appropriate for the patient.
- Waiving delivery charges for home delivery of prescription medication.
- Assuring access by streamlining or eliminating processes for requesting prior authorization, step therapy exceptions, and exceptions for obtaining off-formulary drugs when a drug is unavailable due to supply chain disruptions or similar issues.
- Maximizing the use of telehealth in all appropriate settings by waiving or expediting any network provider credentialing, certification, or pre-authorization requirements.
- Permitting telehealth use by all types of providers, particularly providers of medical/surgical services and providers of mental health and substance abuse disorder services.
- Facilitating telehealth as an infection control measure through waiver of applicable cost-sharing for services provided by telehealth, even for services where cost-sharing might apply for in-person services or treatment.
- If care cannot be provided within the insurer's network, arranging for available and accessible providers outside the network, with the patient responsible only for an amount equal to in-network cost sharing.
- Adopting contingency plans if network providers (especially hospitals) are unable to provide care due to excessive demand related to the COVID-19 emergency, and effecting transfers to the nearest facility (in- or out-of-network) with the capacity to provide medically appropriate care.

HMO Voluntary and Mandatory Procedures

The California Department of Managed Health Care has published three All Plan Letters for HMOs (2020-07, 2020-08, and 2020-09) which contain guidance on social distancing, the provision of health care services during self-isolation orders and reimbursement for telehealth. Highlights of the guidance are as follows:

- HMOs should allow enrollees to receive at least a 90-day supply of maintenance drugs, unless the enrollee's provider has indicated a shorter supply of a drug is appropriate for the enrollee.
- HMOs should suspend prescription drug refill limitations where the enrollee's provider has indicated a refill is appropriate for the enrollee.

- HMOs should waive delivery charges for home delivery of prescription medications.

- For services provided via telehealth, the HMO must not require cost-sharing by the enrollee that is greater than the cost-sharing that would apply had the service been provided in-person. In addition, HMOs should (but are not required to) waive cost-sharing for care delivered via telehealth, even if cost-sharing applies whenever the provider delivers care in-person.

- If an HMO has pre-authorization (or pre-certification) requirements that contracted providers must meet before the HMO will cover care delivered via telehealth, the HMO should either expedite its review process or relax those pre-authorization (or pre-certification) requirements to allow the HMO to more quickly approve providers to offer services via telehealth.

- HMOs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, provided that the service is the same regardless of the method of delivery. For example, if an HMO reimburses a mental health provider $100 for a 50-minute therapy session conducted in-person, the HMO must reimburse the provider $100 for a 50-minute therapy session done via telehealth.

- HMOs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service had been rendered via video, provided the method by which the service is rendered (telephone or video) is medically appropriate for the enrollee.

- HMOs may choose to delay elective surgeries and other non-urgent procedures during this time, provided that the referring or treating provider (or, if applicable, the health professional providing triage or screening services) has determined that a longer waiting time will not have a detrimental effect on the enrollee's health.

- If an HMO does not have sufficient personnel to mail hard-copy notices and other information to enrollees and providers as required by law, the HMO may instead communicate with enrollees and provides electronically or by telephone.

Employer Action

Employers should consider sending a communication to employees residing in California who are not enrolled in the employer's group medical plan, informing them about the special enrollment period to obtain individual health insurance in California. Employers should also forward communications they receive from insurance carriers and HMOs summarizing their responses to changes in coverage to covered employees and COBRA qualified beneficiaries. Employers that are experiencing financial difficulties in paying their monthly group insurance premiums can contact their Account Executive for assistance in coordinating payment deadlines with their insurance carriers.

We are monitoring developments around COVID-19 and will continue to update you.

Resources

- Notice from the California Department of Insurance on the 60-Day Grace Period for Insurance Premium Payments (March 18, 2020), http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/upload/nr030-BillingGracePeriodNotice03182020.pdf
- California Department of Insurance press release discussing special enrollment in Covered California (March 20, 2020), http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/release031-2020.cfm
- California Department of Managed Health Care's All Plan Letters 2020-07, 2020-08, 2020-09, and 2020-10, https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
- Special enrollment at Covered California for the COVID-19 pandemic, https://www.coveredca.com/individuals-and-families/getting-covered/special-enrollment/
- California Department of Insurance COVID-19 State of Emergency Notification Filing Requirements, http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/CDI-Emergency-Notification-Filing-Requirements-COVID-19-3-18-2020.pdf

Initial Guidance on Payroll Tax Credits under the Families First Coronavirus Response Act

Published: March 27, 2020

On March 20, 2020, the Internal Revenue Service, Department of Treasury and Department of Labor announced that employers with less than 500 employees will be able to take advantage of two new refundable payroll tax credits which were created to immediately and fully reimburse them, dollar-for-dollar, for the cost of providing COVID-19 leave to their employees. These tax credits are provided under the Families First Coronavirus Response Act ("FFCRA"), signed by President Trump on March 18, 2020. The intent behind these tax credits is to enable employers to keep their workers on their payrolls and ensure they are not forced to choose between their paychecks and the public health measures necessary to combat the virus.

Briefly, the guidance provides:

- Employers will receive 100% reimbursement for paid leave;
- The credit includes health insurance costs;
- There will be no payroll tax liability for employers;
- Self-employed individuals are entitled to an equivalent credit; and
- Reimbursement will be quick and easy to obtain.

Eligible Employers

Eligible employers under the FFCRA are businesses and tax-exempt organizations with less than 500 employees that are required to provide emergency paid sick leave and emergency paid family and medical leave under the FFCRA. They will be able to claim these tax credits based on qualifying leave they provide to employees between April 1, 2020 and December 31, 2020. Credits are also available to self-employed individuals based on similar circumstances.

Paid Sick Leave Credit

Where an employee is unable to work or telework because the employee is quarantined, and/or where the employee is experiencing COVID-19 symptoms and seeking a medical diagnosis, eligible employers may receive a refundable sick leave credit for sick leave at the employee's regular rate of pay, up to $511 per day and $5,110 in total, for a total of 10 days.

For an employee who is unable to work or telework (1) because of the need to care for an individual subject to quarantine, (2) in order to care for a child whose school is closed or childcare provider is unavailable for reasons related to COVID-19, and/or (3) because the employee is experiencing substantially similar conditions as specified by the Department of Health and Human Services, eligible employers may claim a credit for two-thirds of the employee' regular rate of pay, up to $200 per day ad $2,000 in total, for up to 10 days. It is important to note that eligible employers are also entitled to an additional tax credit determined based on costs to maintain health insurance coverage for the eligible employee during the leave period.

Child Care Leave Credit

Eligible employers are also able to receive a refundable child care leave credit for an employee who has been employed at least 30 days and is unable to work or telework due to a need to care for a child whose school is closed, or child care provider is unavailable for reasons related to COVID-19. The credit shall be equal to two-thirds of the employee's regular pay, capped at $200 per day and $10,000 in total. Up to 10 weeks of qualifying leave can be counted towards the child care leave credit. Eligible employers are also entitled to an additional tax credit determined based on costs to maintain health insurance coverage for the eligible employee during the leave period.

Payment Process

In general, when employers pay their employees, they must withhold federal income taxes and the employees' share of Social Security and Medicare taxes from their employee's paychecks. Employers have to deposit these federal taxes, together with their share of Social Security and Medicare taxes, with the IRS and file quarterly payroll tax returns with the IRS.

Eligible employers who pay qualifying sick or child care leave will be able to retain an amount of the payroll taxes equal to the amount of qualifying sick and child care leave that they paid, rather than deposit them with the IRS. The payroll taxes that are available for retention include withheld federal income taxes, the employee share of Social Security and Medicare taxes, and the employer share of Social Security and Medicare taxes with respect to all employees. In the event there are not enough payroll taxes to cover the cost of qualified sick and child care leave paid, employers will be able to file a request for an accelerated payment from the IRS. The IRS expects to process these requests in two weeks or less. Further details regarding this process are expected soon.

Examples:

- If an eligible employer paid $5,000 in sick leave and is otherwise required to deposit $8,000 in payroll taxes, including taxes withheld from all its employees, the employer could use up to $5,000 of the $8,000 of taxes it was going to deposit for making qualified leave payments. The employer would only be required under the law to deposit the remaining $3,000 on its next regular deposit date.
- If an eligible employer paid $10,000 in sick leave and was required to deposit $8,000 in taxes, the employer could use the entire $8,000 of taxes in order to make qualified leave payments and file a request for an accelerated credit for the remaining $2,000.

Equivalent child care leave and sick leave credit amounts are available to self-employed individuals under similar circumstances. These credits will be claimed on their income tax return and will reduce estimated tax payments.

Exemption for Small Businesses

Businesses with under 50 employees may be exempt from the leave requirements relating to school closings or childcare unavailability due to COVID-19 where the requirements would jeopardize the ability of the business to continue, as indicated in the FFCRA. This relief will be available based on simple and clear criteria that make it available in circumstance involving jeopardy to the viability of an employer's business as a going concern. Emergency guidance and rulemaking will be released by the Department of Labor with details on this exemption.

Enforcement

The Department of Labor will be issuing a temporary non-enforcement policy that provides a period of time for employers to come into compliance with FFCRA. Under this policy, enforcement action will not be brought against any employer for FCCRA so long as the employer has acted reasonably and in good faith to comply with the FFCRA. The Department will focus on compliance assistance during the 30-day period.

Employer Action

Employers should be on the lookout for formal regulations from the IRS and Department of Labor with respect to this recent guidance and should discuss these new tax credits with payroll and tax advisors.

We are monitoring developments on the tax credits and will continue to keep you updated.

Special Enrollment Considerations During the COVID-19 Pandemic

Published: March 30, 2020

Several insurance carriers are communicating their intent to open a “special enrollment period” in connection with the COVID-19 pandemic. This special enrollment period would allow employees, who had previously failed to enroll in coverage for themselves, their spouses, and/or their children, to enroll in employer sponsored coverage. Carriers will permit employers to opt-in or opt-out of special enrollment periods. Below are considerations employers should review when determining whether to use these special enrollment periods.

- Without relief from the Department of Treasury, this type of special enrollment period would likely not be considered a status change event under Section 125 of the Internal Revenue Code. Until further guidance is issued, if an employer offers this special enrollment period, employees and dependents enrolling in coverage during one of these periods should remit contributions on an after-tax basis. Also note that, if an employer pays the cost of an accident or health insurance plan for its employees, including for an employee’s spouse and dependents, the employer’s payments are not considered wages and are not subject to Social Security, Medicare, and FUTA taxes, or federal income tax withholding.

- If employers offer this special enrollment period, plan documents, summary plan descriptions and other participant communications should be reviewed and updated to reflect this special enrollment period. Further, employers should consider communicating potential tax implications with participants.

- This type of special enrollment period may have a financial impact on an employer’s health plan. Employers should weigh the consequences of possible adverse selection that may result from offering this type of special enrollment period with the potential benefits to their employee populations by making such coverage available.

- It should be noted that not all stop-loss carriers may allow for this special enrollment period, They may not agree to cover newly enrolled participants during this period, which may result in significant financial liability to the employers. Employers with self-insured plans should review their stop-loss policies and will likely need to have written authorization from stop-loss carriers

COVID-19 Stimulus Package: The CARES Act

Published: March 30, 2020

On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") into law. It provides support to individuals and businesses that are trying to cope with the coronavirus disease 2019 ("COVID-19") pandemic. We will likely continue to see additional legislation enacted in response to the COVID-19.

The majority of the 800 pages of legislation are aimed at providing relief for individuals and businesses that have been negatively impacted by the pandemic. This Bulletin will focus is on the parts of the CARES Act that are directed towards employee benefit plans and employee leaves of absence.

Briefly, the legislation:

- Expands coverage of COVID-19 testing and preventive services.
- Clarifies that plans and carriers will pay either the negotiated rate or the cash price, as listed on a provider's website, for COVID-19 testing.
- Allows high deductible health plans ("HDHPs") that are compatible with health savings accounts ("HSAs") with plan years before December 31, 2021 to cover telehealth visits prior to satisfaction of the minimum deductible.
- Provides that over-the-counter medicines and drugs are "qualified medical expenses" and may be reimbursed through a health FSA, HRA or HSA on a tax-favored basis without a prescription and expands the definition of "qualified medical expenses" to include menstrual products.
- Includes changes to paid sick leave and family leave provisions created under the Families First Coronavirus Response Act ("FFCRA").

The following provides highlights of the final enacted legislation with respect to employee benefit plans and employee leaves of absence and is not an exhaustive summary.

Coverage of Testing

The CARES Act builds on the insurance coverage provisions included in the FFCRA.

The FFCRA requires all employer-sponsored health plans to provide coverage for testing and other services related to COVID-19 without cost sharing, prior authorization, and other medical management requirements.

The tests and services include:

- In vitro COVID-19 diagnostic products that are cleared or authorized by the FDA, including their administration, and
- Items and services furnished to an individual during health care provider office visits (including telehealth visits), urgent care center visits, and emergency room visits that result in an order for, or administration of, an in vitro diagnostic product, described above.

The CARES Act broadens coverage for COVID-19 tests and services under private plans beyond FDA-approved testing to also include coverage, without cost-sharing, for in vitro COVID-19 diagnostic products for which the developer has requested, or intends to request, emergency use authorization from the FDA, or that a state (which has told HHS it is reviewing such test) has authorized.

The CARES Act provides guidance that leaves open coverage for any "other test that the Secretary determines appropriate."

Reimbursement Rate for Testing

The CARES Act requires that group health plans (or insurers) reimburse providers at the negotiated cost of testing, where applicable, and for out-of-network providers, the group health plan (or insurers) must reimburse the provider at the cash price of the diagnostic testing, as reflected on the website. Providers are required to publicize the price of testing on a publicly available website. Providers who fail to publicize the price of testing will be subject to a fine not to exceed $300 per day.

Preventive Services

The CARES Act provides that if a preventive measure, defined as an "item, service, or immunization that is intended to prevent or mitigate COVID-19" (e.g., a COVID-19 vaccine) becomes available, group health plans must cover such preventive measure with no-cost sharing. The item or service must meet criteria under current U.S. Preventive Services Task Force ("USPSTF") guidelines or have a recommendation from the CDC with respect to an individual for whom the services are intended.

HSAs, FSAs and HRAs

The CARES Act provides much needed clarity with respect to Health Savings Accounts ("HSAs" and telemedicine. For plan years beginning on or before December 31, 2021, the CARES Act includes a safe harbor for high deductible health plans ("HDHPs") that permits pre-deductible coverage for telehealth and remote care services. As a result, HDHPs can allow all services provided through telemedicine or other remote care services to be covered prior to meeting the health plan deductible without jeopardizing an individual's HSA eligibility.

The CARES Act also repeals a rule enacted under the Affordable Care Act that prohibited over-the-counter medicines and drugs, other than insulin, from being qualified medical expenses without a prescription. For expenses incurred after December 31, 2019, participants may utilize HSAs, health flexible savings accounts ("FSAs,") or health reimbursement arrangements ("HRAs") to cover over-the-counter medicines and drugs (e.g., ibuprofen, cold medicines), without a prescription.

The CARES Act further provides that HSAs, health FSA, and HRAs, may be used to purchase certain menstrual care products (e.g., pads and tampons) on a tax-favored basis. These products will be treated as qualified medical expenses under the new legislation. This change applies to expenses incurred after December 31, 2019.

Paid Sick Leave and Expanded Family Medical Leave

The CARES Act provides a few clarifications and makes some relatively small changes to the paid sick leave and extended family leave provisions under FFCRA. The CARES Act:

- Provides for the exclusion of certain US government employers and executive branch employees for good cause;
    - Creates a new rule to define when a rehired employee may be considered an "eligible employee employed for at least the last 30 calendar days" under FFCRA. Under the CARES Act, a rehired employee, who would otherwise qualify as an "eligible employee employed by the employer" includes an employee who:
    - Was laid off by the employer on March 1, 2020 or later;
    - Had worked for the employer for at least 30 days in the last 60 calendar days prior to the lay-off; and
    - Has been rehired by the employer.
- Clarifies the amount of the paid leave benefit is "per employee" (e.g., $511/day/per employee).

The CARES Act includes provisions that are meant to improve the ability of employers to obtain advances on anticipated tax credits for employers for costs associated with paid sick and family leave. The Act allows employers to receive an advance tax credit from the IRS rather than having to be reimbursed on the back end. The CARES Act also provides penalty relief for failure to deposit tax amounts in anticipations of the credits.

Additional guidance from the IRS and DOL providing instructions on the process to obtain the tax credits and addressing additional questions and details on the expanded FMLA and paid sick leave provisions under FFRCA is expected in April.

Employer Action

Employers should:

i. ensure coverage for associated testing for COVID-19 is provided without cost-sharing or other limitation.

ii. confirm the health plan will pay either the plan's negotiated rate for the test, or the providers listed cash price. It appears this would limit a plan from imposing cost-sharing or balance billing in the event an individual received testing from an out-of-network provider; however, we await further guidance.

iii. consider waiving any copays associated with telehealth plans for plan years that begin before December 31, 2021 when offering an HDHP/HSA arrangement as such first dollar coverage is not disqualifying for a limited time.

iv. update documents and announce to employees that over-the-counter medicines and drugs can be reimbursed through tax favored accounts without a prescription and the expanded tax-free treatment of menstrual products.

v. review the FFCRA paid sick leave and expanded family leave requirements and note the changes made by the CARES Act.

We are monitoring developments and will continue to update you.

New Jersey Expands Disability and Leave Benefits to Address COVID-19

Published: March 31, 2020

On March 26, 2020, New Jersey Governor Murphy signed legislation that expands the Temporary Disability Benefits (TDB) and Family Leave Insurance (FLI) programs effective immediately. The law also provides for job protection under the New Jersey Family Leave Act (NJFLA) and expands the Earned Sick Leave Law.

Temporary Disability Benefits and Family Leave Insurance Programs

The law expands the definition of a "serious health condition" in response to the COVID-19 pandemic to include an illness caused by a public health emergency. Workers now have access to TDB and FLI if they are unable to work because they are diagnosed with or suspected of exposure to a communicable disease or they are taking care of a family member in the same situation. The bill does not specifically refer to COVID-19, therefore, this expansion applies to COVID-19 and any public health emergencies declared by the Governor or Commissioner of Health or other public health authority.

The bill eliminates the current one-week waiting period for temporary disability benefits for public health emergency related cases.

Earned Sick Leave

New Jersey's Earned Sick Leave ("ESLL") laws are expanded to allow the use of earned sick time for quarantine or isolation recommended or ordered by a health care provider or public health official as a result of suspected exposure to a communicable disease or to care for a family under the same situation.

Family Leave Act

The legislation modifies New Jersey's Family Leave Act so that the rights to reinstatement to employment provided also apply to those taking leaves for public health emergencies as provided for in the law.

Employer Action

Employers should review their leave policies to ensure compliance with the new guidance.

DOL Guidance on Families First Coronavirus Response Act

Published: March 31, 2020

The Department of Labor ("DOL") has issued multiple forms of guidance including Fact Sheets, Questions and Answers, Posters, and a Field Assistance Bulletin to clarify and address the Families First Coronavirus Response Act (the "FFCRA"). Below is a summary of the highlights of the guidance. It should be noted that guidance from the DOL continues to be released.

Paid Leave under the FFCRA

Private employers with under 500 employees (and public employers) are required to provide two new types of leave to employees under the FFCRA. Please review our previous Bulletins for in depth information on these types of leave. Briefly, the employer must provide:

- Two weeks (up to 80 hours) of paid sick leave at the employee's regular rate of pay where the employee is unable to work or telework because the employee is quarantined (pursuant to federal, state, or local government order or advice of a health care provider), and/or experiencing COVID-19 symptoms and seeking a medical diagnosis; or

- Two weeks (up to 80 hours) of paid sick leave at 2/3 the employee's regular rate of pay because the employee is unable to work because of a bona fide need to (1) care for an individual subject to quarantine (pursuant to federal, state, or local government order or advice of a health care provider), or (2) to care for a child (under 18 years of age) whose school or child care provider is closed or unavailable for reasons related to COVID-19, and/or (3) the employee is experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor; and

- Up to an additional 10 weeks of paid expanded Family and Medical Leave Act ("FMLA") leave at 2/3 the employee's regular rate of pay where an employee, who has been employed for at least 30 calendar days, is unable to work due to a bona fide need for leave to care for a child whose school or child care provider is closed or unavailable for reasons related to COVID-19.

When is the Effective Date of the New Leave Requirements?

The effective date is April 1, 2020, rather than April 2, 2020 as widely understood. The new requirements apply to leave taken between April 1, 2020 and December 31, 2020 and are not retroactive.

Paid leave provided for any qualifying reasons taken before April 1, 2020 does not count against the employee's leave entitlement under the FFCRA.

Once an employer shuts down its business for any reason (and whether or not the employer intends to reopen), employees will not be eligible for paid sick leave or expanded FMLA but may be eligible for unemployment insurance benefits. If an employee was already on paid sick leave or expanded FMLA when an employer shuts down its business, the employer must pay the employee for any paid leave used before the employer closed. Furloughed employees are not entitled for paid sick or expanded FMLA, but may be eligible for unemployment insurance benefits.

How do you Determine How Many Employees an Employer Has?

As stated above, the new leave requirements only apply to private employers with less than 500 employees. Employers should use the number of employees on the day the employee's leave would start to determine whether the employer has fewer than 50 employees for purposes of providing expanded FMLA and paid sick leave. Employers should:

- Count only employees within the United States.
- Include employees on leave and employees placed with the employer by a temporary agency.
- Controlled group rules do not apply. If one entity has an ownership interest in another entity, it is a separate employer unless it meets the (a) "joint employment" test, where two or more businesses exercise some control over the work or working conditions of the employee; or "integrated employer" test, where the factors to be considered are (i) common management, (ii) interrelation between operations, (iii) centralized control of labor relations, and (iv) degree of common ownership/financial control.

What Does "Employed for at least 30 Calendar Days" Mean for Expanded FMLA?

An employee will be considered employed by an employer for at least 30 calendar days if the employee was on the employer's payroll for the 30 calendar days immediately prior to the day the leave would begin. Where temporary employees have been working for an employer and are subsequently hired on a full-time basis, any days previously worked as a temporary employee may count toward the 30-day eligibility period.

When does the Small Business Exemption Apply to Exclude a Small Business from the FFCRA?

Employers with less than 50 employees are exempt from providing (a) paid sick leave due to school or place of care closures or childcare provider unavailability for COVID-19 related reasons and 9b) expanded FMLA due to school or place of care closures or childcare provider unavailability for COVID-19 related reasons when doing so would jeopardize the viability of the small business as a going concern. To claim this exemption, an authorized officer of the business must determine that:

- the provision of the paid leave would result in the small businesses' expenses and financial obligations exceeding available business revenues and cause the small business to cease operating at a minimal capacity;

- the absence of the employee(s) requesting paid leave would entail a substantial risk to the financial health or operational capabilities of the small business because of their specialized skills, knowledge of the business, or responsibilities; or

- there are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services provided by the employee(s) requesting paid leave, and these labor or services are needed for the small business to operate at a minimal capacity.

Who is a "Health Care Provider" who may be Excluded from Paid Leave under the FFCRA by their Employer?

For the purposes of employees who may be exempted from paid sick leave or expanded FMLA by their employer under the FFCRA, a health care provider is anyone employed at any doctor's office, hospital, health care center, clinic, post-secondary educational institution offering health care instruction, medical school, local health department or agency, nursing facility, retirement facility, nursing home, home health care provider, any facility that performs laboratory or medical testing, pharmacy, or any similar institution, employer or entity. The definition is extremely broad and includes any individual employed by an entity that contracts with any of the foregoing and anyone employed by any entity that provides medical services, produces medical products or is otherwise involved in the making of COVID-19 related medical equipment, tests and drugs.

Who is an "Emergency Responder" who may be Excluded from Paid Leave under the FFCRA by their Employer?

An emergency responder for purposes of being excluded from paid sick leave or expanded FMLA by their employer under the FFCRA is an employee who is necessary for the provision of transport, care, health care, comfort and nutrition of such patients, or whose services are otherwise needed to limit the spread of COVID-19. This includes, but is not limited to, military or national guard, law enforcement officers, fire fighters, emergency medical services personnel, etc.

How do you Count Hours for Part-Time Employees?

For purposes of paid sick leave under the FFCRA, a full-time employee is an employee who is normally scheduled to work 40 or more hours per week (the expanded FMLA does not distinguish between full and part-time employees). Part-time employees are entitled to leave for their average number of work hours in a two-week period. Hours of leave for both part-time and full-time employees are calculated based on the number of hours the employee is normally scheduled to work. If the normal number of hours is unknown, or if the employee's schedule varies, employers can use a six-month average to calculate average daily hours. In the event an employee hasn't been employed for at least six months, employers should use the number of hours they agreed upon with the employee to work upon hiring. If no agreement exists, employers may calculate the number of hours of leave based on the average hours per day the employee was scheduled to work over the entire term of his or her employment. Overtime hours must be counted, subject to 80-hour cap for sick leave.

What Does "Unable to Work Including Telework" Mean?

An employee is unable to work if his or her employer has work for the employee and one of the COVID-19 qualifying reasons set forth in the FFCRA prevents the employee from being able to perform that work, either under normal circumstances at their normal worksite or by means of telework. Employees may telework when their employers permit them or allow them to perform work at home or at a location other than their normal workplace. Normal wages must be paid for telework. If an employer and employee agree that an employee will work his or her normal number of hours, but outside his or her normally scheduled hours (for example, early morning or late night), then an employee is able to work, and leave is not necessary. If an employee becomes unable to telework because of one of the qualifying reasons for paid sick or expanded FMLA, the employee is entitled to take paid leave. Employers may allow intermittent paid sick and expanded FMLA while teleworking (unless an employee is teleworking, paid sick leave must be taken in full-day increments). Employers and employees are encouraged to collaborate to achieve flexibility and meet mutual needs.

How Much Should Employees be Paid for Taking Leave?

The answer to this depends on the employee's normal schedule and reason why leave is taken.

Employees are paid as follows:

- For paid sick leave based upon an employee's need for leave due to (1) federal, state, or local quarantine or isolation order related to COVID-19; (2) having been advised by a health care provider to self-quarantine due to concerns related to COVID-19; or (3) experiencing symptoms of COVID-19 and seeking medical diagnosis, the employee will receive for each applicable hour the greater of:
  - the regular rate of pay;
  - the federal minimum wage in effect under the FLSA; or
  - the applicable state or local minimum wage.

  The maximum is $511 per day, or $5,110 total over the entire paid sick leave period.

- For paid sick leave due to: (1) caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; (2) caring for the employee's child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons; or (3) experiencing any other substantially-similar condition that may arise, as specified by HHS, the employee is entitled to compensation at 2/3 of the greater of the amounts above.

  Under these circumstances, the employee is subject to a maximum of $200 per day, or $2,000 over the entire 2-week period.

- For expanded FMLA, the employee can take paid sick leave for the first 10 days of that leave period, or the employee may substitute any accrued vacation leave, personal leave, or medical or sick leave under the employer's policy. For the following 10 weeks, the employee will be paid at an amount no less than 2/3 of the regular rate of pay for the hours he or she would be normally scheduled to work capped at $200/day or $10,000 in the aggregate. The regular rate of pay used to calculate this amount is at or above the federal minimum wage, or the applicable state or local minimum wage.

The regular rate of pay used to calculate paid leave is the average of the employee's regular rate over a period of up to six months prior to the date on which leave is taken. If an employee has worked less than six months for the employer, the regular rate is the average of the employee's regular rate of pay for each week worked for the employer. Commissions and tips should be incorporated into these calculations.

Employers can pay employees in excess of FFCRA requirement, but they cannot claim (and will not receive tax credit for) those amounts in excess of the FFCRA's statutory limits.

Do Employers Have to Continue Health Coverage If an Employee is on Paid Sick or Expanded FMLA?

Yes, employees are entitled to continued group health coverage during these paid leaves on the same terms as if they continued to work.

Can there Be Multiple Qualifying Reasons for Leave?

Yes.

For paid sick leave, the 80 hours of paid sick leave is for one or more qualifying reasons; it is not 80 hours of paid sick leave per qualifying reason.

An employee may qualify for both paid sick leave and expanded FMLA, but cannot receive more than a total of 12 weeks of paid leave. Paid sick leave covers the first 10 workdays of expanded FMLA leave, which is otherwise unpaid. After the first 10 workdays, the employee will receive 2/3 of his or her regular rate of pay.

However, the employee will not receive more than $200 per day or $12,000 for the 12 weeks that include both paid sick leave and FMLA leave when on leave to care for a child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons.

Can an Employee use its Employer's Preexisting Leave Entitlements and FFCRA Paid Leave Concurrently?

No. If an employee is eligible to take paid sick or expanded FMLA under the FFCRA, as well as paid leave that is already provided by the employer, unless the employer agrees, the employee must choose one type of leave to take and may not simultaneously take both, unless the employer agrees to allow the employee to supplement the amount s/he receives from paid sick leave or expanded FMLA, up to his or her normal earnings, with preexisting leave. If an employee chooses to use existing leave the employer has already provided, the employer may supplement or adjust the pay mandated under the FFRCRA with paid leave, but an employer cannot force an employee to use existing leave.

Can an Employer Require Employees to Adjust the FFCRA With Paid Leave Employees Already Have?

No. Under the FFCRA only employees may decide whether to use existing paid vacation, personal, medical or sick leave from the employer's paid leave policy to supplement the amount the employee receives from paid sick leave or expanded FMLA.

Is all FMLA Leave now Paid Leave?

No. Traditional FMLA leave (e.g., FMLA leave available for the serious health condition of the employee or employee's family member rather than related to childcare issues associated with COVID-19) remains unpaid.

Does taking paid leave under the FFCRA count against other types of paid sick leave or FMLA leave?

Paid sick leave under the FFCRA is in addition to other leave provided under federal, state or local law, an applicable collective bargaining agreement or an employer's existing company policy. With respect to family medical leave, an employee may take a total of 12 workweeks of leave during a 12-month period under the FMLA, including the expanded FMLA under the FFCRA.

What Happens if an Employee Takes Paid Sick Leave While in a Waiting Period for Health Coverage?

If an employee elects to take paid sick leave while in a waiting period for his or her employer's health coverage, the employee's health coverage will still take effect after s/he completes the waiting period on the same day the coverage would otherwise take effect even though the employee was absent from work on paid sick leave during the waiting period.

Employee Notice to Employer for Leave

Where leave is foreseeable, an employee should provide notice of leave to the employer as is practicable. After the first workday of paid sick time, an employer may require employees to follow reasonable notice procedures in order to continue receiving paid sick time.

What Notice Must Employers Provide to Employees?

Employers must provide a notice to employees regarding the new leave provisions as follows:

- The notice must be posted in a conspicuous place where employees can see it. For teleworking employees, this includes emailing, direct mailing, or posting to a website.

- There is no requirement to provide it in other languages, but the DOL is working on translations.
- The notice does not need to be provided to former employees, laid off employees, or job applicants, but must be conveyed to new hires.
- All covered employers (including those not normally covered by FMLA) are required to post the notice even if the state requires greater protections.

The notice can be found at: https://www.dol.gov/sites/dolgov/files/WHD/posters/FFCRA_Poster_WH1422_Non-Federal.pdf

Do Employers Need to Keep Records of Employees who Take Leave?

Employers must require employees to provide appropriate documentation supporting the reason for the need for paid sick and expanded FMLA. This documentation includes:

- the employee's name, qualifying reason for requesting leave, statement that the employee is unable to work, including telework, for that reason, and the date(s) for which leave is requested.
- the source of any quarantine or isolation order, the name of the health care provider who has advised the employee to self-quarantine.
- a notice posted on a government, school or day care website, or published in a newspaper, or an email from an employee or official of the school, place of care or childcare provider.

If employers intend to claim a tax credit under the FFCRA for its payment of the sick leave wages, they should retain this documentation in their records and should consult IRS applicable forms, instructions, and information for the procedures that must be followed to claim a tax credit.

What is the DOL's Temporary Non-Enforcement Period?

Field Assistance Bulletin 2020-1 offers a non-enforcement period to employers making a reasonable and good faith effort to comply with the FFCRA from March 18 to April 17, 2020. The Bulletin provides that the DOL will not bring enforcement action against any public or private employer for violations of the FFCRA during this 30-day window as long as the employer has acted reasonably and in good faith. For purposes of this relief, an employer will be found to be acting reasonably and in good faith when all of the following are met:

- The employer fixes any violations (including making employees whole) as soon as possible;
- Violations of the FFCRA were not willful, meaning the employer did not know its acts were in violation or did not act with reckless disregard as to its prohibited conduct; and
- The employer commits in writing to comply with the FFCRA prospectively.

For a copy of the DOL's Questions and Answers, visit https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

San Francisco HCSO & FCO 2019 Reporting Cancelled

Published: March 31, 2020

In response to the COVID-19 pandemic, the San Francisco Office of Labor Standards Enforcement (OLSE) has canceled the requirement for employers to submit the 2019 Annual Reporting Form for the San Francisco Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance (FCO). This form would otherwise have been due by April 30, 2020 or face penalties of up to $500 per quarter.

All other requirements of the HCSO and FCO 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 2020 is April 30, 2020.

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 2020 Notice is available in 6 languages at:

https://sfgov.org/olse/sites/default/files/Document/HCSO%20Files/2020%20HCSO%20Poster.pdf

2020 Compliance Bulletins

State Based

Mandated Long-Term Care Insurance Coming to Washington

Washington State enacted H.B. 1087 to establish the Long-Term Services and Supports Trust Program ("the Program") that creates a long-term care insurance benefit for certain qualified individuals. The Program will be funded by a new payroll tax.

Beginning January 1, 2022, a 0.58% payroll tax will be assessed on employee wages to fund the Program. Employers will be required to collect the premiums through payroll deduction and remit them to the state's Employment Security Department (ESD). Employers are not required to contribute toward the cost of these premiums. Employees who demonstrate that they have long-term care insurance will be exempt from this payroll tax. Self-employed individuals can opt-in to the program.

As an example, an employee with $75,000 in annual wages would pay $435 to fund the Program.

A qualified individual eligible to receive benefits through this program must:

- Be at least 18 years old,
- Be a Washington resident,
- Have paid into the Program for the equivalent of either:
- A total of 10 years or
- Three years within the previous six years.

Benefits become available January 1, 2025 to qualified individuals. To receive benefits through the Program, the individual must be a "qualified individual" and the Department of Social and Health Services must determine that the individual requires assistance with at least three activities of daily living (e.g., bathing, eating, dressing). The maximum lifetime benefit is $36,500.

Employer Action

ESD and other agencies responsible for the administration of the Program will begin rulemaking to implement the long-term care trust fund and benefit. That guidance should help clarify the Program. Notably, it will be important for employers to understand the process for remitting premiums to the state beginning in 2022 and how employees may demonstrate coverage by a long-term care policy to avoid the payroll tax.

2020 Louisiana Benefits Legislative Update

The 2019 regular session of the Louisiana legislature concluded on June 6, 2019 and Governor Edwards signed 45 bills into law, including a handful of health-related bills addressing pharmacy benefit managers ("PBMs") and drug cost transparency, claims reporting, and health insurance-related mandates. While these laws are not directly employer-related, employers should be aware of the changes which are summarized below.

PBM Restrictions and Drug Transparency

SB 41 (Act No. 124) provides for the following increased regulation of PBMs doing business in the state of Louisiana:

- Increased licensing requirements;

- Additions to Louisiana's unfair trade practices including, but not limited to, the following:
  - spread pricing (i.e., charging a health insurer for payment of the same prescription or pharmacy services differently than the amount paid to the pharmacy);
  - steering patients to pharmacies in which the PBM has ownership;
  - reimbursing a local pharmacy less than the amount it reimburses chain, mail-order, or specialty pharmacies for the same drug or device; and
  - requiring a patient to follow step therapy protocols before dispensing a prescription drug in the manner prescribed by the ordering physician.

SB 41 takes effect July 1, 2020.

Prescription Drug Disclosure

HB 119 (Act No. 206) requires a health insurer to provide a prescriber with a list of alternative, disease-specific formulary medications in writing upon denial of prescription drug based on step therapy, fail first protocols, or nonformulary status.

HB 119 will be enforced against a health insurer for acts taking place on or after January 1, 2020 if the health insurer sends an electronic notice. For notices provided in any other manner, the law will be enforceable July 1, 2020.

Increased Reporting and Earlier Renewal Notice

HB 408 (Act No. 112) requires health insurers to provide claims information, plan utilization, and premium information on a monthly basis to large employer clients (more than 50 employees).

Additionally, health insurance carriers are required to provide the employer with more than 50 employees (rather than 100 employees currently) with the premium rates required to renew the group policy within 90 days prior to the date the policy is set to renew.

HB 408 became effective on August 1, 2019. An employer will need to make a request with its insurance carrier to initiate the monthly report.

Contingent ACA-Related Mandated Benefits

SB 173 (Act No. 412), also known as the "Healthcare Coverage for Louisiana Families Protection Act," mandates that health insurers cover essential health benefits and provide certain patient protections currently required under the Affordable Care Act ("ACA") such as:

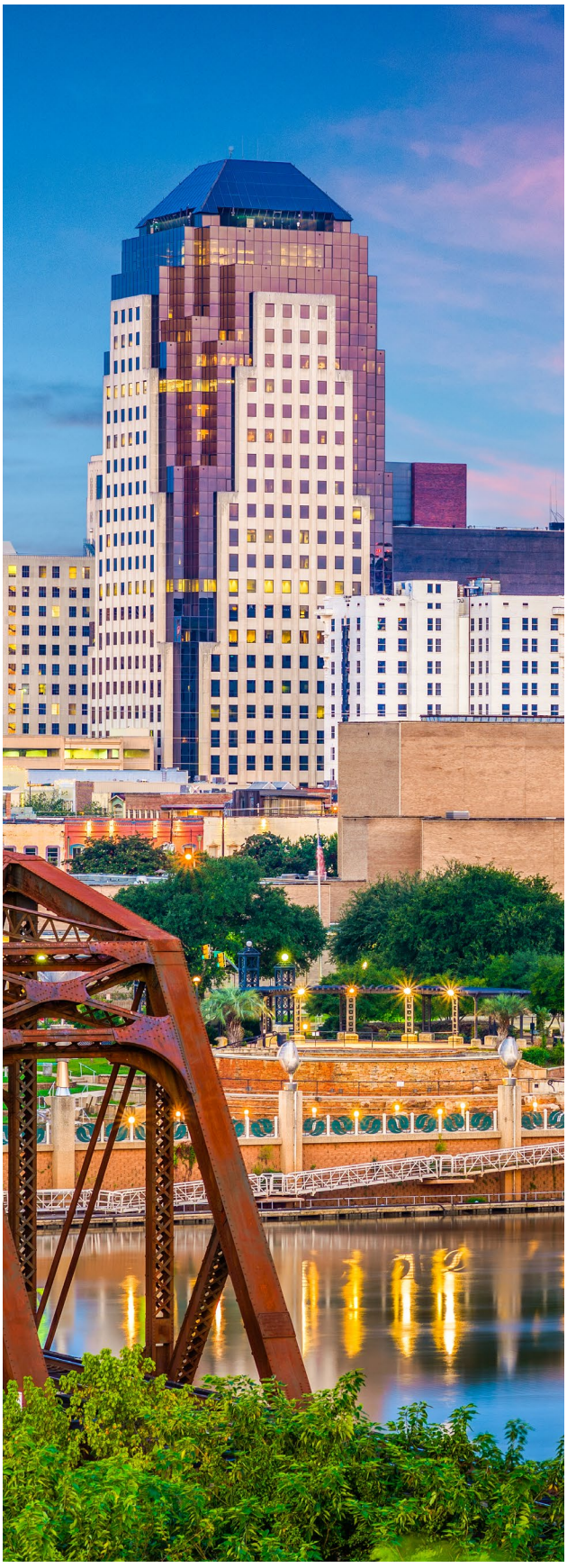
- The prohibition of preexisting condition exclusions;
- The prohibition of annual and lifetime limits; and
- Required eligibility of dependent children to age 26.

This law will take effect immediately upon a final court ruling that the ACA is unconstitutional.

New Mandated Benefit – Cancer Screening

HB 345 (Act No. 118) requires health insurance plans within Louisiana to provide coverage for breast and ovarian cancer susceptibility screening. Health insurance carriers must cover the cost of the genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer when recommended by a health care provider in accordance with United States Preventive Services Task Force recommendations. Coverage provided may be subject to the deductible, coinsurance, and copayment provisions consistent with other benefits provided under the plan. The law applies to fully insured plans. It also purports to apply to self-funded plans, although that application appears to be preempted by ERISA.

HB 345 takes effect for health plans delivered, issued, or renewed on or after January 1, 2020.



Fifth Circuit Affirms ACA's Individual Mandate is Unconstitutional

This article is intended to provide you with an update on current legal challenges to invalidate the ACA. There is no immediate impact to employer-sponsored health plans or other requirements under the ACA.

On December 18, 2019, the U.S. Court of Appeals for the Fifth Circuit affirmed the U.S. District Court for the Northern District of Texas' finding that the Affordable Care Act's ("ACA's") individual mandate is unconstitutional. However, the Fifth Circuit disagreed that the entire ACA must be invalidated and remanded the case back to the Texas U.S. District Court for further review.

Background

One of the ACA's major provisions is that Americans must have health insurance or pay a penalty. That provision was challenged and, on June 28, 2012, the Supreme Court ruled that the Individual Mandate is not a valid exercise of Congress' power under the Commerce Clause (i.e., the federal government cannot force individuals to buy insurance), but nevertheless upheld it due to Congress' power under the Taxing Clause (i.e., the federal government has broad authority to monetarily penalize individuals).

In December 2017, Congress, through the Tax Cuts and Jobs Act, changed the Individual Mandate Penalty to $0, beginning January 1, 2019.

In a renewed effort to strike down the ACA, Texas Attorney General Ken Paxton and 19 other Republican state attorneys general filed a lawsuit which charged that Congress' changes to the law in last year's tax bill rendered the entire ACA unconstitutional. In Texas vs. U.S., Judge O'Connor of the U.S. District Court for the Northern District of Texas agreed with the Republican state attorneys general and invalidated the entire ACA.

The case was appealed to the Fifth Circuit.

Fifth Circuit Court of Appeals Ruling

In its decision on appeal, the Fifth Circuit agreed with the District Court that the ACA's Individual Mandate is only constitutional to the extent that it is paired with an individual mandate penalty tax. Accordingly, the reduction of the individual mandate penalty tax to "$0" as part of the Tax Cuts and Jobs Act renders the ACA's individual mandate unconstitutional.

However, the Fifth Circuit disagreed with the lower court's conclusion that the entire ACA must be struck down if the individual mandate is unconstitutional. The Fifth Circuit remanded the case back to the lower court for a detailed analysis of the ACA provisions, if any, that could be severed from the individual mandate and thereby survive. The Fifth Circuit also directed the lower court to determine whether the decision affects only the three states within the Fifth Circuit (Louisiana, Mississippi and Texas) and whether relief should be limited to those ACA provisions that injured the parties that filed the lawsuit.

It is important to note that because the case has not reached its final resolution, there is no immediate impact on employers or plan sponsors. For now, the ACA remains the law of the land and employers should continue to comply with the various aspects of the law.

Petition to Supreme Court for Expedited Review

Following the Fifth Circuit's ruling, Democrats defending the ACA filed a petition to the Supreme Court for an expedited review of the Fifth Circuit's ruling in an attempt to bypass a lengthy legal battle and have the Court rule on the matter before the 2020 presidential election. However, on January 21, 2020, the Supreme Court rejected this effort by Democrats to fast-track their appeal of the Fifth Circuit's ruling and has instead chosen to adhere to a normal briefing schedule.

Employer Action

There is no immediate impact to employer-sponsored health plans or other requirements under the ACA.

Washington State Health Insurance Response to COVID-19

On March 5, 2020, Washington State Insurance Commissioner Mike Kreidler issued an emergency order requiring health insurance carriers to waive copays and deductibles for any consumer requiring testing for coronavirus disease 2019 (COVID-19).

This mandate is effective March 5, 2020 through May 4, 2020 and applies to all state regulated health insurance plans and short-term limited duration medical plans. It does not directly apply to self-funded group health plans subject to ERISA.

Briefly, carriers are required to:

- Cover, prior to application of any deductible and with no cost-sharing, the health care provider visit and FDA-authorized COVID-19 testing for enrollees who meet the CDC criteria for testing, as determined by the enrollee's health care provider.
- Allow enrollees to obtain a one-time refill of their covered prescription medications prior to the expiration of the waiting period between refills so that enrollees can maintain an adequate supply of necessary medication.
- Suspend any prior authorization requirements that apply to covered diagnostic testing and treatment of COVID-19.

If a carrier has an insufficient number or type of providers in their network to provide testing and treatment of COVID-19, the carrier must ensure that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost than if the provider were in-network.

Employer Action

- Employers with insured group health plans written in Washington should anticipate first dollar coverage for office visits and testing associated with COVID-19. Carriers are likely to make additional information available in the coming days.
- Employers with self-funded group health plans subject to ERISA are not subject to this requirement. However, you can discuss enhanced benefits around office visits and testing for COVID-19 and consider whether to adopt any plan changes. Be aware some carriers and TPAs will require employers sponsoring self-funded group health plans to opt-in to or opt-out of expanded coverage related to COVID-19.

We are monitoring developments around the COVID-19 and will continue to keep you updated.

Oregon Health Insurance Response to COVID-19

On March 5, 2020, Governor Kate Brown announced that Oregon had reached an agreement with health insurance companies to waive cost-sharing for their insureds for coronavirus disease 2019 (COVID-19) testing. No expiration date was included as part of the announcement.

The Oregon Agreement

In Oregon, consumers with fully insured individual and group health plans will not be charged co-payments, co-insurance, or deductibles related to COVID-19 for the following:

- COVID-19 testing at an in-network provider, in-network urgent-care center, or emergency room
- COVID-19 immunizations when they become available

The Oregon agreement has been reached with the following insurers as of the announcement:

- BridgeSpan Health Company
- Health Net Health Plan of Oregon, Inc.
- Kaiser Permanente
- Moda Health Plan, Inc.
- PacificSource Health Plans
- Providence Health Plans
- Regence Blue Cross Blue Shield
- Samaritan Health Plans, Inc.

Oregon is also seeking clarification from the federal government about exceptions to cost sharing for Medicare Advantage plans and health savings account eligible high deductible health plans. The IRS announced on March 11, 2020 that reimbursements prior to satisfaction of the minimum deductible for costs related to testing and treatment of coronavirus will not cause participants in a qualified HDHP to lose eligibility to make HSA contributions.

As with the other directives of this nature, their applicability does not extend to self-funded plans subject to ERISA. Oregon is working on the same agreement with self-funded health plans but no information has been provided on this issue. However, nothing prevents a self-funded plan sponsor from providing the same or similar benefits.

We are monitoring developments around the COVID-19 and will continue to update you.

Alaska Health Insurance Response to COVID-19

On March 6, 2020, the Alaska Division of Insurance issued Bulletin 20-04 requiring health insurers to waive all cost-sharing for testing for coronavirus disease 2019 (COVID-19) through April 30, 2020.

The Alaska Bulletin

The Alaska mandate applies to all state regulated health insurance plans for all patients that meet the testing criteria set forth by the Alaska Division of Public Health and the U.S. Center for Disease Control.

Carriers will be required to:

- waive any cost-sharing for laboratory diagnostic testing for respiratory syncytial virus (RSV), influenza, respiratory panel tests, and COVID-19.

- waive cost-sharing for office, urgent care center, emergency room visit with testing for the above conditions.

The waivers would be applicable at both in and out of network facilities. The Alaska Bulletin also encourages insurers to liberalize telehealth services and reminds them that group insurance cannot require services to be provided by any particular provider or facility.

We are monitoring developments around the COVID-19 and will continue to update you..

Colorado Mandates Paid Leave for COVID-19 Testing

On March 11, 2020, the Colorado Department of Labor and Employment (CDLE) released emergency rules that temporarily require employers in certain industries to provide paid sick leave to employees with flu-like symptoms for the four-day period required for coronavirus disease 2019 (COVID-19) testing. This rule will remain in effect until April 10, 2020 and may be extended if the state of emergency declared by Governor Jared Polis continues.

Paid Leave for COVID-19 Testing

Under the CDLE emergency rules, employers in the following industries are required to provide paid sick leave for an employee with flu-like symptoms who is being tested for COVID-19:

- leisure and hospitality,
- food services,
- childcare,
- education (including related service such as cafeterias),
- home health care,
- nursing home facilities, or
- community living facilities.

The paid sick leave is only required for the four-day period needed for COVID-19 testing and ends if an employee receives a negative COVID-19 test result. Should an employee test positive and require quarantine, the emergency rules do not provide wage replacement for lost work time.

Employers that already provide paid sick leave compliant with the four-day leave requirement are not required to provide additional days of paid sick leave. However, employees that have already exhausted their paid leave allotted by the employer are entitled to additional paid sick days if they subsequently experience flu-like symptoms and are tested for COVID-19.

Rate of Pay

Pay during the mandated four-day period required for COVID-19 testing must be provided at the employee's regular rate of pay. This includes all forms of wages and compensation. For employees paid below minimum wage due to a tip credit, the employee's compensation must be increased to the applicable minimum wage. Where an employee's rate or pay or service hours varied prior to the absence for COVID-19 testing, the employer must determine the employee's rate of pay by averaging the employee's daily pay for the preceding month.

Other Initiatives

Governor Polis' executive order also included directives for the CDLE to:

1. engage in emergency rulemaking for temporary paid sick leave, and

2. identify additional supports and wage replacement.

Accordingly, other wage replacement options for those who test positive for COVID-19, including expanding eligibility for unemployment insurance, are under review by the CDLE.

We are monitoring developments around the COVID-19 and will continue to provide you with timely updates.

Ohio Expands Health Insurance Eligibility for COVID-19 Testing

On March 20, 2020, as a result of the coronavirus disease 2019 ("COVID-19") pandemic, the State of Ohio's Department of Insurance released two new Bulletins pertaining to health insurance in Ohio in response to Governor Mike DeWine's March 9, 2020 Executive Order 2020-01D. Briefly, these Bulletins require:

- fully insured health plans (and stop loss carriers) based in Ohio must continue health benefits eligibility for employees that have reduced hours. This order also gives a grace period of 60 days for the "insured" to defer premium payments.

- health insurance carriers providing fully insured health plans in Ohio must provide certain coverages related to COVID-19 testing.

Health Insurance Coverage Flexibility for Ohio Employees

Bulletin 2020-03 provides that insurers in Ohio must (1) allow employers to continue coverage for employees under the group plan, even if the employee is otherwise ineligible for coverage because of a drop in hours, and (2) allow employers to continue coverage for employees under the group plan regardless of eligibility requirements, like an "actively at work" requirement. Insurers are not permitted to increase premium rates because of COVID-19 related enrollment/participation decreases.

All insurers must give "insureds" an optional grace period, in which the insured may defer premium payments, without interest, for up to sixty (60) days from the premium payment's due date. It is unclear whether this grace period applies to participants or the employer to remit premiums. The order states only that "all insurers are to give their 'insureds' the option of deferring premium payments coming due, interest free, for up to 60 calendars days, interest free, for up to 60 calendar days from each original premium due date." A definition of "insured" is not in the order. It is also unclear if this applies to employees that are terminated – likely it does not. This appears only to apply to those that have had their hours reduced but remain employed. A more likely interpretation is that those that are terminated would be subject to COBRA or state continuation of coverage. Carrier reactions will likely be forthcoming and further guidance would be appreciated.

This order only applies to fully insured health insurance plan written in Ohio. In most cases it does not appear it would apply to a self-insured health plan, as self-insured health plans are not subject to state laws. However, it appears that a stop-loss carrier contract written in Ohio could not deny coverage for an employee that is not a work, but still employed, due to a temporary reduction in hours that would have otherwise made them ineligible under the plan. Additionally, all MEWAs in Ohio are subject to Ohio insurance laws and would need to follow this.

The order was effective immediately on Marc 20, 2020 and is effective until the State of Ohio is no longer under a State of Emergency.

COVID-19 Testing and Treatment: Out-of-Network Coverage

Bulletin 2020-05 provides that, effective March 20, 2020, fully insured health insurance plans in Ohio must:

- Include testing and treatment related to the COVID-19 virus in the definition of emergency medical conditions.

- Cover these emergency services with an out-of-network provider without preauthorization and cover the same cost sharing level as if the provider was in-network.

- Provide benefits with respect to an emergency service (including the testing and treatment of COVID-19) in an amount at least equal to the greatest of the amount negotiated with in-network providers, the amount calculated using the same method the plan generally uses to determine payments for out-of-network services, or the amount that would be paid under Medicare.

Further, fully insured health plans written in Ohio must ensure coverage for out-of-network emergency services (including the testing and treatment of COVID-19) without balance billing.

This order applies to fully insured health insurance plans written in Ohio. Health insurance carriers (not employers) will be responsible for compliance with this mandate. The order does not apply to self-insured plans due to ERISA preemption, but does apply to MEWAs in Ohio.

We are monitoring developments around the COVID-19 pandemic and will continue to update you

Nevada Health Insurance and Paid Leave Response to COVID-19

In response to the COVID-19 pandemic, Nevada has announced the following developments with respect to health insurance and leaves of absence in Nevada:

Special Enrollment Period for Nevada Health Link

The Silver State Health Insurance Exchange has announced that eligible uninsured residents of Nevada have a Special Enrollment Period to obtain an individual health insurance policy from Nevada Health Link, which is Nevada's online Marketplace. The Special Enrollment Period runs through April 15, 2020 and is open to Nevada residents who are not and have not been previously enrolled in Marketplace coverage during 2020. Coverage will begin on April 1, 2020 if applied for on or before April 1. Coverage will begin on May 1, 2020 if applied for between April 2 and April 15, 2020. Employers have the option, but are not required, to inform employees residing in Nevada about the Special Enrollment Period at Nevada Health Link.

Leaves of Absence

The Nevada Labor Commissioner announced on March 11, 2020 that if an employee is subject to a mandatory government quarantine by a federal, state or local agency, and the employee is unable to report to work, the employer should not treat the mandatory government quarantine time as leave that is counted against the employee or taken from the balance of his/her leave, unless the employee elects to use leave (including paid leave), or other leave is required to be used (such as FMLA leave). This guidance is intended primarily for employers with 50 or more employees in Nevada that are providing paid leave accruals to employees under Nevada law for each hour of work performed; employees are eligible to use their paid leave beginning on their 90th day of employment. The announcement recommends that employers with fewer than 50 employees also follow this guidance as needed.

Additionally, the announcement states:

- Depending on the employer's internal policy, employees may not be accruing any type of leave or pay while under a mandatory government quarantine.
- Employers are encouraged to pay employees during the time they are absent on a mandatory government quarantine, and to offer alternative working arrangements (such as teleworking or additional paid time off), but the employer is not required to do so.
- An employee can choose to request to use paid leave or other applicable leave (if available) while absent on mandatory government quarantine, at the employee's option. FMLA leave may also apply to the employee's situation, condition, and length of absence.

Finally, the announcement states that the above guidance does not replace current collective bargaining agreements or other contracts.

COVID-19 Testing and Immunization: Waiver of Cost Sharing

On March 5, 2020, the Nevada Division of Insurance published emergency regulations which state that health insurers:

- Must not impose an out-of-pocket cost for visiting a provider office, urgent care center, or emergency room, when the purpose of the visit is to be tested for COVID-19;
- Must not impose an out-of-pocket cost for COVID-19 testing;
- Must cover the costs of COVID-19 immunization as one becomes available.

The emergency regulations do not apply to self-insured plans or short-term limited duration plans.

The Nevada Division of Insurance later released a Consumer Alert and separate FAQs on the emergency regulations which contain additional information about the cost-sharing waiver. The FAQs re-affirm that health insurers are required to cover – with no out-of-pocket cost – testing for COVID-19 and the office, urgent care center, or emergency room visit (including the patient exam) when the purpose of the visit is to be tested for COVID-19. No "out-of-pocket cost" means that covered individuals cannot be charged a copay or be required to meet a deductible for the test or visit.

The Consumer Alert and FAQs contain contradictory information, however, about the procedure that covered individuals should follow to obtain COVID-19 testing. The Consumer Alert implies that covered individuals can decide for themselves whether to get tested for COVID-19:

If you think you may have COVID-19, your health insurance must pay for the cost of visiting your doctor and the test as a preventive measure. Anyone who may have been exposed to, or is experiencing symptoms of COVID-19, should take immediate precautions to prevent spreading of the virus. A precaution may include consulting with your medical provider to determine whether you need to be tested for the virus.

On the other hand, the FAQs state that covered individuals must contact their health care provider for information about getting tested. On the question of whether the healthcare provider is required to test for COVID-19 if a covered individual has no symptoms but wants to be tested, the answer according to the FAQs is that testing protocols are up to providers, and testing or treatment required to address a patient's situation is between the patient and the patient's provider.

The FAQs also ask what happens if an in-network provider cannot see the covered individual, who then visits an out-of-network provider for COVID-19 testing. The answer is that testing performed by an out-of-network provider must be covered by the health insurer at no out-of-pocket cost, in situations where there is an issue with accessing care through an in-network provider that would prolong testing for COVID-19.

Finally, if a covered individual has COVID-19, the FAQs state that coverage for COVID-19 treatment will depend on the terms and conditions of the insurance policy. Health insurance plans typically cover medically necessary services, according to the FAQs; if the insurance policy has copays and deductibles, they will apply to treatment for COVID-19. Covered individuals are directed to contact their employer and health insurer for more details.

Off-Formulary Prescription Drugs

The Nevada Division of Insurance's emergency regulations state that, to ensure adequate access to prescription drugs due to shortages caused by supply-chain disruptions, health insurers must provide coverage for off-formulary prescription drugs if a formulary drug is not available to treat a covered individual. In addition, the cost to the covered person of the off-formulary prescription drugs in this situation must be the same as the cost for his/her usual medication, according to the Consumer Alert from the Nevada Division of Insurance. The FAQs phrase this requirement in a similar fashion: "If prescription drugs are not available due to supply disruptions, health insurers must cover off-formulary prescriptions at no additional cost to you."

As stated above, the emergency regulations from the Nevada Division of Insurance do not apply to self-insured plans or short-term limited duration plans.

Guidance from Health Insurance Carriers

According to the emergency regulations from the Nevada Division of Insurance, health insurers must issue guidance to covered individuals and network providers to inform them about available benefits, options for medical advice and treatment through telehealth, and preventive measures related to COVID-19.

Employer Action

Employers should consider sending a communication to employees residing in Nevada who are not enrolled in the employer's group medical plan (i.e. they are not eligible for coverage or they waived coverage), informing them about the special enrollment period through April 15, 2020 to obtain individual health insurance from Nevada Health Link. Employers should also review their paid leave policies and procedures for Nevada employees, and ensure that in the event employees are unable to work due to a mandatory government quarantine, they are not required to use their accrued paid leave during the time away (although they may choose to do so). Finally, Nevada employers with insured plans should keep an eye out for carrier information about insurance coverage and COVID-19, and coordinate with carriers if necessary, to distribute the information to covered individuals.

We are monitoring developments around COVID-19 and will continue to update you.

Amendments to Seattle Paid Sick and Safe Time Ordinance

The Seattle Office of Labor Standards amended the Paid Sick and Safe Time (PSST) Ordinance in response to challenges faced by workers caused by the COVID-19 pandemic. Effective March 18, 2020, all employees may use PSST when a family member's school or place of care has been closed. Additionally, employees of businesses with 250 or more full time equivalent employees can use PSST when their place of business has reduced operations or been closed for any health or safety reason.

Background

City of Seattle PSST is employer-paid time off that employees can use for an absence from work due to a personal or family member's physical or mental health condition, illness, or critical safety issues. Prior to the new amendments, employees could use PSST when their child's place of care or school was closed due to the order of a public health official for a health-related reason.

Updated FAQs

The Office of Labor Standards has provided updated FAQs to clarify the changes.

Updated: What is paid sick and safe time (PSST)?

Paid sick and safe time is employer-paid time off that employees can use:

- To care for themselves or a family member for an illness, injury, or health condition
- To go to the doctor to get medical and preventative care for themselves or a family member
- When employees are recommended by public health officials to self-quarantine
- When their family member's school or place of care closes
- When their place of business has been closed by order of public official for health-related reasons
- For a business of 250 or more full-time equivalent employees worldwide: when their place of business closes for any health or safety reason

Updated: Can an employee use PSST if their place of work is closed because of a possible health concern like COVID-19?

Yes, under the following circumstances:

- All employers must allow employees to take PSST if their place of work is closed by order of a public official for a health-related reason.
- Employers of 250 or more full-time equivalent employees worldwide must allow employees to take PSST if their place of work reduces operations or closes for any health or safety related reason. The closure does not have to be ordered or recommended by a public official.

Updated: Can an employee use PSST if their family member's school or place of care is closed?

Yes. An employee may use PSST if their family member's school or place of care has been closed. Prior to the March 2020 amendments, employees could use PSST when their

child's place of care or school was closed due to the order of a public health official for a health-related reason. Now an employee may use PSST if any family member's place of care or school is closed. Also, the law no longer requires that the closure be for a health-related reason or that a public official order the closure.

The definition of qualifying family member has been updated to include a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Employees are not required to share the reason for using PSST, but employers may ask for verification that the use of PSST was for an authorized reason after more than three consecutive workdays of PSST although employers may not inquire about the nature of the use. This means that an employer may ask for documentation that continued use of PSST is necessary but not that the employee explain the nature of the use of PSST.

Additionally, the Office of Labor Standards clearly states that documentation is not required for the use of PSST.

Employer Action

Employers within the City of Seattle and subject to the PSST should consider amending their leave policies to align their policies with the new requirements.

Louisiana Temporarily Expands Access to Telemedicine

On March 23, 2020, Louisiana Insurance Commissioner issued Emergency Rule 37 (the "Rule") expanding access to telehealth services during the COVID-19 pandemic. The Rule is effective March 23, 2020 through April 9, 2020.

The Rule applies to all state regulated health insurance plans, pharmacy benefit managers, and third-party administrators (TPAs) acting on behalf of health insurers and policyholders.

This Rule expands access to telemedicine services so that Louisiana residents are able to continue to receive necessary medical care without an in-person visit to a hospital or clinic in light of the shortage and lack of availability of in-network provider visits. It requires that insurers waive existing telehealth coverage limitations so that a participant can receive covered services through telehealth in the same manner that coverage would have been provided through an in-person visit. The Rule also allows coverage for mental health services provided through telemedicine to the same extent such coverage would be provided through an in-person visit. Under the rule, participants may access telehealth services through their telephone or personal electronic device.

In addition to waiving existing telehealth coverage limitations, the Rule requires that insurers broaden access to telehealth providers by waiving restrictions requiring participants to only conduct telemedicine visits with providers within the insurer's existing telemedicine network. The Rule also waives the requirement that participants have a prior relationship with the provider in order to receive services.

Insurers are required to evaluate their out-of-network costs as they relate to telehealth visits to ensure that participants are not unreasonably charged extra cost-sharing amounts under their health plan if in-network access becomes limited.

Employer Action

Employers with insured health plans written in Louisiana should anticipate coverage and network access changes related to telemedicine services provided through the group health plan.

The Rule is likely a welcome relief for Louisiana residents experiencing difficulties with scheduling in-person visits with their provider in light of the lack of resources and availability of network providers.