2021: Second Quarter

Compliance Digest

Compliance Bulletins Released April-June

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This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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Guidance Issued on the 2021 COBRA Subsidy

Published: April 9, 2021

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

Background

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

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

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

Guidance

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

General Information

Which plans does the COBRA premium assistance apply to?

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

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

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

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

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

Who is eligible to receive the COBRA premium assistance?

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

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

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

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

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

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

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

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

- Medicare.

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

How long does the subsidy last?

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

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

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

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

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

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

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

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

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

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

It is important to note that the additional election period does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's reduction in hours or involuntary termination, or under the extended election rule, 18 months measured from the date of the loss of coverage associated with the qualifying event).

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

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

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

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

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

Premiums

Do AEIs need to apply for the premium assistance?

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

How do AEIs receive the COBRA subsidy?

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

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

Can an individual requested to be treated as an AEI?

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

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

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

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

Can an AEI be charged an "administrative fee?"

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

Notices

What are the notice requirements for employers?

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

- Updated General Notice for qualifying events from April 1, 2021 – September 30, 2021. A general notice to all qualified beneficiaries who have a qualifying event that is a reduction in hours or an involuntary termination of

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

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

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

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

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

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

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

Changing Coverage

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

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

- the COBRA premium charged for the different coverage is the same or lower than for the coverage the individual had at the time of the qualifying event;

- the different coverage is also offered to similarly situated active employees; and

- the different coverage is not limited to only excepted benefits, a QSEHRA, or a health FSA.

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

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

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

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

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

Employer Action

Employers should:

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

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

- Discuss tax credits with payroll departments and tax advisors.

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

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

COVID-19 PPE Now a Qualified Medical Expense

Published: April 12, 2021

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

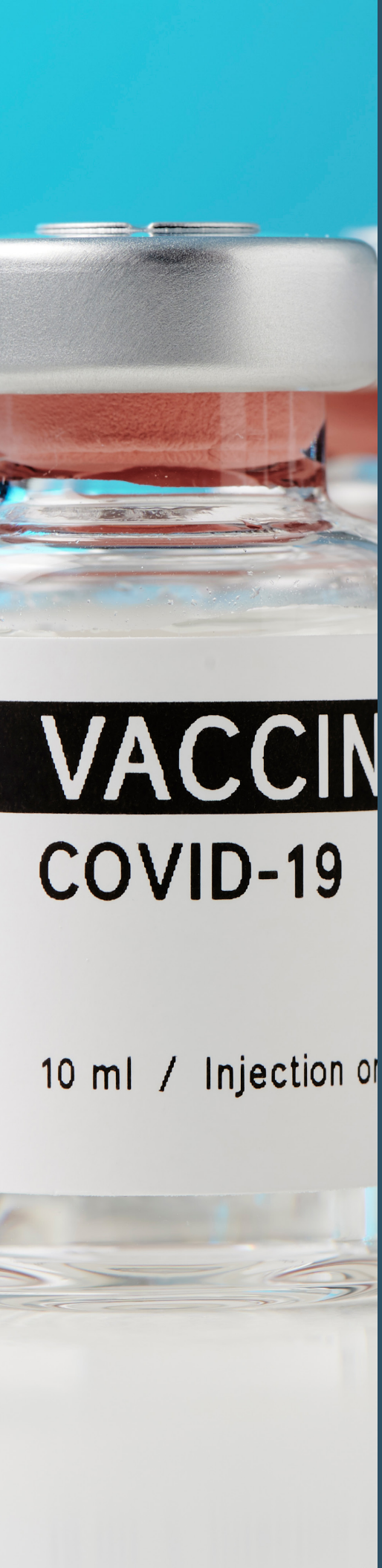
Accordingly, because these amounts are expenses for medical care under § 213(d) of the Internal Revenue Code, these amounts can also be eligible expenses under a health flexible spending account (health FSA), health savings accounts (HSAs), health reimbursement arrangements (HRAs) and Archer medical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

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

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

Employer Action

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



Update on COVID-19 Vaccine and Vaccine Administration Cost

Published: April 23, 2021

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

Background

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

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

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

What's New?

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

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

Employer Action

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

Guidance Issued on MHPAEA Comparative Analysis Requirement

Published: April 26, 2021

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

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

Briefly, the FAQ:

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

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

Below you will find additional details on the guidance.

Background

Mental Health Parity and Addition Act of 2008

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

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

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

The MHPAEA:

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

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

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

- Imposes certain disclosure requirements.

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

The Consolidated Appropriations Act, 2021

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

What's New?

When must the NQTL comparative analysis be available?

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

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

What documentation must be made available?

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

At a minimum, sufficient analyses must include a robust discussion of all of the elements listed below.

1. A clear description of the specific NQTL, plan terms, and policies at issue.

2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

4. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

7. If the plan's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

8. A reasoned discussion of the plan's conclusions as to the comparability of the processes, strategies, and factors, within each affected classification, and their relative restrictiveness, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

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

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

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

Examples of insufficient documentation

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

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

Requests from state regulating agencies and participants and beneficiaries

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

Near-term enforcement priorities

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

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

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

Penalties

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

Employer Action

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

HHS Extends Public Health Emergency until July 20, 2021

Published: May 7, 2021

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

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

Important Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employer Action

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

Employers Encouraged to Provide PTO for Vaccinations

Published: May 10, 2021

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

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

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

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

Tax Credits Under the American Rescue Plan

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

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

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

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

Employer Action

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

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

Annual Out-of-Pocket Maximum Adjustments Announced for 2022

Published: May 11, 2021

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

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

Change to the Out-of-Pocket Maximums

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

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

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

Special Enrollment Period for Individual Coverage

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

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

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

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

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

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

These changes take effect on July 6, 2021.

Employer Action

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

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

San Francisco HCSO 2020 Reporting Cancelled

Published: May 20, 2021

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

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

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

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

2022 Inflation Adjusted Amounts for HSAs

Published: May 21, 2021

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

Annual Contribution Limitation

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

High Deductible Health Plan

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

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

Catch-Up Contribution

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

Excepted Benefit HRA Adjustment

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

IRS Provides Additional Guidance on the COBRA Subsidy

Published: May 24, 2021

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

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

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

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

Eligibility for COBRA Premium Assistance

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

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

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

Other notable eligibility provisions include:

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

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

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

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

Reduction in Hours

An AEI will qualify for COBRA subsidy:

- whether the reduction in hours is voluntary or involuntary,

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

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

Involuntary Termination of Employment

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

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

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

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

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

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

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

An involuntary termination of employment does not include:

- Death of the employee.

- Voluntary retirement.

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

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

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

Coverage Eligible for COBRA Premium Assistance

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

- Vision plans

- Dental plans; and

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

Other notable coverage provisions include:

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

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

Beginning of COBRA Premium Assistance

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

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

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

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

End of COBRA Premium Assistance Period

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

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

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

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

The FAQs clarify:

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

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

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

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

Extended Election Period

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

The FAQs clarify:

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

Extensions Under the Emergency Relief Notices

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

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

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

Additionally:

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

Comparable State Continuation Coverage

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

Calculation of COBRA Premium Assistance Credit

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

Additionally:

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

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

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

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

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

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

Claiming the COBRA Premium Assistance Credit

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

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

- On their Quarterly Form 941; or

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

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

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

The guidance further clarifies:

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

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

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

Employer Action

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

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

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

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

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

IRS Guidance Clarifies DCAP Relief

Published: May 25, 2021

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

Briefly, the guidance confirms that:

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

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

Background

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

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

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

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

Treatment of Unused Benefits Made Available in 2021 or 2022

Notice 2021-26:

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

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

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

The guidance includes helpful examples:

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

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

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

Employer Action

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

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

HHS Expands Interpretation of Sex Discrimination under 1557

Published: May 26, 2021

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

Background

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

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

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

Interpretation Announcement

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

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

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

Employer Action

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

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

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

2021 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 15, 2021

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

The plan years and associated amounts are as follows:

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

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

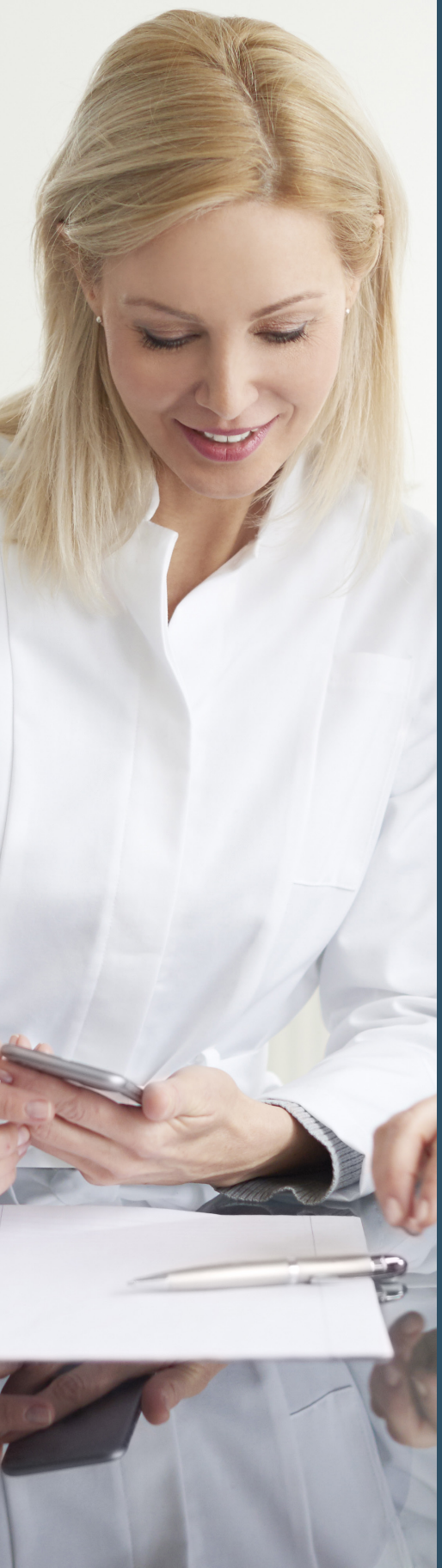
Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

Temporary Transition Relief

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

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

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



New Mandatory Preventive Items and Services

2021 Updates

Published: June 15, 2021

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

Background

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

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

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

Employer Action

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

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

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

Supreme Court Dismisses Latest Challenge to the ACA

Published: June 15, 2021

Background

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

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

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

Court Decision

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

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

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

Employer Action

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

Nevada Paid Leave for COVID-19 Vaccination and Family Care

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

Paid Leave for Vaccination and Other Medical Reasons

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

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

Other considerations are as follows:

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

Exceptions are available for:

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

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

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

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

"Kin Care" Law

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

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

Other considerations are as follows:

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

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

Posting Requirement

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

New Mexico's New Sick Leave Law

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

Applicability

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

Accrual

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

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

The accrual works as follows:

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

Changes in Employment

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

Use of Sick Leave

An employee may use earned sick leave:

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

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

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

Coordination of Leave

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

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

Documentation

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

Types of Documentation

The following must be accepted as reasonable documentation:

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

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

Timing

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

Confidentiality

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

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

Retention

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

Employer Notice

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

Employer Notice

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

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

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

Retaliation

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

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

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

Enforcement

The Division will:

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

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

Penalties

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

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

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

No Preemption

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

Employer Action

Employers should:

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

New Mexico Vaccine Purchase Act Reporting Reminder

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

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

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

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

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

Oregon Considers Delaying Paid Family and Medical Leave

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

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

As proposed, HB 3398 would delay:

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

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

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

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

Dallas Paid Sick Leave Ordinance Invalidated by Federal Court

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

Background

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

New Developments

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

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

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

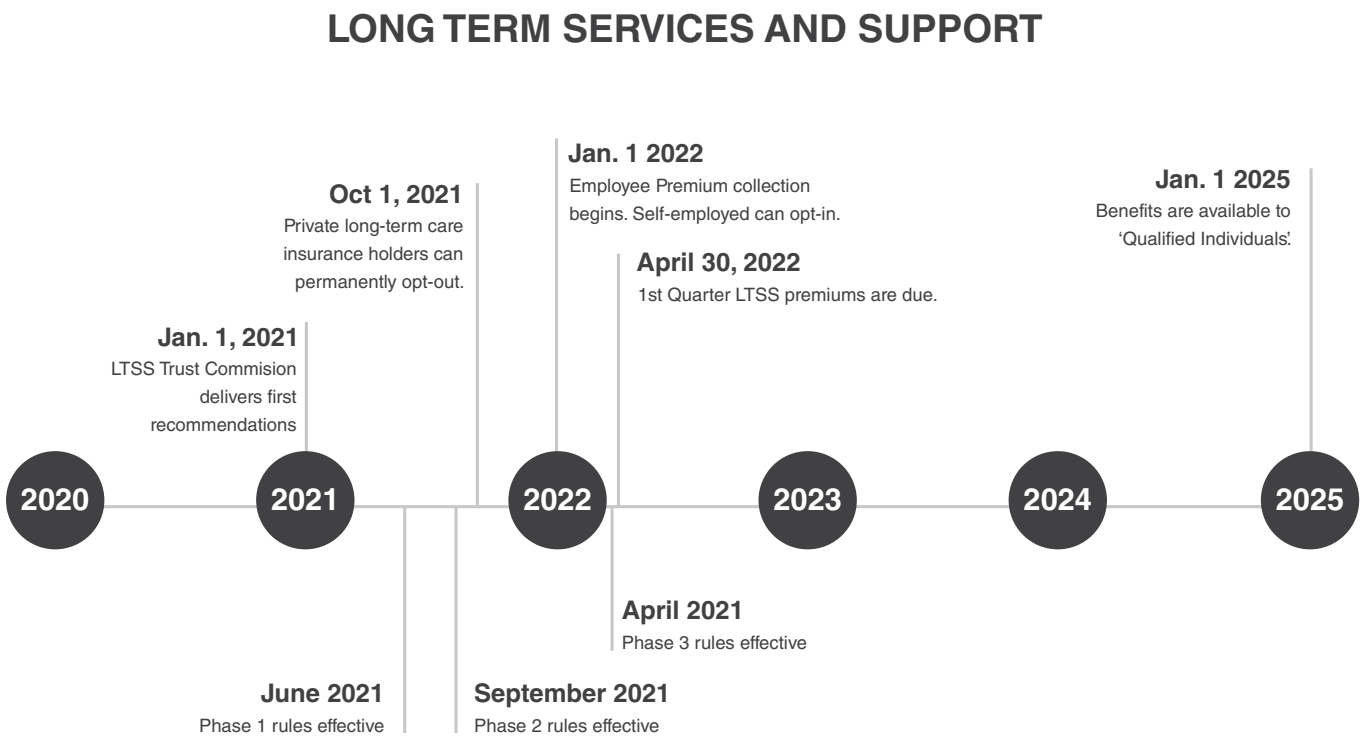
Employer Action

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

Washington Long-Term Care Program Signed into Law

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

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



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

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

Premium Assessment

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

What are wages?

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

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

Do all employees working in Washington pay the premium assessment?

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

The following individuals are exempt from the premium assessment:

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

Footnotes

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

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

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

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

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

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

Reporting And Paying The Premium Assessment

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

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

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

Exempt Employees

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

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

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

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

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

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

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

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

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

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

Briefly, under this definition:

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

Long-term care insurance includes:

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

Long-term care insurance does not include:

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

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

Will there be opportunities to qualify for an exemption later?

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

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

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

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

Footnotes

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

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

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

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

No. Only the employee can apply for the exemption.

Benefits

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

Qualified individual means:

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

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

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

Employer Next Steps

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

Resources

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

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

Washington LTSS Exemption Rule Finalized, New Website Available

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

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

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

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

The following summarizes recent developments.

Final Exemption Rules Adopted

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

Informal Comments Answer Some Outstanding Questions

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

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

New Website for More Information

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

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

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

Washington Modifies Workplace Protections for High-Risk Employees

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

Background

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

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

Employers were also required to maintain employer related health insurance benefits for the duration of time an employee was unable to work after they had exhausted all available paid leave.

Modifications

The Proclamation modifies certain requirements to the expanded workplace protections. Effective April 23, 2021, employers may

- Require medical verification from any employee availing themselves of the protections of the Proclamation as long as they do so according to the required interactive process required by state and federal disability laws.
- Discontinue employer-provided health coverage for high-risk employees electing not to return to work. An employer must provide 14 days advance notice and must ensure that coverage continues through the remainder of the month in which the advanced notice period lapses. This will likely trigger COBRA rights for individuals losing coverage. Keep in mind, individuals protected under FMLA or other state law may still have the right to continue coverage.

Employers may also continue to require employees that do not report to work to give up to five days advance notice to the employer of any decision to return to work. Violations of the proclamation may be subject to criminal penalties.

Employer Action

Employers with employees in Washington will want to carefully review current accommodations for high-risk employees to determine whether medical verifications or changes to benefits protections are warranted. With respect to group health plan coverage, employers should review existing practices. If looking to discontinue benefits employers will need to provide appropriate notice at least 14 days in advance. If group health plan benefits are lost, it is likely to trigger a COBRA event (due to a loss of coverage as a result of a reduction in hours) in which case the individual may be eligible for a COBRA subsidy.

Washington PAL Assessment Begins July 1, 2021

In 2020, the Washington state legislature passed a bill directing the Health Care Authority ("HCA") to collect a covered lives-based assessment from certain health insurance providers to keep the Partnership Access Lines ("PAL") program services up and running. Specifically, the assessment funds the Partnership Access Line and Psychiatric Consultant Line. Briefly, these programs assist providers with managing patient psychiatric needs and helps connect adults and children to care.

Beginning July 1, 2021, this covered lives-based assessment goes into effect.

The assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provide health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

There is an argument that such an assessment may be preempted for self-funded employers subject to ERISA. To date, it is unclear whether an employer has challenged this assessment and whether such challenge would be successful.

A "covered life" for this purpose means a Washington resident who is covered by an assessed entity. This appears to include all covered Washington "belly buttons" of the assessed entity.

The assessed entity will need to register with the HCA (or its designated entity). At this point, there is no guidance as to how to register, but presumably a website will be made available.

Beginning July 1, 2021, no later than the end of the 45 calendar days after the end of each quarter, an assessed entity must submit to HCA (or its designated entity) the total number of Washington resident covered lives for each calendar month of the prior quarter. Presumably, the first reporting period would be July 1, 2021 – September 30, 2021, with a filing due by November 14, 2021.

Each assessed entity will receive a quarterly invoice for its share of the total amount of program costs that are for the proportion of the entity's covered lives and will need to submit timely payment. At this point there is no guidance as to what the per member/per month assessment will be. These invoices are likely to be issued at some point after the covered lives reports are filed.

Employer Action

Employers with a fully insured plan: no action needed. Carriers are responsible for this assessment. Carriers are likely to pass this fee along through premium increases.

Employers with a self-insured group health plan: the employer (or perhaps the TPA on behalf of the employer) will need to register with the state and submit covered lives reports and assessment payments on a quarterly basis. Absent guidance, it appears the first report is due mid-November. At this time, there is no guidance as to how much the assessment will be and the process for submitting reports and paying the assessment. Further guidance is needed.

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