2021: Fourth Quarter

Compliance Digest

Compliance Bulletins Released October-December

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2021 Compliance Bulletins

October

November

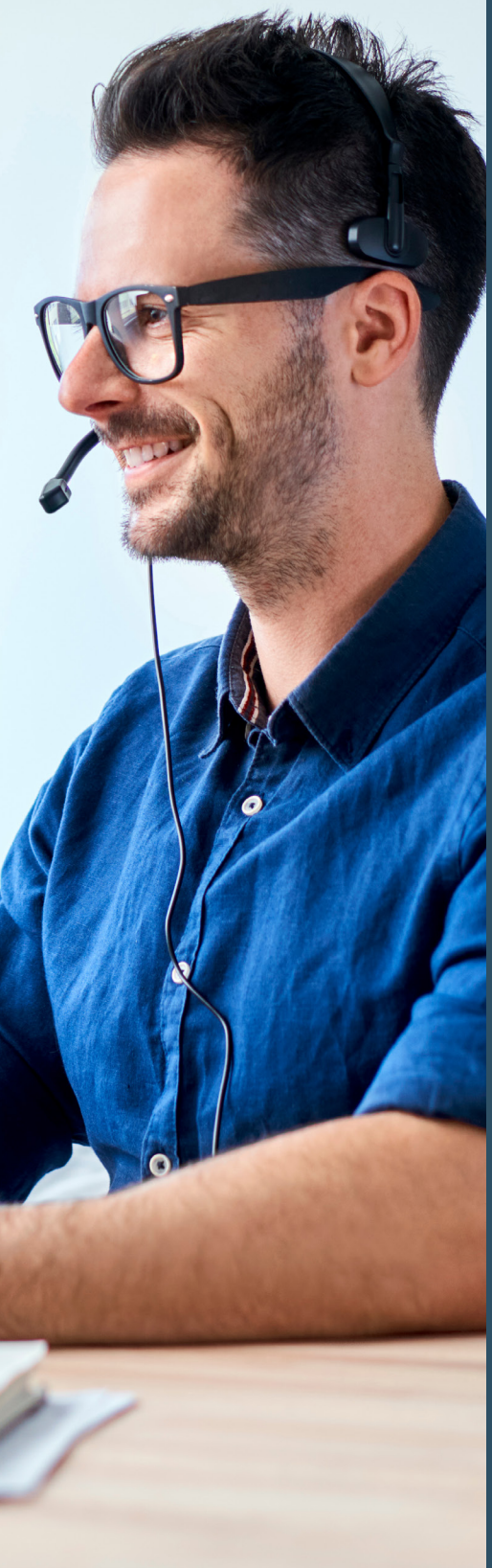
December

2021 State Bulletins

Connecticut

District of Columbia

Washington



FAQs Address COVID-19 Vaccine Group Health Plan Incentives

Published: October 13, 2021

On October 4, 2021, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ Part 50 addressing several important issues concerning group health plans.

Notably, the guidance:

- Confirms incentives in a group health plan (such as premium discounts) are permissible under the HIPAA health-contingent wellness program rules provided the five criteria related to activity-only programs are met.
- Clarifies that group health plans are not permitted to deny eligibility for coverage or exclude coverage for otherwise covered items and services to treat COVID-19 based on an individual's vaccination status.
- Requires immediate coverage for COVID-19 vaccines and their administration according to the applicable scope of the Emergency Use Authorization ("EUA") or approval under a Biologics License Applications ("BLA").

Below you will find details on the guidance.

Group Health Plans and Vaccination Status

The FAQs confirm much of what we thought to be true as it relates to the use of incentives in a group health plan to encourage COVID-19 vaccinations.

A wellness program that conditions a premium discount on an individual obtaining a COVID-19 vaccine is considered an activity-only wellness program, a type of health-contingent program, which must meet the following five requirements:

1. Be reasonably designed to promote health or prevent disease.
2. Provide a reasonable alternative standard to qualify for the discount, at least for individuals for whom it is unreasonably difficult due to a medical condition or medically inadvisable to obtain the COVID-19 vaccination.

For example, an individual shows it is unreasonably difficult due to a medical condition or medically inadvisable to obtain the COVID-19 vaccination; the wellness program must offer the individual a reasonable alternative standard to qualify for the full reward, which may include offering the individual a waiver of obtaining the vaccination or the right to attest to following other COVID-19-related guidelines.

3. Provide notice of the availability of the reasonable alternative standard under the wellness program.

4. Limit the reward so it does not exceed 30% of the total cost of the group health plan coverage.

5. Give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

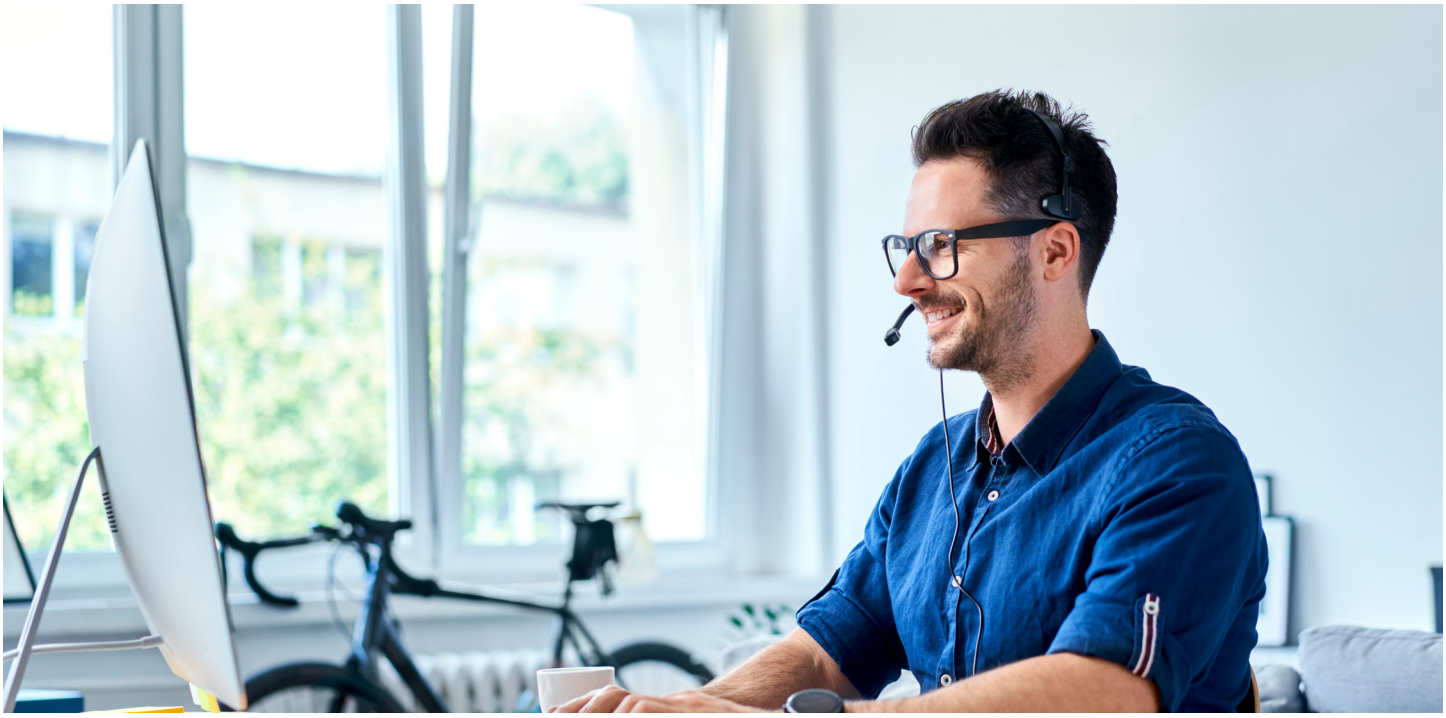
While the example specifically speaks to a "premium discount," a reward in this context may also include a penalty. Therefore, premium surcharges or change in cost-sharing (such as an increased deductible for unvaccinated employees) remain viable options so long as the plan otherwise meets the five HIPAA criteria for activity-only programs.

In addition:

- **Plan Design.** The guidance makes clear that under the HIPAA nondiscrimination rules, a group health plan may not discriminate in eligibility for benefits or coverage based on whether or not an individual obtains a COVID-19 vaccination beyond what is permissible under the voluntary wellness program rules described above. Thus, a group health plan may not condition eligibility for benefits or coverage for otherwise covered items or services to treat COVID-19 on a participant's or beneficiary's status as vaccinated.

- **Affordability.** An FAQ confirms that wellness incentives that relate to the receipt of a COVID-19 vaccination are treated as "not earned" when determining whether the coverage is affordable for purposes of the ACA's employer mandate. Therefore, affordability is determined based on the "unvaccinated" rate.

Finally, compliance with the HIPAA wellness rules is not determinative of compliance with any other law, including GINA, ADA, and state law. Importantly, these FAQs do not address incentives offered by employers as part of workplace policies and unrelated to their group health plan.



Timing and Scope of Coverage for COVID-19 Vaccines

According to the FAQs, effective as of January 5, 2021, non-grandfathered group health plans must cover COVID-19 vaccines and their administration, without cost sharing, immediately once the particular vaccine becomes authorized under an EUA or approved under a BLA and according to the scope of the applicable approval. This includes any EUA or BLA amendment, such as to allow for the administration of an additional dose to certain individuals, administration of booster doses, or the expansion of the age demographic for whom the vaccine is authorized or approved.

This is a change from the earlier rule which provided a 15-business day period after the approval of the Advisory Committee on Immunization Practices ("ACIP") before implementation. The Departments note in the FAQ that they are aware plans and carriers may not have understood this change and will only enforce the timing and coverage requirement prospectively, consistent with the scope of the particular EUA or BLA, to the extent additional coverage beyond what was articulated in previous guidance is required.

Employer Action

If considering COVID-19-related incentives in a group health plan, employers should carefully review this guidance and prepare to comply with the five criteria for health-contingent, activity-only wellness programs.

Employers should not deny eligibility for coverage or otherwise limit/restrict coverage for certain COVID-19 related items and services to unvaccinated participants and dependents.

- Prepare to comply immediately with coverage recommendations on COVID-19 related vaccines, as adopted by ACIP. This will include booster shots and any announced expansion in the age of the population approved for COVID-19 shots.

Attached to this Update is an appendix to highlight additional FAQs and considerations when implementing a COVID-19 vaccination program as part of a wellness program.

Surprise Medical Billing Guidance Clarifies IDR Process and Fees

Published: October 14, 2021

On September 30, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") jointly published additional interim final rules implementing provisions of the No Surprises Act ("NSA"). This is the second set of regulations to address the NSA ("Part II Regulations").

Briefly, as related to group health plans, previously-released "Part I Regulations" addressed, among other things, the following:

1. Protections for group health plan participants to limit out-of-network ("OON") cost-sharing and "balance billing" as they relate to emergency services, OON providers of air ambulance services, and non-emergency services performed by OON providers at in-network facilities (with limited exceptions).

2. A prescribed formula to determine a participant's cost-sharing for these services. In some cases, a state law or the "All-Payer Model Agreement" ("APMA") will determine a recognized amount on which participant cost-sharing amounts are based. Otherwise, participant payments will be based on a recognized amount that is generally the lesser of a qualified payment amount ("QPA") or the OON provider's billed charge.

3. A methodology for determining how much the plan will pay to the OON provider for these services. In some cases, a state law or the APMA will determine plan payment amounts. Otherwise, plan payments will be based generally an amount agreed upon between the plan and the OON provider, or an amount determined in a Federal Independent Dispute Resolution ("Federal IDR") process.

As anticipated, the new Part II Regulations primarily provide guidance on a Federal IDR process. Additional guidance, also issued on September 30, 2021, provides information on fees related to the Federal IDR process for calendar year 2022.

Further, the Part II Regulations address how the NSA interacts with the external review process mandated under the Affordable Care Act and related regulations. This includes expanding claims eligible for external review with respect to NSA-

related adverse benefit determinations, with examples, and directing the applicability of such determinations to grandfathered health plans.

Of particular note:

- The NSA rules take effect for plan years beginning on or after January 1, 2022, and apply to most group health plans (including grandfathered plans), with some exceptions.
- For fully insured group health plans, the carrier will be responsible for compliance.
- For self-funded group health plans, the plan sponsor is responsible and will need to work closely with third-party administrators ("TPAs") to comply with these rules, including implementation of an IDR process.

The Departments request comments on the Part II Regulations by December 6, 2021.

Part II Interim Final Rules

Plan/Provider Payment Process

As previously reported, the plan will determine whether the services are covered by the plan. Within 30 days of receipt of a "clean claim," the plan must send the provider an initial payment or notice of denial of the payment.

The total amount paid by a plan for items and services is referred to as the "OON Rate." Assuming state law and the APMA do not apply, the plan must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee:

- if the plan and the provider or facility have agreed on a payment amount, the agreed-on amount; or
- if the parties (plan and provider) enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

If the initial payment or denial of payment is disputed, the parties will commence an open negotiation period of 30 business days, beginning on the day the plan sends the provider an initial payment or notice of denial of the payment.

Federal IDR Process

Under the Part II Regulations, the steps to the Federal IDR Process are as follows:

1. Following a failed 30-day open negotiation period, either party may initiate the Federal IDR process.
2. The parties then may jointly select a certified IDR entity to resolve the dispute, and such entity cannot have any conflict of interest with either party.

3. If the parties cannot make a joint selection, or there is a conflict of interest with a selected certified IDR entity, the Departments will select a certified IDR entity.

4. The parties will submit their offers for payment along with supporting documentation, to the selected certified IDR entity.

5. Both parties must pay an administrative fee to the Departments – $50 each for 2022.

6. Up front, both parties must pay a certified IDR entity fee to the certified IDR entity, which should be within the range of $200 to $500, though ultimately the fee will only be paid once.

7. The parties may reach a settlement before the certified IDR entity makes a payment determination, in which case each party will receive back one-half the party's certified IDR entity fee, unless the parties agree to an alternate allocation.

8. Absent an earlier settlement, the certified IDR entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount.

9. The non-prevailing party is generally responsible for the certified IDR entity fee. Thus, the certified IDR entity will typically retain the fee paid by the non-prevailing party and return the fee paid by the prevailing party.

10. Note that a certified IDR entity must begin with the presumption that the QPA is the basis for the appropriate OON amount, and generally it must select the offer closest to the QPA. If a party submits additional permissible information, then the certified IDR entity must consider this information if it is credible. The IDR entity should deviate from the offer closest to the QPA only if submitted information clearly demonstrates that the value of the item or service is materially different from the QPA.

The table below provides further details on various deadlines in the Federal IDR process.

Open Negotiation and IDR Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified IDR entity selection	3 business days after the IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by parties	6 business days after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	10 business days after the date of certified IDR entity selection
Payment determination made	30 business days after the date of certified IDR entity selection
Payment submitted to the applicable party	30 business days after the payment determination

IDR Entity Certification Process

The rule includes details on how entities can become certified as independent IDR entities. To be certified by January 1, 2022, such entities should submit their applications by November 1, 2021. Such entities will be certified by the Departments on a rolling basis.

Certified IDR entities must meet monthly reporting requirements on payment determinations to ensure transparency in the IDR process.

Interaction of NSA with External Review Process

The Affordable Care Act, and accompanying regulations, require non-grandfathered group health plans to provide an external review process for disputing denied claims, which generally include the use of an "Independent Review Organization" (IRO). Such denied claims can occur, for example, when a plan administrator determines an item or service is not covered, is subject to restrictions on coverage, or is considered not medically necessary.

The Part II Regulations specifically provide that all plan coverage decisions pertaining to NSA protections in compliance with surprise billing and cost-sharing protections are eligible for external review. They also add several new examples to existing external review regulations, which address where external review would be available under various NSA-related plan determinations where higher cost-sharing was generally applied, including:

- Member's treatment did not involve emergency services
- Disregarding OON anesthesiology at in-network facility with no consideration of NSA applying
- Relying solely on a provider representation that member was in a condition to receive notice about NSA protections and gave informed consent to waive the protections
- No initial review of a proper medical code for certain services (routine post-natal versus neonatology), and possible error in applying informed consent to waive for ancillary services
- No review of in-surgery, OON anesthesiology services or possible error in applying informed consent to waive for ancillary services

The Part II Regulations also provide that grandfathered plans will be subject to external review requirements with respect for NSA-related coverage decisions.

Employer Action

Employers with self-funded group health plans should continue to review NSA requirements with their TPAs for compliance, effective with the first plan year that begins on or after January 1, 2022. That should include confirming that the TPA:

- Will be prepared to administer the Federal IDR process if and when necessary, and
- Can apply the plans' external review process, including working with an IRO, if and when there is a denied member claim relating to surprise billing and cost-sharing protections under the NSA. This includes grandfathered plans.

TPAs may pass costs associated with the IDR process on to plan sponsors.

Telehealth Relief for HDHPs Set to Expire

Published: October 19, 2021

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. Among other things, the CARES Act offered temporary relief related to telehealth and other remote care services when offered with a qualified high deductible health plan ("HDHP") and health savings account ("HSA").

Specifically, for plan years beginning on or before December 31, 2021, telehealth and other remote care services may be offered before satisfaction of the deductible without jeopardizing an individual's eligibility to contribute to an HSA.

Unless further extended by legislation or regulation, this relief expires for plan years that begin on or after January 1, 2022. Employers that took advantage of this relief should now plan to charge a fair market value for telehealth or other remote care services for participants to retain HSA eligibility.

While there is support for further extending or making permanent this relief, to date there has been no legislative or regulatory action.

Employer Action

Employers with HDHPs that offered free (or reduced cost) telehealth or remote care services prior to satisfaction of the deductible should prepare to adjust their plan offerings and charge a fair market value for these services effective with the first plan year that begins on or after January 1, 2022.

We will continue to monitor developments in this area.

HHS Issues Guidance Addressing HIPAA and COVID-19 Vaccinations

Published: October 20, 2021

The Department of Health and Human Services ("HHS") issued guidance in the form of questions and answers addressing how the HIPAA Privacy Rule applies in regard to COVID-19 vaccinations. The guidance makes clear that HIPAA's privacy rules are not an obstacle to an employer that would like to establish a vaccination requirement for its employees and customers.

Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that establishes national standards to protect sensitive patient health information, commonly referred to as "protected health information" or "PHI," from being disclosed without the patient's consent or knowledge. HIPAA has three main components:

1. the Privacy Rule which provides that PHI cannot be used or disclosed without authorization unless it is for treatment, payment or health care operations;

2. the Security Rule which ensures confidentiality, integrity and availability of all electronic PHI that is created, received, maintained or transmitted; and

3. Breach Notification Rule which requires notice when PHI is acquired, accessed, used or disclosed in a manner not permitted under the Privacy rule.

Many employers questioned whether the HIPAA Privacy Rule would limit the ability of an employer to have a mandatory COVID-19 vaccination policy with respect to its employees. The guidance makes clear that HIPAA's Privacy Rule does not prevent an employer from putting forth such a policy.

The Guidance

The guidance restates an established HIPAA principle – that the Privacy Rule only applies to covered entities, including health plans, certain healthcare providers, healthcare clearinghouses and their business associates. While self-funded health plans generally operate through sponsoring employers, the guidance reiterates that the Privacy Rule does not apply to employers acting in their capacity as employers or employment records.

The HIPAA Privacy Rule does not prohibit any person (e.g., an individual or an entity such as a business), including HIPAA covered entities and business associates (which are functioning at such time in their role as an employer), from asking whether an individual has received a particular vaccine, including the COVID-19 vaccines.

HHS also explained that because HIPAA regulates the use and disclosure of PHI and not the ability to request information, the HIPAA Privacy Rule does not prohibit a covered entity from receiving COVID-19 vaccination information. However, after receipt of such information, an employer would likely have a duty to safeguard that information and keep it confidential.

The guidance also provides that an employer may require employees to disclose whether they have received a COVID-19 vaccine to the employer, clients or other parties. HHS observed that federal anti-discrimination laws do not prevent an employer from choosing to require that all employees physically entering the workplace be vaccinated against COVID-19 and provide documentation or other confirmation that they have met this requirement, subject to reasonable accommodation provisions, other equal employment opportunity considerations and conflicting state laws, as applicable. As stated before, once this information is collected, however, it must be kept confidential and stored separately from an employee's personnel file.

The HIPAA rules generally do not regulate what information can be requested from employees as part of the terms and conditions of employment. The following examples from HHS make clear that HIPAA does not prohibit a covered entity or business associate from requiring or requesting each workforce member to:

- Provide documentation of their COVID-19 or flu vaccination to their current or prospective employer.
- Sign a HIPAA authorization for a covered health care provider to disclose the workforce member's COVID-19 or varicella vaccination record to their employer.
- Wear a mask – while in the employer's facility, on the employer's property, or in the normal course of performing their duties at another location.
- Disclose whether they have received a COVID-19 vaccine in response to queries from current or prospective patients.

Finally, HHS provided that the HIPAA Privacy Rule generally does prohibit health care providers from disclosing an individual's PHI, including whether they have received a COVID-19 vaccine, to the individual's employer without consent from the individual, unless an exception applies. Exceptions could include disclosures made for treatment, payment or other health care operations.

Massachusetts Paid Family Leave 2022 Contributions and Benefits

Published: October 26, 2021

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2022. The DFML has also published (i) information regarding an employer's obligation for remitting retroactive contributions for employers moving from an approved private plan to the state plan and (ii) the FY2021 Annual Report for the PFML program.

Contributions

The 2022 contribution rate on eligible wages will be 0.68% (adjusted down from the 2021 rate of 0.75%). Individual contributions are capped by the Social Security income limit, which for 2021 is currently set at $142,800.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2022:

- Medical Leave Contribution: 0.56% of eligible wages allocated as follows:
  - Employer: At least 60% of the medical leave cost is paid by the employer (0.336%)
  - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.224%).

- Family Leave Contributions: 0.12% of eligible payroll deduction
  - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2022 contribution for medical and family leave benefits is .344% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- the portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- the portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2022:

- The MAAWW will be $1,694.24, an increase of 14% from the 2021 MAAWW of $1,487.78.
- The maximum weekly PFML benefit will be $1,084.31, an increase of 28% from the maximum weekly benefit of $850 in 2021.

Moving from a Private Plan to the State Plan

The DFML recently published information regarding an employer's obligation for remitting retroactive contributions to the state for employers with a private plan exemption initially effective prior to January 1, 2021. Employers with this exemption will need to go through one renewal cycle to not owe retroactive contributions. A renewal cycle means an initial term and one renewal term, with each term lasting a period of four completed quarters. An employer that terminates a private plan prior to the renewal cycle requirement will be responsible to remit retroactive contributions back to the effective date of the initial exemption for failure to renew.

An employer with an approved exemption that has renewed for one renewal cycle, and then attempts to terminate during that first renewal cycle (before the renewal cycle is complete), will also be responsible to remit retroactive contributions back to the effective date of the initial exemption for failure to renew.

If an employer has gone through one complete renewal cycle, at that time, an employer may terminate its private plan without owing retroactive contributions.

The DFML has created a table to demonstrate when an employer moving to the state plan would not be responsible for retroactive contributions.

Initial Exemption – Effective Date	First Date an Employer Can Move to State Plan Without Owing Retroactive Contributions
10/01/2019	10/01/2021
01/01/2020	01/01/2022
04/01/2020	04/01/2022
07/01/2020	07/01/2022
10/01/2020	10/01/2022
01/01/2021 or later	At any time. The effective date of the termination of a private plan is on the first day of the first quarter immediately following the date of the termination or nonrenewal.

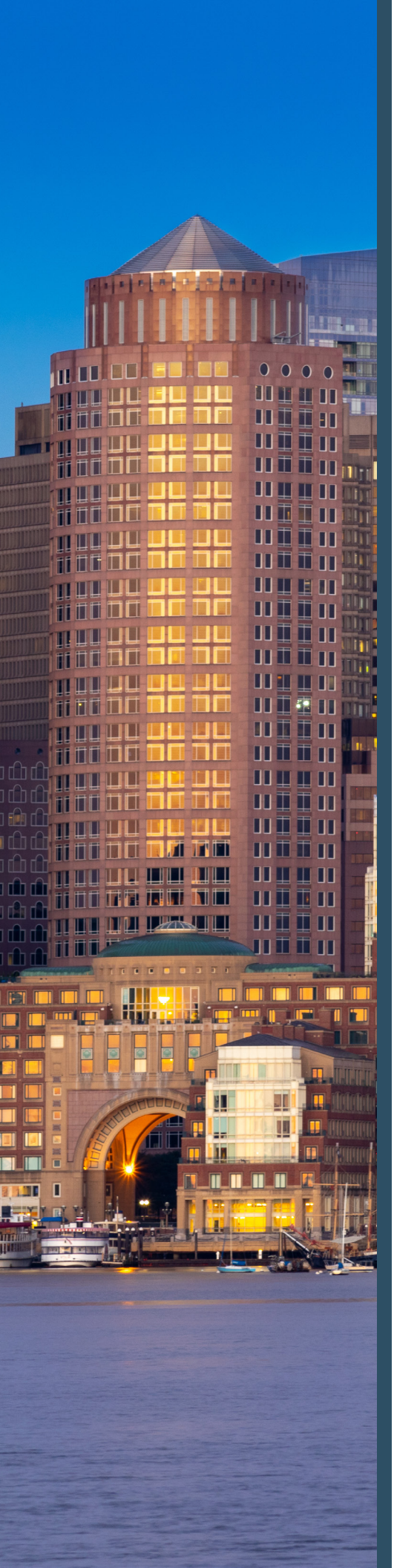
The DFML notes that if the PFML exemption effective date is not aligned with the carrier policy effective date then the employer would be required to remain with the private plan until the PFML exemption end date to ensure no gaps in coverage and that they will not owe retroactive contributions and assessed penalties.

FY2021 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its first annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2021. Because the law required payments to begin on January 1, 2021, this report only contains information from January 1 to June 30, 2021. Subsequent reports will contain information from July 1 to June 30 (the Massachusetts Fiscal Year).

Employer Action

Employers should prepare for the 2022 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2022.



Reminder: Massachusetts HIRD Reporting Due December 15, 2021

Published: October 27, 2021

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure (HIRD) form through the MassTaxConnect (MTC) web portal. The HIRD reporting will be available to be filed starting November 15th **and must be completed by December 15th.**

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. Employers who currently have (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year) are required to complete the HIRD form.

- An individual is considered to be an employee if the employer included such individual in its quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. The employer is required to complete the HIRD form if it reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- For an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is considered to be an employee if he or she is hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs

Massachusetts Establishes COVID-19 Emergency Paid Sick Leave

Published: October 28, 2021

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

Who Must Comply?

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

Qualifying Reasons For Leave

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

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

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

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

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

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

Amount of Benefits Available

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

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

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

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

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

Limits on Benefits Available

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

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

Employer Reimbursement

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

Benefits and Other Protections Available

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

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

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

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

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

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

Notices

Employees

An employee must provide notice to the employer of the need for EPSL as soon as practicable or foreseeable. After the first workday an employee receives EPSL, an employer may require the employee to follow reasonable notice procedures in order to continue receiving EPSL. An employer may not require, as a condition of an employee's taking EPSL, that the employee search for or find a replacement worker to cover the hours during which the employee is using EPSL.

Employers

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

Health Information Protected

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

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

Employer Action

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

Guidance Clarifies Outbreak Period Rules for COBRA

Published: November 2, 2021

Recently, the Internal Revenue Service (“IRS”), in coordination with the Departments of Labor and Health and Human Services (collectively, “the Departments”), issued Notice 2021-58 which clarifies the deadlines for making COBRA elections and premium payments under the Outbreak Period rules.

Background

Briefly, in response to the COVID-19 pandemic, the Departments issued Emergency Relief Notices that established a disregarded period with respect to the following COBRA deadlines:

- 60-day period for individuals to elect COBRA.
- The due dates for making COBRA premium payments.
- The dates for individuals to inform plans of qualifying events or disability determinations.
- The date by which the plan (or sponsor/administrator) must furnish a COBRA election notice.

The disregarded period began on March 1, 2020, is measured on a participant-by-participant basis, and ends the earlier of:

- one year from the date that individuals and plans were first eligible for the relief, or
- 60 days after the end of the National Emergency (the end of the “Outbreak Period”).

There has been a lot of confusion around the Outbreak Period relief and applicable deadlines related to COBRA. IRS Notice 2021-58 provides some welcome clarification.

New Guidance

The guidance clarifies that the disregarded period for electing COBRA and the disregarded period for making the initial or subsequent COBRA premium payments generally run concurrently. This means an individual who delays electing COBRA will have up to one year of total disregarded time to make the COBRA election and to make the initial COBRA payment (unless transition relief applies).

This guidance is helpful, as there was concern that an individual could have an additional year after electing COBRA to make the initial COBRA premium payment. This guidance confirms that the maximum one-year timeframes for the COBRA election and the initial COBRA premium payment run at the same time.

Therefore, individuals must make the initial COBRA election by the earlier of:

- one year and 60 days after the individual's receipt of a COBRA election notice, or
- the end of the Outbreak Period.

If an individual elected COBRA continuation coverage outside of the initial 60-day COBRA election timeframe, that individual generally will have one year and 105 days after the date the COBRA notice was provided to make the initial COBRA premium payment (60 days to make the initial COBRA election plus 45 days to make the initial COBRA premium payment = 105 days.)

If an individual elected COBRA continuation coverage within the initial 60-day COBRA election timeframe, that individual will have one year and 45 days after the date of the COBRA election to make the initial COBRA premium payment.

For each subsequent COBRA premium payment, the maximum time an individual has to make a payment while the Outbreak Period continues is one year from the date the payment originally would have been due, including the mandatory 30-day grace period.

Transition Relief for Premium Payments Due Before November 1

The guidance provides that an individual will not be required to make the initial premium payment before November 1, 2021, even if November 1, 2021 is more than one year and 105 days after the date the election notice was received, provided that the individual makes the initial premium payment within one year and 45 days after the date of the COBRA election.

This transition relief is available because there was some confusion as to whether the disregarded period for making the initial premium payment begins on the date of the COBRA election and individuals who made elections more than 60 days after receipt of the election notice may have less time than they anticipated to make the initial premium payment.

Interaction with COBRA Subsidy

As a reminder, the disregarded periods under the Emergency Relief Notices do not apply to the periods for providing required notices of the American Rescue Plan Act ("ARP") COBRA subsidy or electing subsidized COBRA coverage (the subsidy was available from April 1, 2021 through September 30, 2021).

However, the disregarded periods continue to apply to payments of COBRA premiums after the end of the subsidy period to the extent the individual is still eligible for COBRA and the Outbreak Period has not ended.

How the Relief Applies

The guidance provides 10 examples to better illustrate how the relief applies. A few of these examples are summarized below. The examples assume the Outbreak Period has not ended during the specified periods.

Example 1: COBRA election made more than 60 days after receipt of COBRA election notice.

Joe has a qualifying event triggering COBRA on August 1, 2020 and receives the COBRA election notice that same day. Joe elects COBRA on February 1, 2021, retroactive to August 1, 2020.

- Joe elected COBRA more than 60 days after receipt of the COBRA election notice.
- Joe has until November 14, 2021 (one year and 105 days after August 1, 2020) to make the initial COBRA payment.
- Initial COBRA premium payment would include the months of August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter.

Assume Joe makes his November 2020 payment timely (by December 1, 2021). However, Joe does not make a payment for December 2020 by December 31, 2021. What happens?

- Joe is not entitled to COBRA coverage for any month after November 2020 because he did not pay the December 2020 premium timely.
- The plan is not obligated to cover benefits or services for Joe that were incurred after November 30, 2020.

Example 2: COBRA election made within 60 days after receipt of COBRA election notice.

Mary has a qualifying event triggering COBRA on October 1, 2020 and receives her COBRA election notice that same day. Mary timely elects COBRA on October 15, 2020 (retroactive to October 1, 2020).

- Mary has until November 29, 2021 to make her initial COBRA premium payment (one year plus 45 days after October 15, 2020).
- Mary's initial COBRA premium payment would include only the monthly premium for October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020). Premium payments are due every month after that for the months Mary is eligible for COBRA coverage.

Example 3. Timeframe for electing COBRA.

Karen has a qualifying event triggering COBRA on August 1, 2020 and receives her COBRA election notice that same day.

- Karen has until September 30, 2021 to elect COBRA (one year plus 60 days after August 1, 2020).
- If Karen elects COBRA after September 30, 2020 (but before September 30, 2021), she has until November 14, 2021 to make the initial COBRA premium payment (one year plus 105 days after receipt of the Election Notice). The initial premium payment would include the monthly premiums for August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter.

Example 4. Applying transition relief to COBRA premium payments due before November 1, 2021.

Avery has a qualifying event triggering COBRA on April 1, 2020 and receives the COBRA election notice that same day. Avery elects COBRA on October 1, 2020 retroactive to April 1, 2020. As of July 15, 2021, Avery has not made the initial COBRA premium payment.

- Under the transition relief, Avery has until November 1, 2021 to make her initial COBRA premium payment. This is the case even though November 1, 2021 is more than one year and 105 days after April 1, 2020. This is because, under the transition relief, November 1, 2021 is less than one year and 45 days after Avery's COBRA election date of October 1, 2020.
    - The initial COBRA premium payment would include the monthly premium payments for April 2020 through October 2020.
    - The November 2020 premium is due by December 1, 2021 (one year and 30 days after the November 1, 2020), with premium payments due every month thereafter.

Example 5. Deadline to elect retroactive COBRA under the Emergency Relief Notices and not electing the COBRA subsidy.

Morgan had a qualifying event because he was involuntarily terminated from employment on August 1, 2020 and received a COBRA election notice that same day. As of September 1, 2021, he has not elected COBRA. Morgan also is an assistance eligible individual under ARP and received the required election notice on May 31, 2021. Morgan did not elect COBRA with premium assistance.

- Morgan had until September 30, 2021 to elect COBRA continuation coverage retroactive to August 1, 2020 (one year plus 60 days from August 1, 2020).
- If timely elected, Morgan has until November 14, 2021 to make the initial COBRA premium payment (one year plus 105 days after August 1, 2020).
- The initial COBRA premium payment would include the monthly premiums for August 2020 through October 2020.
- The November 2020 premium payment would be due by December 1, 2021 (one year and 30 days from November 1, 2020) with premium payments due every month thereafter. Because Morgan did not elect the COBRA subsidy when offered, he is not eligible for subsidized COBRA premiums between April 1, 2021 – September 30, 2021.

Employer Action

Employers should:

- Work with their COBRA vendors to understand this new guidance and ensure administration is in accordance with the guidelines. Employers and COBRA administrators should review all the examples from the guidance to better understand these requirements.
- Understand that certain individuals may still elect retroactive COBRA coverage while the Outbreak Period is ongoing. Work with carriers (including stop loss) and TPAs to ensure appropriate coverage is available should an individual elect and pay for retroactive COBRA.
- Continue to monitor guidance and await further information as to when the Outbreak Period will officially expire.

For a copy of Notice 2021-58, visit https://www.irs.gov/pub/irs-drop/n-21-58.pdf.

HHS Extends Public Health Emergency until January 16, 2022

Published: November 8, 2021

On October 15, 2021, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective October 18, 2021. This will once again extend the Public Health Emergency period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire January 16, 2022 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, and 2) 60 days after the announced end of the National Emergency.

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

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

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

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

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

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

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

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

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

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

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

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

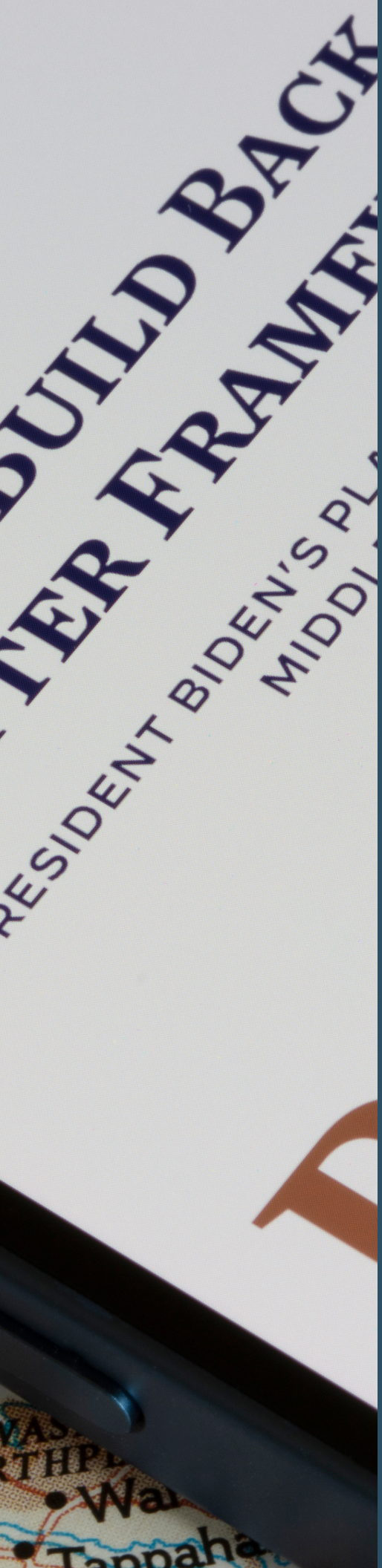
- **ERISA Claims Deadlines.** Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request.

    - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

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

Employer Action

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



Build Back Better Legislation Includes Benefit Provisions

Published: November 9, 2021

During the last week of October 2021, the Biden administration announced a new framework for the budget reconciliation package, known as the Build Back Better Act (H.R. 5376). Subsequently, the U.S. House of Representatives released the legislative text and a section-by-section summary of the new framework. The legislation is still being negotiated, and the timing for when a vote is expected is uncertain.

If the proposed legislation is enacted into law in its current form, the following provisions would have notable impacts on employer-sponsored health and welfare benefit programs.

Increased employer contributions to avoid penalties under the ACA employer mandate

The 9.61% affordability percentage for 2022 would be reduced to **8.5%** (with no inflation adjustment) for 2022 to 2025, to determine whether employer-sponsored coverage is affordable under the Affordable Care Act's employer mandate. The lower affordability percentage means that for coverage to remain affordable, employee contributions toward self-only coverage in the lowest cost plan option offered by the employer would be reduced. This change would apply directly to all of the safe harbor calculations (W-2, Rate of Pay, and Federal Poverty Level ("FPL")) that employers generally use to avoid penalties under the ACA employer mandate.

For example, if enacted "as is," the FPL safe harbor for the lower 48 states for a plan year that begins January 1, 2022 would be $91.23 instead of $103.14 (which is based off of 9.61%, the announced threshold for 2022).

After 2025, the affordability percentage would revert to 9.5%, without any inflation adjustment thereafter.

Increased penalties under the Mental Health Parity and Addiction Equity Act

The legislation would authorize the U.S. Department of Labor to assess civil monetary penalties against plan sponsors and plan administrators for violations

of the Mental Health Parity and Addiction Equity Act ("MHPAEA") in an amount equal to the civil monetary penalties currently imposed under the Genetic Information Nondiscrimination Act ("GINA"). These changes would be effective one year after the date of enactment.

Reinstated and expanded bicycle commuting benefits

The exclusion for qualified bicycle commuting benefits would be reinstated, and the maximum benefit would increase from $20/month to 30% of the qualified parking benefit (i.e., $81/month, based on the 2021 qualified parking benefit of $270/month). In addition, the definition of qualified bicycle benefits would expand to include certain electric bicycles and the lease or rental of a bicycle (including a bikeshare). These changes would be effective for taxable years beginning after December 31, 2021.

Extended Marketplace subsidies

The legislation would extend the higher premium tax credits available in the Marketplace under the American Rescue Plan Act of 2021 ("ARPA") through 2025. In addition, the legislation would go further than ARPA by permitting employees with incomes below 138% of the Federal Poverty Level to obtain premium tax credits from 2022 to 2025 to purchase coverage in the Marketplace even if they have access to affordable healthcare coverage from their employer. The legislation appears to provide employers with relief from ACA penalties in this scenario, although the terms of that relief are uncertain.

In addition, the legislation allocates $195 million to the U.S. Department of Labor for enforcement activities relating to employer-sponsored benefit plans.

Notably, the legislation omits key priorities that were included in earlier versions of the bill, including:

- 12 weeks of federal paid family and medical leave.
- Negotiation of prescription drug prices by the federal government.
- Permanent increase in benefits limits under a dependent care flexible spending arrangement to $10,500.

Employer Action

Employers should continue to monitor the progress of the "Build Back Better" legislation.

Importantly, applicable large employers (i.e., those subject to the ACA employer mandate) should review their group health plan's contribution strategy to determine whether they will have budgetary problems in the event the 8.5% affordability threshold becomes law. They may be required to adjust the dollar amount of their employer premium contributions to preserve affordability and avoid potential exposure to ACA penalties.

OSHA's Emergency Temporary Standard: Guidance on Mandatory COVID-19 Vaccination/Testing

Published: November 9, 2021

On November 5, 2021, the Occupational Safety and Health Administration (OSHA) published its long-awaited Emergency Temporary Standard (ETS), which requires most U.S. employers with 100 or more employees to adopt a mandatory COVID-19 vaccination policy with an option to include an alternative weekly testing program.

The ETS is effective immediately and employers must begin their compliance efforts at once. Employers have until December 5, 2021, to comply with all of the requirements of the ETS, except for the weekly testing option for employees who have not been fully vaccinated. Employers have until January 4, 2022 to comply with the weekly testing option, though employers may begin complying earlier. OSHA anticipates the ETS will be in effect for six months from the date of publication in the Federal Register.

It is important to note that OSHA is seeking comments from the public on the ETS, and there is a possibility that the requirements may be expanded beyond their current parameters. In addition, multiple state attorneys general have filed lawsuits challenging the ETS. On November 6, 2021, a federal appellate court issued a temporary stay on enforcement of the ETS. The outcome of these legal challenge is unknown.

If the ETS survives legal challenge, its current provisions provide employers with a detailed roadmap of what compliance should look like. Notwithstanding the legal uncertainty, employers should take steps to prepare for compliance and monitor developments out of the courts.

Below you will find a summary of the important aspects of the ETS. The summary is not exhaustive and is not a substitute for legal advice.

Covered Employers

Private Sector - Private employers with 100 or more employees at any time during the effective period of the ETS, which begins on November 5, 2021, must comply. Employers must continue to comply for the entire duration of the ETS even if their employee count drops below 100.

Though employers with fewer than 100 employees on November 5, 2021 are not subject to the ETS, if their headcount reaches 100 employees at any time while the ETS is in effect, the employer must promptly comply. It should be noted that private employers with fewer than 100 employees may be required to comply if a state OSHA program requires compliance.

"Employees" include all employees on an employer's payroll including, but not limited to, temporary employees, part-time employees, remote employees and seasonal employees. Independent contractors are not counted as employees. Staffing agency employees are considered employees of the staffing agency and should be included in the staffing agency's headcount.

State and Local Governments - State and local governmental employers with 100 or more employees in states that have state-approved OSHA programs must comply. State and local governmental employers are not typically covered by federal OSHA requirements; however, in order for a state to receive approval to adopt its own State Plan, it must extend federal OSHA requirements to state and local governmental employers. State Plans must fully adopt the ETS by December 5, 2021; thus, their compliance date will be later than November 5, 2021. While State Plans must adopt programs that are "at least as effective as federal OSHA's requirements," states can adopt programs that are more expansive or stringent than the federal requirements. Thus, it is possible that some states may lower the compliance obligation below the 100-employee threshold.

Federal Government - The ETS does not apply to employees of federal agencies, except for those employed by the U.S. Postal Service.

States Prohibiting Mandatory Vaccinations, Testing or Face Coverings

OSHA intends for the ETS to preempt or override any attempts by states or localities to prevent vaccination or mask mandates and intends to invalidate any State or local requirements that ban or limit an employer's authority to require vaccinations, face coverings or testing.

Exempt Employees

Employees who work exclusively from home, who work exclusively outdoors, or who come into the workplace only when other employees (or customers) are not present are not covered by the ETS. However, if any such worker will be entering a covered workplace during times when other employees (or customers) are present, they must either be vaccinated or be able to present a negative test result obtained within seven days of entering the workplace.

Employees with medical conditions or sincerely held religious beliefs that prevent them from being vaccinated, undergoing weekly testing, and/or wearing a mask may be entitled to accommodations under Title VII of the Civil Rights Act or the Americans with Disabilities Act.

It is important to note that employees who have previously been diagnosed with COVID-19 are not exempt from compliance and must either be fully vaccinated or submit to weekly testing.

Full Vaccination

Employees are considered to be "fully vaccinated" two weeks after receiving a single Johnson & Johnson vaccine, or two weeks after receiving the second does of a two-dose vaccine series (i.e., Pfizer or Moderna). The ETS does not include booster shots and additional doses in the definition of fully vaccinated. The ETS provides a limited exception: employees who have completed the entire primary vaccination series by January 4, 2022 do not have to be tested even if they have not completed the two-week waiting period.

Testing

Employees who are not fully vaccinated must comply with the weekly testing requirements of the ETS. This includes unvaccinated employees, partially vaccinated employees and employees who are exempt from vaccination due to religious or disability-based restrictions. A COVID-19 test under the ETS is a test that is:

- cleared, approved or authorized, including in an Emergency Use Authorization (EUA), by the U.S. Food and Drug Administration (FDA) to detect current infection with the SARS-CoV-2 virus (e.g., a viral test);

administered in accordance with the authorized instructions; and

- not both self-administered and self-read unless observed by the employer or an authorized telehealth proctor.

Employees who fail to provide a weekly test result must be removed from the workplace until they can provide a negative test result.

Employers are not required to offer a testing option under the ETS. The ETS provides that employers that choose to adopt a mandatory vaccination-only policy may suspend or terminate employees who refuse to get vaccinated, unless their refusal is due to a medical condition or sincerely held religious belief that prevents them from being vaccinated, in which case reasonable Accommodations may have to be considered.

It is also important to note that the ETS does not require employers to pay for any costs associated with testing, although employers can choose to do so. Individual state or local laws may influence whether employers must cover the costs of testing. Group health plans are not required to cover COVID-19 testing for the purpose of the ETS.

Mask Requirements

Fully vaccinated employees are not required to wear masks. Any employee who is not fully vaccinated must wear a mask while in the workplace and when occupying a vehicle with another person for work purposes except:

- when the employee is alone in a room with floor to ceiling walls and a closed door.
- for a limited time while they are eating or drinking at the workplace, or for identification purposes in compliance with safety and security requirements.
- when the employee is wearing a respirator or facemask.
- where the employer can show that the use of face coverings in infeasible or creates a greater hazard that would excuse compliance (e.g., when it is important to see the employee's mouth for reasons related to their job duties, when the work require the use of the employee's uncovered mouth, or when the use of a face covering presents a risk of serious injury or death to the employee).

The ETS provides that a "face covering" means a covering that:

- completely covers the nose and mouth;
- is made with two or more layers of a breathable fabric that is tightly woven (i.e., fabrics that do not let light pass through when held up to a light source);
- is secured to the head with ties, ear loops or elastic bands that go behind the head. If gaiters are worn, they should have two layers of fabric or be folded to make two layers;
- fits snugly over the nose, mouth and chin with no large gaps on the outside of the face; and
- is a solid piece of material without slits, exhalation valves, visible holes, puncture or other openings.

Employer Support for Vaccination

Employers are required to provide employees with up to four hours of paid time off (PTO) from work for each required dose for a primary vaccination. Booster shots are not considered part of the primary vaccination series. Employees cannot be required to use sick, vacation or PTO time to cover these four hours.

Employers are required to provide "reasonable time and paid sick leave" to employees who suffer side effects from receiving a vaccination and need time off to recover. Employees may use available PTO or paid sick time to cover these absences, but if employees don't have enough accrued time to cover their absence, employers will have to pay for the remaining time off, and cannot advance PTO or sick leave which would result in the employee having a negative balance. The ETS does not require employers to provide PTO in connection with weekly testing, positive test results or quarantining or isolation. It should be noted that state or local laws may impose pay obligations under some of these scenarios.

Information to Provide to Employees

Employers must inform employees, in a language and at a literacy level the employee understands, about the key components of their compliance plan including, but not limited to:

- requirements for COVID-19 vaccination
- applicable exclusions from the written policy (e.g., reasonable accommodations for workers with disabilities or sincerely held religious beliefs)
- information on determining an employee's vaccination status and how this information will be collected
- paid time and sick leave for vaccination purposes and recovery from side effects
- employee obligations to provide prompt notification of positive COVID-19 tests and the employer's removal practices when notified of a positive test result of COVID-19-positive employees from the workplace
- testing and masking requirements
- disciplinary consequences for employees who do not abide by the policy
- vaccine efficacy, safety and the benefits of being vaccinated (by providing the Centers for Disease Control and Prevention (CDC) document "Key Things to Know About COVID-19 Vaccines")
- protections against retaliation and discrimination
- OSHA's prohibitions that impose criminal penalties for knowingly supplying false statements or documentation

Recordkeeping Requirements

Employers are required to keep a list of employee vaccination status that clearly indicates for each employee whether they are:

- fully vaccinated
- partially vaccinated
- not fully vaccinated because of a medical or religious accommodation
- not fully vaccinated because they have not provided acceptable proof of their vaccination status (includes employees who have chosen not to get vaccinated and have opted for weekly testing instead)

The following documents are considered acceptable for proof of vaccination:

- the record immunization from a healthcare provider or pharmacy
- a copy of the U.S. COVID-19 Vaccination Record Card
- a copy of medical records documenting the vaccination
- a copy of immunization records from a public health, state, or tribal immunization information system
- a copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) administering the vaccine(s).

Employers who have adopted a weekly testing option must maintain a record of each weekly test result for every employee subject to testing for the duration of the ETS. Test results are considered medical records under both the ETS and the Americans with Disabilities Act.

Employers must provide employees access to and copies of their individual test records upon request. In addition, upon request, employers must provide employees or employee representatives (such as union representatives) with the aggregate number of fully vaccinated employees at the workplace by the end of the next business day after the request. There is no limit on the number of times these requests can be made. Employers are also required to respond to requests from OSHA for certain records.

Positive Test of Employee/Close Contact with Positive Case

An employee who has tested positive must immediately be removed from the workplace until they either:

- receive a negative result on a COVID-19 NAAT test following a positive result on a COVID-19 antigen test (NAAT tests are less likely to provide false positives);
- meet the return-to-work criteria in the CDC's isolation guidance; or
- receive a recommendation to return to work from a licensed healthcare provider.

Employees who have tested positive for COVID-19 and returned to the workplace should be not subjected to weekly testing for 90 days following the date of their positive test.

The ETS does not require employees who have been exposed to someone diagnosed with COVID-19 to be quarantined; however, the CDC continues to recommend that unvaccinated employees be quarantined after close, prolonged contact with a COVID-positive person, and OSHA encourages employers to consider a quarantine protocol.

Employers are not required to contact trace under the ETS; however, the CDC continues to recommend contact tracing. Some state/local laws may also require contact tracing.

Employers must report each work-related COVID-19 fatality to OSHA within eight hours of learning of the fatality and each work-related COVID-19 in-patient hospitalization within 24 hours. OSHA has prepared a fact sheet explaining these reporting requirements.

Penalties

Employers that do not timely comply with the ETS may face penalties of $13,653 per violation for 2021 (2022 amounts not yet available). Willful or repeated violations can result in penalties of $136,532 per violation. States that operate their own OSHA plans must adopt maximum penalty levels that are at least as effective as federal OSHA.

Employer Action

Employers should prepare to comply and monitor developments out of the courts. If the ETS survives legal challenge, covered employers must have the following in place by December 5, 2021:

- establish a vaccination policy. OSHA has a sample mandatory vaccination policy and a sample vaccination or testing/face covering policy which may be found at https://www.osha.gov/coronavirus/ets2
- determine vaccination status of each employee, obtain acceptable proof of vaccination and maintain records and a roster of vaccination status
- provide support for employee vaccination
- require employees to promptly provide notice of positive COVID-19 test or COVID-19 diagnosis
- ensure employees who are not fully vaccinated wear face coverings when indoors or when occupying a vehicle with another person for work purposes
- provide each employee information about the ETS; workplace policies and procedures; vaccination efficacy, safety and benefits; protections against retaliation and discrimination; and laws that provide for criminal penalties for knowingly supplying false documentation
- report work-related COVID-19 fatalities to OSHA within eight hours and work-related COVID-19 in-patient hospitalizations within 24 hours
- make certain records available

By January 2, 2022, employers must ensure employees who are not fully vaccinated are tested for COVID-19 at least weekly (if in the workplace at least once per week) or within seven days before returning to work (if away from the workplace for a week or longer).

2022 Cost of Living Adjustments

Published: November 15, 2021

The IRS recently released cost of living adjustments for 2022 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual Contribution Limitation

For plan years beginning in 2022, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $2,750 to $2,850.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Annual Maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins in 2022 that can be carried over to the following plan year is $570.

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a maximum of $500 to 20% of the currently indexed health FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2022, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased to $280.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $130,000 to $135,000 for 2022.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2022 increased from $185,000 to $200,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

Non-Grandfathered Plan Out-Of-Pocket Cost-Sharing Limits

The 2022 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $8,700 for self-only coverage and $17,400 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2022, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $5,450 ($11,050 for family coverage) (increased from 2021).

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2022, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Code Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $1,800 (unchanged from 2021).

Health Savings Accounts

As announced in May 2021, the inflation adjustments for health savings accounts (HSAs) for 2022 were provided by the IRS in Rev. Proc. 2021-25.

Annual contribution limitation

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

Qualifying high deductible health plan

For calendar year 2022, a "qualifying high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage (unchanged from 2021), and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,000 for self-only coverage or $14,100 for family coverage.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution

Individuals who are age 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

New Jersey Releases 2022 Disability and Family Leave Amounts

Published: December 1, 2021

New Jersey has announced the 2022 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs as follows:

Maximum TDI and FLI Weekly Benefit	$993
Alternative Earnings Test Amount for TDI and FLI	$12,000
Base Week Amount for TDI and FLI	$240
Taxable Wage Base (employers) for TDI	$39,800
Taxable Wage Base (employees) for TDI and FLI	$151,900
Employee Contribution Rate for TDI	0.14%
Employee Contribution Rate for FLI	0.14%

Temporary Disability Insurance 2022

Temporary Disability Insurance provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons. To be eligible for TDI, employees must have worked 20 weeks earning at least $240 per week ("Base Week Amount") or have earned a combined total of $12,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $993. TDI may be payable for up to 26 weeks in a 52-week period.

Employees and employers contribute to TDI. Employees contribute 0.14% of wages up to the 2022 Taxable Wage Base (Employee) of $151,900 equal to $212.66.

Employers contribute based on TDI experience anywhere from 0.10% and 0.75% of an employee's wages up to the 2022 Taxable Wage Base (Employer) of $39,800. The maximum annual contribution will range between $39.80 and 298.50.

Family Leave Insurance 2022

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member. Similar to TDI, to be eligible for FLI employees must have worked 20 weeks earning at least $240 per week ("Base Week Amount") or have earned a combined total of $12,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $993. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.14% of wages up to the 2022 Taxable Wage Base (Employee) of $151,900 equal to $212.66.

Comparison to 2021

	2022	2021	Percentage Change
Maximum TDI/FLI Weekly Benefit	$993	$903	10.0%
TDI Employee Contribution Rate	0.14%	0.47%	(70.2)%
TDI Maximum Annual Employee Contribution	$212.66	$649.54	(67.2)%
TDI Maximum Annual Employer Contribution	$39.80 to $298.50	$36.20 to $271.50	10.0%
FLI Employee Contribution Rate	0.14%	0.28%	(59.0)%
FLI Maximum Annual Employee Contribution	$212.66	$386.96	(67.2)%

New York State Modifies Paid Family Leave

Published: December 2, 2021

On November 1, 2021 Governor Kathy Hochel signed legislation to expand the definition of a family member to include siblings under New York Paid Family Leave ("NYPFL").

- Effective January 1, 2023 eligible employees will be able to take job-protected NYPFL to care for a sibling.
- The legislation defines a sibling as a biological or adopted sibling, a half-sibling or step-sibling.
- A family member continues to include a child, parent, grandparent, grandchild, spouse, or domestic partner for whom NYPFL may be taken.

NYPFL is currently available to most eligible employees who work for private New York State employers to bond with a new child through birth, adoption or foster care placement, care for a family member with a serious health condition, or assist loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service.

As a reminder, eligible employees may receive up to 12 weeks of partial pay (67% of average weekly wages) to the state maximum weekly benefit. For 2022, the state maximum weekly benefit has been set at $1,068.36.

IRS Releases Proposed Regulations on ACA Reporting and Other Issues

Published: December 6, 2021

On November 22, 2021, the Internal Revenue Service ("IRS") released proposed regulations that provide some relief with respect to ACA reporting requirements.

The proposed rule:

- Makes permanent an automatic extension of 30 days to furnish IRS Forms 1095-C (and 1095-B) to individuals. Effectively, this moves the due date for furnishing these forms to full-time employees and other individuals from January 31 to March 2 each year (or, if March 2nd falls on a weekend or holiday, the next business day).

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.

- Creates an alternative method for furnishing individuals with IRS Form 1095-B (and, in some cases, IRS Form 1095-C) as proof of minimum essential coverage (MEC).

Therefore, with respect to Forms 1095-C for calendar 2021, applicable large employers ("ALEs") have until March 2, 2022 (rather than January 31, 2022) to furnish these forms to full-time employees and other individuals.

It is important to note that the proposed rule does not extend the deadline to file completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) with the IRS. The due date remains March 31, 2022 (or February 28, 2022 for paper filing if filing fewer than 250 forms).

Please note, while the 2021 Forms 1094-C and 1095-C have been finalized, the instructions are not yet available. Once published, the instructions should be available on this website: https://www.irs.gov/forms-pubs/about-form-1095-c.

Below you will find additional details.

Automatic Extension of Time for Furnishing ACA Statements

Under the ACA, January 31 is the deadline to furnish IRS Forms 1095-C and 1095-B to certain individuals (such as full-time employees, in the case of IRS Form 1095-C) with respect to the preceding calendar year. The proposed regulations grant an automatic extension of 30 days in which to furnish these statements to individuals. The extension is automatic; employers or other reporting entities are not required to file a request with IRS, or to demonstrate reasonable cause to justify the extension.

Employers may rely on this relief for calendar year 2021 filings. This means Wednesday March 2, 2022 is the deadline to furnish individuals with a 2021 Form 1095-C or 1095-B.

While the IRS has provided the automatic extension of time to furnish the Form 1095-C (or Form 1095-B), if operating in a state with an individual mandate the timing to furnish proof of coverage to covered residents may be different.

Elimination of Transitional Good Faith Relief

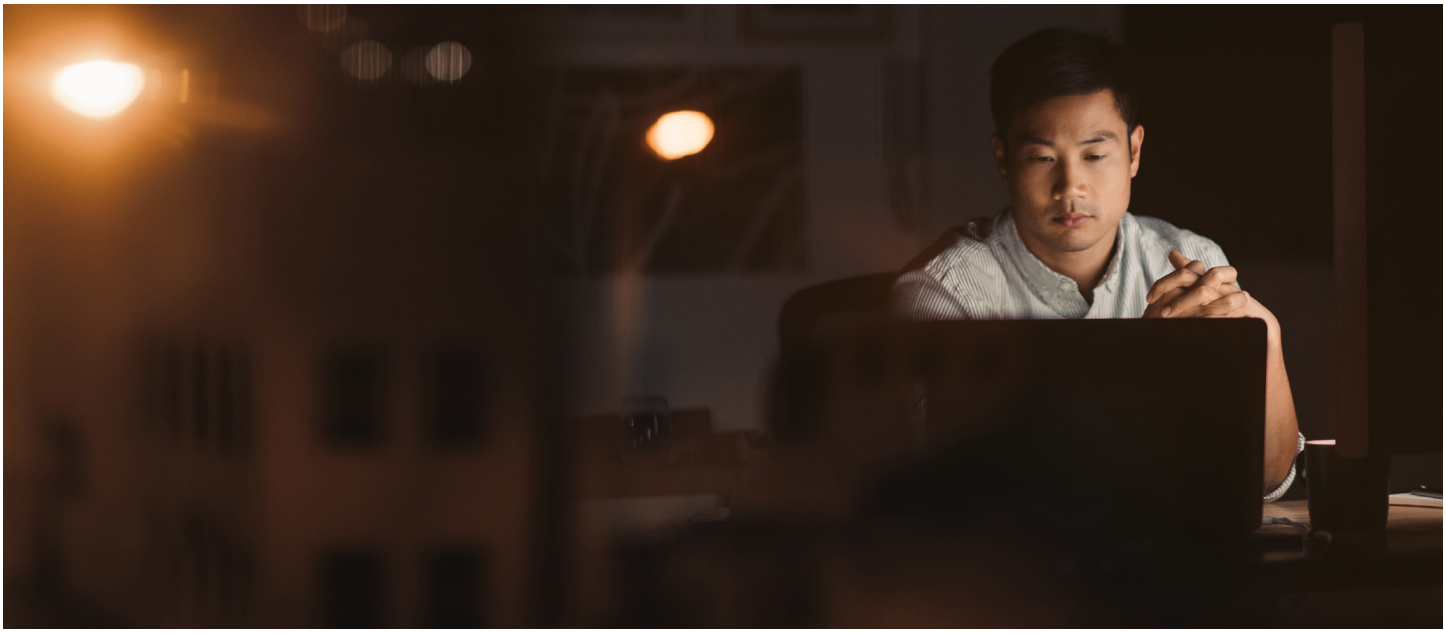
Since 2015, the IRS provided reporting entities with relief from penalties if those entities could show they made good faith efforts to comply with the information reporting requirements. This relief has been extended each year, with the IRS announcing that 2020 would be the last year that transitional good faith relief would be available.

The proposed rule confirms that the good faith relief from penalties for reporting incorrect or incomplete information on Forms 1094-C, 1095-C, 1094-B and 1095-B is no longer available after 2020. For 2021, penalties for incorrect or incomplete forms furnished to individuals can be $280/return. Additionally, incomplete or incorrect forms filed with the IRS may trigger a $280/return penalty.

While the reasonable cause exception remains available and may provide relief from penalties for entities that can show a reasonable cause for failing to timely or accurately complete their reporting requirements, with the elimination of the good faith relief employers will want to take steps to ensure the accuracy of their forms and filings.

Alternative Method for Furnishing ACA Statements

Under the ACA, IRS Forms 1095-C and 1095-B must be sent by first class mail to the last known permanent address of the individual. If no permanent address is known, the statement must be sent by first class mail to the individual's temporary address. The statement may also be furnished electronically if certain requirements are met.



The proposed regulations would make permanent an alternative method for furnishing IRS Forms 1095-B (and, in some limited cases, IRS Forms 1095-C) to individuals, for as long as penalties under the ACA's individual shared responsibility rules remain zero. The alternative method would be available to the following reporting entities:

- Health insurance carriers and plan sponsors (other than ALEs) that are using IRS Form 1095-B to provide proof of MEC
- ALEs with a self-funded group medical plan that are using IRS Form 1095-B or 1095-C to provide proof of MEC to individuals who are not considered "full-time" under the ACA for any month of the calendar year (i.e., non-full-time employees and non-employees covered under the plan during the calendar year)
- Small employers (not ALEs) with a self-funded health plan that are using IRS Form 1095-B to provide proof of MEC

The alternative method is not available to ALEs that are furnishing IRS Form 1095-C to employees considered "full-time" under the ACA for one or more months of the calendar year. Further, the alternative method may not be available if operating in a state with an individual mandate where Forms 1095-C or 1095-B must be furnished to covered residents. Keep in mind, if the alternative method is used, the reporting entity must still file the Form 1095-B with the IRS.

The following steps must be followed by a reporting entity that elects to use the alternative method:

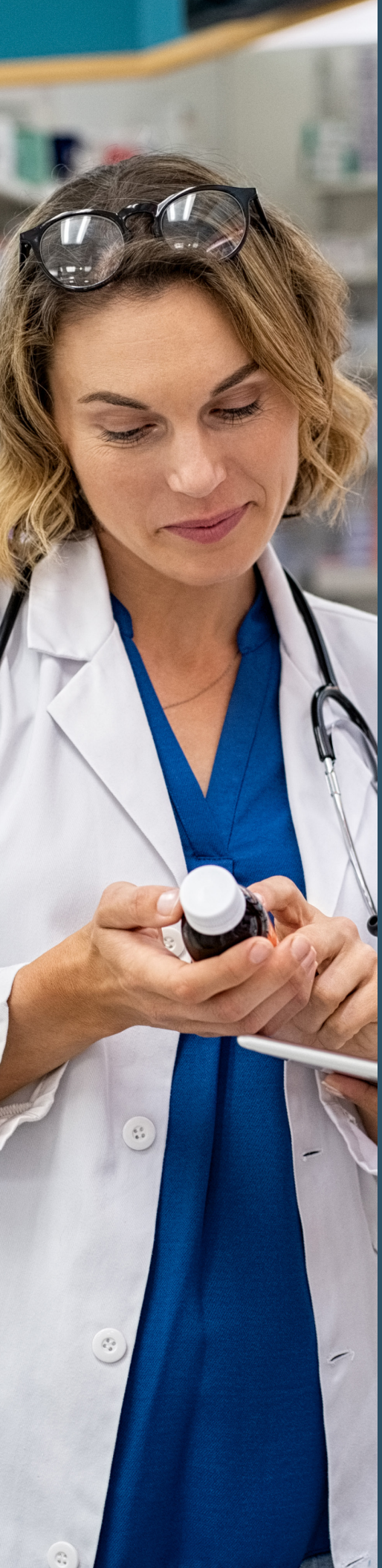
- A clear and conspicuous notice that meets certain technical requirements must appear on the reporting entity's website
- The notice must state that covered individuals may receive a copy of IRS Form 1095-B (and, in some cases, IRS Form 1095-C) upon request, and informs them how the request may be made
- The notice must appear in the same website location through October 15 (or the next business day) following the end of the calendar year
- IRS Form 1095-B (or, in some cases, IRS Form 1095-C) must be furnished to the requesting individual within 30 days after the request is received; the ACA statement may be furnished electronically if certain requirements are met.

If the proposed regulations are finalized without change, the alternative method would be available to reporting entities that are furnishing IRS Forms 1095-B (and, in some cases, IRS Forms 1095-C) for calendar year 2021, as well as for future calendar years.

Employer Action

Employers should continue to monitor the status of the proposed rule.

- With respect to furnishing Forms 1095-C for CY 2021, employers may rely on the proposed rule and must furnish these statements no later than March 2, 2022 (versus January 31, 2022).
- Employers should take extra care that Forms 1094-C and 1095-C are complete and accurate as the transitional good faith relief is no longer available with respect to calendar year 2021 filings (and thereafter).
- Determine whether your carriers will take advantage of the alternative furnishing method with respect to Forms 1095-B they issue.
- If operating in a state with an individual mandate (California, District of Columbia, Massachusetts. New Jersey, Rhode Island and Vermont), and required to furnish covered residents with proof of coverage during the calendar year, ensure you continue to comply with state rules.



Guidance on Prescription Drug Reporting

Published: December 7, 2021

On November 23, 2021, the Office of Personnel Management and the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") published interim final regulations under the Consolidated Appropriations Act, 2021 ("CAA") that require group health plans to submit an annual report to the federal government on prescription drugs and health care spending. The reports for calendar years 2020 and 2021 are due on December 27, 2022, and the reports for subsequent calendar years are due on the following June 1.

The annual reporting requirement generally applies to all group health plans. It does not apply to excepted benefit plans, short-term limited duration insurance, and health reimbursement arrangements and certain other account-based plans.

Fully insured group health plans can transfer the reporting obligation to the insurance carrier by entering into a written agreement that obligates the carrier to perform the reporting function. The carrier will then be liable for any reporting violation.

A self-funded group health plan can also enter into a written agreement with a third-party administrator ("TPA"), or a pharmacy benefit manager ("PBM") or other third party, to fulfill the reporting function, but the plan remains liable for any reporting violation.

According to the interim final regulations, the following information must be included in the annual report filed with the federal government:

- Total healthcare spending, broken down by type of cost (hospital care, primary care, specialty care, prescription drugs, and other medical costs, including wellness services)
- The 50 most frequently dispensed name-brand prescription drugs
- The 50 prescription drugs that generated the highest total annual spending
- The 50 prescription drugs with the greatest increase in total annual spending compared to the previous calendar year

- Prescription drug rebates, fees and other remuneration paid by drug manufacturers to the plan in each therapeutic class of drugs, as well as for each of the 25 drugs that generated the highest rebate amounts
- The impact of prescription drug rebates, fees and other remuneration on premiums and out-of-pocket costs

The interim final regulations contain standards and definitions that, for example, identify prescription drugs on a uniform basis regardless of dosage strength, package size, or mode of delivery.

Information in the report must be aggregated separately for each state in which coverage was provided under the plan, except as set forth in the following chart:

Type of Group Health Plan	Information Must Be Aggregated in the Report
Self-funded plan	For the state in which the plan sponsor has its principal place of business
Fully insured plan (other than a plan described below)	For the state where the insurance contract was issued
Health coverage provided through a group trust or multiple employer welfare arrangement ("MEWA")	• For the state where the employer has its principal place of business, if the plan is sponsored at the individual employer level; or • For the state where the association has its principal place of business, if the association qualifies as the employer under federal ERISA law; or • For the state where the association is incorporated, if the association has no principal place of business and qualifies as the employer under federal ERISA law
Individual health insurance sold through an association	For the issue state of the certificate of coverage

The Departments intend to compile and analyze the reports that it receives under the interim final regulations, and to publish its findings every two years to better understand prescription drug pricing trends and their effect on premiums and out-of-pocket costs.

Employer Action

While the deadline for calendar year 2020 and 2021 reporting is a year out (December 27, 2022), employers should start discussing next steps with brokers, carriers, TPAs and PBMs.

Fully insured plans. Employers should enter into written agreements with their insurance carriers and HMOs to transfer the reporting obligation and liability to the carrier.

Self-funded plans. Employers should enter into written agreements with TPAs, PBMs, or other third parties to ensure the vendor will provide the required reporting to the Departments. As the self-funded plan remains liable for reporting, employers should monitor the reporting efforts of the TPA or other third party to help minimize the exposure to liability for any reporting violation.

Winter Action Plan to Battle COVID-19

Published: December 10, 2021

On December 2, 2021, the Biden administration issued a nine-pronged plan to combat COVID-19 as the winter months approach and the new Omicron variant poses risk of new infections. The plan covers:

1. Boosters for adults
2. Vaccinations to protect children and keep schools open
3. Expanded free at-home testing
4. International travel protections
5. Workplace protections
6. Rapid response teams to battle rising cases
7. Supplying treatment pills to help prevent hospitalizations and death
8. Continued commitment to global vaccination efforts
9. Steps to ensure preparation for all scenarios

Aspects of this plan will affect employers and group health plans, as follows:

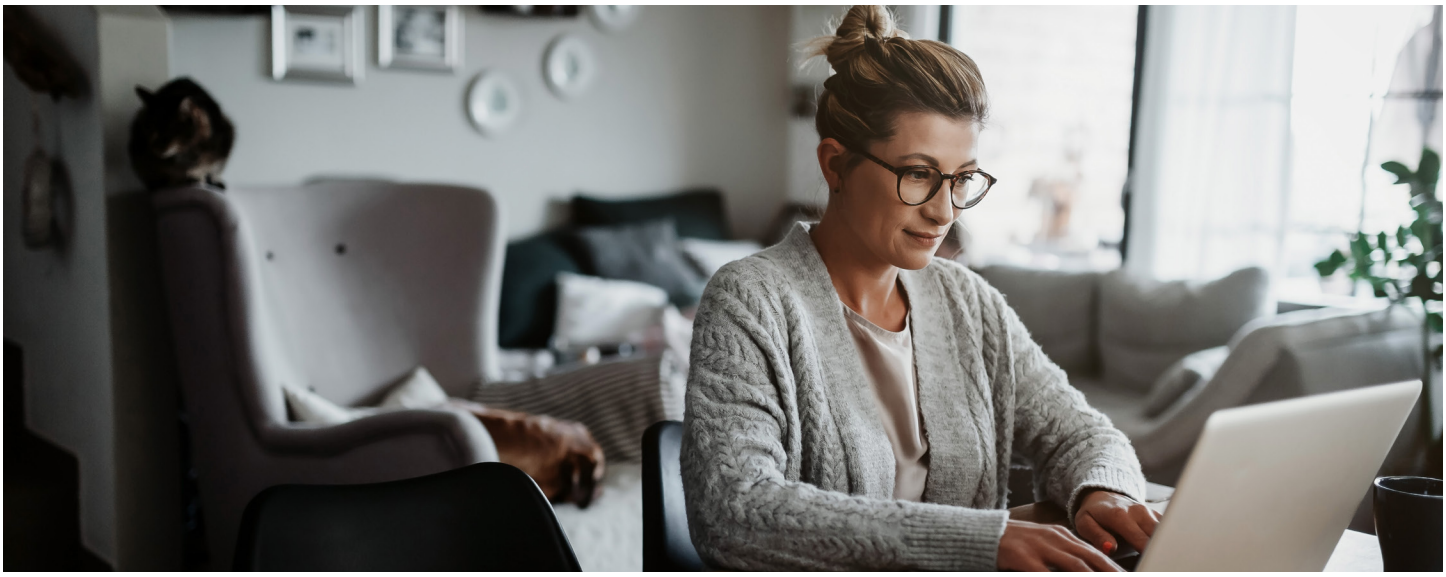
- **Expanded free at-home testing.** The Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") are directed to issue guidance by January 15, 2022, to clarify that individuals who purchase over-the-counter ("OTC") COVID-19 diagnostic tests can seek reimbursement from their group health plan or health insurance issuer to cover the cost of the OTC test during the public health emergency. The plan notes that, consistent with current guidance, group health plans are not required to cover testing for public health surveillance or employment purposes.

- **PTO for booster shots.** While all federal employees currently receive paid time off to get booster shots, employers are called upon to provide the same paid time off for their employees, if they are not doing so already, including paid time off for family members getting their first, second, or booster shots.

- **Targeting outreach to Medicare beneficiaries.** CMS is launching an initiative to get Medicare beneficiaries booster shots. CMS will be sending all Medicare beneficiaries a notice providing information on access to booster shots in their community as well as emails.

- **Protecting Workplaces to Keep Businesses Open.** The administration is calling on businesses to move forward with requiring their workers to get vaccinated or be tested weekly. No new guidelines or requirements are part of this provision. The emphasis on encouragement is likely in response to the ongoing legal challenges to the federal vaccine mandates. Currently, the courts have issued an enforcement stay with respect to the OSHA Emergency Temporary Standard ("ETS"), applicable to private employers, and a nationwide preliminary injunction with respect to both the CMS interim final rule applicable to health care workers and the federal contractor mandate.

Future guidance is expected to clarify and implement the provisions outlined in this plan. We are monitoring this information and will report on developments.



Final 2021 Instructions for Forms 1094-C and 1095-C Issued

Published: December 17, 2021

The IRS released final Instructions for Forms 1094-C and 1095-C for calendar year 2021 reporting.

Background

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

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2021 in preparation to complete, furnish and file these forms for 2021.

As previously reported, the IRS issued a proposed rule that:

- Makes permanent an automatic extension of 30 days to furnish IRS Forms 1095-C to individuals. Therefore, for calendar year 2021, the due date to furnish Form 1095-C to full-time employees and other individuals is March 2, 2022.

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.

The instructions generally reinforce what is set forth in the proposed rule, with some new information as it relates to an individual coverage health reimbursement arrangement ("ICHRA").

What's New?

Other than what was previously announced, the changes included in the 2021 instructions are minimal.

New Codes for ICHRAs

If an ALE offers an ICHRA for 2021, the Form 1095-C has been modified to add new codes 1T and 1U for ICHRAs offered to the employee and spouse but not dependents.

2021 Penalties

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. Good faith relief is no longer available. However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2021, the following penalties may apply:

- Failure to file a correct return is $280/statement (total calendar year penalty not to exceed $3,426,000).
- Failure to furnish a correct statement is $280/statement (total calendar year penalty not to exceed $3,426,000).

An employer that fails to both file and furnish a correct statement is subject to a combined penalty of $560/statement with a maximum penalty of $6,852,000.

Employer Action

Employers should begin preparing and ensure that statements are furnished to full-time employees and other individuals by March 2, 2022. If you are an employer with employees residing in a state with an individual mandate (e.g., California, the District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont) the deadlines may be different than what is required by the IRS. Many states are still reviewing their policies in light of the recently announced federal delay.

Employers should be certain the statements are complete and accurate since the good faith relief is no longer available.

OSHA's Emergency Temporary Standard

Guidance on Mandatory COVID-19 Vaccination/Testing

Published: December 21, 2021

UPDATE: On December 17, 2021, in a 2-1 decision, the 6th Circuit Court of Appeals allowed the Occupational Safety and Health Administration's ("OSHA") Vaccination and Testing Emergency Temporary Standard ("ETS") to move forward by lifting an earlier court's stay that had put the ETS on hold. In response to the court's decision, OSHA has initiated an aggressive implementation and enforcement schedule.

While OSHA expects covered employers to begin complying immediately, the agency has said it will delay enforcement of the vaccination requirements of the ETS until January 10, 2022, and will wait until February 9, 2022, to start enforcing the optional testing component of the ETS. Both of those dates are quickly approaching.

Although the ETS is moving forward for now, the litigation process continues, as the parties challenging the ETS immediately appealed the court's decision to the U.S. Supreme Court. While the Supreme Court will ultimately determine the ETS' fate, in the interim, OSHA has made it clear that it intends to move forward with full enforcement. As a result, covered employers will have to decide how best to re-start their compliance efforts.

Background

On November 5, 2021, OSHA published its long-awaited Emergency Temporary Standard (ETS), which requires most U.S. employers with 100 or more employees to adopt a mandatory COVID-19 vaccination policy with an option to include an alternative weekly testing program.

While the ETS was effective immediately, legal challenges and a nationwide stay halted OSHA's implementation and enforcement efforts. On December 17, 2021, the 6th Circuit Court of Appeals dissolved the stay, allowing the ETS to take effect. The states and businesses challenging the requirement have appealed the court's decision to the U.S. Supreme Court, who may have the final word on whether the ETS remains in effect.

With the ETS now in effect, employers should consider their compliance efforts. To account for the uncertainty created by the stay, OSHA is exercising enforcement discretion with respect to the compliance dates to provide employers with sufficient time to come into compliance.

OSHA will not issue citations for non-compliance with any of the requirements of the ETS before **January 10, 2022** and will not issue citations for non-compliance with the weekly testing requirements before **February 9, 2022** so long as the employer is exercising reasonable, good faith efforts to come into compliance with the standard. OSHA plans to work closely with the regulated community to provide compliance assistance.

This is a rapidly changing environment, but if the ETS survives legal challenge, its current provisions provide employers with a detailed roadmap of what compliance should look like. Even with the legal uncertainty, employers should take steps to prepare for compliance and monitor developments out of the courts.

Below you will find a summary of the important aspects of the ETS. The summary is not exhaustive and is not a substitute for legal advice.

Covered Employers

Private Sector

Private employers with 100 or more employees at any time during the effective period of the ETS, which begins on November 5, 2021, must comply. The definition of "employee" includes all employees on an employer's payroll, including temporary employees, part-time employees, remote employees, seasonal employees, etc. Independent contractors are not counted as employees. Staffing agency employees are considered employees of the staffing agency and are included in the staffing agency's headcount, not the host employer's headcount.

Employers with 100 or more employees on November 5, 2021 must continue to comply for the entire duration of the ETS even if their employee count subsequently drops below 100.

Employers with fewer than 100 employees on November 5, 2021 are not subject to the ETS; however, if headcount reaches the 100-employee threshold at any time while the ETS is in effect, then the employer must promptly comply.

State and Local Governments

State and local governmental employers with 100 or more employees in states that have state-approved OSHA programs must comply. State and local governmental employers are not typically covered by federal OSHA requirements. However, a condition for a state receiving approval to adopt its own State Plan is that it extends federal OSHA requirements to state and local governmental employers.

Employers not Covered

The following employers are not covered under the ETS:

- Workplaces covered by other federal mandates, such as the previously issued Healthcare ETS, or federal contractor employers covered by the Safer Federal Workforce Task Force COVID-19 Workplace Safety Guidance
- State and local governmental employers in states without approved state OSHA programs
- Private employers with fewer than 100 employees, unless a state OSHA program requires them to comply

States must adopt programs that are "at least as effective as federal OSHA's requirements;" however, OSHA allows states to adopt programs that are more expansive or stringent than the federal requirements, so it's possible that some states may lower the compliance obligation below the 100-employee threshold.

Some states, like Montana and Texas, have laws or executive orders that may prevent vaccine or mask mandates. OSHA believes it has the authority to preempt or override any attempts by states or localities to prevent vaccination or mask mandates. According to the guidance: "OSHA intends for the ETS to preempt and invalidate any

State or local requirements that ben or limit an employer's authority to require vaccination, face covering, or testing."

Exempt Employees

Employees who work exclusively from home, who work exclusively outdoors, or who come into the workplace only when other employees (or customers) are not present are not covered by the ETS. However, if any such worker will be entering a covered workplace during times when other employees (or customers) are present, they must either be vaccinated or be able to present a negative test result obtained within seven days of entering the workplace.

Employees with medical conditions or sincerely held religious beliefs that prevent them from 1) being vaccinated, 2) undergoing weekly testing, and/or 3) wearing a mask may be entitled to accommodations under Title VII of the Civil Rights Act or the Americans with Disabilities Act.

Employees who have previously been diagnosed with COVID-19 are not exempt from compliance and must either be fully vaccinated or submit to weekly testing.

Full Vaccination

Employees are considered to be "fully vaccinated" two weeks after receiving a single Johnson & Johnson vaccine, or two weeks after receiving the second does of a two-dose vaccine series (i.e., Pfizer or Moderna). Booster shots and additional doses are not included in the definition of fully vaccinated under the ETS.

Testing

Employers do not have to offer a testing option. The ETS states that employers must adopt a mandatory vaccination program, but that employers may also choose to adopt a weekly testing option. As OSHA puts it, for an employer that decides to adopt a weekly testing option, "that simply means that employees themselves may choose not to get vaccinated, in which case they must get tested and wear face coverings per the requirements of the standard."

According to the ETS, employers that choose to adopt a mandatory vaccination-only policy may suspend or terminate employees who refuse to get vaccinated, unless their refusal is due to a medical condition or sincerely held religious belief that prevents them from being vaccinated, in which case reasonable accommodations may have to be considered.

Covered employees who are not "fully vaccinated" must comply with the weekly testing requirements of the ETS. This includes unvaccinated employees, partially vaccinated employees and employees who are exempt from vaccination due to religious or disability-based restrictions.

Under the ETS, a COVID-19 test under the ETS is a test that is:

- cleared, approved or authorized, including in an Emergency Use Authorization (EUA), by the U.S. Food and Drug Administration (FDA) to detect current infection with the SARS-CoV-2 virus (e.g., a viral test);
- administered in accordance with the authorized instructions; and
- not both self-administered and self-read unless observed by the employer or an authorized telehealth proctor.

Acceptable tests include tests processed by a laboratory (whether collected at home or at a testing facility), tests witnessed or overseen by the employers or professionals (including telehealth), and tests where specimen collection and processing is either done or observe by an employer. Both Nucleic Acid Amplification Tests (NAAT) and antigen tests are acceptable, so long as they are not self-administered and self-read. However, antibody tests do not meet the definition of COVID-19 test for the purposes of the ETS.

The ETS does not require employers to pay for any costs associated with testing, although employers can choose to do so. Individual state or local laws may influence whether employers must cover the costs of testing. Group health plans are not required to cover COVID-19 testing for employment purposes.

Employees who fail to provide a weekly test result must be removed from the workplace until they can provide a negative test result.

Mask Requirements

Fully vaccinated employees are not required to wear masks. Any employee who is not fully vaccinated must wear a mask while in the workplace and when occupying a vehicle with another person for work purposes except under the following circumstances:

- when the employee is alone in a room with floor to ceiling walls and a closed door.
- for a limited time while they are eating or drinking at the workplace, or for identification purposes in compliance with safety and security requirements.
- when the employee is wearing a respirator or facemask.
- where the employer can show that the use of face coverings in infeasible or creates a greater hazard that would excuse compliance (e.g., when it is important to see the employee's mouth for reasons related to their job duties, when the work require the use of the employee's uncovered mouth, or when the use of a face covering presents a risk of serious injury or death to the employee).

Employer Support for Vaccination

Employers are required to provide employees with up to four hours of paid time off (PTO) from work for each required does for a primary vaccination. Booster shots are not considered part of the primary vaccination series. Employees cannot be required to use sick, vacation or PTO time to cover these four hours.

Employers are required to provide "reasonable time and paid sick leave" to employees who suffer side effects from receiving a vaccination and need time off to recover. Available PTO or paid sick time may be used to cover these absences, but if employees don't have enough accrued time to cover their absence, employers will have to pay for the remaining time off, and cannot advance PTO or sick leave which would result in the employee having a negative balance. The ETS does not require employers to provide PTO in connection with weekly testing, positive test results or quarantining or isolation. It should be noted that state or local laws may impose pay obligations under some of these scenarios.

Information to Provide to Employees

The ETS requires employers to adopt a robust compliance policy and inform employees, in a language and at a literacy level the employee understands, about the key components of their compliance plan including, but not limited to, the following:

- requirements for COVID-19 vaccination
- applicable exclusions from the written policy (e.g., reasonable accommodations for workers with disabilities or sincerely held religious beliefs)
- information on determining an employee's vaccination status and how this information will be collected
- paid time and sick leave for vaccination purposes and recovery from side effects
- employee obligations to provide prompt notification of positive COVID-19 tests and the employer's removal practices when notified of a positive test result of COVID-19-positive employees from the workplace
- testing and masking requirements
- disciplinary consequences for employees who do not abide by the policy
- vaccine efficacy, safety and the benefits of being vaccinated (by providing the Centers for Disease Control and Prevention (CDC) document "Key Things to Know About COVID-19 Vaccines")
- protections against retaliation and discrimination
- OSHA's prohibitions that impose criminal penalties for knowingly supplying false statements or documentation

Recordkeeping Requirements

Employers are required to keep a list of employee vaccination status that clearly indicates for each employee whether they are:

- fully vaccinated
- partially vaccinated
- not fully vaccinated because of a medical or religious accommodation
- not fully vaccinated because they have not provided acceptable proof of their vaccination status (includes employees who have chosen not to get vaccinated and have opted for weekly testing instead)

The following documents are considered acceptable for proof of vaccination:

- the record immunization from a healthcare provider or pharmacy
- a copy of the U.S. COVID-19 Vaccination Record Card
- a copy of medical records documenting the vaccination
- a copy of immunization records from a public health, state, or tribal immunization information system
- a copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the healthcare professional(s) or clinic site(s) administering the vaccine(s).

Employers who have adopted a weekly testing option must maintain a record of each weekly test result for every employee subject to testing for the duration of the ETS. Test results are considered medical records under both the ETS and the Americans with Disabilities Act.

Employers must provide employees access to and copies of their individual test records upon request. In addition, upon request, employers must provide employees or employee representatives (such as union representatives) with the aggregate number of fully vaccinated employees at the workplace by the end of the next business day after the request. There is no limit on the number of times these requests can be made. Employers are also required to respond to requests from OSHA for certain records.

Positive Test of Employee/Close Contact with Positive Case

An employee who has tested positive must immediately be removed from the workplace until they either:

- receive a negative result on a COVID-19 NAAT test following a positive result on a COVID-19 antigen test (NAAT tests are less likely to provide false positives);
- meet the return-to-work criteria in the CDC's isolation guidance; or
- receive a recommendation to return to work from a licensed healthcare provider.

Employees who have tested positive for COVID-19 and returned to the workplace should be not subjected to weekly testing for 90 days following the date of their positive test.

The ETS does not require employees who have been exposed to someone diagnosed with COVID-19 to be quarantined; however, the CDC continues to recommend that unvaccinated employees be quarantined after close, prolonged contact with a COVID-positive person, and OSHA encourages employers to consider a quarantine protocol.

The ETS does not require contract tracing. However, the CDC continues to recommend contact tracing. Some state/local laws may also require contact tracing.

Employers must report each work-related COVID-19 fatality to OSHA within eight hours of learning of the fatality and each work-related COVID-19 in-patient hospitalization within 24 hours.

Penalties

Employers that do not timely comply with the OSHA ETS may face penalties of $13,653 per violation for 2021 (2022 amounts not yet available). Willful or repeated violations can result in penalties of $136,532 per violation. States that operate their own OSHA plans must adopt maximum penalty levels that are at least as effective as federal OSHA.

Employer Action

Though the outcome of the legal challenges remains uncertain, employers should prepare for compliance with the ETS. Employers should review their preparedness using the checklist below:

By January 10, 2022, covered employers must have the following in place:

- ❑ Determine whether you will adopt a vaccination only policy, or a vaccination plus testing policy.
- ❑ Establish a vaccination policy. OSHA provides a sample mandatory vaccination policy and a sample vaccination or testing/facing coverage policy at https://www.osha.gov/coronavirus/ets2
- ❑ Determine vaccination status of each employee, obtain acceptable proof of vaccination, maintain records and a roster of vaccination status.
- ❑ Provide support for employee vaccination.
- ❑ Require employees to promptly provide notice of positive COVID-19 test or COVID-19 diagnosis.
- ❑ Remove any employee from the workplace who received positive COVID-19 test or COVID-19 diagnosis.
- ❑ Ensure employees who are not fully vaccinated wear face coverings when indoors or when occupying a vehicle with another person for work purposes.
- ❑ Provide each employee information about the ETS; workplace policies and procedures; vaccination efficacy, safety and benefits; protections against retaliation and discrimination; and laws that provide for criminal penalties for knowingly supplying false documentation.
- ❑ Report work-related COVID-19 fatalities to OSHA within 8 hours and work-related COVID-19 in-patient hospitalizations within 24 hours.

By February 9, 2022:

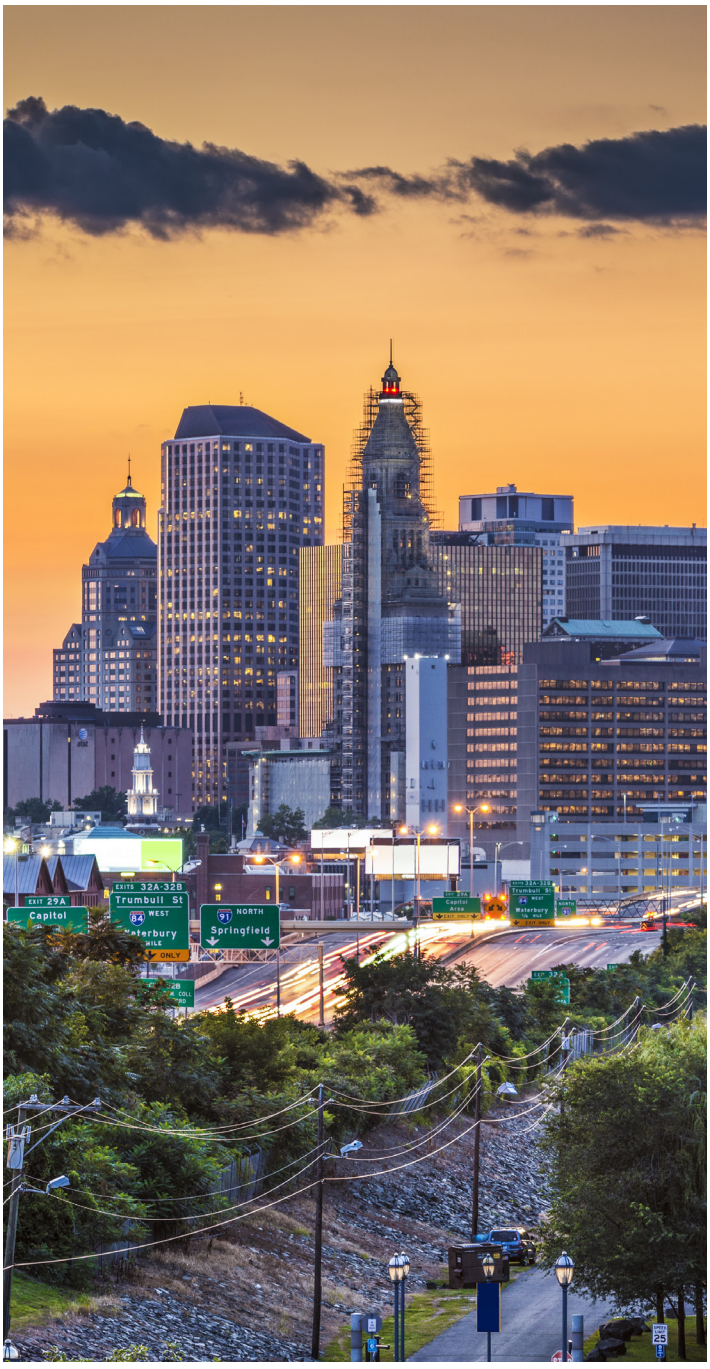
- ❑ Ensure employees who are not fully vaccinated and who have indoor contact with others as part of their jobs are tested for COVID-19 at least weekly or within 7 days before returning to work if away from the workplace for a week or longer.

Reminder: Connecticut PFML Benefits Begin January 1, 2022

Beginning **December 1, 2021**, covered employees under the Connecticut Paid Family Medical Leave Act may begin to submit applications for paid leave benefits for future leaves with a benefit start date of **January 1, 2022** and beyond. Benefit payments for approved paid leave begin **January 1, 2022.**

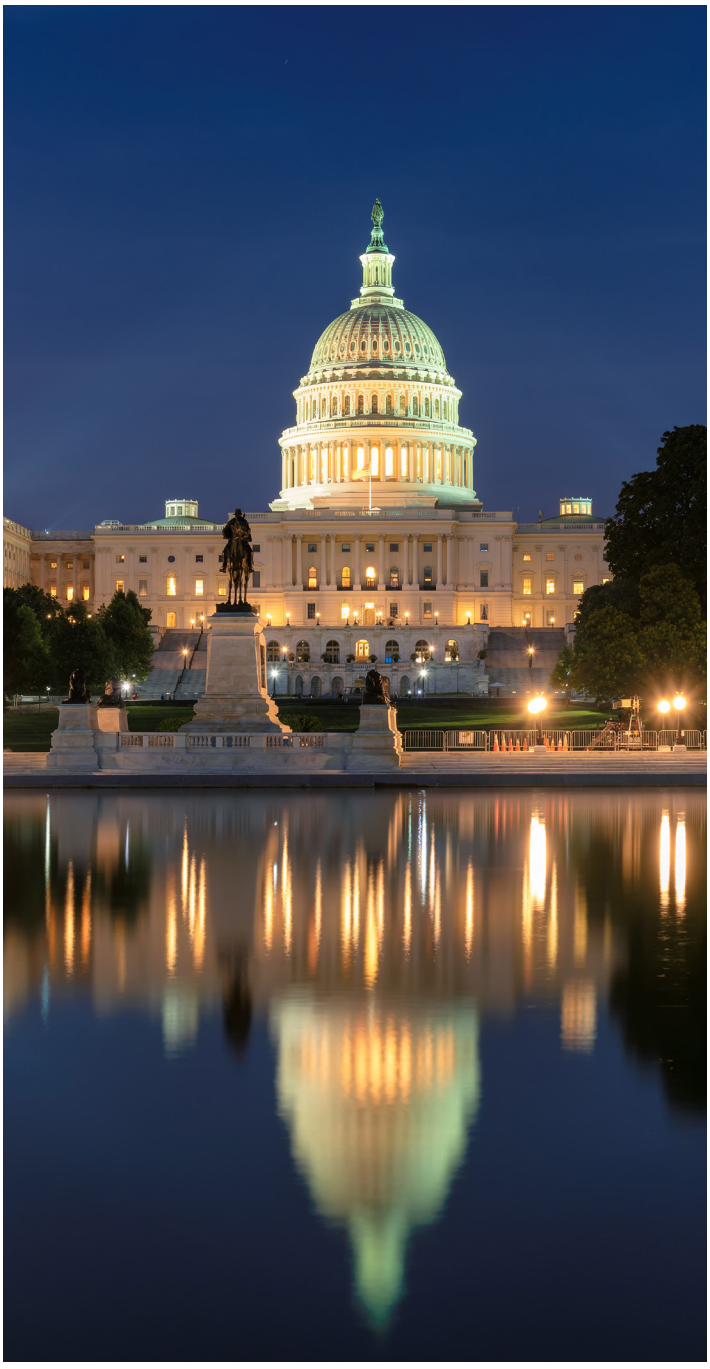
As of January 1, 2021, employees began contributing through payroll deductions to Connecticut's Family Leave Insurance Program or to an approved private plan. Beginning January 1, 2022, employees will be eligible for up to 12 weeks of paid family and medical leave and an additional two weeks of leave if a health provider determines the individual requires more recovery time in the event of incapacity due to birth or pregnancy, for a total of 14 weeks. Eligible employees will receive partial pay, defined as 95% of 40 times up to the state minimum wage (threshold) and 60% on earnings above the threshold to a state maximum to bond with a new child, care for a seriously ill family member, care for an employee's own serious health condition, for a qualifying exigency arising out of family member being on active duty, or to serve as an organ or bone marrow donor.

Employers should continue working with employment counsel, payroll processors, and approved private plan vendors to ensure they are complying. We will continue to monitor this issue as well and will keep employers updated as applicable.



District of Columbia Expands Paid Leave Benefits

The Universal Paid Leave Emergency Amendment of 2021 ("PLEAA") was enacted by the District of Columbia ("D.C.") Council on August 23, 2021. Beginning October 1, 2021, covered employees will have expanded paid leave benefits under D.C.'s existing paid leave statutes.



Background

D.C. currently has existing legislation which provide various forms of paid and unpaid leave for covered employees. These laws are as follows:

- The Universal Paid Leave Amendment Act of 2016 ("UPL") – Provides paid leave for parental, family and medical leave. A covered employee is eligible for up to a maximum of eight weeks of parental leave, six weeks of family leave, and two weeks of medical leave in a calendar year period. These benefits are administered through the District's Paid Family Leave program ("PFL").

- Family and Medical Leave Act of 1990 – Requires covered employers to allow up to sixteen weeks of unpaid leave during a 24-month period for qualifying family and medical leave.

Expanded Paid Leave

The PLEAA has made several significant amendments to the existing paid leave requirements under the UPL and PFL for covered employees. These amendments include:

- Added a new and separate category of paid leave in the form of "Prenatal leave" and provides two weeks of paid prenatal leave benefits, which is in addition to the eight weeks already provided for parental leave.

The eligible reasons for taking prenatal leave include:
- routine and specialty appointments,
- exams and treatments associated with a pregnancy provided by a healthcare provider,
- prenatal check-ups,
- ultrasounds,
- treatment for pregnancy complications,
- bedrest that is required or prescribed by a health care provider, and
- prenatal physical therapy

- Medical leave duration has been increased to six weeks (previously it was two weeks) and the definition of "qualifying medical leave" has been updated to include:
  - Miscarriage, and
  - Stillbirth

- While the combined maximum duration for benefits received in a single 52-week period generally remains at eight weeks, a covered employee may receive maximum benefits for both prenatal and parental leave, which will result in a maximum duration of ten weeks total paid leave duration.

- The PFL's one-week waiting period has been temporarily suspended, meaning that covered employees will be eligible for benefits immediately. This will remain in effect from October 1, 2021 through one year following the end of D.C.'s public health emergency.

- Benefits under the PFL can now be applied retroactively so long as a claim is filed within 30 days.

Expiration

As an emergency Act, the PLEAA will expire after 90 days, unless renewed. However, it is important to recognize that the Fiscal Year 2022 Budget Support Act contains identical provisions, which would make the amendments to the UPL and PFL permanent if enacted. The Budget Support Act is currently awaiting Congressional review.

Employer Action

- Await further guidance from the Mayor's Office (which is required to be released by October 31, 2021). This guidance will include an updated PFL poster which must be posted pursuant to the existing rules governing this requirement.

- Ensure that all personnel dealing with leave requests are familiar with the new requirements concerning Prenatal leave and the expanded eligibility reasons for medical leave.

WA Cares Fund Exemption Applications Now Open

On October 1, 2021, the window to apply for a permanent exemption from the Washington long-term care program opened.

As background, beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund" or "WA Cares Coverage"). WA Cares Fund will provide long-term care benefits to eligible Washington residents (up to $36,500). All wages are subject to the premium assessment; there is no cap.

If eligible, employees may apply to the Employment Security Division ("ESD") for an exemption from the premium assessment. If approved, the employee is permanently excluded from the state's long-term care coverage and benefits.

To qualify for a permanent exemption, an individual must:

- Have purchased a qualifying private long-term care insurance plan before November 1, 2021;
- Be at least 18 years of age; and
- Submit an exemption application to ESD.

Applications will be accepted through December 31, 2022. After that date, the application window is permanently closed. It should be noted that employers cannot apply for the exemption on behalf of employees.

ESD will review applications and notify individuals who are eligible for an exemption. The exemption will take effect the quarter after the application is approved by ESD.

Employees will need to provide current (and future) employers with a copy of the exemption approval letter to avoid the premium assessment.

Exemption Application

Employees can go to the WA Cares Fund website and click the button labeled "Apply for an Exemption" to start the process.

Notably, the following steps must be completed:

- **Create a SAW Account.** An employee will need to create a SecureAccess Washington (SAW) account by going to secureaccess.wa.gov and clicking the "SIGN UP!" button. An employee may already have SAW account related to other agency services (e.g., Department of Licensing).

- **Add Paid Family and Medical Leave to the Account.** If not already included, the employee will need to add Paid Family and Medical Leave as a new service in the account.

- **Add WA Cares Exemption Account.** Once logged into the Paid Family and Medical Leave section, there is an option to create a WA Cares Exemption Account.

- **Apply for the Exemption.** Once the WA Cares Exemption Account is created, the employee will apply for an exemption. Employees will need to answer some questions and upload proof of identity (e.g., valid driver's license or passport).

- **Await Approval.** Upon completion and submission, ESD will review the application and notify the employee if approved for an exemption.

While the online system went live on October 1, it subsequently went down for maintenance. It is possible that the website will continue to experience delays or systems issues as ESD manages the volume of applications.

Washington's Implementation of Federal No Surprises Act

Washington state's Balance Billing Protection Act ("BBPA") prohibits balance billing for certain emergency and non-emergency services provided by out-of-network ("OON") facilities or providers. The BBPA applies to:

- Fully insured, regulated health insurance plans (including group health plans), except grandfathered plans; and
- Plans offered to public employees.

While self-funded ERISA group health plans are not subject to the BBPA, employers sponsoring such arrangements may opt-in to BBPA balance billing protections.

The federal No Surprises Act ("NSA") was enacted as part of the Consolidated Appropriations Act, 2021 ("CAA") and takes effect for plan years that begin on or after January 1, 2022. The NSA also prohibits balance billing in certain circumstances and provides additional consumer protections in group health plans.

The NSA applies to all group health plans (including grandfathered plans, fully insured and self-funded plans).

With both a state and federal law offering protections around balance billing, there is confusion as to how these two laws will interact when both may apply. On November 1, 2021, the Washington Office of Insurance Commissioner ("OIC") released Technical Assistance Advisory 2021-05 providing guidance on implementation of the NSA.

Background

The BBPA became effective on January 1, 2020 and prevents some balance billing of insured individuals when OON facilities or providers bill patients for unpaid amounts if the patient's insurer does not pay the full billed amount. The BBPA provides the following balance billing protections:

- Prohibits an OON provider or facility from balance billing a covered individual for:
  - emergency services, and
  - non-emergency health care services when provided at an in-network facility if the services are provided by an OON provider and involve surgical or ancillary services (e.g., pathology, anesthesiology).
- Creates a mechanism for the carrier and the OON provider or facility to resolve payments. The carrier will pay the OON provider or facility a "commercially reasonable" amount, based on payments for the same or similar service in a similar geographic area. If the carrier and provider or facility cannot agree on a price for the covered services, they can go to binding arbitration, but they cannot bill the covered individual for the amount in dispute.

A notice of consumer rights must be made available by the provider to individuals describing the protection afforded by the BBPA. Individuals may not be asked to consent to a balance bill or waive the protections of the BBPA.

The NSA becomes effective January 1, 2022 and prohibits balance billing for:

- Emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved;
- Non-emergency services performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers); and
- Air ambulance services provided by OON providers.

The NSA also contains consumer protection provisions relating to:

- Transparency in coverage
- Price comparison tools
- Additional consumer disclosures on insurance ID cards
- Continuity of care
- Provider network directory accuracy
- Air ambulance reporting
- Prescription benefit and drug cost reporting

BBPA and NSA

The NSA preempts state laws only when those laws are less restrictive than the NSA. Based on this, where the OIC has authority, it will enforce the provisions of the NSA that are broader (i.e., require more) than the BBPA. This includes the following:

- Balance billing prohibitions that are broader than the BBPA scope of services including emergency post-stabilization care
- Prohibition on balance billing for grandfathered health plans
- Requirements for in-network cost sharing for individuals that relied on a provider directory maintained by the insurer indicating a provider was in-network
- Prohibitions on balance billing for continuation of care patients for 90 days after a provider becomes OON
- Cost sharing calculations for individuals and dispute resolution for
  - coverage under grandfathered health plans
  - services covered by the NSA (but not BBPA) – for example, non-emergency neonatology and intensivists
- External review requirements to determine if balance billing protections are applicable
- Consumer disclosures on insurance ID cards
- Disclosure requirements to enrollees regarding balance billing protections

In some respects, the BBPA requires more than the NSA. Therefore, certain provisions of the BBPA (not found in the NSA) will remain in effect, including:

- Prohibitions on individual consent to waive balance billing protections
- Notice requirements regarding whether a health plan is subject to BBPA
- Notice requirements indicating whether a claim was processed in accordance with the BBPA
- Provider directory requirements
- BBPA methods for cost-sharing calculations and dispute resolution for OON provider payments
- Transparency tools for price and quality information
- Enrollee notification requirements upon provider termination by a health carrier

Deferred Enforcement

OIC authority extends over insurance carriers and fully insured group health plans as well as self-funded plans that opted into BBPA protections. Accordingly, OIC will defer enforcement against some entities and of some NSA provisions to align with enforcement deferrals announced by the Departments.

The entities against which OIC will not take enforcement action include:

- Air ambulance services
- Self-funded group health plans that did not opt-in to the BBPA (the Departments will be responsible for enforcement)
- Health services providers and facilities

The OIC will defer enforcement of the following NSA provisions:

- Price comparison tools availability requirements deferred until plan years beginning on or after January 1, 2023
- Advance EOB requirements pending additional regulations by the Departments

Model Notice

The OIC developed a revised standard template to serve as a single notice of consumer rights under both the BBPA and NSA. The notice should be provided to enrollees in any communication that authorizes non-emergency surgical or ancillary services at an in-network facility. Employers sponsoring fully insured group health plans or self-funded group health plans that opted-in to the BBPA should use the new notice beginning January 1, 2022.

Draft Legislation to Align BBPA and NSA Requirements

The OIC has also requested legislation to align the BBPA with the NSA to avoid unnecessary confusion from the overlapping provisions of the laws as well as reducing administrative costs for service providers and insurers. The implementation of the NSA described in Technical Advisory 2021-05 would be applicable until this draft legislation becomes law. It is expected that the legislature will take up this matter in the 2022 session.

The proposed legislation would:

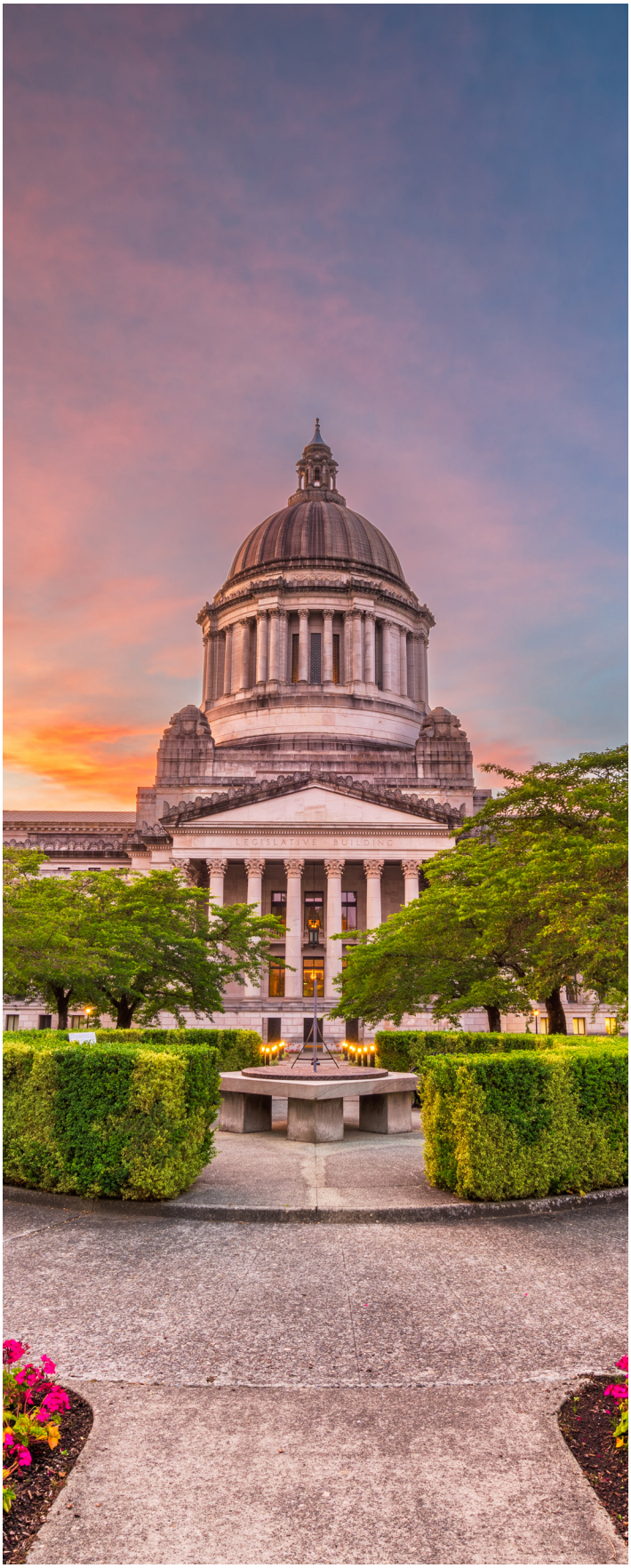
- Add behavioral health emergency facilities as emergency services providers;
- Require coverage of behavioral health emergency services and crisis services at certain facilities without prior authorization;
- Expand the scope of BBPA balance billing protections to align with NSA including post stabilization and non-emergency, non-ancillary services at in-network facilities;
- Aligns dispute resolution process for fully insured and self-funded group health plans;
- Clarifies that OON payment provisions of BBPA and NSA will not satisfy OIC network adequacy standards;
- Clarifies OIC authority to enforce all provisions of the NSA and CAA; and
- Preserves prohibition of informed consent to waive balance billing protections.

Employer Next Steps

Employers sponsoring fully insured plans should be able to rely on their carriers for compliance with the balance billing protections of the BBPA and NSA but may need to confirm that other requirements, such as those related to consumer protections will be satisfied. For example, this may include confirming insurance ID card disclosures, continuity of care protections, and provider network accuracy provisions have been implemented.

Employers sponsoring a self-funded arrangement will be required to comply with the NSA effective for the first plan year that begins on or after January 1, 2022. Further, employers sponsoring ERISA self-funded plans that have opted into the BBPA should work with TPAs to confirm compliance with all aspects of the BBPA and NSA and that TPAs are monitoring for additional guidance as it becomes available.

We will continue to monitor for developments related to these requirements.



Washington Increases Paid Family and Medical Leave Premium

The Washington Employment Security Department ("ESD") announced an increase in the premium rate for Washington Paid Family and Medical Leave ("WA PFML"). The premium rate will increase to 0.6% of employee wages up from the current 0.4%. The increase is effective for the first quarter of 2022 and should be reflected in contributions and reporting for all pay dates on or after January 1, 2022.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family leave through the state insurance fund or an approved voluntary plan that may be insured or self-funded. On January 1, 2019, Washington began collecting premiums to fund the program. Premiums are funded by employee and employer contributions based on employee wage up to the social security cap ($142,800 in 2021). Employers have also been required to report employee wages and hours when premiums are remitted to ESD.

2022 Premium Changes

Effective for payrolls on or after January 1, 2022:

- the premium amount is increasing to 0.6% of employee wages.
- the wages subject to premiums are increasing to $147,000 to reflect the higher social security wage cap for 2022.
- the employer portion of the premium is being reduced to 26.78% and the employee portion is increasing to 73.22% to reflect actual usage of the available family and medical leave benefits.

Employers with fewer than 50 employees are not required to contribute the employer portion.

EXAMPLE of annual premium amount for an employee earning $75,000 in 2021 and 2022

- Total annual premium in 2021: $75,000 x 0.4% = $300.00
  - Employee cost: $189.99
  - Employer cost: $110.01
- Total annual premium in 2022: $75,000 x 0.6% = $450.00
  - Employee cost: $329.49
  - Employer cost: $120.51

Note – Beginning January 1, 2022, ESD will be updating the reporting system for paid leave and Washington Cares Fund so that employers can report and pay employee premiums for both WA PMFL and WA Cares Fund at the same time. The WA Cares Fund premiums are paid by employees via payroll deductions.

Employer Action

Employers should confirm their payroll systems are prepared to deduct the new rates from employee paychecks beginning on January 1, 2022. Employers that do not increase employee deductions to reflect the correct amount will not be able to recover any amounts from employees with catch-up deductions from later payrolls but will still be required to contribute the higher premiums.

Washington State PAL Assessment Initial Amount Released

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL Assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021.

On October 1, 2021, WAPAL Fund issued the 2022 WAPAL Fund monthly assessment rate. The monthly assessment rate is based on the number of covered lives each month and may be adjusted in the future depending on funding needs. The 2022 monthly assessment rate is $0.13 per covered life per month.

The PAL Assessment applies to "assessed entities" – defined to mean:

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

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services. The first covered lives report and payment deadline is November 15, 2021 for the months of July, August and September 2021.

Example. If a self-funded group health plan has 1,000 covered lives for the months of July, August and September 2021, the PAL assessment for the quarter is $390.

As a reminder, assessed entities are required to register on the WAPAL Fund website (www.wapalfund.org) to create an account to file covered lives reports. Covered lives reports are filed on a quarterly basis to receive an invoice for the quarterly assessment before the payment deadline. Generally, the payments are due 45 days after the end of the quarter as follows:

- March 31: payment due May 15
- September 30: payment due November 15
- June 30: payment due August 15
- December 31: payment due February 15

Carriers are responsible for this assessment for fully insured health plans. Employers sponsoring self-funded health plans are generally responsible for the assessment; however, third-party administrators ("TPAs") may provide assistance with reporting and paying the assessment.

Employer Action

No employer action required if health plan coverage is insured.

Employers sponsoring self-funded plans should work with their TPAs to confirm their plan is registered and prepared to file the covered lives report and pay the assessment. Once the invoice for the payment due has been received, payments can be made by check via U.S. Mail or by ACH at the choice of the payer.