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2022 YEAR IN REVIEW

Compliance Digest

COMPLIANCE BULLETINS
RELEASED JANUARY - DECEMBER

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2022 Compliance Bulletins

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New PCOR Fee Announced

Published: January 11, 2022

On December 21, 2021, the IRS released Notice 2022-04, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2021 and before October 1, 2022 is $2.79.

The PCOR filing deadline is August 1, 2022 for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2021. Carriers are responsible for paying the fee for insured policies.

2022 Form 720, due August 1, 2022:

Plan Year	Amount of PCOR Fee
February 1, 2020 – January 31, 2021	$2.66/covered life/year
March 1, 2020 – February 28, 2021	$2.66/covered life/year
April 1, 2020 – March 31, 2021	$2.66/covered life/year
May 1, 2020 – April 30, 2021	$2.66/covered life/year
June 1, 2020 – May 31, 2021	$2.66/covered life/year
July 1, 2020 – June 30, 2021	$2.66/covered life/year
August 1, 2020 – July 31, 2021	$2.66/covered life/year
September 1, 2020 – August 31, 2021	$2.66/covered life/year
October 1, 2020 – September 30, 2021	$2.66/covered life/year
November 1, 2020 – October 31, 2021	$2.79/covered life/year
December 1, 2020 – November 30, 2021	$2.79/covered life/year
January 1, 2021 – December 31, 2021	$2.79/covered life/year

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in Summer 2022 of the fee and additional information for filing and paying the PCOR fee with the IRS.

Guidance Issued on Broker Compensation Disclosure

Published: January 11, 2022

As reported earlier, beginning December 27, 2021, covered service providers (brokers and consultants) of ERISA-covered group health plans, regardless of size, must provide responsible plan fiduciaries information on direct and indirect compensation in writing.

On December 30, 2021, the DOL released Field Assistance Bulletin No. 2021-03, which provides guidance on this new broker transparency law. While many questions remain unanswered, there is some helpful relief and clarification. The following summarizes the key points.

Good Faith Relief

The DOL indicated that it expects that covered service providers will adopt various methods to make the required disclosure regarding their services and compensation in a way that complies. It will not treat them as having failed to make required disclosures to a responsible plan fiduciary as long as the person makes disclosures in accordance with a good faith, reasonable interpretation of the law. The DOL further indicated that a good faith and reasonable step for a group health plan service provider would be to take into account the DOL's guidance on its regulation for pension plans, as applicable.

Covered Benefits

The covered group health plans include both insured and self-insured group health plans, including grandfathered health plans and stand-alone dental and vision benefits, but do not include qualified small employer health reimbursement arrangements. A covered group health plan also includes "excepted benefits" that are group health plans. While not expressly called out, this likely includes certain excepted benefits like EAPs and onsite clinics.

Effective Date

Only contracts or arrangements for services which are entered into, extended, or renewed on or after December 27, 2021 are required to comply with the disclosure requirements. The date on which a contract or arrangement is entered into between a broker and a plan fiduciary is considered to be the date the contract or arrangement was "executed." For example, if a plan fiduciary enters into a new service contract with a broker on December 15, 2021 for the plan year beginning on January 1, 2022, the service contract will be treated as having been "executed" on December 15, 2021, which is prior to December 27, 2021, so that the contract is not subject to the new compensation disclosure requirements.

Also, pending further guidance, in the case of a broker that enters into a contract or arrangement with a plan fiduciary through use of a broker of record ("BOR") agreement, the date the contract or arrangement will be considered entered into is the earlier of:

- the date on which the BOR agreement is submitted to the insurance carrier; or
- the date on which a group application is signed for insurance coverage for the following plan year provided that the submission or signature is done in the ordinary course and not to avoid its disclosure obligations.

Unknown Compensation

ERISA Sec. 408(b)(2)(B) requires covered service providers to make the required disclosures to responsible plan fiduciaries reasonably in advance of the date they enter

into a contract or arrangement with a covered group health plan. The DOL recognizes that covered service providers may be unable to state with precision the amount of compensation they expect to receive for services, because the methodology by which certain components of their compensation is determined will depend on decisions or variables that are not known before, or even at the time, the contract or arrangement is entered into and, in fact, may change over the term of the contract or arrangement. The DOL takes the view that disclosure of compensation in ranges may be reasonable in circumstances when the occurrence of future events or other features of the service arrangement could result in the service provider's compensation varying within a projected range. The DOL indicates that the following language in the preamble to the DOL's final regulation for covered service provider disclosures to pension plan fiduciaries is relevant:

> *… such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue. To ensure that covered service providers communicate meaningful and understandable compensation information to responsible plan fiduciaries whenever possible, the DOL cautions that more specific, rather than less specific, compensation information is preferred whenever it can be furnished without undue burden.*

No matter the methodology used to disclose compensation, the adequacy of the disclosure should be measured against a principal objective of the statutory provision which is to provide the responsible plan fiduciary with sufficient information about the compensation to be received by covered service providers to allow the fiduciary to evaluate the reasonableness of the compensation, and the severity of any associated conflicts of interest. The duties of prudence and loyalty in ERISA Sec. 404 apply to a responsible plan fiduciary's decisions to hire service providers and to monitor service provider arrangements. What constitutes adequate disclosure for a specific compensation arrangement will depend on the facts and circumstances of the service contract or arrangement.

Covered Service Providers

The bulletin confirms that the definition of a covered service provider is not limited to service providers who are licensed as or who market themselves as "brokers" or "consultants." Pending further guidance, the DOL's enforcement policy will apply to parties who reasonably and in good faith determine their status as a covered service provider. Whether a person acts reasonably and in good faith depends on the facts of the particular situation. Service providers who reasonably expect to receive indirect compensation from third parties in connection with advice, recommendations, or referrals regarding any of the listed services in footnotes 1 and 2 should be prepared, if the DOL is auditing their compliance, to be able to explain how a conclusion that they are not covered service providers is consistent with a reasonable good faith interpretation of the statute.

Future Guidance

The DOL does not believe that comprehensive implementing regulations are needed. However, the department will monitor feedback from stakeholders to assess whether additional guidance may be necessary to assist covered service providers and plan fiduciaries in complying with the new disclosure requirements.

Guidance Issued Expanding Coverage for COVID-19 Testing

Published: January 14, 2022

On January 10, 2022, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ Part 51 requiring group health plans to cover, without cost-sharing, over-the-counter ("OTC") COVID-19 diagnostic tests obtained without the involvement of a health care provider. This provision is effective for OTC COVID-19 tests purchased on or after January 15, 2022, and continues for the duration of the Public Health Emergency (currently set to expire January 16, 2022 – however another 90-day extension is expected).

Briefly:

- Group health plans (and health insurance carriers) must cover diagnostic OTC COVID-19 tests obtained without the involvement of a health care provider without cost-sharing, prior authorization, or other medical management requirements.
- Plans can either reimburse members for their OTC COVID-19 test purchases after manually submitting a claim, or the plan may arrange to pay the merchant directly ("direct coverage") allowing plan members to receive the OTC COVID-19 tests with no cost sharing at the point-of-sale.
    - If the plan provides direct coverage, reimbursement for OTC COVID-19 tests purchased outside a preferred network may be limited to the lesser of $12/test or the actual cost of the test.
    - Plans that do not provide for direct coverage must reimburse the individual for the full cost of the test.
- Plans must cover 8 individual at-home OTC COVID-19 tests per person enrolled in the plan per month. That means a covered family of 4 can obtain 32 tests per month for free.
- Plans are not required to cover the cost of OTC COVID-19 tests for employment and surveillance purposes.

Frequently Asked Questions

Q: Are group health plans required to cover OTC COVID-19 tests without an order or individualized clinical assessment by a health care provider?

A: Yes. Beginning January 15, 2022, group health plans (and health insurance carriers) must cover diagnostic OTC COVID-19 tests obtained without the involvement of a health care provider without cost-sharing, prior authorization, or other medical management requirements.

Under the existing law, diagnostic OTC COVID-19 tests are covered without cost-sharing when an individual has an order or individualized clinical assessment from a health care provider. Such coverage remains in effect. The limits described in this article as they relate to OTC COVID-19 tests obtained without a health care provider (e.g., 8 tests/month, $12/test when direct coverage is an option) do not

apply when an individual has an order or individualized clinical assessment from a health care provider.

Q: How is the coverage provided?

A: Plans and carriers may choose whether to provide "direct coverage" for OTC COVID-19 tests to participants by reimbursing sellers directly without requiring individuals to provide upfront payment or require participants to purchase the OTC COVID-19 test and then submit a claim for reimbursement from the plan.

The Departments strongly encourage plans and carriers to adopt a "direct coverage" approach.

Q: What is "direct coverage"?

A: Direct coverage for OTC COVID-19 tests means that a participant is not required to submit a claim to seek reimbursement from the plan for the purchase of the test. Instead, the plan makes systems and technology changes necessary to process the plan's payment to the preferred pharmacy or retailer directly (including direct-to-consumer shipping programs) with no upfront out-of-pocket expenditure.

A plan must take reasonable steps to ensure that participants have sufficient access to OTC COVID-19 tests, through an adequate number of retail locations (including both in-person and online). Whether there is adequate access should be determined based on all relevant facts and circumstances, such as the locality of participants under the plan and current utilization of the plan's pharmacy network. Plans should communicate with members to ensure that participants are aware of key information needed to access OTC COVID-19 tests, such as dates of availability of the direct coverage program and participating retailers or other locations.

If the plan is unable to meet the requirements of the direct coverage safe harbor, the plan must provide for the full reimbursement of OTC COVID-19 tests. This may occur, for example, when there are substantial delays for obtaining a COVID-19 test through a direct-to-consumer shipping program versus obtaining other items through this same program.

Q: Can the plan limit coverage only to OTC COVID-19 tests that are provided through preferred pharmacies or other retailers?

A: No. Generally, a plan or carrier may not limit coverage only to tests that are provided through preferred pharmacies and other retailers.

A plan that provides for direct coverage of OTC COVID-19 tests in accordance with the guidance may limit reimbursement for OTC COVID-19 tests from non-preferred pharmacies and other retailers to the lesser of (1) the actual price, or (2) $12/test.

Example:

Plan provides direct coverage

If a plan has set up a network of preferred stores, pharmacies, and online retailers at which a participant can obtain a test with no out-of-pocket expense at the point-of-sale, the participant can still obtain tests from other retailers outside of that network. The plan may reimburse at a rate of up to $12 per individual test (or the cost of the test, if less than $12).

Plan does not provide direct coverage

If a plan has not set up a network of preferred stores, pharmacies, and online retailers at which a participant can obtain a test with no out-of-pocket expense at the point-of-sale, the participant will be reimbursed the full cost of the test. For example, the participant buys a two-pack of tests for $34, the plan would reimburse $34 (as opposed to $24 had the plan set up a network for individuals to obtain the test without an out-of-pocket expense).

Q: How many OTC COVID-19 tests must the plan provide without cost-sharing?

A: A plan or carrier may limit the number of OTC COVID-19 tests purchased by a participant without the involvement of a health care provider to no less than 8 tests per 30-day period (or per calendar month). For a covered family of 4, this means the plan must provide for up to 32 tests in a month.

Q: What is the effective date?

A: Plans and carriers are required to cover OTC COVID-19 tests purchased on or after January 15, 2022. Plans and carriers may, but are not required to, provide such coverage for OTC tests purchased before January 15, 2022.

The guidance confirms that the non-enforcement relief for mid-year changes to an SBC remains available with respect to this change.

Q: Are plans permitted to address suspected fraud or abuse?

A: Yes. Plans and carriers may take reasonable steps to prevent, detect, and address fraud and abuse.

For example, a plan may require:

- An attestation that the OTC COVID-19 test was purchased by the participant for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.

- Documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test (e.g., the UPC code for the OTC COVID-19 test and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC COVID-19 test).

Q: Are plans required to cover OTC COVID-19 tests that are for employment purposes?

A: No. Consistent with earlier guidance, plans are not required to provide coverage of testing (including an OTC COVID-19 test) that is for employment purposes.

Q: How can plans facilitate access to, effective use of, and prompt payment for OTC COVID-19 tests?

A: Plans and carriers may provide education and information resources to support consumers seeking OTC COVID-19 testing, provided the resources make clear that the plan or carrier provides coverage for, including reimbursement of, all OTC COVID-19 tests under the guidance. This may include:

- information on the difference between OTC COVID-19 tests and other tests ordered by a provider or processed in a laboratory,

- quality and reliability information for specific testing products,

- how to obtain a test directly from the plan without cost-sharing (the direct coverage option, if applicable), and

- how to submit a claim (paper or electronically) and receive reimbursement directly from the plan.

Employer Action

Employers should:

- Discuss this expanded coverage with their carriers and TPAs, including whether the carrier or plan will provide for direct coverage of OTC COVID-19 tests.

- Consider notifying participants of the expanded coverage and how to obtain free OTC COVID-19 tests.

Supreme Court Effectively Ends OSHA Vaccination Emergency Temporary Standard

Published: January 18, 2022

In a 6-3 decision issued on January 13, 2022, the Supreme Court reimposed a legal stay that prevents OSHA from enforcing its vaccination Emergency Temporary Standard (ETS). And while the matter is being sent back to the 6th Circuit Court of Appeals for further review, the conclusions drawn by the Court almost certainly means the end of the ETS.

How did we get here?

The ETS was formally published on November 5, 2021, with initial compliance dates of December 5, 2021, and January 4, 2022. Shortly thereafter, the 5th Circuit Court of Appeals issued a legal stay that put the ETS on pause and temporarily prevented OSHA from enforcing it. There were numerous legal challenges to the ETS, which were quickly consolidated and given to the 6th Circuit Court of Appeals for adjudication. The 6th Circuit lifted the legal stay and allowed OSHA to move forward with enforcement. In response, OSHA issued new compliance dates of January 10, 2022, and February 9, 2022, while the case was appealed to the Supreme Court.

What did the Supreme Court say?

The primary question before the Supreme Court was whether the scope of the vaccine ETS exceeded the statutory authority given to OSHA to issue emergency temporary standards. The Court started its analysis by acknowledging that OSHA has the power to regulate occupational risks and dangers. It then asked the question whether the ETS targeted occupational hazards, or whether it was actually regulating public health more broadly, which would exceed OSHA's authority. While the court recognized that OSHA has the power to regulate COVID-19 risks in environments that may be uniquely susceptible to transmission (such as COVID-19 research labs, cramped workspaces, etc.), it concluded that the breadth of the ETS went beyond clearly identifiable occupational hazards, and thus was tantamount to an impermissible public health measure:

Although COVID-19 is a risk that occurs in many workplaces, it is not an occupational hazard in most. COVID-19 can and does spread at home, in schools, during sporting events, and everywhere else that people gather. That kind of universal risk is no different from the day-to-day dangers that [we] all face from crime, air pollution, or any number of communicable diseases. Permitting OSHA to regulate the hazards of daily life—simply because most Americans have jobs and face those same risks while on the clock—would significantly expand OSHA's regulatory authority without clear congressional authorization.

As a result, the Court decided that the parties opposing the ETS "are likely to succeed on the merits of their claim that [OSHA] lacked authority to impose the mandate", so it reimposed the stay and sent the matter back down to the 6th Circuit for further review of the merits of the case. However, the Supreme Court's reasoning and analysis all but ensures that the 6th Circuit will come to the same conclusion.

What does this mean for employers?

Employers will no longer have to comply with the ETS, which means that they will now have greater latitude to decide what COVID-related practices are best for their workplaces. Employers that have already started complying with the provisions of the ETS can continue to do so, if they choose, or they can discontinue some or all of the measures they've adopted at this point. Employers that

were holding off on compliance while waiting for the Supreme Court's decision will now have to decide whether they want to modify any of their existing safety practices. As employers make these decisions, a few things should factor into the consideration process:

- The Supreme Court's focus was on whether OSHA exceeded its statutory authority, which has nothing to do with what workplace practices individual employers can choose to adopt. As a result, the decision does not impact the vaccination, testing, and masking practices options that employers can choose from.

- OSHA still has authority under its General Duty Clause to inspect and penalize what it considers to be unsafe COVID-related practices, although its scope and power under the General Duty clause is much narrower than under the ETS. Indeed, in response to the Supreme Court's decision, OSHA has put employers on notice of its continuing commitment to address COVID-19 safety in the workplace:

  Regardless of the ultimate outcome of these proceedings, OSHA will do everything in its existing authority to hold businesses accountable for protecting workers, including under the COVID-19 National Emphasis Program and General Duty Clause.

- States that have approved state OSHA programs could independently choose to pursue implementation of their own versions of the ETS, and even states without their own OSHA programs may have Departments of Health or other agencies that have made specific recommendations for COVID-related workplace safety practices.

- Employers covered by the vaccination mandates imposed on federal contractors (the federal contractor mandate) and certain recipients of Medicare and/or Medicaid funds (the CMS mandate) may still have to comply with those requirements, since in a separate opinion the Supreme Court upheld the CMS mandate and is expected to eventually weigh-in on the federal contractor mandate.

In other words, the ETS was not the only variable that might influence employer practices, which means that employers should be mindful as they decide what COVID-related practices to adopt going forward. In doing so, it will be important to work with trusted advisors and vendors to help make the best decisions for each workplace.

HHS Extends Public Health Emergency until April 16, 2022

Published: January 21, 2022

On January 14, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective January 16, 2022. 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 April 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.

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

Employers, insurers and other coverage providers must:

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

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

Background

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

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

Required Forms

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

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

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

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

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

Employers with Fully Insured Coverage

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

Employers with Self-Insured Coverage

The employer files with the state a fully completed 1095-C, 1095-B or NJ-1095 form for each primary enrollee (employee, COBRA participant, retiree, non-employee

member) covered under the plan for at least one month of the calendar year and furnishes a form to NJ residents.

Employers Participating in a Multiemployer Arrangement

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

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

Employer Action

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

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

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

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

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.

- **Over-The-Counter ("OTC") COVID-19 Testing:** Beginning January 15, 2022 all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

- **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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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.

DOL Penalties Increase for 2022

Published: January 26, 2022

The Department of Labor (DOL) published the annual adjustments for 2022 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2022

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

Description	2022 Penalty (New)	2021 Penalty (Old)
Failure to file Form 5500	Up to $2,400 per day	Up to $2,259 per day
Failure of a MEWA to file reports	Up to $1,746 per day	Up to $1,644 per day
Failure to provide CHIP Notice	Up to $127 per day per employee	Up to $120 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$127 per day per violation (per participant/beneficiary)	$120 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,264 per failure	Up to $1,190 per failure
Failure to furnish plan documents (including SPDs/SMMs)	$171 per day $1,713 cap per request	$161 per day $1,613 cap per request
Genetic information failures	$127 per day (per participant/beneficiary)	$120 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,192 minimum	$3,005 minimum
Failure to meet genetic information requirements – not de minimis failures	$19,157 minimum	$18,035 minimum
Cap on unintentional failures to meet genetic information requirements	$638,152 maximum	$601,152 maximum

Employer Action

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

Additional Guidance Addresses ACA Preventive Care Mandate

Published: January 31, 2022

As part of FAQ 51, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued guidance clarifying several Affordable Care Act ("ACA") preventive care coverage issues applicable to non-grandfathered group health plans.

As background, non-grandfathered group health plans must cover certain in-network preventive care items and services without cost-sharing.

FAQ 51 addresses preventive care requirements that relate to colonoscopies and coverage for female contraceptives as follows:

- Colonoscopy coverage. For plan years that begin on or after May 31, 2022, a group health plan (or carrier) must cover without any cost-sharing a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography).

- Contraceptives. The Departments have received a number of complaints and reports that covered individuals are being denied otherwise mandated contraceptive coverage. Examples include: denying brand name contraceptives when the provider determines the product is medically necessary for the individual, imposing onerous fail-first requirements before the plan will cover a medically necessary contraceptive product, and failing to provide an easily accessible, transparent and expedient exception process that is not unduly burdensome.

The Departments are reminding plans to comply with the contraceptive services coverage requirements. This includes the requirement that, if an individual and their attending provider determine that a particular service or FDA-approved, cleared, or granted contraceptive product is medically appropriate for the individual (whether or not the item or service is identified in the current FDA Birth Control Guide), the plan or issuer must cover that service or product without cost sharing.

The Departments are actively investigating complaints and may initiate enforcement or other corrective measures.

Employer Action

Employers should ensure their plans will comply with the additional coverage requirements for colonoscopies effective for plan years that begin on or after June 1, 2022. Plans should also review coverage of contraceptive services considering the Departments latest FAQ.

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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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.

Guidance Issued on New York Paid Sick Leave

Published: February 07, 2022

On December 22, 2021, the New York Department of Labor ("NYDOL") issued guidance in response to stakeholder comments about the New York Sick Leave Law ("NYSLL"). This guidance provides clarity on a variety of implementation topics and does not alter or amend prior NYSLL regulations issued in December 2020.

Background

All New York employers are subject to the NYSLL. The amount of sick leave that must be made available is determined based on the size of the employer as follows:

- Employers with less than 100 employees nationwide will be required to provide up to 40 hours of paid sick time per calendar year, although unpaid sick leave is required for employers with fewer than five employees and income less than $1 million in the prior tax year.

- Employers with 100 or more employees nationwide will be required to provide 56 hours of paid sick time per calendar year.

Employees will accrue 1 hour of sick time for every 30 hours worked and begin to accrue hours toward sick leave beginning as of their date of hire. Sick time may be used for an employee's own, or a family member's mental or physical illness, preventive care or care and services related to domestic violence.

Recent Guidance

Summarized below are highlights from the recent guidance to address stakeholder comments:

- All employees of the employer nationwide are to be considered in determining employer size for the application of the NYSLL, although sick leave rights only apply to employees in New York state.
- Employees may carry-over an unlimited number of unused sick leave hours to the following year. Employers however are permitted to limit the leave taken in any year to the maximum amount required to be provided to such employee (e.g., 40 hours for midsized employers and 56 hours for large employers).
- While the statute requires that employers carry over unused sick leave to the next calendar year, employers have the option to: (1) give employees the choice to voluntarily elect to use and receive payment for paid sick leave prior to the end of a calendar year or carry over unused sick leave; or (2) only allow employees to carry over unused sick leave.
- Employees must be allowed to use sick leave time upon accrual of the sick leave hours. No additional waiting period may be imposed. Employers that front-load sick time hours must permit newly hired employees to utilize their sick leave at date-of-hire.
- An employer may not deny an employee leave while attempting to confirm the basis for the leave. If the employer discovers the request to be false or fraudulent, disciplinary action may be taken against the employee. Employers are cautioned to not penalize or otherwise retaliate against an employee for submitting such a request or attestation.
- The NYDOL does not believe a documentation requirement for leave less than three days is necessary for investigation into potential employee abuse of sick leave and otherwise believes documentation requirements are sufficient.
- The NYDOL intends to publish a template that employees may use to attest to the need for sick leave

Employer Action

Employers with New York employees should review the latest guidance and work with counsel to ensure adherence to the sick leave statute, implementing regulations and the latest guidance.

State Health Coverage Reporting Requirements for CY 2021

Published: February 08, 2022

The IRS has made permanent an automatic 30-day extension to March 2, 2022 for furnishing Affordable Care Act ("ACA") Forms 1095-C (or 1095-B) to full-time employees and other individuals to demonstrate proof of health insurance coverage for each month in the 2021 calendar year ("CY"). Form 1094-C and all Forms 1095-C for the prior CY must be furnished to the IRS by March 31 each year (unless eligible for paper filing, then by February 28).

For ACA compliance, the IRS permits insurance carriers to post information on their website how plan members may access and receive a copy of the Form 1095-B in lieu of automatically mailing (or electronically issuing) statements to plan members. Insurance carriers must still prepare Forms 1095-B and file these forms with the IRS no later than March 31, 2022.

Currently five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia have enacted individual health insurance mandates with their own requirements for:

- furnishing information regarding health insurance coverage to residents of the state, and
- filing that information with certain state agencies.

These requirements and deadlines may (or may not) align with the federal requirements. Below is a chart summarizing the important deadlines related to 2021 coverage for employers with employees in individual mandate states. Some of these deadlines may change as states consider whether to extend relief similar to federal reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2022	March 31, 2022. No penalties will be assessed if filed by May 31, 2022
District of Columbia	March 2, 2022	April 30, 2022 (30 days after federal deadline)
Massachusetts	January 31, 2022	January 31, 2022
New Jersey	March 2, 2022	March 31, 2022
Rhode Island	January 31, 2022	March 31, 2022
Vermont	N/A	N/A

Important issues to consider regarding furnishing and issuing state-level MEC information are as follows:

- State residents: Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.

- Employers with fully insured plans: Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency. The District of Columbia also has reporting obligations for certain employers sponsoring fully insured plans. It is important to note that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.

- Employers with fully insured plans issued out-of-state: Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.

- Employers with self-funded plans: Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state individual mandate reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.

Allegheny County, Pennsylvania Implements New Paid Sick Leave Requirements

Published: February 11, 2022

On September 14, 2021, the Allegheny County Council passed the Allegheny County Sick Leave Ordinance ("the Ordinance"). The new paid leave rules will require covered employers to allow up to 40 hours per year of paid sick leave to eligible employees. The Ordinance was effective as of December 15, 2021, with fines for violations suspended until December 15, 2022.

Who is Covered by the Ordinance?

Covered employers are defined broadly to include any entity (public or private) situated or doing business within Allegheny County which employs at least one or more compensated employees. Only employers with 26 or more employees (performing services anywhere) are required to provide paid leave. In making this determination, all employees, excluding the owner(s) should be counted. Part-time employees should be counted as one employee rather than as a fraction of an employee.

What Individuals are Eligible for Paid Leave?

The Ordinance applies to all part-time and full-time employees performing compensated services for the employer within Allegheny County. Independent contractors, state and federal employees and seasonal employees, and members of a construction labor union covered by a collective bargaining agreement are not eligible.

How are Leave Benefits Accrued?

Beginning December 15, 2021, current employees must be permitted to accrue at least one (1) hour of paid sick leave for every 35 hours worked within Allegheny County, up to a maximum of 40 hours of paid sick leave in a calendar year. Employees hired after December 15, 2021, will begin accruing leave as of their date of hire. Employees must be allowed to carry over accrued, unused paid sick leave from one calendar year to the next calendar year; however, employers are not required to permit carryover where the employer front-loads 40 hours of paid sick leave at the beginning of each calendar year.

When Can Paid Sick Leave be Used?

Covered employees may use accrued sick leave beginning on the 90th calendar day following their date of employment. Accrued sick leave may be used for any of the following reasons:

- An employee's own mental or physical illness, injury, or health condition, including diagnostic, treatment, and preventive medical care for the illness, injury, or health condition;
- Care of a family member with a mental or physical illness, injury, or health condition including diagnostic, treatment, and preventive medical care for the illness, injury, or health condition;
- Closure of the employee's place of business by order of a public official due to a public health emergency;
- An employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; and
- Care for a family member when it has been determined by the health authorities having jurisdiction over or by a health care provider that the family member's presence in the community would jeopardize the health of others because of the family member's exposure to a communicable disease, whether or not the family member has actually contracted the communicable disease.

How is Paid Leave Requested?

Covered employees must request paid sick leave from their employers.

- Where possible, the request must include the anticipated duration of the leave.
- An employer may require reasonable advance notice (not to exceed 7 days) of a leave request where the need for the use of paid leave can be foreseen by the employee (for example, a previously scheduled appointment with a health care provider). Where 7-days advance notice is not possible, employees must give notice as soon as possible.
- Where the need for sick leave is foreseeable, the employee must make a reasonable effort to schedule the use of such leave in a manner not unduly disruptive to the employer's operations.
- For paid leave lasting 3 or more days, an employer may require reasonable documentation to prove that the paid leave was used for a permissible purpose.

Can an Employer Substitute Other Paid Leave to Meet the Ordinance's Requirements?

Yes. An employer that provides covered employees with other forms of paid sick leave, such as PTO, that meets the requirements of the Ordinance (including accruals, reasons for leave, and other conditions) will not be required to provide additional paid sick leave.

Are Employers Required to Distribute a Notice to Covered Employees?

Yes. Employers must give written notice (in English, Spanish, and any other primary language used in the workplace) to covered employees. This notice must include:

- the employees' entitlement to leave;
- the amount of paid sick leave;
- the terms of its use;
- the prohibition against retaliation for the use of paid leave; and
- that each employee has a right to file a complaint for any violation or denial of sick leave by an employer.

This notice should be displayed in a conspicuous and accessible location at the worksite or, if working remotely, the notice may be provided on an individualized basis in the employees' primary language in a physical or electronic format that is reasonably conspicuous and accessible.

A sample notice can be found on the website.

Are Employers Required to Distribute a Notice to Covered Employees?

Employers must keep records documenting the number of hours worked and paid sick time taken by employees for two (2) years.

Employers should choose a reasonable system for providing notification of accrued sick leave. Suggested methods include making accrued leave available on pay stubs or in an online system that is accessible by covered employees.

Failure to adhere to the recordkeeping requirements will result in a presumption that the employer has violated the Ordinance (absent clear and convincing evidence to the contrary).

Employer Next Steps

Covered employers should:

- evaluate any existing paid sick leave to determine whether it meets the minimum requirements under the Ordinance and, if it does not, work to amend their existing leave policies to align with these new requirements.
- unionized construction employers should review their sick leave polices to ensure only non-unionized employees are covered.
- begin documenting hours worked and paid sick leave earned back to December 15, 2021.
- provide any paid sick time earned and requested.
- post the notice in a conspicuous and accessible location.

Medicare Part D – CMS Notification Reminder

Published: February 14, 2022

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

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

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

For example, an employer with a **calendar year plan** (January 1 – December 31, 2022) must complete this reporting **no later than Tuesday, March 1, 2022**.

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

Annual Out-of-Pocket Maximum Adjustments Announced for 2023

Published: February 14, 2022

On December 28, 2021, the Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2023 ("the Notice"). HHS historically publishes the Notice as a proposed rule and then finalizes the rule. The guidance clarifies that, beginning with the 2023 calendar year, the payment parameters portion of the Notice will be published by January of the year preceding the applicable calendar year. This guidance is considered a final rule that addresses certain provisions of the Affordable Care Act ("ACA").

For purposes of employer-sponsored health plans, the final rule includes caps on out-of-pocket dollar limits for non-grandfathered group health plans with plan years that begin in 2023.

Change to the Out-of-Pocket Maximums

Under the final rule, non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2023 as follows:

- $9,100 for self-only coverage (up from $8,700 in 2022); and
- $18,200 for coverage other than self-only (up from $17,400 in 2022).

Note that different out-of-pocket limits apply to qualified high-deductible health plans, for purposes of making contributions to a health savings account ("HSA"). The 2023 HSA thresholds will likely be announced in June 2022.

Employer Action

Employers should update out-of-pocket limits for plan years beginning on or after January 1, 2023.

New OTC COVID-19 Testing Coverage Guidance Published

Published: February 17, 2022

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") released additional guidance to assist group health plans in implementing the over-the-counter ("OTC") COVID-19 testing coverage requirements previously discussed in FAQs Part 51. FAQs Part 52 were published on February 4, 2022, in response to stakeholder questions.

Briefly, the FAQs provide the following guidance:

- Group health plans have flexibility in establishing their direct coverage program.
- A plan will not be out of compliance with the direct coverage safe harbor because there is a temporary testing shortage, provided that the plan offers a direct coverage option.
- To prevent fraud and abuse, plans may limit reimbursements to established retailers and disallow the reimbursement of tests purchased from a private individual, online auction, or resale marketplace.
- The relief does not apply to COVID-19 OTC tests that are self-administered but require processing by a laboratory.
- If funds from a tax-advantaged account, such as an HSA or health FSA, are used to purchase an OTC test, these tests are not eligible for reimbursement from the health plan.

Additional Information

Q. Is there flexibility in how group health plans establish their direct coverage program to satisfy the requirements of the safe harbor in FAQs Part 51, Q2?

Yes, the guidance clarifies that group health plans will have significant flexibility in the design of their direct coverage program if the program provides adequate coverage through both a direct-to-consumer shipping mechanism and an in-person mechanism. Direct coverage for OTC COVID-19 tests means that a participant is not required to submit a claim to seek reimbursement from the plan for the purchase of the test. Instead, the plan makes systems and technology changes necessary to process the plan's payment to the preferred pharmacy or retailer directly (including direct-to-consumer shipping programs) with no upfront out-of-pocket expenditure.

Regarding the direct-to-consumer shipping mechanism, this requirement can be met by:

- Any program which provides direct coverage of OTC COVID-19 test for enrollees in the health plan without the individual being required to purchase the test at an in-person location;
- Utilizing a pharmacy or other retailer's online or telephone ordering system; and
- Paying all reasonable shipping costs and sales taxes in a manner consistent with how the plan covers other items supplied through mail order (for example, pharmacy benefits).

Adequate access to an in-person mechanism will depend on an examination of all relevant facts and circumstances. The guidance has clarified that such facts include:

- The locality of enrollees under the plan;
- Current utilization of the plan's pharmacy network by enrollees (when utilizing the pharmacy network as part of the direct coverage option);
- How enrollees are notified of network retail locations; and
- Which tests are covered by the plan under the direct coverage option.

Plans are not required to provide coverage for all manufacturers of COVID-19 testing but may instead limit coverage to specific manufacturers that the plan has a contractual relationship with or from whom the plan is able to secure tests directly.

Q. Will a temporary testing supply shortage cause a plan to be out of compliance with the safe harbor in FAQs Part 51, Q2?

No, a plan will not be considered out of compliance due to a temporary testing supply shortage which impacts its ability to offer adequate coverage as long as the plan otherwise meets the requirements for the safe harbor.

Q. Is a plan permitted to address suspected fraud or abuse?

Yes. FAQs Part 51, Q4 specifically allowed for plans to address suspected fraud and abuse and this new guidance provides welcome suggestions on how this can be accomplished.

Plans are permitted to take reasonable steps to prevent and detect fraud and abuse by limiting reimbursements to tests purchased from established retailers and denying reimbursements for tests purchased from a private individual, online auction, or resale marketplace.

Plans may require documentation of the product and seller's identity, such as:

- UPC codes;
- Serial numbers; or
- Original receipt.

If implementing such a limitation, the plan should communicate necessary information to the plan's enrollees regarding retailers covered by the plan, as well as those tests or retailers which will be denied a reimbursement.

Q. Are COVID-19 tests which are self-administered, but require the sample to be sent to a laboratory for processing required to be covered by a plan pursuant to this guidance?

No. A test must be both self-administered and self-read (without the involvement of a healthcare provider) for a health plan to be required to cover it, pursuant to the requirements in FAQs Part 51. Importantly, a COVID-19 test which is not self-administered and/or not self-read but is prescribed by a physician and otherwise meets the requirements under the Families First Coronavirus Response Act ("FFCRA") must be covered by the plan according to the FFCRA's terms.

Q. How are health plan reimbursements affected by the usage of HSAs, health FSAs, and HRAs to initially purchase the tests?

While COVID-19 OTC tests are considered a qualified medical expense under the Internal Revenue Code, tests purchased from tax-advantaged accounts, such as HSAs, health FSAs, and HRAs, are not eligible for reimbursement by a health plan. IRS rules prevent an individual from being reimbursed more than once for the same medical expense (often referred to as "double dipping").

Health plans may wish to notify enrollees not to utilize such tax-advantaged funds to purchase OTC COVID-19 test for which they will later seek reimbursement from the health plan.

Employer Action

Employers should:

- Discuss with carriers, TPAs, and PBMs how this new guidance affects any direct coverage options which have already been established.
- Communicate any limitations on OTC test points of sale.
- Consider notifying enrollees to avoid utilizing an HSA, health FSA, or HRA to purchase OTC COVID-19 tests that they wish the plan to later reimburse.

No Surprises Act IDR Process Altered by Court Order

Published: March 21, 2022

Under the No Surprises Act ("NSA"), when out-of-network ("OON") providers cannot agree to a payment amount from insurers, the payment amount is determined by an Independent Dispute Resolution ("IDR") process.
On February 23, 2022, the United States District Court for the Eastern District of Texas invalidated portions of the interim final rules regarding IDR that presumed the qualified payment amount ("QPA") to be the proper payment amount. The court order does not affect any other rules under the NSA.

Background

As previously reported, with respect to group health plans (and health insurance carriers), the NSA provides protection as it relates to OON cost-sharing and "balance billing" with respect to:

- Emergency services,
- Non-emergency services delivered by OON providers at in-network facilities, and
- OON air ambulance services.

The law also establishes a pathway for resolving payer-provider payment disputes using negotiation and arbitration. If entities are unable to come to an agreement, the IDR process requires each party to submit a final payment offer and the arbiter will select one of these offers as the final payment amount. The arbitrator's decision is final and generally may not be appealed. The Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") published interim final rules implementing the NSA.

The interim final rules at issue in this case required the certified IDR entity to 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.

The Court's Decision

The Texas Medical Association had filed suit seeking to block the rules from taking effect. They argued that the NSA did not include the deference to the QPA that the interim final rule required. The court determined that the presumption that the QPA should be the proper payment amount was contrary to the plain language of the statute and therefore exceeded the rulemaking authority of the Departments. The court invalidated the deference to the QPA in the IDR process but did not affect any other parts of the NSA.

DOL Memorandum and Future Outlook

On February 28, 2022, the DOL issued a memorandum explaining that the guidance relating to the QPA presumption for IDR was being withdrawn to be updated and reissued. The Memorandum also emphasized that consumers continue to be protected from surprise medical bills for OON emergency services, OON air ambulance services, and certain OON services received at in-network facilities.

The Departments may appeal the Texas court's decision to the 5th Circuit Court of Appeals. Further, there are similar cases pending before other federal courts on this issue. It is possible a future ruling could create a split in the circuits which ultimately may need to be resolved by the Supreme Court.

Employer Action

Carriers are generally responsible for compliance in the fully insured market.

Employers sponsoring self-funded group health plans will want to review the NSA requirements with their TPAs for compliance with the IDR process. The presumption that the QPA was the proper payment amount may have made the IDR process more predictable and may have served to avoid some disputes from being resolved through IDR. The court order does not affect any other aspect of the IDR process.

Temporary Telehealth Relief for HSA Plans

Published: March 25, 2022

On March 15, 2022, the President signed government funding legislation, the Consolidated Appropriations Act, 2022 ("CAA-22"), into law. The legislation includes a prospective extension of relief that allows first dollar coverage of telehealth services from April 1, 2022 through December 31, 2022. This relief allows individuals with High Deductible Health Plans ("HDHPs") to receive free telehealth services prior to the satisfaction of their minimum deductible and remain eligible to make Health Savings Account ("HSA") contributions.

Background

Individuals may contribute to an HSA if they are covered by a qualifying HDHP and do not have other disqualifying coverage. Generally, telehealth or other remote health care services are considered other health care coverage that, if provided before satisfaction of the required deductible, may be disqualifying for purposes of contributing to an HSA.

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

Consolidated Appropriations Act, 2022

CAA-22 prospectively extends the CARES Act relief for the months of April – December 2022. The relief is permissive (not mandatory). As such, employers are not required to provide free or reduced-cost telehealth services to employees.

Importantly, because the relief is not retroactive or tied to when a plan year begins (or ends), it creates a few administrative complexities for employers to consider. For example:

- **Calendar year plans (January 1, 2022 – December 31, 2022):** The CARES Act relief expired after December 31, 2021. Therefore, telehealth services that are provided for free or at a reduced cost before satisfaction of the deductible between January 1, 2022 – March 31, 2022 may be disqualifying coverage for purposes of HSA eligibility. This would mean no HSA contributions are permitted between January 1, 2022 and March 31, 2022. Beginning April 1, 2022 free or reduced cost telehealth (or other remote services) may be provided until December 31, 2022.

- **Non-calendar year plans:**

    - Example: March 1, 2021 – February 28, 2022 plan year. The CARES Act relief expired after February 28, 2022. Therefore, telehealth services that are provided for free or at a reduced cost before satisfaction of the deductible in the month of March 2022 may be disqualifying coverage for purposes of HSA eligibility and no HSA contributions would be permitted. Beginning April 1, 2022 free or reduced cost telehealth (or other remote services) may be provided until December 31, 2022.

    - Example: July 1, 2021 – June 30, 2022 plan year. The CARES Act relief expires after June 30, 2022. However, under CAA-22, telehealth or other remote care services may continue to be provided for free (or at a reduced cost) without jeopardizing HSA eligibility until December 31, 2022. The relief expires after December 31, 2022.

The examples above indicate no HSA contributions should be made for the months where an individual has disqualifying coverage. While this is generally correct, there is a special rule, the "last-month rule," which may permit an individual to make a full years' worth of HSA contributions without tax consequences if the individual is considered HSA eligible on Dec. 1 and remains HSA eligible for the following 13 months. Individuals should review their circumstances with tax advisors to understand whether this rule may be applicable.

Employer Action

Employers offering HDHPs with HSAs should consider whether to re-implement (or continue) free telehealth as part of a benefit offering. Employers with calendar year plans may have already re-introduced a cost associated with telehealth for HDHP/HSA participants once the CARES Act relief expired and should consider whether to waive those costs again given the temporary nature of this relief. Additionally, employers with non-calendar year plans should consider the administrative and communication burdens that may be imposed by providing relief that may expire prior to the end of the current plan year.

It is important that employers review these changes with their carriers, TPAs and telehealth vendors to understand their approach and communicate any changes with participants.

2022 State-Based Compliance: Quarter One

Illinois

Louisiana

Oklahoma

Washington

Illinois Consumer Coverage Disclosure Act Update

Last year, Illinois passed the Consumer Coverage Disclosure Act that requires employers with employees in Illinois to distribute certain information regarding their group health plan to all employees eligible for the plan in Illinois.

As a reminder, the law requires employers to distribute information to employees comparing the essential health benefits covered on the Illinois individual marketplace (the "Benchmark Plan") with the benefits covered on the group health plan. The comparison must state whether the group health plan covers each of the essential health benefits that plans are required to cover on the Illinois individual marketplace. The Illinois Department of Labor (the "Department") has clarified certain provisions of the law and provided a template for employers to use as well answered certain frequently asked questions. Both can be found at:
https://www2.illinois.gov/idol/Laws-Rules/FLS/Pages/Consumer-Coverage-Disclosure-Act.aspx.

The distribution must be made to all employees eligible for the group health plan that work in Illinois, regardless of where those employees reside. Whether an employee works in Illinois will be determined using a base of operations test and considers all relevant factors.

Employers must provide this information to Illinois employees upon hire, annually, and upon request. At this point, no guidance suggests an employer would be precluded from including the distribution with regular open enrollment disclosures and notices on an annual basis prospectively.

If an employer offers multiple group health plans to employees working in Illinois, a disclosure must be made with respect to each plan option (e.g., HDHP and PPO).
If the health coverage offered by the employer covers some of the benefits on the Benchmark Plan but not to the extent required by the Benchmark Plan, the disclosure should indicate "partial" coverage and explain how the coverage differs.

For example: The Benchmark Plan covers cardiac rehabilitation therapy for up to 6 months after a heart attack. If the employer's group health plan covers cardiac rehabilitation therapy for 3 months after the heart attack, the template should reflect "partial" coverage and explain how the group health plan differs from the Benchmark Plan.

Failure to comply with this disclosure requirement may result in penalties. For employers with 4 or more employees the penalties are:

1st offense = not to exceed $1,000

2nd offense = not to exceed $3,000

3 or more offenses = not to exceed $5,000

The amount of the penalty will also consider good faith efforts made by the employer to comply and the gravity of the violation. In assessing any applicable penalty, the Department will count all employees across the country (i.e., to determine if an employer has 4 or more employees), but employers will not be required to distribute the disclosure to any employees that do not work in Illinois and are eligible for the employer's group health plan.

Employer Action

- Employers should work to complete and distribute the disclosure as soon as practicable.
- Employers may satisfy the distribution requirements by providing the information via email to employees or providing the information on a website that an employee is able to regularly access.
    - It is important to distribute the information in a trackable format; the Department requires employers to be able to demonstrate that each employee received the information, and such records must be retained for a period of one year.
- We also recommend discussing with your insurance carrier(s) to determine what assistance they may be able to provide.

Should you have any questions regarding the completion of the or the application of the Illinois Consumer Coverage Disclosure Act to your company, reach out to your legal counsel or contact your service team.

New Louisiana Law Impacts HSA Eligibility

Under LA. R.S. 22:976.1, effective June 21, 2021, when calculating an enrollee's contribution to any applicable cost-sharing requirement under a medical plan, a health insurance issuer must include any amounts paid by the enrollee or on behalf of the enrollee by another person. "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing in order to receive a specific healthcare service, including a prescription drug.

This law does not apply to self-funded plans. It appears to apply only to policies written in Louisiana and not to policies written outside Louisiana as to insureds in Louisiana.

While this new law reduces health care costs for consumers, it could render any individuals enrolled in a high-deductible health plan ("HDHP") ineligible to have contributions made to a health savings account ("HSA"). This is because HSA-eligible individuals generally must meet the statutory minimum deductible ($1,400 self-only/$2,800 family for 2022) without help from outside sources other than an HSA.

On February 14, 2022, the Louisiana Department of Insurance acknowledged the conflict and issued Bulletin 2022-01 to inform health insurance issuers offering HDHPs of the potential tax consequences created by this statute. It cautioned that this requirement is mandatory and may not be waived by either party. Therefore, it concludes, consumers enrolled in HDHPs with HSAs are advised to avoid the use of third-party payments, such as pharmacy discount cards.

Discount cards that entitle holders to obtain discounts for health care services or products at managed care market rates will not disqualify an individual from being an eligible individual for HSA purposes if the individual is required to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied. Although the answer is not clear, use of a manufacturer coupon program should not affect HSA eligibility, provided the support is not credited toward the deductible.

Employers offering insured HDHPs to their employees and all health insurance issuers carrying HDHP products in Louisiana are advised to notify insureds enrolled in HDHPs with HSAs to avoid such use.

It does not appear that the Louisiana Department of Insurance has authority over employers. However, employers may have a general fiduciary duty to so inform employees.

Employer Action

Employers with insured plans written in Louisiana should consider communicating to HDHP enrollees with HSAs the consequences of using third party payments when paying for prescriptions.

New Oklahoma Law Impacts HSA Eligibility

Under Oklahoma HB 2678, beginning November 1, 2021, a health insurer or a pharmacy benefits manager is required to "include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement." This includes drug manufacturers' coupons, cash from charities, discount cards, vouchers, and other payments from third parties.

This law does not apply to self-funded plans. It appears to apply only to policies written in Oklahoma and not to policies written outside Oklahoma as to insureds in Oklahoma. Insurers are continuing to evaluate the application.

While this new law reduces health care costs for consumers, it could render any individuals enrolled in a high deductible health plan ("HDHP") ineligible to have contributions made to a health saving account ("HSA"). This is because HSA-eligible individuals generally have to meet the statutory minimum deductible ($1,400 self-only/$2,800 family for 2022) without help from outside sources other than an HSA.

The Oklahoma Insurance Department acknowledged the conflict and is actively seeking clarification regarding the interaction of the two laws, but stated:

In the interim, the administration of pharmacy claims must be in compliance with state law, which will require the issuer to combine all payments made toward a prescription when calculating the enrollee's total contribution.

Employer Action

Employers with insured plans written in Oklahoma should consider communicating to HDHP enrollees with HSAs the consequences of using third party payments when paying for prescriptions. Employers with insured plans written outside Oklahoma should look for information from their carriers should they determine that compliance with this law is required.

Washington Payroll Tax Delayed until 2023 and Other Developments

On January 27, 2022, Governor Inslee signed into law two bills (SHB 1732 and ESHB 1733) that make significant changes to the state's Long-Term Services and Supports Trust Program (the "Trust Program" also referred to the "WA Cares Fund"). As previously reported, the governor and state legislative officials announced a delay in the collection of premium assessments until some adjustment to the program can be made during the 2022 legislative session.

The two bills modify the WA Cares Fund as follows:

SHB 1732 – takes effect immediately upon enactment.

- Delays the collection of premium assessment for the WA Cares Fund until July 1, 2023. Originally, the 0.58% payroll tax began on January 1, 2022. Any premiums collected from employees before July 1, 2023 must be refunded to the employee within 120 days of collection
- Delays the availability of approved services under the program until July 1, 2026 (originally available January 1, 2025).
- Allows individuals born before January 1, 1968 who do not meet the 10-year minimum for paying premiums to receive partial benefits based on the number of years of premium payments.

ESHB 1733 – takes effect June 8, 2022 (90 days after adjournment of the session).

- Establishes four new categories of employees who may be eligible for a voluntary exemption from the payment of premiums under the WA Cares Fund. Employees eligible for one of these exemptions must still apply with the state.
    - **Disabled veterans.** An employee who is a veteran of the United States military who has been rated by the United States Department of Veterans Affairs as having a service-connected disability of at least 70 percent.
    - **Spouse or registered domestic partners of an active duty service member.** An employee who is the spouse or registered domestic partner of an active duty service member of the United States Armed Forces. The exemption must be discontinued within 90 days of either the employee's spouse or registered domestic partner being discharged or separated from military service, or the dissolution of the employee's marriage or registered domestic partnership.

- **Temporary employee with a nonimmigrant visa.** An employee who holds a nonimmigrant visa for temporary workers who is employed by an employer in Washington. The exemption must be discontinued within 90 days of an employee's nonimmigrant visa for temporary workers status being terminated and the employee becoming a permanent resident or citizen employed in Washington

- **Employee resides outside of Washington.** An employee who is employed in Washington but maintains a permanent residence outside of Washington as the employee's primary location of residence. The exemption must be terminated within 90 days of the employee establishing a permanent address within Washington as the employee's primary location of residence.

It should be noted that SHB 1732 and ESHB 1733 do not include a new window for individuals to obtain private long-term care insurance and qualify for an exemption (an amendment to this effect was voted down). Under the current law, employees who are at least 18 years of age needed to secure a private long-term care insurance policy before November 1, 2021 in order to apply for an exemption from the premium assessment and permanent exclusion from the WA Cares Fund. There are other bills introduced in the legislature to establish a voluntary exemption from the payment of premiums due to hardship (HB 1597)), for recent graduates who obtain private long-term care insurance within 36 months of the date of graduation (HB 1599), and for retired veterans and retirement eligible veterans (SB 5611). It is unclear whether these (or other) exemptions will pass this session.

Employer Action

Employees will not begin contributions toward the WA Cares Fund until July 1, 2023.

Employers that decided to collect WA Cares Fund premiums beginning January 1, 2022 will need to make sure those premiums are timely refunded to employees.

Washington State Lowers PAL Assessment

On January 25, 2022, the Washington Health Care Authority ("HCA") approved a reduction in the PAL assessment amount. The WAPAL Fund announced a lower monthly assessment amount of $0.07 per covered life effective for payments due on February 15, 2022.

Background

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

The 2022 WAPAL Fund monthly assessment rate was previously set at $0.13 per covered life. The assessment amount is based on the number of covered lives each month. The WAPAL Fund Advisory Council reviewed the fiscal operations of the WAPAL Fund and determined that the rate could be reduced based on reported covered lives exceeding initial estimates.

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 next reporting and payment deadline is February 15, 2022 for the months of October, November, and December 2021.

The WAPAL Fund is administered by KidsVax. In the event that an employer pays the PAL assessment for February at the higher monthly rate of $0.13 per covered life, KidsVax will automatically process refunds of any overpayments.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at the reduced rate for the payment due February 15, 2021. A third-party administrator ("TPA") may be assisting with this process. Employers that make their February payment at the higher rate should watch for a refund of excess funds from KidsVax. If not refunded within 30 days of payment, employers are directed to notify KidsVax.

Carriers are responsible for the payment for fully insured group health plans. No employer action necessary.

2022 Compliance Bulletins: Quarter Two

April

May

June

HHS Extends Public Health Emergency until July 15, 2022

Published: April 20, 2022

On April 12, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective April 16, 2022. 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 July 15, 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, or 2) 60 days after the announced end of the COVID-19 National Emergency.

The following summarizes benefit plan provisions that are directly impacted by the extension of the Emergency Period and highlights the relief with respect to the ongoing Outbreak Period. Other temporary benefit plan provisions and changes that are allowed due to the ongoing pandemic are not included.

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.

- **Over-The-Counter ("OTC") COVID-19 Testing:** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

- **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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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).

Note: There is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

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 plan requirements. 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.

Proposed Regulations to Fix ACA's Affordability "Family Glitch"

Published: May 3, 2022

The Treasury Department and the Internal Revenue Service ("IRS") recently proposed regulations that would expand the availability of premium tax credits in the Marketplace. For purposes of eligibility for a premium tax credit, the proposed rule provides that:

- Affordability of employer-sponsored coverage for family members would be determined based on the employee's cost to cover the employee and the family members.
- The determination of whether employer-sponsored coverage for family members provides minimum value would be based on the family coverage.

If finalized in their current form, the proposed rules are expected to take effect in the 2023 tax year.

While these proposed changes would not affect the affordability determination for purposes of the Affordable Care Act's ("ACA") employer mandate, they would indirectly impact employer plans as more family members may qualify for premium tax credits and choose to enroll in coverage through the Marketplace.

Background

Under the current rules, individuals are not eligible for premium tax credits in the Marketplace if they are offered employer-sponsored group health plan coverage that is "affordable" and provides minimum value. For this purpose, employer-sponsored coverage is considered "affordable" if an employee is not required to pay more than 9.5% of household income for self-only coverage (9.61% for 2022 - the applicable percentage for 2023 has not yet been announced). If this is the case, then the coverage is considered affordable for both the employee and the employee's family members, regardless of how much the employee must pay to cover those family members. This is known as the "family glitch."

An employer-sponsored plan provides minimum value if the plan's share of the total allowed cost of benefits provided is at least 60%. Under current rules, as long as self-only coverage offered by an employer provides minimum value to an employee, then coverage offered to the employee's family members is also considered to provide minimum value.

Proposed Rule

Affordability

The proposed rule would refine the definition of affordable coverage to make it easier for family members to qualify for premium tax credits. Employer-sponsored coverage would be considered affordable for family members (thereby disqualifying them from eligibility for premium tax credits) only if the portion of the annual premium the employee must pay for family coverage does not exceed 9.5% of household income (as indexed).

As a result, when assessing whether an individual has received an affordable offer of employer-sponsored coverage, the Marketplace would look separately at the employee's cost of self-only coverage (to determine the employee's eligibility for premium tax credits), and at the employee's cost to cover the family (to determine the family members' eligibility for premium tax credits). There will likely be scenarios where an employee has an offer of self-only coverage that is affordable, but the offer of coverage to the family members is considered unaffordable (thus potentially qualifying those family members for premium tax credits).

For this purpose, family coverage means all employer plans that cover any related individual other than the employee, including a self-plus-one plan for an employee enrolling one other family member in the coverage. The proposed rule details scenarios that may arise to determine whether employer coverage is affordable, including situations where an individual has offers of coverage from multiple employers or where covered family members are not part of the employee's tax family (e.g., a non-tax dependent child, or a spouse filing separately).

Minimum Value

The proposed rule would also amend the premium tax credit eligibility rules related to minimum value. An employer-sponsored plan would be considered to provide minimum value for family members if the plan's share of the total allowed costs of benefits provided to family members is at least 60%, and the plan includes substantial coverage of inpatient hospital services and physician services.

Employer Action

The proposed rule does not impact the determination of whether employer-sponsored coverage is affordable for purposes of avoiding a shared responsibility penalty under the ACA's employer mandate. Whether coverage is affordable for this purpose continues to be based solely on the cost of self-only coverage in the lowest-cost plan that provides minimum value.

However, should the rule take effect as currently written, employers may see employees more closely evaluate options for family members in the Marketplace. Employees may find Marketplace coverage more cost effective than the employer plan and move their family members off the group health plan coverage.

Further, it is possible the Form 1095-C will be revised with new offers of coverage codes, since the IRS will need to understand whether affordable and minimum value offers of coverage were made to family members who otherwise may obtain a premium tax credit in the Marketplace.

2023 Inflation Adjusted Amounts for HSAs

Published: May 10, 2022

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying high deductible health plans ("HDHPs") effective for calendar year 2023, and the maximum amount that may be made newly available for excepted benefit health reimbursement arrangements ("HRAs"). All limits have increased from the 2022 amounts, some significantly.

For the Bulletin, see Rev. Proc. 2022-24, April 29, 2021, https://www.irs.gov/pub/irs-drop/rp-22-24.pdf.

Annual Contribution Limitation

For calendar year 2023, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $3,850; the limitation on deductions for an individual with family coverage under a high deductible health plan is $7,750.

High Deductible Health Plan

For calendar year 2023, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,500 for self-only coverage or $3,000 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,500 for self-only coverage or $15,000 for family coverage.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. 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 qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Excepted Benefit HRA Adjustment

For plan years beginning in 2023, the maximum amount for an excepted benefit HRA that may be made newly available for the plan year is $1,950.

July 1 Deadline Approaching for Machine-Readable Files

Published: May 26, 2022

On October 29, 2020, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") finalized proposed rules regarding transparency requirements for non-grandfathered group health plans. The Transparency in Coverage ("TiC") rules initially required disclosures of pricing and cost-sharing under plans to first take effect beginning January 1, 2022. On August 20, 2021, the Departments issued an FAQ that delayed the TiC requirement to publish certain machine-readable files ("MRFs") on a public website.

Briefly, the TiC rules require public disclosure, via MRFs, of the following information:

1. In-network provider rates for covered items and services; and

2. Out-of-network allowed amounts and billed charges for covered items and services.

A third required MRF disclosing negotiated rates and historical net prices for covered prescription drugs is currently delayed pending future guidance.

Employers sponsoring non-grandfathered insured and self-funded plans should be prepared to comply with the MRF disclosure requirements, as follows:

- For plan years that begin between January 1, 2022, and July 1, 2022, the files must be posted by July 1, 2022.

- For plan years that begin after July 1, 2022, the information must be posted in the month the plan year begins.

- Going forward, the information must be updated monthly and clearly indicate the date the files were most recently updated.

Who is Responsible for Compliance?

Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. If the carrier fails to provide full or timely information, the carrier (not the plan/employer) is liable.

Similar relief is not available to self-funded group health plans. While a self-funded health plan may contract with a third party (like the third-party administrator or "TPA") to provide the required disclosure, the plan is ultimately responsible.

Good Faith Compliance – Safe Harbor

A plan or carrier will not fail to comply with these requirements when, acting in good faith and with reasonable diligence:

- an error or omission in the required disclosure is made, provided the information is corrected as soon as practicable.

- the internet website hosting the MRF files is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable.

Further, when information must be obtained from a third party, the plan or carrier will not fail to comply with this requirement because it relied in good faith on the information provided by the third party, unless it is known (or reasonably should have known) the information is incomplete or inaccurate.

What is the Disclosure Requirement?

MRFs will typically contain vast amounts of data such that they will be quite large. They will be in a machine-readable language such that the data will not be easy to interpret or search, and few, if any, plan sponsors will be able to meet the disclosure requirements on their own. Thus, carriers and TPAs are assisting plan sponsors in complying with these requirements by hosting the files and posting them on public servers or websites they will maintain.

This disclosure requirement is unique in that it must be made to the public as opposed to most disclosure requirements that are limited to plan participants. As such, posting the information or a link to the information on a company's intranet or behind a password protected page will not be sufficient disclosure.

A conservative reading of the requirements suggests a plan sponsor should post a link to the MRFs on its public-facing website even if the carrier or TPA is doing the same on behalf of the plan.

> **Example.** ABC Company sponsors a self-funded medical plan. Green TPA provides ABC Company with a Uniform Resource Locator ("URL," briefly, a website address) where MRFs for the plan will be posted publicly and updated. ABC Company adds the URL
> link to their public-facing company website.

If a plan has multiple carriers or TPAs, multiple links may be necessary.

Several carriers and TPAs are taking this position, though further guidance would be welcome.
For example, UnitedHealthcare takes the following position: "The regulation requires self-funded customers accessing the UnitedHealthcare public MRF website to add the URL to their own public website." See Transparency in Coverage – External Frequently Asked Questions (May 5, 2022), page 15.

Direct Provider Contracting and Alternative Payment Models

For certain self-funded plans, one approach to controlling the cost of care involves plan sponsors directly contracting with providers or facilities to provide services to plan participants for discounted amounts. This is often in addition to the more prevalent commercial approach whereby a plan rents an established network from an insurance carrier or TPA. If the plan's TPA is not adjudicating claims for these unique agreements, the TPA may not have access to the required information to meet the TiC MRFs requirements. Plans should be proactive in coordinating with all applicable vendors and service providers to ensure accurate data is posted by the applicable deadline.

Further, the Departments recently issued FAQ 53 that addresses the compliance challenge for plans that have an alternative payment model and may not always provide a certain dollar amount for services and items before they are provided. Specifically, the plan may have negotiated rates with providers based upon a "percentage of billed charges" which would only ensure an accurate dollar amount after the services or item has been provided. As the rule's purpose is to provide transparency in advance of the cost of these services, this alternative payment arrangement posed compliance challenges.

In response, the Departments have provided a safe harbor for arrangements that do not permit plans to accurately determine dollar amounts for contracted items and services in advance of their provision. The safe harbor allows plans to:

- report a percentage number instead of a dollar amount for contractual arrangements where the plan or carrier pay the in-network provider a percentage of billed charges; and

- disclose an open text field for outlining formulas, variable methods, or other information necessary to understand the arrangement when a percentage or dollar amount is not possible.

The Departments caveated that the safe harbor does not exist for arrangements where it still is possible to sufficiently disclose a dollar amount.

Employer Action

Employers sponsoring non-grandfathered fully insured group health plans should obtain written assurances that the carrier will be responsible for posting the MRFs. Employers with fully insured plans may post a link to the MRFs from the carrier on their public website. Coordinate with IT resources to ensure that a link to the MRFs is posted timely.

Employers sponsoring self-funded non-grandfathered group health plans should:

- Reach out to TPAs (or other vendors) to ensure that they will assist in creating and posting the MRFs on behalf of the plan. It appears that most national carriers acting as TPAs on self-funded business have indicated they will support creating and posting this information.

- Add a link to the MRF URL to the employer's public-facing website. Coordinate with IT resources to ensure that a link to the MRFs is posted timely.

2022 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 1, 2022

The Patient-Centered Outcomes Research (PCOR) fee filing deadline is August 1, 2022, for all self-funded medical plans and HRAs for plan years ending in 2021. The IRS issued Notice 2022-04 announcing the adjusted fee amount for this year.

The plan years and associated amounts are as follows:

Plan Year END Date	Amount of PCOR Fee	Payment and Filing Date
January 31, 2021	$2.66/covered life/year	August 1, 2022
February 28, 2021	$2.66/covered life/year	August 1, 2022
March 31, 2021	$2.66/covered life/year	August 1, 2022
April 30, 2021	$2.66/covered life/year	August 1, 2022
May 31, 2021	$2.66/covered life/year	August 1, 2022
June 30, 2021	$2.66/covered life/year	August 1, 2022
July 31, 2021	$2.66/covered life/year	August 1, 2022
August 31, 2021	$2.66/covered life/year	August 1, 2022
September 30, 2021	$2.66/covered life/year	August 1, 2022
October 31, 2021	$2.79/covered life/year	August 1, 2022
November 30, 2021	$2.79/covered life/year	August 1, 2022
December 31, 2021	$2.79/covered life/year	August 1, 2022

Employers with self-funded health plans ending in 2021 should use the 2nd quarter Form 720 to file and pay the PCOR fee by August 1, 2022. The information is reported in Part II.

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

For additional information, please visit the following IRS sites:

- **Form 720, Quarterly Federal Excise Tax Return, instructions and forms:** https://www.irs.gov/forms-pubs/about-form-720
- **Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers:** https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- **PCOR Filing Due Dates and Applicable Rates Chart:** https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates

Mental Health Conditions Can Trigger FMLA

Published: June 21, 2022

In May 2022, the Wage and Hour Division of the U.S. Department of Labor released Fact Sheet #280 related to mental health conditions and the Family and Medical Leave Act ("FMLA").

As background, among the qualifying reasons that a person may qualify for FMLA leave are:

- To care for a spouse, son, daughter, or parent who has a serious health condition; and
- Because of a serious health condition that makesthe employee unable to perform the functions of his or her position.

A **serious health condition** is defined as an illness, injury, impairment, or physical or mental condition that involves (1) inpatient care in a hospital, hospice or residential medical care facility or (2) continuing treatment by a health care provider.

The fact sheet clarifies that a serious mental health condition that requires inpatient care includes an overnight stay in a hospital or other medical care facility, such as, for example, a treatment center for addiction or eating disorders.

In addition, the fact sheet notes that a serious mental health condition that requires continuing treatment by a health care provider includes:

- Conditions that incapacitate an individual for more than three consecutive days and require ongoing medical treatment by a health care provider, including a psychiatrist, clinical psychologist, or clinical social worker; and
- Chronic conditions (e.g., anxiety, depression, or dissociative disorders) that cause occasional periods when an individual is incapacitated and require treatment by a health care provider at least twice a year.

In the fact sheet, examples are provided outlining situations that can trigger FMLA (or military caregiver leave):

- The employee's own serious mental health condition
- A family member's serious mental health condition
- An adult child (unable to care for him/herself) with a serious mental health condition
- A military family member's serious mental health condition

Employer Action

Employers should ensure that they comply with applicable state and federal laws, including FMLA. Additionally, employers should make sure they appropriately determine whether a particular mental health condition of an employee or dependent rises to the level of a serious health condition warranting FMLA.

Philadelphia Re-Enacts Emergency Paid Sick Leave Benefits

Published: June 23, 2022

On March 9, 2022, the Philadelphia City Mayor signed into law an ordinance amending the city's existing public health emergency leave requiring covered employers to provide continuing paid COVID-19 leave through December 31, 2023.
The law became effective on March 9 and is the third iteration of the COVID-19 paid leave mandate.

Background

On September 17, 2020, Philadelphia passed the Public Health Emergency Leave Bill (the "COVID-19 Leave"), which provided paid "public health emergency leave" to individuals who work within the geographic boundaries of Philadelphia. The COVID-19 Leave expanded paid sick leave benefits to individuals who were not otherwise covered by the Families First Coronavirus Response Act. The COVID-19 Leave expired on December 31, 2020 and was expanded on March 29, 2021. On March 9, 2022, an ordinance was signed into law requiring covered employers to provide continuing leave through December 31, 2023 (the "2022 COVID-19 Leave"). While there are a few differences from the COVID-19 Leave, the most notable difference in this iteration is the amount of leave that must be provided by employers

Overview

Under the 2022 COVID-19 Leave, eligible employees are entitled to paid "public health emergency leave." Eligible employees may use this leave for situations when they are unable to work due to one or more of the following:

- A determination from a public official, health care provider or employer that the employee would jeopardize the health of others because of exposure to COVID-19, or he or she is showing symptoms, regardless of whether he or she was diagnosed with or tested positive for COVID-19
- Caring for a family member in a similar situation
- Isolating due to diagnosis of, or testing positive for COVID-19, or isolation due to having symptoms, or to seek or obtain diagnosis
- Caring for a family member who is isolating due to diagnosis of, or testing positive for COVID-19, or isolation due to having symptoms, or to seek or obtain diagnosis
- Caring for a child whose school was closed due to COVID-19
- An employee's need to be vaccinated, including a booster
- An employee's need to recover from a vaccination side effect

Covered Employers and Eligible Employees

The 2022 COVID-19 Leave applies to employers with 25 or more employees (previously the leave only applied to employers with 50 or more employees). To be a covered employee, an employee must have worked for a covered employer for 90 or more days and:

- Works for an employer within Philadelphia;
- Normally works for that employer within the city of Philadelphia but is currently teleworking from any other location due to COVID-19; or
- Works for that employer from multiple locations or from mobile locations, as long as 51% or more of the employee's time is spent working within the city of Philadelphia.

Amount of Leave

Under the 2022 COVID-19 Leave, employers are required to provide less leave than before. Employers must provide the following amounts of paid leave:

- Employees who work 40 or more hours per week are entitled to 40 hours of leave, unless the employer designates more (previously this was 80 hours)
- Employees who work less than 40 hours per week are entitled to leave in an amount equal to the time the employee is otherwise scheduled to work, or actually works, on average in a 7-day period, whichever is greater, unless the employer designates more
- Employees whose weekly schedule varies are entitled to the average number of daily hours the employee was scheduled over the past 90 days of work, including hours where the employee to ok leave of any type, multiplied by 7.

Rate of Pay

Employers must provide paid leave at the covered employee's regular rate of pay, with the same benefits (including health care benefits) as the employee normally receives from the employer.

Notice Requirements

Employers must provide employees with notice of the need for leave as practicable and as soon as feasible, but only when the need for the leave is foreseeable. Philadelphia's Department of Labor published a model notice satisfying these requirements that can be found at https://www.phila.gov/media/20220315165758/2022-COVID-19-Pandemic-Paid-Sick-Leave-NOTICE-POSTER-ENG.pdf. The notice must be conspicuously displayed in the workplace or, if the employer does not have a physical workplace or an employee teleworks, the notice must be provided through electronic communication or a conspicuous posting in the web-based platform. The notice must also be included in any employee handbook.

Employees are entitled to job restoration to the same position held when the 2022 COVID Leave began. Employers can request an employee submit a self-certified statement stating that leave was taken for a covered reason under the 2022 COVID-19 Leave. Employers cannot require employees to find a replacement to cover their leave, nor can they retaliate against employees who use or request leave.

Coordination with Other Paid Leave

The 2022 COVID-19 Leave is in addition to all other paid leave an employer provides and cannot be reduced by the amount of any paid leave an employee has previously received. Employees may not be required to use other paid leave available before using the 2022 COVID-19 Leave unless state or federal law requires otherwise. In certain situations, as set forth below, employers can use pre-existing benefits to satisfy COVID-19 leave requirements:

- Where employees complete the majority of their work through telework, employers are not required to change existing policies or provide an additional paid leave if the existing policies provide teleworking employees with at least 80 hours of paid leave in 2022 and employees can use such paid leave for the same purposes and under all of the same conditions as set forth under the Ordinance.

- Where an employer's existing leave policy provides 120 hours or more of paid time off in 2022, whether or not such leave is specifically designated as sick leave, if such leave can be used for the same purposes and under all of the same conditions as the 2022 COVID-19 Leave. Additionally, a provision that differs from the previous version of leave provides that, for employers that operate on a 7.5-hour workday and consider an employee working 37.5 hours a week to be a full-time employee, the amount of leave required to qualify for this exemption is 112.5 hours.

- Where federal or state laws require employees to provide paid leave or paid sick time related to COVID-19, employers may substitute leave under the federal or state law to the extent they coincide and the relevant federal or state law permits such concurrent use of paid leave.

- Where an employer has adopted a policy which provides its employees with additional paid time specifically for use for COVID-19, employers may substitute leave under such employer policy for the 2022 COVID-19 Leave to the extent they coincide.

Employer Action

Employers with employees performing service in Philadelphia should work with labor and employment counsel to review their leave policies and procedures to ensure that they are compliant with the 2022 COVID-19 Leave.

Delaware Enacts New Paid Family and Medical Leave Requirement

Published: June 28, 2022

On May 10, 2022, Governor John Carney signed the “Healthy Delaware Families Act” (“the Act”) into law, making Delaware the eleventh state to offer paid family leave in the country.

Overview

- The new paid leave requirements are applicable to any employer that employs 10 or more employees in Delaware.
- The Act establishes three categories of leave including: parental leave; medical leave; and family caregiving leave.
- Employers with 10-24 employees are only subject to the parental leave provisions. Employers with 25 or more employees are subject to all leave provisions. Employers with fewer than 10 employees are not obligated to participate in the leave program, although an employer can opt-in for a 3-year participation period.
- Benefits will be funded by employer and employee contributions. The contribution percentages have been established by the Act for years 2025 and 2026, with the state’s Department of Labor setting the contributions annually beginning in 2027.
- Contributions are scheduled to begin January 1, 2025, while benefit applications will commence January 1, 2026.

Employee Eligibility

To be eligible for, and receive benefits from the program, employees must have been employed for at least 12 months by the employer from whom leave is being requested and have worked a minimum of 1,250 hours over the 12-month period prior to requesting benefits.

The employee must also primarily work at a site located in Delaware. If the employee reports to work at a location outside of Delaware, the employer has discretion to classify that employee as eligible for participation in the state's leave program. Employees employed by the state whose work is classified as "Casual Seasonal" are ineligible to participate in the program.

Reasons for Leave

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth, adoption or after the placement of the child through foster care or for adoption;
- To care for a family member with a serious health condition;
- To provide leave to the employee due to a serious health condition that results in the employee being unable to perform the functions of their position or
- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee

Benefit Amount and Duration

The program will pay 80% of the covered individual's average weekly wages during the 12-month period prior to their application. For 2026 and 2027, the benefit payments will be capped at a maximum of $900 per week and indexed for inflation thereafter. The minimum weekly benefit cannot be less than $100, unless the employee's average weekly wages are less than $100 per week. In those instances, the employee's benefit will be their full weekly wage.

If the leave is intermittent or partial, benefits will be prorated but are not payable if less than one workday of covered leave is taken by the employee.

Benefits for eligible employees under the Act are capped as follows:

- Parental leave: up to 12 weeks in an application year.
- Medical and family caregiving leave: The maximum aggregate number of weeks available is 6 weeks in any 24-month period.
- Once every 24-month period for all leave except parental leave.
- If two parents are entitled to leave and work for the same employer, the employer is allowed to aggregate the number of weeks of leave to which they are both entitled to a total of 12 weeks during a 12-month period.

Contribution Rates

For 2025 and 2026, the contribution rates as a percentage of an employee's wages will be as follows:

- Parental Leave: 0.32%
- Medical Leave: 0.40%
- Family Caregiving Leave: 0.08%

An employer may deduct from the wages of each employee up to 50% of the contribution required, however, the employer at its own election can pay some or all of the employee's share of the contribution. Beginning in 2027, the contribution rates will be adjusted annually.

Employee Benefit Application

Employees who apply for benefits must provide written certification which includes the following information:

- The date when the serious health condition commenced;

- Information related to the condition provided by a healthcare provider;
- Duration of the condition; and
- A statement that they are unable to perform their job duties, or if the employee is looking to take family caregiving leave, a statement that the leave is to care for a family member who has a serious health condition.

Employer Private Plan Substitution

If the employer already has a paid leave program that provides medical, family caregiving and parental leave benefits, and that program is subsequently approved by the state, the employer will not have to remit contributions to fund the state's leave program. Employers must submit applications for approval to the state by January 1, 2024. To be approved, the employer's leave program must meet the Act's requirements and cannot impose additional conditions or restrictions beyond those permitted by the law.

If the employer's private plan does not cover all three leave types (for example, the policy only covers medical leave), the employer is permitted to participate in the state's paid leave program by remitting contributions for those leave benefits not covered by their private plan.

Employee Notice Requirements

If the need for use of leave is foreseeable, an employer may require the employee to give at least 30 days' written notice before taking leave. If the leave is unforeseeable, notice to the employer from the employee will be due as soon as practicable.

Leave covered by this Act may also qualify as leave under the FMLA and must run concurrently with FMLA leave. Employers are permitted to require that payments made under this leave program are coordinated with payments made to the employee under a separate leave policy (e.g., employer's private plan or a collective bargaining agreement). Employers can require employees to use their unused paid time off before they can take leave covered by this Act. However, eligible employees cannot collect more than 100% of their regular wages from leave programs.

Employer Responsibilities

An employer must provide written notice to each employee of their rights under this Act at the time of the employee's hire, whenever an employee requests covered leave, or the employer has reason to believe an employee's leave is due to a qualifying event.

The notice must contain:

- The procedure an employee must utilize to file their claim;
- The amount of family and medical leave benefits;
- The employee's rights to leave benefits and job protection, as well as protection from discriminatory and retaliatory actions of their employer for requesting and/or using leave benefits, and to file a complaint for alleged Act violations; and

- Whether leave benefits are available to the employee through the state or the employer's approved private plan.

An employer must:

- Continue any health benefits that a covered employee is enrolled during any leave taken under the Act.
- Protect and restore an employee to their position (or an equivalent) prior to taking eligible leave.

If the employee is entitled to greater benefits under a collective bargaining agreement or prior employer policy, the employer is obligated to follow those policies and cannot utilize the Act as a reason to reduce

Employer Action

Employers should:

- Await published regulations from the Delaware Department of Labor and review and examine their existing paid leave policies (and their employee handbook) to determine whether they can utilize these policies to satisfy, or supplement, their requirements under the Act.
- Apply for approval with the Delaware Department of Labor by January 1, 2024, if seeking to substitute an existing leave or private insurance policy.
- Provide written notice to all covered employees of their rights and duties under the Act.

2022 State-Based Compliance: Quarter Two

Maryland

Oklahoma

Connecticut

Washington

Maryland Enacts New Paid Family and Medical Leave Requirement

On April 11, 2022, the Maryland State Legislature voted to override Governor Larry Hogan's veto of SB 275, known as the Time to Care Act of 2022 ("the Act"). The Legislature's vote to override the Governor's veto made Maryland the tenth state to offer paid family leave in the country.

Overview

- The new paid leave requirements are applicable to any employer that employs at least one individual in Maryland. The Act does not specify whether this number is limited to employees in Maryland or inclusive of all employees of an employer, regardless of residence or workplace. Employers with more than 15 total employees are required to pay into the state benefit fund.

- The benefits will be funded primarily by employer and employee contributions. The amount of the employee payroll tax has not yet been determined; however, the Maryland Department of Labor will determine an appropriate tax rate in the future.

- The payroll tax provisions of the Act are scheduled to begin on October 1, 2023, while benefits applications are scheduled to begin January 1, 2025.

- The Maryland Department of Labor is required to issue regulations by June 1, 2023.

Employee Eligibility

In order to be eligible for, and receive benefits from, the program, employees must have worked at least 680 hours over the twelve-month period preceding the date on which the leave is set to begin. There is no distinction between full-time and part-time employees.

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth or after the placement of the child through foster care, kinship care, or adoption;

- To care for a family member with a serious health condition;

- To provide leave to the employee due to a serious health condition that results in the employee being unable to perform the functions of their position;

- To care for a service member who is the employee's next of kin; or

- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee.

Benefit Amount and Duration

The program will replace up to 90% of weekly wages for an employer's lowest-paid eligible employees, with a lower percentage of wages replaced for those who earn higher incomes. Benefit payments will be capped at a maximum of $1,000 per week. The maximum benefit amount is indexed for inflation.

Benefit payments will be calculated based on the employee's average weekly wage over the last 680 hours that the individual was paid divided by the number of weeks worked. If the leave is intermittent or partial, a different formula for how to calculate the payment owed to the employee will be utilized.

Eligible employees may receive benefit payments for up to 12 weeks in an application year. An employee may be eligible for an additional 12 weeks of paid leave if, for example, the employee is ordered to bed rest by their attending physician prior to delivery of their child.

Employee Benefit Application

Employees who apply for benefits must provide written certification which includes the following information:

- The date when the serious health condition for the employee, their family member or service member began;
- Facts related to the condition provided by the licensed healthcare provider;
- Probable duration of the condition; and
- A statement that they are unable to perform their job duties.

Additional information will be requested when the leave is to care for a family member or due to deployment for a family member.

Leave Substitution

A covered employer may satisfy their requirements under the Act through other employer-provided leave, private insurance, or a combination of both. The substituted employer provided leave or insurance policy must pay benefits and offer terms (including eligibility, rights, and protections) equal to or exceeding those required by the Act. A private employer plan must be filed with the Maryland Department of Labor for approval.

Employee Notice Requirements

If the need for use of leave is foreseeable, an employer may require the employee to give at least 30 days' written notice before taking leave. If the leave is unforeseeable, notice to the employer from the employee will be due as soon as practicable.

If the leave requested by the eligible employee is to be taken on an intermittent leave basis, the employee must make a reasonable effort to schedule the leave in a manner that does not unduly disrupt the operations of the employer and provide reasonable prior notice of the reason why the intermittent leave is necessary. Intermittent leave cannot be taken in increments of less than 4 hours.

In all leave circumstances, the Act requires that eligible employees exhaust all employer-provided leave that is offered outside of the leave provided by the Act prior to making an application for benefits to the program.

Employer Responsibilities

An employer must provide written notice to each employee of their rights under this Act at the time of the employee's hire and then annually thereafter.

The notice must contain:

- The procedure an employee must utilize to file their claim;
- Advise the employee of their responsibility to provide proper notice prior to commencing leave and associated penalties for failure to do so;
- Note the employee's rights to job protection and to file a complaint for alleged Act violations; and
- A description of prohibited activities, penalties and complaint procedures under the Act.

If an employee requests leave under the Act, or the employer knows that the employee is on leave for an eligible reason, the employer will notify the employee of their eligibility to take leave within 5 business days.

An employer must:

- Continue any health benefits that a covered employee is enrolled during any leave taken under the Act.
- Protect and restore an employee to their position (or an equivalent) prior to taking eligible leave.

If the employee is entitled to greater benefits under a collective bargaining agreement or prior employer policy, the employer is still obligated to follow those policies and cannot utilize the Act as a reason to reduce the employees' rights under those leave policies.

Employer Action

Employers should:

- Await published regulations from the Maryland Department of Labor, expected in June 2023.
- Review and examine their existing paid leave policies (and their employee handbook) to determine whether they will want to utilize these policies to satisfy, or supplement, their requirements under the Act.
- Contemplate whether to participate in the state program or offer a private program (e.g., substitute existing leave or purchase a private insurance policy). Note, employer will need to apply for approval from the state's Department of Labor to offer an alternative plan. Guidance on this process is expected.
- Provide written notice to all covered employees of their rights and duties under the Act.

Oklahoma's Abortion Prohibitions and Their Impact on Health Plans

Similar to the Texas Heartbeat Act, Oklahoma's SB 1503 bans abortion after about six weeks of gestation except in the case of medical emergency. It was signed into law on May 3, 2022.

On May 25, 2022, another bill (HB 4327) which bans abortion at the time of fertilization with exceptions for medical emergencies or if the pregnancy was a result of rape, sexual assault, or incest reported to law enforcement was signed into law.

Both bills are effective immediately upon enactment and allow civilians to file lawsuits against people performing or facilitating access to abortion care. They also attempt to strip Oklahoma's state courts from any jurisdiction to consider whether the law violates state constitutional protections.

These bills are two of the three major abortion bans in Oklahoma passed in a little over a month. The other bill is SB 612 which was signed into law on April 12, 2022 and makes it illegal to perform or attempt to perform an abortion except to save the life of a pregnant woman in a medical emergency. A person convicted of performing or attempting to perform an abortion is guilty of a felony punishable by a fine not to exceed $100,000.00 and/or by confinement in the custody of the Department of Corrections for a term not to exceed ten years.

Civil Penalties

Both SB 1503 and HB 4327 allow any person to bring a civil action against any person who:

1. Performs or induces an abortion in violation of their terms;

2. Knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise, if the abortion is performed or induced in violation of their terms, regardless of whether the person knew or should have known that the abortion would be performed or induced in violation of their terms; or

3. Intends to engage in the conduct described by (1) or (2) above.

If a claimant prevails, the court will award:

1. Injunctive relief sufficient to prevent the defendant from violating these laws or engaging in acts that aid or abet violations of these laws;

2. Statutory damages in an amount of not less than $10,000 for each prohibited abortion that the defendant performed or induced;

3. Nominal and compensatory damages if the plaintiff has suffered harm from the defendant's conduct, including but not limited to loss of consortium and emotional distress; and

4. Court costs and attorney fees.

The statute of limitations is six years.

Importantly, in the context of employee benefits, an employer whose plan covers abortion could be held liable. The laws could also potentially affect employees at clinics, anyone who provides transportation for a patient to an abortion provider, those who donate funds for an abortion, and friends or family members who provide information to a patient about where to get an abortion.

While ERISA generally preempts any state law (other than a criminal law) that relates to employee benefit plans, it will be interesting to see whether challenges to preemption arise in this context.

Employer Action

Oklahoma employers with self-funded plans covering abortion should decide whether they want to continue to do so.

Employers should watch for further developments.

Connecticut Publishes Model Notice under CTFMLA and CTPL

As previously reported, the Connecticut Family Medical Leave Act ("CTFMLA") and the Connecticut Paid Leave Act ("CTPL") require employers to notify employees of certain rights under the Acts. The Connecticut Department of Labor ("CTDOL") and the Connecticut Paid Leave Authority ("CTPLA") have recently published a model notice for employers to provide employees which serves as a combined notice of eligibility and rights and responsibilities. The notice requirement is effective July 1, 2022. The notice may be found at: https://portal.ct.gov/-/media/DOLUI/NEW-53122-Prototype-of-Employers-Written-Notice-to-Employees-of-Rights-under-CTFMLA-and-CTPL.pdf.

Background

Beginning July 1, 2022, employers are required to provide written notice to each of their employees:

- Describing job-protected leave provided under CTFMLA;
- The opportunity to apply for income-replacement benefits from the CTPLA;
- The retaliation protections provided by the CTFMLA; and
- The employee's right to file a complaint with the Labor Commissioner.

Employer Notification

Under the Acts, employers are required to provide written notice at the time of hiring and annually thereafter. According to proposed amended CTFMLA regulations that have not been finalized, the notification can be satisfied by including the notice or policy in employee handbooks or other written guidance to employees concerning employee benefits or leave rights, if written materials exist, or by distributing a copy of the notice or policy to each new employee upon hiring. The proposed regulations and the CTDOL inform that employers may create their own forms or policies (as opposed to using the model combined notice) so long as they contain the information required by the regulations. The proposed regulations also inform distribution of the notice or policy may be accomplished electronically.

Employer Action

Employers should work with employment and labor counsel to review their leave policies and procedures to ensure they are compliant with the written notice requirement effective July 1, 2022. In addition, employers should monitor the CTDOL and CTPLA's websites for additional guidance and regulations.

Updates to Washington's Paid Family and Medical Leave Program

Governor Inslee signed into law legislation (2SSB 5649) that updates and modifies Washington's Paid Family and Medical Leave program ("WA PFML").

Notable modifications are as follows:

- Family leave for death of qualified family members. Allows family leave to be taken by an employee during the seven calendar days following the death of a family member for whom the employee:

  – would have qualified for medical leave for the birth of their child; or

  – would have qualified for family leave to bond with their child.

- Postnatal leave as medical leave unless employee chooses otherwise. Specifies that leave taken by certain employees in the first 6 weeks after giving birth must be medical leave unless the employee chooses to use family leave. A certification of serious health condition form is not required for paid leave benefits used in the postnatal period.

- Collective bargaining exception expires. Sunsets the collective bargaining agreement exception on December 31, 2023.

- ESD to post employers with approved voluntary plans. Requires the state's Employment Security Department ("ESD") to publish a list of employers with approved voluntary plans on its website.

- ESD will likely issue further guidance on these changes.

Washington State Lowers PAL Assessment Again

On May 25, 2022, the Washington Health Care Authority ("HCA") approved a reduction in the PAL assessment amount for fiscal year 2023. The WAPAL Fund announced a lower monthly assessment amount of $0.06 (reduced from the current $0.07) per covered life effective for payments due on November 15, 2022.

Background

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

The 2022 WAPAL Fund monthly assessment rate was previously set at $0.13 per covered life and was reduced to $0.07 per covered life for payments due February 15, 2022. The assessment amount is based on the number of covered lives each month. The WAPAL Fund Advisory Council reviewed the fiscal operations of the WAPAL Fund and determined that the rate could be reduced.

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 next reporting and payment deadline is August 15, 2022, for the months of April, May, and June 2022. The payment rate for payments due on August 15, 2022 is $0.07 per covered life.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at:

- The current rate of $0.07 for the payment due August 15, 2022 and
- The lower rate of $0.06 for the payment due on November 15, 2022.

A third-party administrator ("TPA") may be assisting with this process. Employers that make a payment at the higher rate should watch for a refund of excess funds from KidsVax. If not refunded within 30 days of payment, employers are directed to notify KidsVax.

Carriers are responsible for the payment for fully insured group health plans. No employer action is necessary.

2022 Compliance Bulletins: Quarter Three

July

August

September

New Mandatory Preventive Items And Services - 2022 Updates

Published: July 18, 2022

Most plans will be required to cover new preventive items and services beginning later this year or in 2023 (depending on the plan year), including ones related to condoms, double-electric breast pumps, suicide risk screening for adolescents, and diabetes screenings for certain populations.

Background

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

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

New Preventive Items and Services

The USPSTF newly covered items and services are as follows:

Topic	USPSTF Recommendation	Effective for Plan Years Beginning On or After
Gestational Diabetes: Screening asymptomatic pregnant persons at 24 weeks of gestation or after	Screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	September 1, 2022
Prediabetes and Type 2 Diabetes: Screening asymptomatic adults aged 35 to 70 years who have overweight or obesity	Screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	September 1, 2022
Chlamydia and gonorrhea screening for sexually active women, including pregnant persons 24 years or younger	Screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	October 1, 2022
Aspirin use to prevent preeclampsia and related morbidity and mortality: preventive medication pregnant persons at high risk for preeclampsia	Use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia.	October 1, 2022
Prevention of dental caries (cavities) in children younger than 5 years: screening and interventions	Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	January 1, 2023

Effective for plan years beginning on or after January 1, 2023, the HRSA newly covered items and services specifically for women are as follows:

Topic	USPSTF Recommendation
Obesity Prevention in Midlife Women	Counseling midlife women aged 40 to 60 years with normal or overweight body mass index (“BMI”) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
Breastfeeding Services and Supplies	Breastfeeding equipment and supplies must currently be covered. New guidance expands on the description to specifically include double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.
Contraception	Male condoms must be covered.

Screening for Human Immunodeficiency Virus Infection ("HIV")	HIV screening for all adolescent and adult women must currently be covered. New guidance specifies that adolescent and adult women ages 15 and older can receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Risk assessment and prevention education for HIV infection begins at age 13 and continues as determined by risk.
Well-Woman Preventive Visits	Women must currently be offered at least one preventive care visit per year beginning in adolescence and continuing across the lifespan. New guidance indicates that preventive services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Well-women visits include pre-pregnancy, prenatal, postpartum and interpregnancy visits.

Effective for plan years beginning on or after January 1, 2023, the HRSA newly covered items and services specifically for children and adolescents are as follows:

- An assessment for risks for cardiac arrest or death in ages 11-21 years was added.
- An assessment for hepatitis B virus infection in newborn to 21-year olds was added.
- Screening for suicide risk for ages 12-21 to the current Depression Screening category was added
- Psychosocial/behavioral assessment coverage was expanded to behavioral/social/emotional screening for newborn to 21-year olds.
- There is a clarifying reference to dental fluoride varnish and fluoride supplementation.

Employer Action

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

Fully insured health plans: Carriers are generally responsible for compliance and should include these benefits as applicable.

Self-funded health plans: Discuss with TPAs to ensure coverage is in effect for plan years that begin on or after the applicable effective dates.

HHS Extends Public Health Emergency Until October 13

Published: July 25, 2022

On July 15, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective July 15, 2022. 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 October 13, 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, or 2) 60 days after the announced end of the COVID-19 National Emergency

The following summarizes benefit plan provisions that are directly impacted by the extension of the Emergency Period and highlights the relief with respect to the ongoing Outbreak Period. Other temporary benefit plan provisions and changes that are allowed due to the ongoing pandemic are not included.

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.

- **Over-The-Counter ("OTC") COVID-19 Testing:** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

- **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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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).

Note: There is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

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 plan requirements. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements.

New Guidance On Prescription Drug Reporting Requirement

Published: August 01, 2022

As previously reported in December 2021, Section 204 of the Consolidated Appropriations Act, 2021 ("CAA") requires plan sponsors of group health plans to submit information annually about prescription drugs and health care spending to Centers for Medicare and Medicaid Services ("CMS") on behalf of the departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, the "Departments"). The first deadline is **December 27, 2022**. CMS recently updated guidance related to this reporting requirement that provides some helpful clarification.

What Must Be Reported?

- Plan name
- Plan number
- Plan year
- Employer size
- Plan sponsor's principal place of business
- Premiums (for self-funded plans, the premium equivalents)
- Average monthly premiums paid by the employer and the enrollees
- States in which the plan is offered
- Number of enrollees
- 50 most common brand prescription drugs dispensed
- 50 most costly drugs to total annual spending
- 50 drugs with the greatest year-over-year cost increase for the plan
- Total spending by the plan broken down by:
    - Types of cost (e.g., hospital, primary care, specialty care, medical benefit drugs, and other medical costs and services
    - Plan and enrollee spending on prescription drugs
- Impact on premiums and out-of-pocket cost associated with rebates, fees, or other payments by drug manufacturers to the plan (narrative response)
    - Includes prescription drug rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed for each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year

Who Must Report?

Employers with fully insured or self-funded (includes level funded) group health plans, including grandfathered plans, church plans subject to the Internal Revenue Code, and governmental plans.

The term "group health plan" does not include excepted benefits such as onsite clinics and accident-only policies. It also does not include account-based plans (e.g., HRAs or health FSAs).

Periods That Must Be Reported

Information is reported on a calendar year basis, regardless of plan year. This is referred to as a "reference year."

How is Reporting Done?

Data is reported through the RxDC module in the Health Insurance Oversight System ("HIOS"). An account must be created unless the employer:

- already has a HIOS account; or
- is not uploading anything because another vendor is handling the full filing; or
- where the employer is uploading partial data, not including any files.

NOTE: It can take up to two weeks to create an account so plan sponsors should plan accordingly.

The instructions to create a CMS Enterprise Portal and HIOS accounts are in the HIOS Portal User Manual. The instructions for using the RxDC module are in the RxDC HIOS User Manual. To log in to HIOS, go to the CMS Enterprise Portal at https://portal.cms.gov/portal/.

Can a Vendor Submit Information on an Employer's Behalf?

Yes.

Insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier.

Self-funded plans may enter into a written agreement with their third-party administrator ("TPA"), pharmacy benefit manager ("PBM"), or other vendor to fulfill reporting function on behalf of the plan; however, the plan sponsor remains liable for any failures.

An entity that submits some or all required information is called a "reporting entity." Reporting entities may charge additional fees for compiling and filing the data.

A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf. For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file and separately contract with a PBM to submit the Top 50 Most Costly Drugs file. Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.

Some of the above-listed data points may not be known by the issuer, TPAs, PBMs, or other vendors. Employers should be prepared to receive a request for information from the carrier, TPA, or PBM and either timely provide the information or prepare to do a partial filing.

Some carriers, TPAs, and PBMs have started to release information as it relates to this reporting. For example:

- UnitedHealthcare has indicated they will submit the full report for fully insured business. For self-funded business:
    - UnitedHealthcare will submit the full report where coverage is integrated with UnitedHealthcare (includes UMR and All Savers).

- If UHC is not the PBM (carve-out, including OptumRx Direct) or stop loss administrator, plan sponsors must ensure their vendors submit the appropriate files.

- CVS (a PBM) offers an option where it will submit certain data files (D3-D8) on behalf of the plan, but the employer remains responsible for submitting all Plan Files, Data Files D1-D2, and the narrative response (likely in coordination with the medical plan TPA).

If a plan, issuer, or carrier changes vendors during the reference year (such as changing a TPA or PBM), there are two reporting options:

1. The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or

2. The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data.

Either way, the plan sponsor must ensure that all their data is reported and that it is not double reported.

For mixed-funded plans, which generally self-fund some benefits and fully insure other benefits, the self-funded business is reported in the self-funded market segment and the fully insured business is reported in the fully insured market segment. For example, suppose a large employer self-funds the pharmacy benefit of a plan and purchases insurance for the medical benefits. In this case, the pharmacy benefits would be attributed to the market segment for self-funded large employer plans and the medical component of the same plan would be attributed to the fully insured large group market.

Currently, CMS does not have a mechanism to notify plans, issuers, or carriers when data has been submitted on their behalf. To confirm submission, plans should contact their reporting entities directly.

Fully-Insured to Self-Insured (or vice versa) during the Reference Year

The fully insured business is reported in the small group or large group market segments and the self-funded business is reported in the self-funded small employer or large employer market segments.

Deadline

The last day to submit data for the 2020 and 2021 reference years is December 27, 2022. The deadline for subsequent reference years is June 1st of the calendar year immediately following the reference year. So, June 1, 2023, is the second deadline, reporting calendar year 2022 information.

Penalty for Noncompliance

The penalty is $100 per affected individual. In addition, the DOL can enforce compliance.

Relief

For the 2020 and 2021 reference years only, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are not available and they are reported for the 2022 reference year and all future reference years.

Additional Information

For additional information on the requirements, please visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

1. For this purpose, a “clean claim” means the plan received the information necessary to adjudicate a claim for payment for such services.

IRS Announces 2023 ACA Affordability Indexed Amount

Published: August 08, 2022

The IRS recently announced in Revenue Procedure 2022-34 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be **9.12%** for plan years that begin in 2023. This is a notable decrease from the 2022 percentage amount (9.61%), and below the original 9.5% threshold.

Background

Rev. Proc. 2022-34 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2023

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2023 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

1. **The W-2 safe harbor.** The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.12% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. **Rate of pay safe harbor.** The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.12% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

3. **Federal Poverty Level ("FPL") safe harbor.** Coverage is affordable if it does not exceed 9.12% of the FPL. For a 2023 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than **$103.28** (48 contiguous states), $129.12 (Alaska), or $118.78 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2023 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

Further Guidance Issued On Contraceptive Coverage

Published: August 12, 2022

On July 28, 2022, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 54 to clarify protections for contraceptive coverage under the Affordable Care Act (the "ACA"). In January 2022, the Departments had issued guidance on the ACA Preventive Care Mandate, including contraception.

Background

As background, non-grandfathered group health plans must cover certain in-network preventive care items and services without cost-sharing. This includes, with respect to women, contraceptive services.

On December 30, 2021, the Health Resources and Services Administration ("HRSA") expanded the 2019 recommendation to include contraceptives that are not female-controlled, such as male condoms (which must be covered by the plan when prescribed).

Changes in recommendations or guidelines are typically applicable on the first day of the plan year that begins on or after the date that is one year after the date on which the recommendation or guideline is issued. Therefore, plans and issuers must currently provide coverage consistent with the new 2021 guidelines beginning with plan years starting on and after December 30, 2022 (compliance for calendar year plans begins on January 1, 2023).

FAQ Part 54

The Departments issued FAQ Part 54:

- In response to reports that individuals continue to experience difficulty accessing contraceptive coverage without cost sharing;
- To clarify application of the contraceptive coverage requirements to fertility awareness-based methods and to emergency contraceptives; and
- To address federal preemption of state law.

The Departments specifically note their commitment to ensuring access to contraceptive benefits without cost-sharing as entitled under the law and will take enforcement action as warranted. Violations may be subject to an excise tax of $100 per day per affected individuals under Code Sec. 4980D.

Briefly, the FAQs provide the following clarifications:

- Plans must cover, without cost sharing, items and services that are integral to the furnishing of recommended preventive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before provision of certain forms of contraceptives, such as an intrauterine device (also known as an IUD), regardless of whether the items and services are billed separately.

- In addition to what's outlined in the HRSA guidelines, plans must cover without cost sharing any contraceptive services and FDA approved, cleared, or granted contraceptive products that an individual and their attending provider havedetermined to be medically appropriate, whether or not those services or products are specifically identified in the categories listed in the HRSA-guidelines, including contraceptive products more recently approved, cleared, or granted by the FDA.

- Consistent with previous guidance (and as supported by HRSA guidelines), plans must cover, without cost sharing, (1) FDA-approved emergency contraception (levonorgestrel), and (2) emergency contraception (ulipristal acetate), including OTC products, when the product is prescribed for an individual by their attending provider. This includes when they are prescribed for advanced provision. The Departments encourage (but do not require) plans to cover dispensing of a 12-month supply of contraception (such as oral contraceptives) at one time without cost-sharing.

- Confirms the 2021 HRSA guidelines include "screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). This includes instruction in fertility awareness-based methods, including lactation amenorrhea.

- The guidance reaffirms that a health savings account ("HSA"), a health reimbursement arrangement ("HRA") and a health flexible spending account ("FSA") can reimburse an individual for the cost (or portion of the cost) incurred for OTC contraception to the extent that cost is not paid or reimbursed by another plan or coverage. Plans that cover the costs of OTC contraceptives without a prescription should advise individuals not to seek reimbursement from these tax favored accounts (no double dipping).

The FAQ further highlights when medical management may (and may not) be used for contraceptives. Specifically, the Departments caution plans and issuers of implementing burdensome, unreasonable medical management techniques which included situations such as:

- Denying coverage for all or particular brand name contraceptives, even after the individual's attending provider determines and communicates to the plan or issuer that a particular service or FDA-approved, cleared, or granted contraceptive product is medically necessary with respect to that individual;

- Requiring individuals to fail first using numerous other services or FDA-approved, cleared, or granted contraceptive products within the same category of contraception before the plan or issuer will approve coverage for the service or FDA-approved, cleared, or granted contraceptive product that is medically necessary for the individual, as determined by the individual's attending health care provider.

- Requiring individuals to fail first using other services or FDA-approved, cleared, or granted contraceptive products in other contraceptive categories before the plan or issuer will approve coverage for a service

- or FDA-approved, cleared, or granted contraceptive product in a particular contraceptive category.
- Imposing an age limit on contraceptive coverage instead of providing these benefits to all individuals with reproductive capacity.
- Requiring a participant or beneficiary to go through the plan's or issuer's internal claims and appeals process to obtain an exception to an adverse benefit determination.

Finally, the Departments specified that federal law would preempt any state law to the extent that it prevents the application of the ACA's preventive care mandate and highlights the Departments enforcement authority over plans.

Employer Action

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

Fully insured health plans. Carriers are generally responsible for compliance and should include these benefits as applicable.

Self-funded health plans. Discuss with TPAs to ensure coverage is in effect for plan years that begin on or after the applicable effective dates.

New Philadelphia Employee Commuter Transit Benefit Programs

Published: August 15, 2022

On June 22, 2022, Mayor Jim Kenney signed the Employee Commuter Transit Benefit Ordinance into law (the "Ordinance"). The Ordinance adds new commuter transit benefit programs in Philadelphia that require certain employers to provide a mass transit and bicycle commuter benefit program, beginning on December 31, 2022.

Who Does this Apply to?

Covered Employers are employers that employ at least 50 Covered Employees. Covered Employees are those who work at least 30 hours per week within the geographic boundaries of Philadelphia for the same employer within the previous 12 months.

What Must be Provided?

Covered Employers are required to make at least one of the following employee commuter transit benefit programs availability to all of their Covered Employees:

- Election of a pre-tax, payroll deduction for Mass Transit Expenses;
- An employer-paid benefit where the Covered Employer provides a pass, token, fare card or similar item entitling a person to transportation on public transit; or
- Any combination of the above. For 2022, the IRS will allow employees to set aside a maximum of $280 per month for commuter benefits on a tax-free basis.

In addition, Covered Employers also must offer their Covered Employees who regularly use a bicycle for commuting to and from work, a tax-free reimbursement of Qualified Bicycle Expenses, up to $20 per month. Cyclists are not permitted to exclude qualified bicycle commuting reimbursements from their income for federal income tax purposes for years 2018 through 2025.

What is a Mass Transit Expense?

A Mass Transit Expense is an expense incurred for a Fare Instrument or transportation in a commute highway vehicle, if used for travel between an employees' residence and workplace.

What Qualifies as a Bicycle Expense?

A Qualified Bicycle Expense is a reasonable expense incurred by a Covered Employee who regularly uses a bicycle for commuting to and from work. This includes the purchase, maintenance, repair and storage expenses related to bicycle commuting.

What is the Effective Date of the Ordinance?

The effective date of these programs is December 31, 2022. Covered Employees may report their employer. If a Covered Employer does not comply with the Ordinances within 30 days after a written warning by the agency designated by the Mayor, fines ranging from $140 to $300 per day may be imposed for each day the Covered Employer fails to comply (each a separate violation).

Employer Action

Covered Employers should:

- Review their current policies related to any commuter transit benefit program and ensure they comply with the Ordinance
- Begin taking steps to implement a commuter transit benefit program if they do not currently have one in place
- Notify employees of the new benefits once any new commuter benefit programs are implemented
- Keep an eye out for additional guidance and discuss next steps with their payroll providers and third-party vendors

New Cost-Sharing Disclosure In 2023-Reminder

Published: August 24, 2022

Another compliance deadline is quickly approaching. For plan years that begin on or after **January 1, 2023**, group health plans must provide for advance disclosure of cost-sharing information to enrollees seeking health services, upon request and to the extent practicable.

The format of the disclosure is through an Internet-based self-service tool, telephone, or paper format (upon request).

The tool allows the enrollee to compare the amount of cost-sharing that he or she would be responsible for with respect to a discrete covered item or service by billing code or descriptive term. The required information relates to geographic region and in-network and out-of-network providers and initially addresses 500 items and services. Full compliance (all items and services) is required for plan years beginning on or after January 1, 2024.

Specifically, the following cost-sharing information must be disclosed. The information should be accurate as of the time the request is made.

Content	Description
Estimated cost-sharing	An estimate of the covered enrollee's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan.
Accumulated amounts	Accumulated amounts of cost-sharing that the enrollee has already incurred under the plan at the time the request is made. This includes a current statement of how much the enrollee has already paid toward the deductible and out-of-pocket limit.
In-network negotiated rates	The plan would need to disclose the dollar amount they have agreed to pay in-network providers for a certain service or prescription drug.
Out-of-network allowed amounts	The plan must provide the maximum amount that could be paid by the plan for a particular service or drug that is out-of-network.
If applicable, bundled payment arrangements	Cost-sharing information for each item and each service within the bundle must be disclosed.
Pre-requisites	Any coverage prerequisites (e.g., prior authorization or step therapy) before an enrollee can receive a service or item.

Disclosure	Disclosure that includes definitions of key terms, disclaimers related to billed charges versus estimated charges, a reminder that balance billing is not included in cost estimates, and contact information for questions. A model notice is available.

Good faith relief is available. When a plan or carrier makes an error or omission when acting in good faith and with reasonable diligence a plan will not fail to comply because:

- An error or omission in the required disclosure is made, provided the information is corrected as soon as practicable.
- The internet website is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable.
- Information must be obtained from a third party to comply with this requirement, and is relied upon in good faith, unless it is known (or reasonably should have known) the information is incomplete or inaccurate.

Insurers are responsible for compliance with respect to insured plans. Employers with a fully insured plan can agree in writing to have the carrier provide the disclosure. If the carrier fails to comply, the carrier (and not the plan's sponsor) is liable.

While employers are responsible for compliance with respect to self-funded plans, third party administrators are expected to handle this task on their behalf. Employers should seek written assurances of their assistance with this requirement.

Additional guidance may be issued before the effective date. We will continue to monitor developments.

Inflation Reduction Act-Health Care Considerations

Published: August 25, 2022

On August 16, 2022, President Biden signed the "Inflation Reduction Act" into law. The legislation includes key health care,tax, and climate change components.

As it relates to health care, the bill:

- Temporarily extends through 2025 the expanded premium tax credits available in the Marketplace. Originally, under the American Rescue Plan Act ("ARPA"), the expanded subsidies were only available in 2021 and 2022.

- Creates a safe harbor that permits first dollar coverage for "selected insulin products" under a qualified high deductible health plan ("HDHP"), effective for plan years beginning on or after January 1, 2023.

    - "Selected insulin products" means any dosage form (such as vial, pump, or inhaler dosage forms) of any different type of insulin (such as rapid-acting, short-acting, intermediate-acting, long-acting, ultra-long-acting, and premixed).

    - Under earlier guidance, insulin and other glucose lowering agents may be treated as preventive care for individuals diagnosed with diabetes. Many HDHPs may already cover insulin as preventive care under this guidance.

- Includes several provisions under Medicare, particularly with respect to pharmaceutical coverage and Medicare Part D.

    - Permits the federal government to negotiate directly with pharmaceutical manufacturers on prices for certain Medicare prescription drugs beginning in 2026. In addition, beginning in 2023 the law requires drug companies to pay a rebate to the government if prices rise faster than inflation.

    - Sets a $35 cap on out-of-pocket costs for insulin for those with Medicare coverage.

    - Sets a $2,000 "hard" cap on Medicare Part D out-of-pocket cost sharing starting in 2025.

It should be noted that the pricing negotiated by the government, as well as the rebates, are not available to commercial plans (including employer-sponsored health plans). Because of this, and with the additions of the new cap on insulin and the upcoming hard cap on Medicare Part D out-of-pocket cost, there could be a cost-shifting by the pharmaceutical manufacturers and/or pharmacy benefit managers to the commercial marketplace.

Employer Action

If offering an HDHP with an HSA, the law codifies the ability of a plan to provide first dollar coverage for insulin without jeopardizing an individual's ability to make HSA contributions.

Employers should stay informed as to the impact on prescription drug costs in the commercial market as a result of the federal government new negotiation power. While this will not take effect until 2026, it will be important to watch the costs in this area.

New York Extension Of Paid Leave For COVID-19 Vaccinations

Published: August 26, 2022

Governor Cuomo signed legislation on March 12, 2021, requiring all New York public and private employers to provide employees up to four (4) hours of paid leave per required dose of the COVID-19 vaccine. Employees requiring two separate injections (e.g., the Pfizer and Moderna COVID-19 vaccines) will be entitled to up to eight (8) hours of paid leave. The provisions of this Act took effect immediately and are in effect through December 31, 2022.

On June 28, 2022, New York Governor Kathy Hochul signed into law a bill extending the state's COVID-19 vaccine paid leave law for an additional year, through December 31, 2023. The law permits paid time off for boosters, as well.

As a reminder, the following are key points of interest for the COVID-19 vaccination leave:

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

Employer Action

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

HHS Proposes Expanded Section 1557 Nondiscrimination Rules

Published: September 09, 2022

On July 25, 2022, the Department of Health and Human Services ("HHS") issued a proposed rule that intends to broaden the interpretation and application of the nondiscrimination rules under Section 1557 of the Affordable Care Act ("ACA") to include:

- Reinstatement of protections on the basis of gender identity,
- Expanding who is subject to Section 1557, and
- Reinstating certain notice requirements.

While Section 1557 generally applies to covered entities, these changes may impact some employer sponsored group health plans.

Background

Section 1557, which has been in effect since the ACA was enacted in 2010, prohibits discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability. Initial regulations issued in May 2016 were partially repealed under current regulations issued in June 2020. There have also been numerous court challenges under Section 1557, including those on religious grounds.

This article only addresses details under the proposed rule that would likely apply to employers who sponsor group health plans. If finalized as is, the new rule's effective date would generally be 60 days after publication in the Federal Register. However, it appears provisions applicable to plans would be effective as of the next plan year.

Highlighted Changes to the Rule

The related HHS press release highlights changes under the rule, as follows (with additional commentary added):

» Reinstates the scope of Section 1557 to cover HHS' health programs and activities.

- This would broaden the situations where Section 1557 may apply, by mostly reverting back to the 2016 rule, and undoing the 2020 rule that narrowly applies to entities "principally engaged" in healthcare.
- For employer purposes, the proposed rule would generally apply to every health program or activity, any part of which receives federal financial assistance, directly or indirectly, from HHS.
- "Covered entities" are recipients of such assistance and could include state or local health agencies;

- hospitals; health clinics; health insurance issuers; physician's practices; pharmacies; community-based health care providers; nursing facilities; and residential or community-based treatment facilities.

- A "health program or activity" will mean any project, enterprise, venture or undertaking to provide or administer health-related services, health insurance coverage, or other health-related coverage; provide assistance to persons in obtaining health-related services, health insurance coverage, or other health-related coverage; provide clinical, pharmaceutical, or medical care; engage in health research; or provide health education for health care professionals or others.

» Clarifies the application of Section 1557 nondiscrimination requirements to health insurance issuers that receive federal financial assistance.

- This would undo the 2020 rule that narrows applicability specifically to health insurance products for which an issuer received federal financial assistance.

- Any health insurance issuer receiving any federal financial assistance, such as through offering of Marketplace coverage, would have to comply with nondiscrimination requirements for all its health insurance business, including when it serves as a TPA for self-insured group health plans.

    - The Office of Civil Rights (OCR) can hold TPAs responsible for discriminatory action the TPAs control with respect to plan design and administration.

- Most significantly, the proposed rule would not apply Section 1557 to an employer's employment practices, including its health benefits programs, even if offered by a covered entity such as a health care provider.

    - For a discriminatory self-insured plan design controlled by a plan sponsor, whether or not a covered entity, OCR can refer complaints to the EEOC or the DOJ, such as for possible violations of Title VII of the Civil Rights Act of 1964.

    - Though employers sponsoring employee health benefit plans may not be directly subject to the proposed rule, individuals covered by such plans may have certain rights and receive various communications from an issuer or TPA pertaining to Section 1557.

» Aligns regulatory requirements with Federal court opinions to prohibit discrimination on the basis of sex including sexual orientation and gender identity.

- This is consistent with the Supreme Court conclusion in Bostock v. Clayton County, GA, and HHS' previously announced interpretation and enforcement of Section 1557 pursuant to that case.

New FAQ Addresses NSA And TiC Rules

Published: September 13, 2022

The Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 55, providing guidance as it relates to certain aspects of the No Surprises Act ("NSA") and the Transparency in Coverage ("TiC") final regulations. FAQ 55 includes 23 questions and answers. The guidance is lengthy and very detailed. Below you will find some of the key highlights of the guidance.

No Surprises Act

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

- Emergency services;
- Non-emergency services delivered by OON providers at in-network (participating) facilities; and
- OON air ambulance services.

The FAQ:

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

- Addresses how the NSA applies to plans without a network of providers, closed network plans and air ambulances services;

- Confirms the NSA applies to emergency services furnished in behavioral health crisis facilities;
- Clarifies the disclosure requirements and provides a revised model disclosure notice for group health plans; and
- Further explains calculating the qualifying payment amount ("QPA") and answers various questions related to the federal independent dispute resolution ("IDR") process.

No Network Plans

In a plan that does not have a network of providers (e.g., reference-based pricing plans):

- The surprise billing protections apply to OON emergency services and OON air ambulance services. However, the protections with respect to non-emergency services provided by OON providers at in-network facilities would never be triggered if a plan does not have a network of participating facilities.
- Cost-sharing for OON items and services subject to the NSA is based on the lesser of the billed charge or the QPA. When a plan does not have sufficient information to calculate a median contracted rate, for example because the plan does not have a network of participating providers for the items or services involved, the QPA should be calculated using an eligible data base in accordance with the regulations.
- Out-of-pocket spending incurred by a participant for emergency services should be counted against the maximum out-of-pocket ("MOOP") spending with respect to providers who do not accept the reference price. Under the NSA, this definition is expanded to include post-stabilization services that are emergency services.

Closed Network Plans

The NSA protections for emergency services, non-emergency services furnished by an OON provider at an in-network facility, and air ambulance services apply if those services are otherwise covered under the plan, even if the plan does not provide coverage OON.

This requirement may result in the plan providing benefits for OON items and services subject to the NSA even if the plan would not otherwise cover these items and service on an OON basis.

Disclosures for Protection Against Balance Billing

Under the NSA, a group health plan and carrier must make a disclosure of the protections under the NSA publicly available, posted on a public website of the plan or carrier and included on each explanation of benefits ("EOB") for NSA claims.

The FAQ:

- Clarifies that if a group health plan does not have a website, the plan may satisfy the public posting requirement by entering into a written agreement with a carrier or TPA to post the information on its public website where information is normally made available to participants. This would apply in instances where the plan sponsor (for example, an employer) may maintain a public website, but the group health plan sponsored by the employer does not.
- Confirms that plans are not required to provide information on all state balance billing laws in the required disclosure. Rather plans are only required to provide information on applicable state laws regarding OON balance billing. If a plan is a self-funded ERISA plan, generally state balance billing laws are not applicable; therefore, a plan does not need to include state balance billing information. However,if a self-funded plan has voluntarily "opted in" to a state balance billing law, the plan must disclose that information.

The model NSA disclosure has been updated for use by group health plans and carriers for plan years beginning on

or after January 1, 2023. Before this date, a plan may use either the original model notice or the updated version. For the revised instructions and notice, visit: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (starts on page 14).

Calculating the Qualifying Payment Amount

The FAQ provides additional clarification on calculating the QPA by provider specialty and permits self-funded health plans with multiple benefit options administered by different TPAs to calculate median contracted rates separate for those benefit packages administered by the TPA (instead of having to aggregate the rate across separate benefit package options administered by separate TPAs).

Federal IDR Process

The FAQ offers further clarification on the federal IDR process to ensure billing disputes are resolved in a timely manner. Among other requirements, the FAQs address timeframes and additional disclosures that must be satisfied when the plan makes an initial payment or send notice of a denial of payment to a provider or facility, and the process for initiating an open negotiation period that must precede any initiation of the federal IDR process.

Transparency in Coverage

The final TiC rule requires group health plans and carriers make public three machine-readable files ("MRFs") disclosing:

1. In-network rates,

2. OON allowed amounts and billed charges, and

3. Negotiated rates and historical net prices for covered prescription drugs.

With respect to (1) and (2), the requirement to post MRFs took effect July 1, 2022 (for plan years that began between January 1, 2022 and July 1, 2022) and, for plan years that begin after July 1, 2022, the file must be posted in the month the plan year begins. These files must be updated monthly. The MRF related to prescription drugs is not being enforced pending further guidance.

In addition, for plan years beginning on or after January 1, 2023, group health plans and carriers must disclose cost sharing information with respect to 500 identified items and services in advance of receiving care. Full compliance is required for plan years beginning on or after January 1, 2024.

TiC – Machine-Readable Files

There was some confusion with respect to the website posting requirement under the regulations. The FAQ confirms:

- If a group health plan does not have its own public website, nothing in the final rules requires the plan to create its own website for the purposes of providing a link to a location where the MRFs are publicly available.

- A plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the machine-readable files on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable.

TiC – Cost-Sharing Disclosure

The FAQ provides a link to the list of the 500 items and services that must be included in the first phase of implementation of the internet-based self-service tool: www.cms.gov/healthplan-price-transparency/resources/500-items-services.

The Departments will update the list quarterly to reflect changes (including the retirement of any codes) and provide a reasonable period of time for plan and carriers to update their tools to reflect current codes.

Plans and carriers should refer to this webpage for the most up-to-date list of codes to comply with the requirements regarding the self-service tool for plan years beginning on or after January 1, 2023.

Employer Action

The guidance provides helpful clarification. Many aspects of the NSA and TiC rules are functions of plan administration and claims payment; support from carriers and third-party administrators ("TPAs") is essential for compliance.

For fully insured plans, these requirements should be handled by the carrier.

For a self-funded plan (including level-funded), the plan is ultimately responsible for compliance and should work with third party administrators to ensure the plan is administered in accordance with the NSA and TiC rules.

Additional Guidance On New Prescription Reporting Requirement

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As previously reported in 2021, Section 204 of the Consolidated Appropriations Act, 2021 ("CAA") requires plan sponsors of group health plans to submit information annually about prescription drugs and health care spending to Centers for Medicare and Medicaid Services ("CMS") on behalf of the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, the "Departments"). The first deadline is December 27, 2022. CMS recently updated guidance related to this reporting requirement that provides some helpful clarification.

What is Reported?

- Plan name
- Plan number
- Plan year
- Employer size (self-funded plans must elect an reasonable method of determining determine number of employees)
- Plan sponsor's principal place of business (for self-funded MEWAs, employer's principal place of business)
- Premiums (premium equivalents for self-funded plans)
- Average monthly premiums paid by the employer and the enrollees
- States in which the plan is offered
- Number of enrollees
- 50 most common brand prescription drugs dispensed
- 50 drugs with the greatest year-over-year cost increase for the plan
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, medical benefit drugs, and other medical costs and services)
  - Plan and enrollee spending on prescription drugs
- Impact on premiums and out-of-pocket costs associated with rebates, fees, or other payments by drug manufacturers to the plan (narrative response)
  - Includes prescription drug rebates, fees, and any other renumeration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed for each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year

Who must Report?

Employers with fully insured or self-funded (includes level funded) group health plans, including grandfathered plans, church plans subject to the Internal Revenue Code, and governmental plans.

The term "group health plan" does not include excepted benefits such as onsite clinics and accident-only policies. It also does not include account-based plans (e.g., HRAs or health FSAs).

What Periods are Reported?

Information is reported on a calendar year basis, regardless of plan year. This is referred to as a "reference year."

How is Date Reported?

Data is reported through the RxDC module in the Health Insurance Oversight System ("HIOS"). An account must be created unless the employer:

- Already has a HIOS account; or
- Is not uploading anything because another vendor is handling the full filing; or
- Where the employer is uploading partial data, not including any files.

NOTE: It can take up to two weeks to create an account so plan sponsors should plan accordingly.

The instructions to create a CMS Enterprise Portal and HIOS accounts are in the HIOS Portal User Manual. The instructions for using the RxDC module are in the RxDC HIOS User Manual. To log in to HIOS, go to the CMS Enterprise Portal at https://portal.cms.gov/portal/.

Can a Vendor Submit Information on the Employer's Behalf?

Yes. Insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier.

Self-funded plans may enter into a written agreement with their third-party administrator ("TPA"), pharmacy benefit manager ("PBM"), or other vendor to fulfill reporting function on behalf of the plan; however, the plan sponsor remains liable for any failures.

An entity that submits some or all required information is called a "reporting entity." Reporting entities may charge additional fees for compiling and filing the data.

A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf. For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file and separately contract with a PBM to submit the Top 50 Most Costly Drugs file. Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.

Some of the above-listed data points may not be known by the issuer, TPAs, PBMs, or other vendors. Employers should be prepared to receive a request for information from the carrier, TPA, or PBM and either timely provide the information or prepare to do a partial filing.

If a plan, issuer, or carrier changes vendors during the reference year (such as changing a TPA or PBM), there are two reporting options:

1. The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or
2. The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data.

Either way, the plan sponsor must ensure that all their data is reported and that it is not double reported.

For mixed-funded plans, which generally self-fund some benefits and fully insure other benefits, the self-funded business is reported in the self-funded market segment

and the fully insured business is reported in the fully insured market segment. For example, suppose a large employer self-funds the pharmacy benefit of a plan and purchases insurance for the medical benefits. In this case, the pharmacy benefits would be attributed to the market segment for self-funded large employer plans and the medical component of the same plan would be attributed to the fully insured large group market.

Currently, CMS does not have a mechanism to notify plans, issuers, or carriers when data has been submitted on their behalf. To confirm submission, plans should contact their reporting entities directly.

What if a Plan Changes from a Fully-Insured Product to Self-Funded Coverage in the Middle of the Reference Year or Vice Versa?

The fully insured business is reported in the small group or large group market segments and the self-funded business is reported in the self-funded small employer or large employer market segments.

When is the Deadline and What is the Penalty for Noncompliance?

The last day to submit data for the 2020 and 2021 reference years is **December 27, 2022.** The deadline for subsequent reference years is **June 1st** of the calendar year immediately following the reference year. So, June 1, 2023, is the second deadline, reporting calendar year 2022 information.

The penalty is $100 per affected individual. In addition, the DOL can enforce compliance.

Is there any Relief?

For the 2020 and 2021 reference years only, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are not available and they are reported for the 2022 reference year and all future reference years.

There remain many unanswered questions with respect to this reporting. Hopefully, the Departments will issue further guidance before the due date.

Issuers, TPAs, PBMs, and other third-party vendors are expected to be reaching out to plan sponsors in the coming months.

Medicare Part D Notification Requirements

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Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is “creditable” or “non-creditable.” This notification must be provided prior to October 15th each year. Also, following the plan’s annual renewal, the employer must notify the Centers for Medicare & Medicaid Services (“CMS”) of the creditable status of the drug plan.

Employers should send these notices no later than October 15, 2022 if they haven’t done so already.

Below you will find information that summarizes these requirements in more detail.

What are the Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, generally imposes a lifetime penalty for late enrollment if an individual delays enrolling in Part D after initial eligibility (for example, after reaching age 65), unless the individual continues to be covered by an employer’s group medical plan because of active employment or COBRA, and coverage under the plan is “creditable” (meaning equal to or better than coverage provided under a Part D standard plan).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters (notices last updated by CMS for use on or after April 1, 2011).

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

To Whom Should the Participant Notice Be Sent?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to (but no more than 12 months before) October 15th each year (or next working day);
- Prior to (but no more than 12 months before) an individual's Initial Enrollment Period for Part D (three months before the month of the person's 65th birthday);
- Prior to (but no more than 12 months before) the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable, or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, CMS will consider the first two bullet points satisfied. Many employers provide the notice in connection with the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should also provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice Be Sent?

Entities have flexibility in the form and manner in which they provide notices to participants.

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements in 29 CFR § 2520.104b-1(c)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must

be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

> If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Personalized Notices

A personalized notice is only provided upon request of the beneficiary. If an individual requests a copy of a disclosure notice, CMS recommends that entities provide a personalized notice reflecting the individual's information.

For more information on the participant disclosure requirement, visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

CMS Notification

When and How Should Notification Be Given to CMS?

Employers will also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (March 1, 2023 for a 2023 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

Notice must be submitted electronically by completion of a form found at:
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

Additional guidance on completing the form, including screen shots, is available at:
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/2009-06-29_CCDisclosure2CMSUpdatedGuidance.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected total of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

Some plans will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.

2022 MLR Rebate Checks To Be Issued Soon To Fully Insured Plans

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As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers are required to distribute MLR checks to employers by September 30, 2022.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What Do I Do with this MLR Rebate Check?

Insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to enrollees.

This does not apply to self-funded plans.

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- Who receives a rebate (e.g., current participants v. former participants);
- The form of the rebate (e.g., premium reduction v. cash distribution);
- The tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- What, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the Rebate Amount Be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any Communication?

Yes. For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [September ___] paychecks.

What will the Form of Rebate to the Employer Be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will the Rebate be Issued?

Rebates must be paid by September 30 each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do Employers Have to Give Some or All of the Rebate to Participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015 provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do Rebates Need to be Made to Participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the Form of Rebate to Participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants. This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants. This is administratively burdensome and results in tax consequences to former participants.
- The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the Federal Tax Implications to Employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.

- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

What are the Tax Implications to Employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When Employees Pay Premiums on a Pre-Tax Basis, does Reducing a Participant's Premiums Mid-Year Allow them to make Election Changes?

Probably not. If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.

- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.

Final Rules Adopt Administrative Changes To The No Surprises Act

Published: September 22, 2022

On August 26, 2022, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") published final rules on the No Surprises Act, making changes to the administrative duties of insurance carriers, HMOs, third-party administrators, out-of-network healthcare providers, and certain other entities responsible for the Act's implementation.

The new rules, which take effect on October 25, 2022, are narrow in scope, and include the following changes:

- During processing of claims under the No Surprises Act, if "down-coding" occurs (i.e., the group medical plan alters or replaces the medical billing codes chosen by the out-of-network healthcare provider, resulting in a lower claim payment), then the final rules impose additional disclosure requirements on the plan.

- If a group medical plan and an out-of-network healthcare provider are unable to agree on the final claim payment under the No Surprises Act, and the dispute is referred to a certified independent dispute resolution entity ("IDR entity"), the final rules require the IDR entity to consider more evidence before making its decision, and to disregard any presumption in favor of the qualified payment amount ("QPA") (contrary to the position previously taken by the Departments).

Background

The No Surprises Act, which was enacted into law as part of the Consolidated Appropriations Act, 2021, generally limits out-of-network cost sharing, and prohibits balance billing, when participants in a group medical plan receive (1) emergency services from an out-of-network healthcare provider, (2) non-emergency services from an out-of-network healthcare provider at an in-network medical facility, or (3) air ambulance services.

The Departments then published interim final rules on the No Surprises Act in July 2021 and in October 2021. Certain aspects of the October 2021 interim final rules were subsequently set aside by a federal district court. Rather than appeal the court's decision, the Departments decided to alter the interim final rules, resulting in publication of the current rules.

Down-Coding

According to the final rules, "down-coding" occurs when the insurance carrier, HMO or third-party administrator for a group medical plan alters a medical billing code to another code, or alters, adds, or removes a modifier, if the changed code or modifier is associated with a lower claim payment compared to the code or modifier that was chosen by the out-of-network healthcare provider.

The final rules state that, whenever "down-coding" occurs under the No Surprises Act, the insurance carrier, HMO or third-party administrator for the group medical plan is required to furnish the following additional information to the out-of-network healthcare provider:

- A statement that the medical billing code or modifier chosen by the out-of-network healthcare provider was down-coded;
- An explanation of why the code or modifier was down-coded, including a description of which codes were altered (if any), and which modifiers were altered, added, or removed (if any); and
- The amount that would have been paid by the plan had the code or modifier not been down-coded.

Additionally, the final rules state that the Departments are responsible for monitoring the accuracy of claim payment calculations under the No Surprises Act and is committed to conducting audits for that purpose.

Determination of Claim Payments under Independent Dispute Resolution

Under the No Surprises Act, if the insurance carrier, HMO or third-party administrator for the group medical plan is unable to reach agreement with an out-of-network healthcare provider on the final claim payment (which is called the "out-of-network rate"), then either party may refer the dispute over the out-of-network rate to a certified independent dispute resolution entity. Then:

- Each party will make an offer regarding the out-of-network rate to the IDR entity, along with arguments in support of its offer.
- The IDR entity must select one of the two offers as the out-of-network rate for each item or service that is subject to the dispute.

Before the federal district court set aside portions of the interim final rules, the IDR entity began with the presumption that the QPA constituted a reasonable market-based payment for the relevant items and services. The IDR entity would then evaluate additional information from the parties (subject to certain restrictions set forth in the interim final rules) before making its decision.

The final rules remove the presumption in favor of the group medical plan, and also remove certain restrictions on information that may be furnished by the parties in support of their offers. The final rules now specify that the IDR entity must consider all credible information submitted by the parties and determine which offer best reflects the appropriate out-of-network rate.

Examples of information that may be submitted to the IDR entity include the following:

- If the out-of-network healthcare provider is a Level 1 trauma center, the provider could furnish (a) information showing that the scope of services available at the facility was critical to the delivery of emergency services to the patient, given the patient's health condition at the time, and (b) information showing that the offer made by the group medical plan is based on emergency services from lower level facilities (i.e., not Level 1 trauma centers).

- If the out-of-network healthcare provider submits information showing that the patient's condition required the taking of a comprehensive history, a comprehensive examination, and a medical decision of high complexity, the group medical plan could respond with information showing that these factors are already included within the medical billing code chosen by the plan as the basis for its offer.

In addition, the final rules require the IDR entity to explain its payment determinations and underlying rationale in a written decision submitted to the parties and the Departments.

Employer Action

For fully insured group medical plans, the insurance carrier or HMO is responsible for complying with the final rules.

For self-funded group medical plans, the third-party administrator should be handling compliance with the final rules, although the employer or other plan sponsor is ultimately liable for any noncompliance. It will be important for the employer or other plan sponsor to monitor and confirm that the TPA is operating the plan in compliance with the final rules, especially in view of the Departments' promise to conduct audits of claim payment calculations under the No Surprises Act.

New York Paid Family Leave 2023 Contributions and Benefits

Published: September 23, 2022

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2023, will be reduced by **10%** and be set at **.455%** of weekly wages.

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the annualized New York State Average Weekly Wage ("NYAWW"). For 2023:

- NYAWW in effect will be **$1,688.19**, an increase of 5.9% from the 2022 NYAWW of $1,594.57. The annualized NYAWW is **$87,785.88**.
- The maximum annual employee contribution will be $399.43 ($423.71 in 2022).

The PFL benefit is 67% of an employee's Average Weekly Wage (up to the NYAWW) payable for 12 weeks. For 2023:

- The maximum weekly PFL benefit will be **$1,131.08** ($1,068.36 in 2022).
- The maximum annual PFL benefit payable for 12 weeks will be **$13,572.96** ($12,820.32 in 2022).

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a 52-consecutive week period is limited to 26 weeks.
- If an employee begins continuous leave in 2022 and the leave extends into the 2023, the benefit is based on the rate in effect on the first day of leave (i.e., in 2022) and is not recalculated at the 2023 rate.
- If an employee begins intermittent leave in 2022 and the leave extends into the following year and there is at least a three-month lapse in days taken under NYPFL, the leave is considered a new claim under the law in 2023 and the benefit is calculated at the 2023 rate.

Employer Action

Employers should prepare for the 2023 New York PFL contribution and benefit changes that begin in January. PFL coverage will typically be added as a rider on an employer's existing disability insurance policy, although benefits can be provided through a self-funded plan approved by the New York Workers' Compensation Board.

2022 State-Based Compliance: Quarter Three

Colorado

Massachusetts

Washington

Oregon

Colorado Enacts New Paid Family and Medical Leave Requirement

On November 3, 2020, Colorado voters approved the Colorado Paid Family and Medical Leave Insurance Act ("the Act"), creating the Paid Family and Medical Leave Insurance program ("the FAMLI program"). Joining a handful of other states with similar laws, the FAMLI program will provide most Colorado employees with partial wage replacement for 12-16 weeks of leave, depending on the circumstances. The state recently published guidance regarding the FAMLI program.

Overview

- The FAMLI paid leave requirements are applicable to any employer that employs at least one individual in Colorado.
- Benefits will be funded by employer and employee contributions. In the program's first two years, the initial premium rate will be 0.9% of wages per employee. Beginning in 2025, the FAMLI program director can set the premium up to 1.2% of an employee's taxable wages.
- Employers with 10 or more employees must pay at least 50% of the premium. Employers with fewer than 10 employees do not have to contribute to the program, but do need to remit their employees' share of premium payments.
- Contributions are scheduled to begin January 1, 2023, while paid benefits under the FAMLI program will commence January 1, 2024.

Covered Employers

Most Colorado employers will be covered by the FAMLI program. Private employers with at least one employee in Colorado must provide paid family and medical leave to its eligible Colorado employees.

Local government employers, including charter schools, may choose to opt out of the FAMLI program by holding a vote in 2022. If a local government declines to participate in the program, notice must be provided to its employees within 30 days of the vote. This notice must inform its employees that they may still opt into the FAMLI program individually similar to self-employed individuals or independent contractors.

Local governments must also notify the FAMLI Division in writing of their decision to opt out of the program by January 1, 2023. Failure to do so will result in presumed participation in the FAMLI program.

Regardless of the decision to opt out or participate, local governments are required to register with FAMLI's online employer service system. This registration allows FAMLI to track the local government employer's participation decision, including the obligation to revisit an opt out vote after eight years. Also, the online registration facilitates the submission of wage reports and individually participating employees' premium deductions via payroll deductions from local governments that have opted out of fully participating.

Federal government employees and certain railroad employees are not covered by the FAMLI program.

Employee Eligibility

To be eligible, and receive benefits from the FAMLI program, employees must have earned at least $2,500 in wages in the State of Colorado during the 12-month period prior to requesting benefits. There is no distinction between full-time and part-time employees.

Employees that work a portion of their time within Colorado may also be eligible for paid leave. Specifically, the following employees are eligible for the paid leave:

- Employees who perform work both within and outside of Colorado but work outside of Colorado is incidental to employee's work within the state, or is temporary or transitory and consists of isolated transactions; or
- Employees whose work is not primarily localized in any state, but some work is performed in Colorado and:
  - » The employer's base of operations is in Colorado, or, if the employer does not have a base of operations, the employee's work is directed or controlled from Colorado; or
  - » The employer's base of operations nor place from where the work is directed is not from any state, but the employee's individual residence is in Colorado.

Self-employed individuals and independent contractors may also be eligible if they have opted into coverage for no less than three years and live and work in Colorado.

Reasons for Leave

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth, adoption or placement through foster care;
- To care for a family member with a serious health condition;
- To provide leave to the employee due to a serious health condition;
- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee; and
- The employee, or a family member of the employee, is a victim of domestic violence, stalking, or sexual assault.

Benefit Amount and Duration

Covered individuals will be eligible for paid leave equal to:

- 90% of their average weekly wage for the portion of their wages equal to or less than 50% of the state average weekly wage; and
- 50% of the portion of their wages that exceeds the state average weekly wage.

For covered leave beginning before January 1, 2025, benefit payments will be capped at $1,100 per week. Thereafter, the maximum weekly benefit will be 90% of the state average weekly wage.

Covered individuals are eligible to receive benefit payments for up to 12 weeks in an application year. An individual may receive an additional four weeks of paid leave if they have a serious health condition related to pregnancy or childbirth complications, for a total of 16 weeks.

Contribution Rates

Beginning January 1, 2023, employers and their employees will be responsible for funding the FAMLI program. The initial premium rate is 0.9% of wages per employee. In 2025, the premium may increase up to 1.2% of an employee's taxable wages. Employers with 10 or more employees are required to pay at least 50% of the premium, but may choose to contribute a larger percentage. Employers with fewer than 10 employees are not required to contribute, but must still remit their employees' share of premium payments equal to 50% of the 0.9% premium rate (i.e., 0.45% of wages per employee).

The "wages" subject to the FAMLI program's payroll tax include salary or hourly wages, commissions, payments on a project basis, bonuses, or other forms of compensation (e.g., lodging and board, payments in kind, etc.). However, premiums are capped at the Social Security Wage base, which for 2023 is projected to be $155,100. This would result in a total maximum annual premium of $1,395.90 (combined employer and employee contribution) for the 2023 calendar year.

Employers must submit to the Colorado Department of Labor and Employment ("CDLE") both their share, if required, and their employees' share of the FAMLI premiums through an online system at the end of each quarter. These quarterly filings should be similar to how most companies currently submit their unemployment insurance.

Employer Private Plan Substitution

A covered employer may satisfy their obligations under the program through their own, approved private paid medical and family leave plan. To be approved, the private plan must be as generous as the FAMLI program, offering at a minimum the same rights, protections and benefits. Employees can be required to contribute to the private plan, but not more than what the employee would otherwise be required to contribute under the FAMLI program.

Additional details regarding private plan substitutions are expected from the CDLE and an update will be provided once available.

An employer may choose to have the FAMLI program to run concurrently with FMLA and should update their leave documents accordingly if that is their intent.

Employee Notice Requirements

If the need for FAMLI leave is foreseeable, employees must provide their employer with at least 30 days' advance notice before taking leave. If the leave is unforeseeable, notice to the employer will be due as soon as practicable. Employees must also make reasonable efforts to schedule their FAMLI leave so that is does not unduly interrupt their employer's operations.

In many circumstances, FAMLI leave may also qualify as leave under the FMLA and may run concurrently with FMLA leave. Employers are permitted to require that payments made under the FAMLI program are coordinated with payments made to the employee under a disability policy or other leave policy offered solely for FAMLI purposes. However, employees can't be required to use or exhaust any accrued vacation, sick, or other paid time off prior to or while receiving FAMLI benefits. The employer and employee may mutually agree to such an arrangement, but the total weekly benefit received by the employee can't exceed their average weekly wage.

Employer Responsibilities

Employers must prominently post the FAMLI Division's poster, available here, in the workplace and provide this written notice to employees upon hire. In addition, upon learning that a covered individual has experienced or is experiencing a triggering event under the program, the employer must remind the employee about the FAMLI benefit and provide the written notice.

Employer Action

Employers should:

- Determine how FAMLI will apply to your business – Consider your FAMLI plan options. While markets for private plans are not yet available and details on self-insured options are still forthcoming, you should start having conversations now on your intended course of action.
- Estimate your premium liability – The CDLE has provided a FAMLI premium and benefits calculator, available HERE.
- Update employee communications – Incorporate language into benefit guides regarding FAMLI premium deductions beginning January 1, 2023. Provide written notice to all covered employees of their rights and duties under the FAMLI program, including the FAMLI Division's poster.
- Register with the FAMLI Division – Await published guidance from the FAMLI Division on how to establish your account and/or providing information on a private plan.
- Prepare to collect premiums – If you use a payroll company, or if you process payroll in-house, you will need a plan to have the FAMLI premiums deducted and submitted to the CDLE beginning January 1, 2023.

Massachusetts Releases 2023 MCC Amounts

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 02-22 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage (MCC) regulation, 956 CMR 5.00. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2023 and provides those respective dollar amounts, which are unchanged from 2022.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

The 2007 regulations mandated a $2,000/$4,000 deductible limit and a separate prescription deductible limit of up to $250/$500 for in-network covered services. In 2013, after recognizing that the deductible limits were out-of-step with some segments of the market and health care cost inflation, the Health Connector approved the indexing of deductibles according to a federal indexing statute. However, that statute was repealed before the indexing could ever take effect, which means that the deductible limits had not changed since 2007.

The Health Connector published updated MCC regulations on December 27, 2019, effective January 1, 2020. Part of the updated regulations indexed the deductible limits to the annual out-of-pocket maximum ("OOPM") adjustment percentage under federal law, rounded down to the next $50.

Administrative Bulletin 02-22 sets the 2023 maximum MCC deductibles as $2,850/$5,700. If the plan has a separate prescription drug deductible, the amounts cannot exceed $350/$700 and the total maximum deductible applies.

Out of Pocket Maximums

In 2017, the Health Connector published Administrative Bulletin 02-17, tying the indexed OOPMs under MCC to the federally indexed OOPMs that apply to non-grandfathered plans.

For 2023, the OOPM will be $9,100/$18,200.

What Else do you Need to Know?

Administrative Bulletin 02-22 takes effect immediately; although the indexed amounts are unchanged, the amounts in this Bulletin are applicable to employer-sponsored plans with plan years beginning on or after January 1, 2023.

2023 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2023 health care expenditures required by the Improving Access to Medical Care Hotel Employees Ordinance, Seattle Municipal Code (SMC) 14.28.

Covered employers must make healthcare expenditures to or on behalf of covered employees (hourly employees who work an average of 80 hours or more per month for a covered employer) to improve their access to medical care. The amounts of the healthcare expenditure are adjusted each calendar year.

For the 2023 calendar year (January 1 to December 31, 2023), the adjusted rates are:

- $518 per month for an employee with no spouse, domestic partner, or dependents;
- $881 per month for an employee with only dependents;
- $1,036 per month for an employee with only a spouse or domestic partner;
- $1,555 per month for an employee with a spouse or domestic partner and one or more dependents.

For most covered employers, the Ordinance was effective July 1, 2020 or the next scheduled annual open enrollment period for health coverage (if offered) after July 1, 2020.

It should be noted that in the latest legal developments, the 9th Circuit Court of Appeals ruled that the Ordinance was not preempted by ERISA. The ERISA Industry Committee (on behalf of its affected members) applied to the Supreme Court to hear the case. As of the date of publication, the Supreme Court has not decided whether to add the matter to the docket.

Employer Action

- Covered employers subject to the Ordinance should comply (or prepare to comply) with the law.
- If compliance is required with a plan year that begins in 2023 plan year, the adjusted rates should be used to determine appropriate expenditures.
- Include the adjusted rates of the expenditure as part of the annual notification required to covered employees.
- Monitor OLS FAQs and website for further information.

Paid Leave Oregon Update – Equivalent Plans

Oregon enacted a paid family and medical leave law that will be effective January 1, 2023, known as Paid Leave Oregon ("PLO"). Recently, the Oregon Employment Department ("OED") finalized rules related to equivalent plan application and approval. Employers intending to sponsor equivalent plans, whether fully insured or self-funded, may now submit equivalent plan applications or a declaration of intent if the actual plan design has not been finalized.

Background

On June 1, 2019, Governor Kate Brown signed HB 2005 into law, establishing the Paid Family and Medical Leave Insurance Fund ("PFMLIF") and making Oregon the eighth state to pass a paid family and medical leave law.

- The PFMLIF will be funded by employer contributions and employee payroll deductions
- The law will be phased in with contributions beginning in January of 2023 and benefits becoming available in September of 2023
- The total contribution amount will equal 1% of employee wages capped at $132,900 in 2023

All employers will participate in the state insurance fund unless the employer establishes an approved equivalent plan to provide these benefits. On August 22, 2022, additional rules were finalized related to equivalent plans.

Paid Leave Oregon Website

The PLO website has been updated to provide extensive information for employers including program information, employer resources, printable forms, and FAQs. Employers interested in sponsoring an equivalent plan, whether insured or self-funded, can now access the Equivalent Plans Guidebook that provides information on sponsoring an equivalent plan to comply with PLO requirements. Employers can also access the Equivalent Plans Checklist to assist them in preparing their equivalent plan application.

Equivalent Plan Application

Equivalent plan applications can now be submitted to OED via "Frances," the online reporting portal used by Oregon employers to submit required reporting and premiums for PLO. Frances is also used for reporting and payment of unemployment insurance premiums. All Oregon employers will need to register with Frances if they have not already done so.

Employers will have until November 30, 2022 to apply for an equivalent plan that can be approved by the January 1, 2023 effective date for premium collection.

Equivalent plan applications will be processed within 30 days. Approved equivalent plans will be effective on the first day of the quarter following approval. Printable application forms are available on the PLO website along with information explaining the proof of solvency requirements that are needed for equivalent plan approval.

Declaration of Intent

Employers that are not prepared to complete an equivalent plan application but intend to sponsor an equivalent plan prior to the September 4, 2023 effective date for benefits may complete a Declaration of Intent that will allow the employer to delay premium collection and payment until September 4, 2023. The Declaration of Intent must be followed by an equivalent plan application no later than May 31, 2023, in order to have the equivalent plan approved on time.

Employers that file the Declaration of Intent but fail to obtain equivalent plan approval will be required to pay all owed employee and employer premiums due from January 1, 2023. In this situation, employers may not take deductions from employees to pay premiums that were not deducted when due.

Model Notice (Poster)

Updated resources also include the model notice that all employers are required to post and provide to all covered employees. The notice should be provided to all covered employees at the time of hire and anytime the policy or procedures change. The notice should be provided in the language that the employer typically uses to communicate with employees. The employer resources page provides the model notice in twelve (12) languages.

Employer Action

Employers intending to sponsor an equivalent plan should review the Equivalent Plan Guidebook and Equivalent Plan Checklist, both available on the PLO employer resources website in multiple languages.

Declarations of Intent and/or equivalent plan applications should be submitted as soon as possible.

Employers that want an equivalent plan effective January 1, 2023, will need to apply no later than November 30, 2022.

2022 Compliance Bulletins: Quarter Four

October

November

December

New Jersey New Poster Requirements

Published: October 7, 2022

On August 1, 2022, the New Jersey Division on Civil Rights (DCR) finalized regulations to increase the visibility and effectiveness of posters required by the State of New Jersey. Among other things, these regulations require employers to display posters informing people of their rights under New Jersey's Law Against Discrimination ("NJLAD") and Family Leave Act ("NJFLA"). The regulations went into effect immediately.

Background

The NJLAD protects New Jersey employees from discrimination in the workplace. It prohibits all employers in the State of New Jersey from discriminating against and harassing employees (and prospective employees) based on their protected status (including, but not limited to, race, national origin, age, sex, gender identification, sexual orientation, marital status, religion, disability, pregnancy, military status). Under the law, employers cannot refuse to hire, fire, or otherwise discriminate against an individual in compensation or other terms, conditions or privileges of employment based on the individual's protected status.

The NJFLA permits eligible employees to take up to 12 weeks of family leave in a 24-month period without losing their jobs. Employers with at least 30 employees are subject to the NJFLA.

Who Must Display the Posters?

All employers of employees covered by the NJLAD and NJFLA must display the required posters. Employers with prior versions of these posters already displayed should remove them and replace them with the new, updated and amended posters. mTo assist employers in determining which posters apply to them, DCR has created an employer flowchart which can be found at https://www.njoag.gov/wp-content/uploads/2022/07/Flowchart_Employment.pdf

Where Are These Posters Found?

The posters can be found on DCR's website and can be both downloaded and printed. The Employment Poster can be found at https://www.njoag.gov/wp-content/uploads/2022/07/Employment.pdf and the Family Leave Act Poster can be

found at https://www.njoag.gov/wp-content/uploads/2022/07/Family-Leave-Act.pdf. Any poster printed from the website must be printed on no smaller than letter size paper (8½ by 11 inches) and contain text that is fully legible and large enough to be easily read. The posters can also be found at any of DCR's offices.

How Should the Posters be Displayed?

The updated posters must be displayed in a place that is easily accessible to all employees and prospective employees.

What if Employees Only Work Remotely?

In the event an employer does not have a physical location, employers should display the required posters on an internet site or intranet site that is accessed by all employees and where other notices are customarily displayed to employees.

Employers are also required to distribute copies of the NJLAD and NJFLA posters to each employee annually, on or before December 31 of each year, and upon the first request of an employee. The posters can be distributed in the following ways:

- Printed material, including, but not limited to, paycheck inserts, a brochure or similar informational packet provided to new hires, an attachment to an employee manual or policy book, or a flyer distributed at an employee meeting.
- An internet or intranet website, if the site is for the use of all employees, can be accessed by all employees, and the employer provides notice to the employees of its posting.

What is the Penalty for Not Complying?

Failure to display the required posters can result in fines up to $10,000.

Where Can More Information on the Regulations be Found?

DCR has posted Frequently Asked Questions on its website regarding the regulations. The FAQs can be found at: https://www.njoag.gov/wp-content/uploads/2022/08/Poster-Regulations-FAQ.pdf

Employer Action

Employers should ensure they are properly posting and distributing (where applicable) all of the required updated posters.

Final Regulations To Fix The ACAs Affordability Family Glitch

Published: October 17, 2022

On October 11, 2022, the Treasury Department and Internal Revenue Service ("IRS") finalized regulations that expand the availability of Marketplace premium tax credits for employees' family members. The final rule generally follows the proposed rule issued in April 2022. To qualify for a premium tax credit, the final rule provides that:

- Affordability of employer-sponsored coverage for family members would be determined based on the employee's cost to cover the employee and the family members.

- The determination of whether employer-sponsored coverage for family members provides minimum value would also be based on the coverage available to family members.

The rule takes effect for plan years beginning on and after January 1, 2023.

These regulations do not affect the affordability determination for purposes of the Affordable Care Act's ("ACA") employer mandate; however, they may indirectly impact employer plans as more family members may qualify for premium tax credits and choose to enroll in coverage through the Marketplace.

Simultaneously, the IRS released Notice 2022-41, creating a new permitted election change under the Section 125 cafeteria plan rules. The Notice permits, but does not require, an employer with a non-calendar year plan to allow an employee to prospectively revoke a pre-tax election for family coverage under a group health plan to enable one or more family members to enroll in Marketplace coverage.

Additional details follow.

Background

Currently, individuals are not eligible for Marketplace premium tax credits if they are offered employer-sponsored group health plan coverage that is "affordable" and provides "minimum value."

For this purpose, employer-sponsored coverage is deemed "affordable" if an employee is required to pay no more than 9.5% (indexed each year – 9.61% for 2022 and 9.12% for 2023) of household income for self-only coverage. Coverage is considered affordable for both the employee and the employee's family members, regardless of how much the employee must pay to cover those family members under the employer's group health plan. This is known as the "family glitch."

An employer-sponsored plan provides "minimum value" if the plan's share of the total allowed cost of benefits provided is at least 60% and includes substantial coverage of inpatient hospital services as well as physician services. Under current rules, when self-only coverage offered by an employer provides minimum value to an employee, the coverage offered to the employee's family is also considered to provide minimum value.

Affordability

Consistent with the proposed changes, the final rule refines the definition of affordable coverage to make it easier for family members to qualify for premium tax credits. Employer-sponsored coverage would be considered affordable for family members (thereby disqualifying them from eligibility for premium tax credits) only if the portion of the annual premium the employee must pay for the family coverage does not exceed 9.5% of household income (as indexed).

As a result, when assessing whether an individual has received an affordable offer of employer-sponsored coverage, the Marketplace would look separately at the employee's cost of self-only coverage (to determine the employee's own eligibility for premium tax credits) and at the employee's cost to cover the family (to determine the family members' eligibility for premium tax credits). There will likely be scenarios wherein an employee has an offer of self-only coverage that is affordable, but the offer of coverage to the family members is considered unaffordable (thus potentially qualifying those family members for new premium tax credits).

For this purpose, family coverage means all employer plans that cover any related individual other than the employee, including a self-plus-one plan for an employee enrolling one other family member in the coverage. The final rule provides various examples that may arise to determine whether employer coverage is affordable, including situations where an individual has offers of coverage from multiple employers or where covered family members are not part of the employee's tax family (e.g., a non-tax dependent child or a spouse filing separately).

The final rule does not affect the affordability test for employees. Employees remain ineligible for premium tax credits in the Marketplace if offered affordable self-only coverage from their employer.

Minimum Value

The final rule also amends the premium tax credit eligibility rules related to minimum value. An employer-sponsored plan would be considered to provide minimum value for family members if the plan's share of the total allowed costs of benefits provided to family members is at least 60%. Note that it would be unusual to have a plan design where an employer offers minimum value coverage to an employee but not the family members.

The final rule also confirms that, to provide coverage of minimum value, the plan must include substantial coverage of inpatient hospital services as well as physician services.

The final rule does not affect the minimum value test for employees.

Implementation

The Department of Health & Human Services ("HHS") will revise the Marketplace application process to include new questions about offers of employer coverage to family members and will work with the individual state marketplaces to ensure that the entities take necessary steps to educate the public. The IRS also expects to update forms and publications ahead of the 2023 Marketplace annual enrollment season.

Although a model notice was requested during the comment period, the final rule imposes no new notice requirements on employers. The preamble also confirms that the IRS does not intend to update Forms 1095 to require additional data elements.

Corresponding Cafeteria Plan Changes – IRS Notice 2022-41

Under existing Section 125 cafeteria plan rules, an employee may not revoke a pre-tax salary reduction election associated with family group health plan coverage during the plan year and elect self-only coverage (or another form of family coverage, such as employee plus one) solely to allow one or more family members the ability to enroll in the Marketplace. This restriction applies even if the family member is newly eligible to enroll due to a special enrollment opportunity or during the Marketplace annual open enrollment. This tends to be an issue for non-calendar year plans.

To address this situation, the IRS issued Notice 2022-41 which permits (but does not require) an employer with a non-calendar year plan to adopt an amendment to the cafeteria plan to allow an employee to prospectively revoke a pre-tax election for family coverage under a group health plan when:

- one or more related individuals are eligible for a special enrollment period to enroll in Marketplace coverage or one or more already-covered related individuals seeks to enroll in the coverage during the Marketplace's annual open enrollment period; and

- the revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual(s) in the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. If the employee does not enroll in Marketplace coverage, the employee must elect self-only coverage (or family coverage including one or more already-covered related individuals) under the group health plan.

A cafeteria plan may rely on the reasonable representation that the employee and/or related individuals have enrolled or intend to enroll in the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

To allow for this change, the cafeteria plan must be amended on or before the last day of the plan year in which the election
is allowed and the amendment may be effective retroactively to the first day of the plan year provided the cafeteria plan operates in accordance with the Notice, and the employer informs participants of the amendment.

For a plan year that begins in 2023, an employer may amend a cafeteria plan to adopt the new permitted election change at any time on or before the last day of the plan year that begins in 2024.

In no event may an employer amend a cafeteria plan to allow an election to revoke coverage on a retroactive basis. In addition, the health FSA election may not be changed under this provision.

Employer Action

The final rule does not impact the determination of whether employer-sponsored coverage is affordable for purposes of avoiding a shared responsibility penalty under the ACA's employer mandate. Whether the coverage is affordable for this purpose continues to be based solely on the cost of self-only coverage in the lowest-cost minimum value plan.

The rule confirms that there will be no changes or additional information required on the ACA forms 1095-B and 1095-C as a result of the changes made under the final rule.

However, employers may see employees more closely evaluate options for family members in the Marketplace during this open enrollment season. Employees may find Marketplace coverage more cost effective than the employer plan and remove their family members from the group health plan.

What to do?

- Employers may consider outreach and communication to employees and their families to educate them on the premium tax credits that may newly be available on the Marketplace.

- Employers with non-calendar year plans should consider whether to adopt this discretionary cafeteria plan provision allowing employees the opportunity to revoke prospective elections in response to the premium tax credits available on the Marketplace. Employers adopting this change should update their plan documents accordingly and communicate the change with participants.

HHS Extends Public Health Emergency Until January 11

Published: October 17, 2022

On October 13, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency. This will once again extend the Public Health Emergency Period (the 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. The Emergency Period is now set to expire January 11, 2023 (unless further extended or shortened by HHS). HHS should provide at least 60 days advance notice if the Emergency Period will not extend again. We should know by November 12, 2022, if this is the last extension.
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, or 2) 60 days after the announced end of the COVID-19 National Emergency. As of now, the National Emergency is set to expire after February 28, 2023, unless the President announces another continuation.

The following summarizes benefit plan provisions that are directly impacted by the extension of the Emergency Period and highlights the relief with respect to the ongoing Outbreak Period. Other temporary benefit plan provisions and changes that are allowed due to the ongoing pandemic are not included.

Some carriers and TPAs are beginning to take steps to address how a plan will treat COVID-19 benefit requirements once the Emergency Period ends. Options for plan sponsors include maintaining the status quo or removing or limiting coverage that is required while the Emergency Period is in effect.

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.

- **Over-The-Counter ("OTC") COVID-19 Testing:** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

- **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. Note, COVID-19 vaccines are considered mandatory preventive care under the ACA and will need to be covered in-network at 100% even after the Emergency Period expires.

- **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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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).

It should be noted that there is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

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 plan requirements. 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.

2023 Cost Of Living Adjustments

Published: October 25, 2022

The IRS recently released cost of living adjustments for 2023 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 2023, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $2,850 to $3,050.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health FSA, 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 2023 that can be carried over to the following plan year is $610 (up from $570 in 2022).

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 static maximum of $500 to 20% of the currently indexed heath FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2023, 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 from $280 to $300.

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 employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $135,000 to $150,000 for 2023.

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 2023 increased from $200,000 to $215,000.

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

As previously reported, the 2023 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $9,100 for self-only coverage and $18,200 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 2023, 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 $5,850 ($11,800 for family coverage) (increased from 2022).

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2023, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Treas. Reg. 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 $1,950 (increased from $1,800 in 2022).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts (HSAs) for 2023 were provided by the IRS in Rev. Proc. 2022-24.

Annual contribution limitation

For calendar year 2023, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $3,850; the limitation on deductions for an individual with family coverage under a high deductible health plan is $7,750.

High deductible health plan

For calendar year 2023, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,500 for self-only coverage or $3,000 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,500 for self-only coverage or $15,000 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 Section 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Prescription Drug Reporting Reminder

Published: October 31, 2022

As previously reported, plan sponsors of group health plans must submit information annually about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services (“CMS”). The first deadline is December 27, 2022 for reporting on calendar years 2020 and 2021.

Most commonly:

- The carrier will submit on behalf of an insured medical plan.
- The TPA will file on behalf of a self-funded plan (includes a level funded plan) with an integrated medical/drug plan.
- The TPA and PBM will partially file on behalf of a self-funded plan with a carved-out drug program, but the employer may have responsibility for the other parts of the filing.

However, the exact process will depend on the carrier/TPA/PBM and their processes may not yet be announced or may have changed since the last communication. So, there are two important action items:

1. All employers should check with their carriers/TPAs/PBMs now to find out what level of assistance they will provide. Carriers/TPAs/PBMs may need information from plan sponsors and the deadline may be fast approaching, well in advance of the actual deadline.

1. In some cases, employers will have to submit at least part of the filing. For example:

    a. All UHC ASO Key Accounts and some of the Blues require employers to submit a partial file (P2; D1) for both integrated and carved-out self-funded programs.

    b. CVS will submit the files in a carve-out drug plan if the employer was with CVS for the full reporting year. If not, CVS will prepare the reports, but the employer must submit them.

If an employer must submit some of the files on behalf of the group health plan, the employer must register with HIOS before filing and receive account information which can take up to two weeks. These employers will need to appoint two individuals, with at least one of those individuals designated as the "RxDC Submitter," and should start the process now. CMS has resources available to assist in this process:

- HIOS Portal RxDC Quick Guide, https://regtap.cms.gov/uploads/library/HIOS-Portal-RxDC-Quick-Guide-09-06-2022.pdf

- HIOS RxDC User Manual, https://regtap.cms.gov/uploads/library/HIOS-RxDC-User_Manual-10-18-2022.pdf

The penalty for noncompliance is $100 per affected individual. In addition, the DOL can enforce compliance.

Additionally:

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

- Employers with self-funded plans should enter into written agreements with TPAs/PBMs to ensure the vendor will provide the required reporting to CMS. 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.

- The next deadline for RxDC reporting is June 1, 2023 for 2022 calendar year.

San Francisco HCSO Expenditures and Reporting Update for 2023

Published: November 4, 2022

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2023 have been released, and the HCSO Annual Reporting Form for calendar year 2022 is due on May 1, 2023.

2023 Minimum Expenditure Rates

Under the HCSO, covered employers must make minimum health care expenditures at the following rates for each hour worked by covered employees in San Francisco:

Employer Size	Number of Employees	2022 Health Care Expenditure Rate	2023 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.30 per hour payable	$3.40 per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.20 per hour payable	$2.27 per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2023 the maximum required health care expenditure for a covered employee of a large employer is $584.80 per month ($3.40/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $390.44 per month ($2.27/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2022, the earnings threshold for these employees to be exempt from the HCSO is $109,643 per year (or $52.71 per hour). As of January 1, 2023, the new threshold will be $114,141 per year (or $54.88 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement (OLSE) HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2022 is expected to become available on the HCSO website by April 1, 2023, and is due by May 1, 2023 (the next business day after the normal April 30 deadline, which falls on a Sunday in 2023).

It should be noted that, due to the COVID-19 pandemic, OLSE did not require employers to submit the HCSO Annual Reporting Form for calendar years 2019 and 2020, although employers were still obligated to make minimum health care expenditures under the HCSO. This waiver was not extended, and employers were required to submit the HCSO Annual Reporting Form for calendar year 2021 by May 2, 2022 (the next business day after the normal April 30 deadline, which fell on a Saturday in 2022).

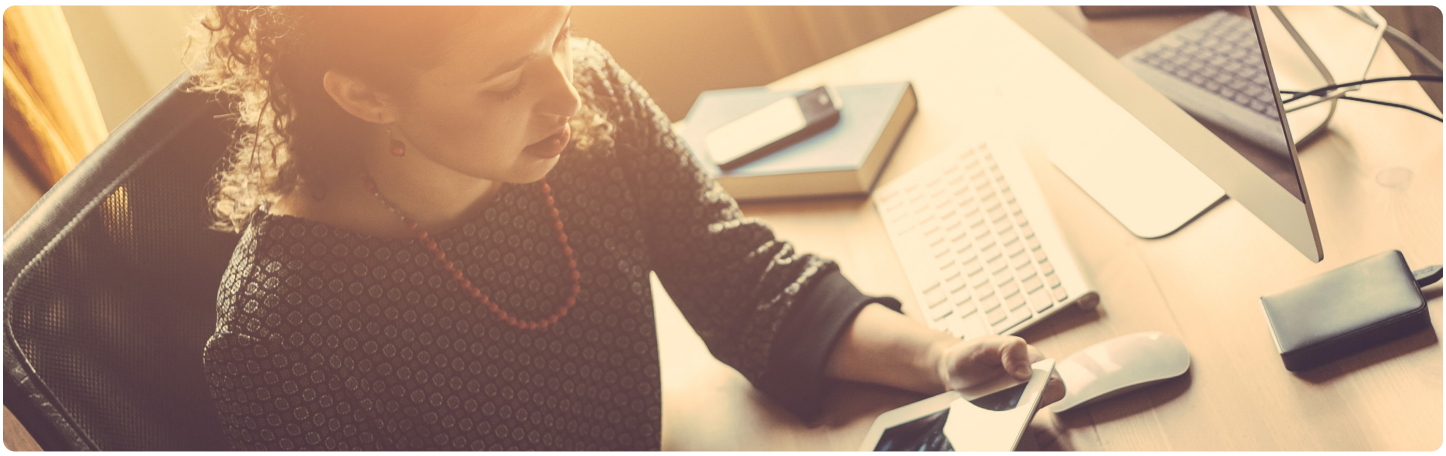
Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2023 at the new rates for employees in San Francisco.

The 2023 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2022. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2023 version of the poster by January 1, 2023.

https://sfgov.org/olse/employer-annual-reporting-form-instructions

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2022 no later than May 1, 2023.



California Extends 2022 COVID-19 Paid Leave Program, Adds Grants

Published: November 18, 2022

On September 29, 2022, California Governor Newsom signed Assembly Bill No. 152 ("AB 152") into law. AB 152 extends the 2022 COVID-19 Supplemental Paid Sick Leave provisions through December 31, 2022. In addition, AB 152 makes up to $50,000 of grant money available to reimburse a qualifying small business or nonprofit organization for COVID-19 Supplemental Paid Sick Leave provided to employees.

Background

Beginning January 1, 2022, public and private employers that employ more than 25 employees are generally required to provide 2022 COVID-19 Supplemental Paid Sick Leave to employees working in California who are unable to work or telework for the employer because of specified reasons relating to COVID-19. Covered employees can generally take up to 80 hours of 2022 COVID-19 Supplemental Paid Sick Leave.

New Expiration Date

The 2022 COVID-19 Supplemental Paid Sick Leave provisions, as originally enacted into law, expired on September 30, 2022. AB 152 extends the 2022 COVID-19 Supplemental Paid Sick Leave provisions for an additional three months. The new expiration date is December 31, 2022.

AB 152 does not provide employees with any new allotment of paid leave; it merely gives employees more time to use any unused hours of 2022 COVID-19 Supplemental Paid Sick Leave.

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

- English – https://www.dir.ca.gov/dlse/COVID19resources/2022-COVID-19-SPSL-Poster.pdf
- Spanish – https://www.dir.ca.gov/dlse/COVID19resources/Spanish/2022-COVID-19-SPSL-Poster.pdf

Administrative Changes

In addition to the new expiration date, AB 152 makes several changes to the administrative requirements for 2022 COVID-19 Supplemental Paid Sick Leave.

According to the original provisions (which continue to apply under AB 152), a covered employee qualifies for 2022 COVID-19 Supplemental Paid Sick Leave when the employee is unable to work or telework because of a positive COVID-19 diagnostic test. When that happens, the employer can require the employee to submit to a follow-up COVID-19 diagnostic test (paid for by the employer) on or after the fifth day after the original positive test.

AB 152 adds that if the follow-up test is positive, the employer may require the employee to submit to another COVID-19 diagnostic test (paid for by the employer) within no less than 24 hours. The employer has no obligation to provide 2022 COVID-19 Supplemental Paid Sick Leave to an employee who refuses to submit to these tests.

Availability of Grant Money

Included within AB 152 is the California Small Business and Nonprofit COVID-19 Supplemental Paid Sick Leave Relief Grant Program, which can provide up to $50,000 of grant money to a qualifying small business or nonprofit organization to reimburse it for COVID-19 Supplemental Paid Sick Leave provided to employees between January 1, 2022 and December 31, 2022.

To qualify for grant money under this program, a small business or nonprofit organization must meet several requirements, including the following:

- It has 26 to 49 employees.
- It began operating before June 1, 2021, is currently active and operating, and has a physical presence in California.
- For a small business, it is organized as a "C" corporation, an "S" corporation, a cooperative, a limited liability company,
  a partnership, or a limited partnership.
- For a nonprofit organization, it is a registered 501(c)(3) (i.e., a charitable organization), 501(c)(6) (i.e., a business league, chamber of commerce, or trade association), or 501(c)(19) (i.e., a veterans' organization).

Certain businesses and organizations are ineligible to receive grant money under the program, including government entities (other than Native American tribes); businesses primarily engaged in political or lobbying activities; passive businesses and investment companies; financial institutions and businesses primarily engaged in the business of lending (such as banks, finance companies, and factoring companies); businesses engaged in any activity that is unlawful under federal, state, or
local law; and businesses that restrict patronage for any reason other than capacity.

To apply for grant money under the program, small businesses and nonprofit organizations should contact the California Office of Small Business Advocate (known as "CalOSBA"), which is part of the California Governor's Office of Business and Economic Development (known as "GO-BIZ"). The program remains in effect until January 1, 2024.

New PCOR Fee Announced

Published: November 29, 2022

On November 14, 2022, the IRS released Notice 2022-59, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2022 and before October 1, 2023 is $3.00.

The PCOR filing deadline is July 31, 2023 for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2022. Carriers are responsible for paying the fee for insured policies.

PCOR Fee due July 31, 2023:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2022	$2.79/covered life/year
February 28, 2022	$2.79/covered life/year
March 31, 2022	$2.79/covered life/year
April 30, 2022	$2.79/covered life/year
May 31, 2022	$2.79/covered life/year
June 30, 2022	$2.79/covered life/year
July 31, 2022	$2.79/covered life/year
August 31, 2022	$2.79/covered life/year
September 30, 2022	$2.79/covered life/year
October 31, 2022	**$3.00/covered life/year**
November 30, 2022	**$3.00/covered life/year**
December 31, 2022	**$3.00/covered life/year**

Employer Action

No action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in mid-2023 of the fee and additional information for filing and paying the PCOR fee with the IRS.

Updated Guidance on Election Changes to Include Calendar Year Plans

Published: November 29, 2022

Recently, the Treasury Department and Internal Revenue Service ("IRS") finalized regulations to fix the "family glitch" and expanded Marketplace premium tax credits for employees' family members when employer-sponsored coverage is not affordable. Simultaneously, the IRS issued Notice 2022-41, creating a new, permitted election change under the Section 125 cafeteria plan rules related to the "family glitch" fix. As originally published, the guidance was limited to non-calendar year cafeteria plans.

However, the IRS (quietly) updated Notice 2022-41 to remove the limiting language.

As a result, plan sponsors of calendar year (and non-calendar year) section 125 cafeteria plans are now permitted, but not required, to amend their section 125 plan document to allow plan participants to prospectively revoke a pre-tax election for family coverage under a group health plan to enable one or more family members to enroll in Marketplace coverage.

Employer Action

Now that the new permitted election change includes calendar year plans, applicable plan sponsors should consider whether to adopt this discretionary cafeteria plan provision allowing employees the opportunity to revoke prospective elections in response to the premium tax credits available on the Marketplace. Employers adopting this change should update their plan documents accordingly and communicate the change with participants.

RxDC Reporting Due December 27 2022

Published: November 29, 2022

As previously reported, plan sponsors of group health plans must submit information annually about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services ("CMS"). The first deadline is **December 27, 2022**, for reporting on calendar years 2020 and 2021. The next deadline is **June 1, 2023**, for reporting on calendar year 2022.

Most commonly:

- The carrier will submit on behalf of an insured medical plan.
- The TPA will file on behalf of a self-funded plan (includes a level funded plan) with an integrated medical/drug plan and stop loss insurance.
- The TPA and PBM will partially file on behalf of a self-funded plan with a carved-out drug program and/or carved-out stop loss, but the employer may have responsibility for the other parts of the filing.

However, the exact process will depend on the carrier/TPA/PBM and their processes may not yet be announced or may have changed since the last communication. It is important to know how your carriers, TPAs and PBMs will assist in this process.

Recently, some TPAs of self-funded plans have changed direction and indicated that if the plan has any carve-out arrangements (e.g., pharmacy and/or stop loss) the employer may be responsible for filing a P2 and partial D1 to reflect stop loss premium and/or pharmacy information that is not captured in the TPA's system. The TPA may not collect this information to include in the D1 that it files with CMS.

If an employer must submit some of the files on behalf of the group health plan, the employer must register with HIOS and receive account information before filing which can take up to two weeks. These employers will need to appoint two individuals, with at least one of those individuals designated as the "RxDC Submitter," and should start the process now.

CMS has resources available to assist in this process:

- HIOS Portal RxDC Quick Guide, https://regtap.cms.gov/uploads/library/HIOS-Portal-RxDC-Quick-Guide-09-06-2022.pdf
- HIOS RxDC User Manual, https://regtap.cms.gov/uploads/library/HIOS-RxDC-User_Manual-10-18-2022.pdf

RxDC Reporting Relief and Submission Grace Period for 2020/2021

Published: December 28, 2022

As previously reported, group health plans must submit information annually about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services ("CMS"). This is known as the RxDC reporting requirement and the first deadline is **December 27, 2022**, for reporting on calendar years 2020 and 2021.

Very late on December 23, 2022, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") issued FAQ Part 56 addressing this requirement.

Specifically, as it relates to the 2020/2021 data, the guidance announces:

1. **Good Faith Relief.** The Departments will not take enforcement action with respect to any plan or issuer that uses a good faith, reasonable interpretation of the regulations and the RxDC Reporting Instructions in making its submission.

2. **Submission Grace Period.** A plan or issuer will not be considered to be out of compliance with these requirements provided that a good faith submission of the 2020 and 2021 data is made on or before **January 31, 2023**.

3. **Limited Email Submission Option.** Where the plan (or the reporting entity) is submitting only the plan list (P2), premium and life-years data (D1), and narrative response, and is not submitting any other data, it may submit the file by email to RxDCsubmissions@cms.hhs.gov instead of submitting in HIOS.

    - The emailed submission must include the plan list file, premium and life-years data (data file D1), and a narrative response. The submission may include optional supplemental documents. The name of each file should include the reference year of the submission, the plan list or data file type (e.g., P2, D1), and the name of the group health plan sponsor.

It should be noted that, if an employer, as the plan sponsor, must submit a P2 and D1 on behalf of the group health plan (often the case where the plan has a stop loss or pharmacy carveout), this relief is helpful as the employer will not need to create a HIOS account. Rather, the employer should be able to complete the files and submit them via email to CMS, in accordance with the instructions.

The guidance also includes flexibility as it relates to multiple submissions by the same reporting entity, submission of the same data file by multiple reporting entities, and a suspension of certain aggregation rules, among other guidance.

While these flexibilities apply only to the submission of data for the 2020 and 2021 reference years, the Departments will monitor stakeholder compliance efforts to determine whether to extend these flexibilities for future reporting deadlines. Any extension of these flexibilities will be communicated through guidance in advance of the relevant reporting deadline.

Employer Action

Generally, carriers are filing the RxDC on behalf of fully insured group health plans. With respect to self-funded health plans the TPA may assist with some, or all, of the reporting. Where a self-funded health plan has carve-out benefits (such as stop loss or pharmacy), the employer/plan sponsor may be required to file certain data files.

Employers required to file should do all of the following:

- Continue to comply with RxDC reporting requirements for 2020/2021 data, understanding that they have relief for good faith mistakes and have until January 31, 2023 to submit the 2020/2021 data (instead of December 27, 2022).
- Where applicable, consider taking advantage of the email submission option for P2, D1, and narrative response versus the HIOS platform.
- Await further guidance on the next deadline – June 1, 2023 – for calendar year 2022 RxDC reporting. While the relief announced in FAQ 56 pertains only to 2020/2021 data, it will be interesting to see if any of the relief carries over into future reporting.

Telehealth Relief for HSAs Extended in Last Minute Funding Package

Published: December 28, 2022

On December 23, 2022, the House passed a 4,155-page funding bill, the Consolidated Appropriations Act of 2023 ("CAA-23"), that includes a two-year extension on telehealth relief for high deductible health plans ("HDHPs") offered with health savings accounts ("HSAs"). Included as a safe harbor, the bill provides that for plan years beginning after December 31, 2022 and before January 1, 2025:

- a plan shall not fail to be an HDHP if telehealth or other remote care services are offered before satisfaction of the minimum deductible; and
- coverage for telehealth or other remote care services is considered disregarded coverage for purposes of HSA eligibility.

The bill now goes to the President, who is expected to sign it into law.

Background

As background, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") offered temporary relief related to telehealth and other remote care services when offered with an HDHP and HSA for plan years that began before December 31, 2021. The Consolidated Appropriations Act, 2022 ("CAA-22") prospectively extended this relief, but only for the months of April through December 2022. Barring congressional action, the relief was set to expire December 31, 2022.

This latest extension under CAA-23 provides for two more years of relief based on the plan year's start date. The relief is optional; employers are not required to offer free or reduced cost telehealth or other remote care services as part of their plan design.

Other Changes

The year-end funding bill also:

- Eliminates the opt-out opportunity for compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA") for nonfederal governmental health plans; and
- Includes new grants for states to ensure compliance and enforcement of MHPAEA in the carrier market.

Employer Action

Employers with telemedicine (or other remote care services) and HSA-compatible HDHPs should consider whether to offer free (or reduced cost) services with their HDHPs for plan years beginning after December 31, 2022. It should be noted that employers with non-calendar year plans are not technically eligible for this new relief until the first plan year that begins after December 31, 2022. As such, free (or reduced cost) telehealth or other remote care services could be disqualifying coverage from January 1, 2023 to the day before the first day of the 2023 plan year. It is not clear whether this gap was intentional.

Employer should also communicate any changes to the telehealth or remote care benefits to participants as soon as possible.

Annual Out-of-Pocket Maximum Adjustments Announced for 2024

Published: December 30, 2022

On December 13, 2022, the Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2024 ("the Notice"). For purposes of employer-sponsored health plans, the guidance includes the caps on out-of-pocket dollar limits for non-grandfathered group health plans with plan years that begin in 2024.

Elimination of Transitional Good Faith Relief

Non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2024, as follows:

- $9,450 for self-only coverage; and
- $18,900 for coverage other than self-only.

Note that different out-of-pocket limits apply to qualified high-deductible health plans, for purposes of making contributions to a health savings account ("HSA"). The 2024 HSA thresholds will likely be announced in June 2023.

Employer Action

Employers should update out-of-pocket limits for plan years beginning on or after January 1, 2024.

Final Rule on ACA Reporting and 2022 Forms and Instructions

Published: December 30, 2022

On December 12, 2022, the Internal Revenue Service ("IRS") released final regulations with respect to ACA reporting requirements. These rules are substantially similar to the proposed rule issued in November last year.

The final rule:

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.
- 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 the next business day if March 2nd falls on a weekend or holiday).
- Creates an alternative method for furnishing individuals with IRS Form 1095-B as proof of minimum essential coverage (MEC).

Applicable large employers ("ALEs") have until March 2, 2023 (rather than January 31, 2023) to furnish Forms 1095-C for calendar year 2022 to full-time employees and other individuals.

The final 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, 2023 (or February 28, 2023 for paper filing if filing fewer than 250 forms).

On December 15, 2022, the final instructions for 2022 Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) were issued without substantive change from the prior year.

Additional details on the final rule follow.

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. The relief allowed employers flexibility to correct filed forms without penalty. While this relief had been extended each year, the IRS announced that 2020 would be the last year that transitional good faith relief would be available.

The final 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 2022, penalties for incorrect or incomplete forms furnished to individuals can be $290/return. Additionally, incomplete or incorrect forms filed with the IRS may trigger a $290/return penalty.

This means that an employer that requests corrections in response to an IRS inquiry related to Forms 1094-C or 1095-C may be liable for penalties based on the number of forms that are corrected.

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.

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 final regulations make permanent an automatic extension of 30 days in which to furnish these statements to individuals. This means Wednesday March 2, 2023, is the deadline to furnish individuals with a 2022 Form 1095-C or 1095-B.

The extension is automatic; employers or other reporting entities are not required to file a request with the IRS, or to demonstrate reasonable cause to justify the extension.

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.

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 final regulations make permanent an alternative method for furnishing IRS Form 1095-B to individuals, for as long as penalties under the ACA's individual shared responsibility rules remain zero. The alternative method is 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 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

- It should be noted that 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 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 if October 15 falls on a Saturday, Sunday, or legal holiday) following the end of the calendar year to which the form relates

- IRS Form 1095-B 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.

Employer Action

With respect to furnishing Forms 1095-C for CY 2022, employers must furnish these statements to individuals no later than March 2, 2023. Final Forms and Instructions are now available.

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.

Employers should know whether carriers will take advantage of the alternative furnishing method with respect to Forms 1095-B they issue.

Employers 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, should continue to comply with state rules.

2022 State-Based Compliance: Quarter Four

Washington

District of Columbia

Colorado

New Hampshire

Oregon

Supreme Court Denies Challenge to Seattle's Hotel Ordinance

Under the City of Seattle's Improving Access to Medical Care for Hotel Employees Ordinance, employers are required to provide hourly, non-supervisory employees working in large hotels and certain ancillary hotel businesses with increased access to medical care by mandating a monthly healthcare expenditure or direct payment. This type of law is often referred to as "pay or play."

The law went into effect for most covered employers on July 1, 2020, or at the earliest annual open enrollment period for health coverage after July 1, 2020 (if the employer offers health coverage to employees). The required monthly contribution rates vary based on family size and are adjusted annually for inflation. For 2023 the required monthly expenditure for a single employee is $518, for an employee with a spouse/partner and dependents is $1,555.

Legal Challenges

Since 2018, the ERISA Industry Committee ("ERIC") on behalf of affected members, has been challenging the Ordinance in federal courts, arguing the law is preempted by ERISA. The lower courts in the 9th Circuit held in favor of the City. In January 2022, ERIC filed a petition for certiorari with the U.S. Supreme Court to weigh in whether ERISA preempts this type of "pay or play law" and resolve a split between the circuits on this issue. On November 21, 2022, the Supreme Court declined to hear the petition.

Employer Action

This decision by the Supreme Court not to take the case effectively ends challenges to Seattle's Ordinance. Employers subject to the Ordinance should continue to comply with these requirements.

WA Cares Opt-out for Private LTC Insurance Closes Dec. 31, 2022

For individuals who purchased a private long-term care policy ("LTC") before November 1, 2021, the window to apply for a permanent exemption from the WA Cares Fund is quickly coming to an end. If they haven't already done so, eligible individuals must submit an exemption application to the Washington Employment Security Division ("ESD") no later than December 31, 2022. After this date, applications for this exemption will no longer be accepted or approved.

Additional information follows.

Background

Beginning July 1, 2023, 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"). 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 with private long-term care insurance may apply to the ESD for a permanent exemption from the premium assessment. If approved, the employee is permanently excluded from the state's long-term care coverage and benefits.

Private LTC Exemption Application

To qualify for this 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.

The last day to apply for this exemption is December 31, 2022. After that date, this application window is permanently closed. There is no new opportunity to apply for this exemption.

Employees can go to the WA Cares Fund website to apply for an exemption. There are several steps to follow, which are outlined on the website here. Employers cannot apply for an 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.

New Exemptions

Beginning January 1, 2023, Washington workers will be eligible for exemptions from WA Cares if any of the following apply to them:

- Live outside of Washington.
- Are spouses or domestic partners of active-duty military personnel.
- Have non-immigrant visas.
- Are veterans with a 70% service-connected disability rating or higher (this is a permanent exemption).

Workers will only qualify for these exemptions as long as these circumstances apply. Workers will no longer qualify for an exemption if:

- They change their permanent residence to within Washington.
- Their immigration status changes, and they become a permanent resident.
- Their spouse is separated from military service or the marriage/partnership is dissolved.

Unlike the exemption for private long-term care insurance purchased before November 1, 2021, these new exemptions will be available on an ongoing basis beginning Jan. 1, 2023. Additional information on the application process is expected from ESD after the first of the year.

Employer Action

Employees who qualify for an exemption must apply for the exemption no later than December 31, 2022. In the Appendix below, provides a sample communication to employees reminding them of this deadline. This can be used as a starting point should you want to remind employees of the application deadline.

Employees have the responsibility to notify and provide employers with a copy of any approved exemption letter for ESD. Once provided with that letter (and the effective date has passed), employers should not withhold premiums for WA Cares Fund. Any incorrectly withheld premiums should be returned to the employee.

Employers with Washington employees should coordinate with payroll to begin collecting WA Cares premiums from employees who do not have an exemption beginning July 1, 2023.

District of Columbia Requires Employers to Offer Parking Cashout

In April 2020, the District of Columbia passed the D.C. Transportation Benefits Equity Amendment Act of 2020 ("The Act"). The effective date of the Act was delayed pending a period of congressional review. It was recently announced that the Act will become effective for certain employers on January 15, 2023.

What Does the Act Require?

The Act requires that certain employers who offer a "parking benefit" to an employee must offer the employee a parking cashout. A parking cashout is provided as an incentive to an employee, in the form of compensation or alternative transportation benefit, to forgo the parking benefit provided by the employer.

Who is Required to Offer a Parking Cashout?

D.C. employers with 20 or more covered employees who offer a parking benefit to employee(s) must comply with the requirement to provide a parking cashout.

A covered employee (for purposes of determining whether an employer is considered a "covered employer") is a full-time or part-time employee who:

- Performs 50% or more of their work in D.C., or
- Whose employment is based in D.C. and a substantial amount of their work is performed in D.C. with less than 50% of their work performed in any other state.

Importantly, "covered employee" appears to apply only to the determination of whether an employer is a "covered employer," not for purposes of determining who must receive a parking cashout.

Exemptions

An employer that would otherwise be considered a covered employer can be exempted from these requirements if:

- They owned (and continue to own) their parking before October 1, 2020;
- They are under a current parking lease which was entered into prior to October 1, 2020. These employers are exempt until the lease expires (regardless of any possible extensions); or
- They are a hospital or university with pre-existing campus plans.

Who Must Receive An Offer Of A Parking Cashout?

Any employee who is offered a parking benefit by a covered employer must receive the offer of a parking cashout.

What Must Be Offered As The Parking Cashout?

An employee who receives an offer of a "parking benefit" must receive an offer of a "parking benefit equivalent." This equivalent benefit may be provided as one of the following:

- A Clean Air Transportation Fringe Benefit in an amount equal to or greater than the monthly market value of the parking benefit offered to the employee;

- Pay the D.C. Department of Transportation ("DDOT") a Clean Air Compliance Fee of $100 per month for each employee who is offered a parking benefit; or

- Implement a transportation demand plan.

Clean Air Transportation Fringe Benefit?

A Clean Air Transportation Fringe Benefit is a benefit equivalent to the market value of the parking benefit offered by the employer and may be offered through a qualified mass transit transportation ("transit passes"), vanpooling, or bicycle commuting expense reimbursement benefit.

- A covered employer choosing this route must notify employees of their rights to cashout their parking benefit by accepting the Clean Air Transportation Fringe Benefit.

- Employees accepting the cashout fringe benefit must then (on an annual basis) estimate the amount of the offered benefit that will be used for transportation purposes.

- If an employee estimates that they will utilize less than the full market value of the parking benefit (and/or if the market value of the benefit exceeds the statutory limits imposed under Code §§132(f)(5)(2)) (for 2023, $300/month) the employer must still pay the difference in the form of additional compensation, an increase to the employer's health insurance contribution, or a combination of both.

An employee cannot accept both the parking benefit and a Clean Air Transportation Fringe Benefit.

Transportation Demand Management ("TDM") Plan

An employer can comply with the Act by developing a TDM plan and submitting the plan to DDOT for review and approval. The TDM plan must provide strategies and a timeline for the employer to reduce the number of commuter trips made by car by at least 10% from the previous year and continuing until total commuter trips made by car are 25% or less than the original amount.

- DDOT has provided a template for employers to utilize in developing their TDM plan.

- The TDM plan must be submitted to DDOT through their reporting platform. Once submitted, the DDOT will either approve or reject the TDM plan.

- TDM plans must be submitted to DDOT by the reporting deadline of January 15, 2023.

What if an Employer Chooses to Pay a Clean Air Compliance Fee?

An employer can choose to comply with the Act by paying DDOT a compliance fee equivalent to the number of employees offered a parking benefit multiplied by $100 per month.

Reporting Requirements

Employers are required to submit a report to DDOT every two (2) years with the first reporting requirement due on January 15, 2023.

Employers providing a Clean Air Fringe Benefit must provide DDOT with the following information:

- Total number of employees;
- The number of employees:
    - Offered a parking benefit;
    - Using a parking benefit;
    - Offered a Clean Air Transportation Fringe Benefit;
    - Using a Clean Air Transportation Fringe Benefit; and
- The market value of the Clean Air Transportation Fringe Benefit offered by the employer.

Employers with approved TDM plans must provide the DDOT with evidence demonstrating the employer's implementation of the plan within 90 days of the approval.

- Additionally, employers must submit annual reports regarding the form of commuter transportation for the previous calendar year.
- DDOT will conduct an annual audit to ensure employer compliance.

Employers complying with the Act by paying a Clean Air Compliance Fee must submit proof of payment every two (2) years to the DDOT. This must include the number of employees that the employer is paying the Clean Air Compliance Fee for.

Exempt employers must still report their exemption to DDOT every two (2) years.

Employer Action

- Determine whether you are a covered employer under the Act, and if so, determine which method of compliance you will implement.
- If choosing the Transportation Demand Management Plan approach ensure that your plan is submitted to the DDOT for approval by January 15, 2023.
- If you are a covered employer (or an exempt employer), ensure that you are prepared to submit any required reporting to DDOT by January 15, 2023.

Multiple Updates to Colorado FAMLI Paid Leave

As previously reported, Colorado has implemented a new paid family leave program to be administered by the state's FAMLI Division ("the Division") with contributions for the program paid equally by employers and employees.

In general, employers with at least one employee that works in Colorado must register with the FAMLI Division and commence payment into the state system as of January 1, 2023. Employer registration is expected to start in early December 2022. Registration is available at: **https://famli.colorado.gov/my-famli-employer**. Employees will be able to begin using FAMLI leave effective January 1, 2024.

Private Plan Option

Employers will have an option to submit their own or carrier sponsored private plan to the state instead of using the FAMLI system. All employers subject to FAMLI Paid Leave must register and pay the 2023 contributions, regardless of the intent to eventually implement an approved private plan. If a private plan is approved, the 2023 employer and employee contributions received by the Division will be eligible for reimbursement to the employer.

The Division has indicated that it expects to start accepting applications for private plans sometime between the first and third quarters of 2023. Additional guidance on what is required for a compliant private plan is available at the Division's website.

FAMLI Leave Updates

Notices and Toolkits

The FAMLI Division has prepared notices and an employer toolkit to assist employers with their reporting and payment duties. Employers are required to notify their employees about the FAMLI program by January 1, 2023.The employer toolkit includes the following documents in English and Spanish:

- Employer Required 2023 Program Notice Poster which must be posted in a prominent workplace location beginning January 1, 2023;
- Breakroom Poster;
- Paycheck Stuffer;
- 2023 Employee FAMLI Handbook;
- Pay Stub Sample;
- HR Fact Sheet; and
- Local Government Fact Sheet

Interaction with Other Leave Benefits

The Division has also released guidance on how FAMLI Paid Leave will interact with other types of leave including paid, unpaid, and required leave has been disclosed. As coordination can have an impact on any of these benefits, it is imperative that employers review their existing leave policies and handbooks to ensure proper communication on how these benefits interact. Below is guidance that we have received from the Division.

FAMLI and Workers' Compensation

FAMLI benefits do not run concurrent with Workers' Compensation. Furthermore, if the work absence would be eligible for coverage under Workers' Compensation, then FAMLI leave is not available. To assist with this process, the employee's application requesting FAMLI leave must disclose if their serious health condition was caused by or related to a workplace injury or illness. The application must also include medical certification, which will also affirm the injury's origin. If the employee's condition is denied under Workers' Compensation, the employee can reapply or reopen their FAMLI leave application for the same health condition.

a. FAMLI and Unemployment Benefits

FAMLI benefits and unemployment benefits do not run concurrently. If the employee's absence from work entitles them to unemployment benefits, the individual is not eligible for FAMLI leave.

The employee must inform the FAMLI Division if they apply for or receive unemployment benefits while on FAMLI leave and, if so, the FAMLI benefit will be classified as an overpayment.

Failure to comply with these requirements can result in the employee's disqualification from FAMLI benefits.

b. FAMLI and Employer Paid Leave

While the FAMLI Act and its regulations do not entitle an employee to receive both paid leave from the employer and FAMLI benefits for the same leave, an employer and employee may mutually agree to allow the employee to use any accrued employer-provided paid leave to supplement the FAMLI benefit. Absent written documentation of the mutual agreement, the FAMLI Division will presume that such an agreement to supplement the FAMLI leave benefit is present

However, a mutual agreement between the employer and employee is not necessary for the employee to use paid sick leave prior to receipt of FAMLI benefits.

The supplemental pay amount cannot exceed the difference between the FAMLI benefit and the employee's average weekly wage.

c. FAMLI and Employer Provided Benefits

The FAMLI Act and regulations only require a participating employer to maintain health care benefits. All other benefit continuation is subject to the employer's existing rules and policies.

Premiums for health care can be collected by the employer by any of the following:

- Deductions from the employer-provided paid leave used to supplement the FAMLI benefits;
- Deductions from wages upon the employee's return to work;
- Establishment of a repayment plan as agreed upon by the employer and employee; or
- Any other legal means (e.g., lawsuit).

d. FAMLI and Short-Term Disability ("STD")/Long-Term Disability ("LTD")

If the employer satisfies the FAMLI notice requirement, the employer can count the amount and duration of the FAMLI benefit against the amounts and duration provided under the applicable STD/LTD policies. An employer can require FAMLI benefits to run concurrent with STD/LTD and the terms of the STD/LTD policy will govern who provides notice about the benefits received by the employee to the policy's plan administrator – employer, employee, or both.

a. FAMLI and Family and Medical Leave Act ("FMLA")

FAMLI leave that also qualifies for federal FMLA must run concurrently.

Pre-Paying for FAMLI Benefits

The Division also addressed how employers can pre-pay FAMLI benefits before an employee is approved for leave by the FAMLI Division. An employer may register as a "pay-in-pending" employer with the FAMLI Division and any FAMLI benefits awarded to an employee would be paid directly to the employer as a reimbursement. An employee, however, is not required in this regard to apply for FAMLI benefits.

If the reimbursement to the employer is less than what the employer paid to the employee, the employer may not recoup the difference from the employee. The registered employer retains the right to appeal the FAMLI Division's determination of benefits.

For employers that choose not to register as a pay-in-pending employer but still pre-pay the employee's FAMLI benefit:

- The employer would not be entitled to reimbursement of the employer-provided paid leave;
- The employer may lawfully recoup from the employee the amount it paid and the amount that it was reimbursed by the FAMLI Division; and
- The employer does not have appeal rights to the FAMLI Division's determination of benefits.

Employer Action

As the state continues to provide additional information about the FAMLI program (with contributions set to begin January 1, 2023), employers should regularly check the FAMLI Division's main website and subscribe to their newsletter for updates.

New Hampshire Paid Family and Medical Leave Approaching

As previously reported, New Hampshire established the New Hampshire Paid Family and Medical Leave ("NH PFML") Plan which provides 60% of wages up to 6 weeks of work per year for personal health or family reasons. State employees will automatically be covered with the state paying the full cost of coverage. All other public and private New Hampshire employers and individuals may voluntarily enroll in the state-sponsored plan. Employers should note they will have responsibilities under both the employer sponsored and individual insurance options. The coverage will be effective January 1, 2023.

What's New?

There are two ways to participate in the NH PFML Plan: employer sponsored or individual coverage.

Employer Sponsored

Employers can purchase a fully insured plan through a state-approved carrier or provide benefits through self-insured employer equivalent benefit coverage.

Employers can choose between a 6-week or 12-week paid benefit that includes a 7-calendar day unpaid elimination period per year. The leave can be taken all at once (continuous) or in partial days (intermittent) with a minimum of 4-hour increments.

Insured plans will be individually underwritten by the carrier. An employer may fully fund the NH PFML Insurance premium cost on their employees' behalf, split the premium cost with employees or pass on the full cost to employees.

Employers purchasing NH PFML Insurance through MetLife (the state's NH PFML insurance partner) qualify for a Business Enterprise Tax ("BET") Credit equal to 50% of the NH PFML Insurance 6-week premium the employer pays. Employers will need to complete and submit the most recent Schedule of Business Profits Tax ("BPT") Credit (Form DP-160) to the New Hampshire Department of Revenue Administration to claim the NH business tax credit. Employers who purchase NH PFML Insurance from insurance carriers other than MetLife will not qualify for the BET Credit.

Individual Insurance

Individuals who work in New Hampshire for employers who choose not to offer NH PFML coverage or employer equivalent benefit coverage can purchase a NH PFML individual plan for themselves. The NH PFML Plan for individuals provides a 6-week paid benefit that includes a 7-month waiting period before a claim may be submitted and a single unpaid work week before benefits may be paid. The leave can be taken all at once (continuous) or in partial days (intermittent) with a minimum of 4-hour increments.

Premiums will be $5 maximum per week or $260 annually. Employers with 50 or more employees will be required to set up payroll deductions to support individuals who have purchased NH PFML through the state's insurance partner,

MetLife. If an employee enrolls as an individual, the employer will be contacted by MetLife to set up the payroll deductions and will be given remittance instructions. Employers with fewer than 50 employees may have individuals who enroll for individual coverage. These employees will be responsible for premium payments.

Claims Process

All employers must participate in the claims process for their covered employees. Covered employees submit NH PFML insurance claims directly to MetLife; however, employers are obligated to address employee questions and direct workers to MetLife.

Employers must also provide wage and leave information, work schedules and other benefits information to MetLife to support NH PFML insurance claims processing.

Coordination of Benefits

NH PFML Insurance is designed to coordinate with other types of leave and employee benefits:

- If employees qualify for short-term disability, they will not qualify for NH PFML Insurance benefits for the same days absent;
- If employees are eligible to receive workers' compensation, they will not qualify for NH PFML Insurance benefits;
- NH PFML Insurance will run concurrently with the federal Family and Medical Leave Act (FMLA) when a worker is eligible for qualifying leave under both programs; or
- Any other paid benefit coordination is based on employer policy, NH statute and rules of the MetLife agreement.

Key Dates

NH PFML Plan: Begins January 1, 2023

Employer Open Enrollment: Begins December 1, 2022

Individual Open Enrollment: Begins December 1, 2022

Employer Action

With the NH PFML start dates rapidly approaching, employers should review their current leave programs, discuss with their employment and labor counsels, leave management vendors, payroll departments and payroll vendors how this law will impact their current programs. Employers should note they will have responsibilities under NH PFML whether or not they choose to offer an employer sponsored benefit.

Oregon and Washington Issue Joint Paid Leave Guidance

On October 7, 2022, the Oregon Employment Department ("OED") and the Washington Employment Security Department ("ESD") issued a joint letter providing welcomed guidance assisting Washington and Oregon employers in determining which leave program employees are subject to when they work in multiple states. Employees should only be covered by one program and the premiums paid to that program would be based on all wages paid.

Background

Paid Leave Oregon ("PLO") and Washington Paid Family and Medical Leave ("WAPFML," and collectively, "the Programs") are separate paid leave programs that provide wage replacement benefits for certain protected family, medical, and safe (domestic violence) leaves to employees working in Oregon and Washington. The programs are funded by employer and employee contributions. Employee contributions are deducted from employee paychecks. Visit the following websites for Frequently Asked Questions:

https://paidleave.oregon.gov/employers/Pages/frequently-asked-questions.aspx

https://paidleave.wa.gov/help-center/employers/

Joint Letter Guidance

PLO and WAPFML require contributions to their programs for all covered employees. For both PLO and WAPFML, employee coverage is based on where work is performed. While both PLO and WAPFML define place of performance and localization of work for purposes of coverage under the Programs, it was not clear how employers were to determine which program covered an employee when an employee worked in both states. For example, if an employee worked at an employer worksite location in Washington and also from home in Oregon, was the employee covered by PLO, WAPFML, or both Programs?

The Joint letter provides helpful guidance for employers to resolve the coverage question.

Where is the work performed?

Both states tell employers to first consider where the work is performed, before looking at other aspects of employment. If all work is performed in one state, then the employee is covered by that state's program and all of the employee's wages are reportable to that state.

Example: If all the work is physically performed in Oregon, all of the employee's wages associated are reportable to Oregon.

Is work performed in more than one state?

If the work is performed in multiple states, the employer should look to the state that is the base of operations. If there is no base of operations, then look to where the direction and control comes from.

Examples:

- If the base of operation or direction and control comes from Oregon, all of the employee's wages associated are reportable to Oregon.
- If the base of operation or direction and control comes from Washington, all of the employee's wages and hours associated are reportable to Washington.

Is work performed in multiple states and direction or control of work is located in a state where the employee does not work?

In this instance, the employee is covered by the program from their state of residence and all of the employee's wages are reportable to that state.

The joint letter also provides some common scenarios to further illustrate the application of the guidance to different employee situations.

Employer Action

Employers that have not determined whether their employees are covered by PLO or WAPFML should consider their employee's specific situations in light of the additional guidance. Once coverage under PLO or WAPFML is determined, then all wages earned are reportable with that state's program. An employee covered under PLO that happens to work some time in WA would still have all wages earned reported to Oregon. In no event should an employee be covered by both PLO and WAPFML.

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BECAUSE EMPLOYEES MATTER

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