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New York Issues Guidance on COVID-19 Quarantine Leave

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On March 18, New York passed its own response to COVID-19 and implemented new paid leave for employees who are subject to a mandatory or precautionary order of quarantine or isolation issued by a governmental entity ("Quarantine Order"). Employees can get financial compensation by using a combination of benefits, which includes a new employer-provided paid sick leave (depending on the size of the employer), Paid Family Leave and disability benefits. New York has issued guidance in the form of Frequently Asked Questions clarifying the new employer-paid sick leave law. Below are highlights of the guidance.

If an employee is under a Quarantine, s/he may be eligible under the new employer-paid sick law for certain benefits in connection with a leave pursuant to a Quarantine, as follows:

- Employers with 10 or less employees as of January 1, 2020 who made $1 million or less in 2019 must provide employees with unpaid sick leave, but employees may be eligible to receive their weekly wages through a combination of NY PFL and NY DBL up to a maximum of $2,884.62 per week.

- Employers with 10 or less employees as of January 1, 2020 who make more than $1 million in 2019 and employers with 11-99 employees as of January 1, 2020 must provide employees 5 days of paid sick leave, followed by unpaid sick leave and guaranteed access to NY Paid Family Leave and NY DBL for the period of the quarantine, where employees may be eligible to receive their weekly wages through a combination of NY PFL and NY DBL up to a maximum of $2,884.62 per week.

- Employers with 100 or more employees as of January 1, 2020 and public employers must provide employees 14 days of paid sick leave at their regular rate of pay, which should cover the mandatory or precautionary quarantine or order of isolation.

Payment for Leave

For the 5 or 14-day paid leave period (the "Quarantine Leave"), employees must be paid the amount they would otherwise have received if they had been continuing to work. Hourly, part-time, commissions salespeople and other employees who are not paid a fixed wage should be paid an amount that is determined by the employer looking at a representative period-of-time to set the employee's average daily pay rate. There is no waiting period for Quarantine Leave.

The number of paid days is calendar days, and the pay required should represent the amount of money the employee would have otherwise received for the Quarantine Leave. For example, if an employee of a large employer would otherwise have worked three days during that 14-day Quarantine Leave, the employee would be entitled to only 3 days of paid sick leave. Payments to employees should be made in the paycheck for the applicable pay period for the Quarantine Leave.

Employees do not have to apply for employer-paid sick leave for a Quarantine Leave. If an employee runs out of paid sick days, s/he would need to apply for Paid Family Leave and disability benefits for compensation during the rest of his or her quarantine. To apply for Paid Family Leave and disability benefits for the rest of an employee's Quarantine Leave, an employee must:

- Complete either the Request for COVID-19 Quarantine Leave for Yourself form package or Request for COVID-19 Quarantine Leave for Minor Dependent Child form package (located at PaidFamilyLeave.ny.gov/COVID-19;
- send the completed forms to the employer to complete (the employer has three business days to complete); and
- submit completed forms together with the Quarantine Order.

Once the employee's package is submitted, the insurance carrier must pay or deny the claim within 18 calendar days. If the claim is denied, employees may file a request for arbitration to have the claim reviewed by a neutral arbitrator.

Eligibility

Employees that independently choose to Quarantine themselves are not eligible for a Quarantine Leave. Employees who do not show symptoms and who are physically able to work through remote access or similar means, are not eligible for Quarantine Leave. If an employee is subject to a Quarantine because s/he voluntarily traveled to a country with level two or three health notice from the CDC even after notice of the travel health notice and if such travel was not work related, the employee is not eligible for a Quarantine Leave. Finally, employees of employers who temporarily shut down or go out of business due to COVID-19 are not eligible for a Quarantine Leave but may be eligible for unemployment benefits.

Coordination of Leave

Quarantine Leave is available retroactively and may be taken even if the Quarantine Order was issued prior to the enactment of New York's employer-paid sick leave law.

Quarantine Leave must be provided separately from any other accrued leave and employers may not require employees to use existing sick leave or other paid time off for a Quarantine Leave.

If an employee's child's school is closed due to a Quarantine Order, the employee may be eligible to take Quarantine Leave. However, if the school was closed for preventative social distancing, the employee would not be eligible.

An employee who is under a Quarantine Order may also be eligible for Paid Family Leave/disability benefits for himself or herself unless s/he is not showing symptoms and is physically able to work through remote access or similar means. Available employer-paid sick leave must be exhausted before taking Paid Family Leave and disability benefits – an employee can apply for these benefits for the remainder of the Quarantine Leave, as discussed above.

Employees in New York who are also covered by the Families First Coronavirus Response Act are eligible to receive the difference between what the federal legislation provides and what is available under the New York law. We are hopeful that guidance will be issued that will provide specific details on the coordination between these two laws.

Job Protection

Employees are entitled to job protection under the new employer-paid sick leave law and are entitled to be restored to the position they held prior to taking Quarantine Leave. Any Quarantine Leave may not be counted as an absence that may lead to or result in discipline, discharge, demotion, suspension or any other adverse action.

DOL Issues Temporary Rule: Regulations Regarding FFCRA Leave

Published: April 8, 2020

The Department of Labor ("DOL") issued temporary regulations to implement emergency paid leave under the Families First Coronavirus Response Act ("FFCRA"), as well as additional FAQs that provide much needed clarification on many aspects of the new requirements. Below you will find highlights of the new guidance.

Background

Effective April 1, 2020 and ending on December 31, 2020, private employers with under 500 employees (and public employers) are required to provide two new types of leave to employees under the FFCRA. Please review our previous Bulletins for in depth information on these types of leave.

Emergency Paid Sick Leave

Under the Emergency Paid Sick Leave Act ("EPSLA"), employers must provide two weeks (up to 80 hours) of paid sick leave (at full pay up to $511 per day per employee) where the employee is unable to work or telework because the employee is quarantined by a federal, state or local government order or provider, or the employee experiences COVID-19 symptoms and is seeking a medical diagnosis. Employers must provide two weeks (up to 80 hours) of paid sick leave (at 2/3 employee's regular rate of pay up to $200 per day per employee) where the employee is unable to work or telework because the employee is (1) caring for an individual subject to a federal, state or local quarantine order or provider order, (2) caring for a child under 18 whose school or child care provider is closed/unavailable due to COVID-19, and/or (3) experiencing a substantially similar condition specified by the Secretaries of the HHS, Treasury and Labor Departments (none have been identified to date by the Departments).

Expanded FMLA leave

Under the Emergency Family and Medical Leave Expansion Act ("EFMLEA"), employers must provide up to 12 weeks of expanded family and medical leave (after the first two weeks, up to 10 weeks must be paid at 2/3 pay up to $200 per day per employee) to employees employed at least 30 calendar days who are unable to work or telework because they are caring for their son/daughter whose school or child care

provider is unavailable due to COVID-19. During the first two weeks of unpaid leave, employees may use paid sick leave under the EPSLA, as described above.

Certain small businesses (under 50 employees) are eligible for relief if providing these paid leaves would jeopardize the business' viability.

Payroll tax credits are available to private employers for all qualifying paid wages and allocable costs related to the maintenance of health coverage under any group health plan while the employee is on the leave.

How Much Time of the EFMLEA is Unpaid?

The regulations clarify that the first two weeks (rather than 10 days as indicated in the FFCRA) of EFMLEA is unpaid, though an employee may substitute paid sick leave under EPSLA or other employer paid leave policy during this time.

EPSLA and EFMLEA should work together to permit the employee to have a continuous income stream while taking FFCRA leaves.

Is a Quarantine/Isolation Order the Same as Stay-at-Home or Shelter-at -Home?

A quarantine or isolation order incorporates a broad range of governmental orders, including orders that advise some or all citizens to shelter-in-place, stay-at-home, quarantine or otherwise restrict their own mobility.

The regulations clarify that paid sick leave is only available if being subject to one of these orders prevents the employee from working or teleworking. The threshold question is whether the employee would be able to work or telework "but for" being required to comply with a quarantine or isolation order. It should also be noted that an employee will not be eligible for paid sick leave in the case where the employee is self-quarantining due to COVID-19 type symptoms but is not seeking a medical diagnosis or advice of a health care provider.

Who is an "Individual" that may be taken care of in connection with EPSLA?

For purposes of sick leave related to caring for an individual subject to quarantine, the individual being cared for must be an immediate family member, roommate, or similar person with whom the employee has a relationship that creates an expectation that the employee would care for the person if he or she self-quarantined or was quarantined. The individual must be unable to care for him or herself due to a diagnosis of COVID-19 (or is particularly vulnerable to COVID-19) and depends on the employee for care, and providing such care prevents the employee from working or teleworking.

Who is Considered a "Child" and What is Considered a "Child Care Provider" under the FFCRA?

Under part of the EPSLA and the EFMLEA, an employee may take paid sick leave only when the employee needs to, and actually is, caring for his or her child. This leave is not generally necessary if another suitable individual such as a co-parent, co-guardian or the usual childcare provider is available to provide the care the employee's child needs. An employee's child can be over the age of 18 if the child has a disability and cannot care for him or herself due to the disability, provided that the child's school or place of care is closed, or childcare provider is unavailable due to COVID-19 reasons.

The DOL's FAQs also provide the following definitions:

Place of Care: A place of care is a physical location in which care is provided for your child. The physical location doesn't have to be solely dedicated to such care and includes, for example, day care facilities, preschools, before and after school care programs, schools, homes, summer camps, summer enrichment programs and respite care programs.

Child Care Provider: A childcare provider is someone who cares for your child and includes individuals who are paid to provide childcare, such as nannies, au pairs, and babysitters. In addition, it also includes individuals who provide care at no cost and without a license on a regular basis, such as grandparents, aunts, uncles or neighbors.

What Happens to an Employee's Health Care Coverage When on an FFCRA Leave?

An employee who takes an FFCRA leave is entitled to continue coverage under the employer's group health plan on the same terms as if the employee did not take the leave. This includes medical care, surgical care, hospital care, dental care, eye care, mental health counseling, substance abuse treatment and other benefit coverage. If an employer provides a new health plan or benefit package option, or changes health benefits while an employee is taking paid sick leave or expanded family and medical leave, the employee is entitled to the new or changed plan/benefits to the same extent as if the employee was not on leave. Employer must give employees notice of any opportunity to change plans or benefits and if the employee requests the changed coverage, it must be provided by the employer.

Employees on FFCRA leave remain responsible for paying the same portion of the plan premium that the employee paid prior to taking the leave. The employee's share of premiums must be paid by the method normally used during any paid leave; in many cases, this will be through a payroll deduction.

For unpaid leave, or where pay is insufficient to cover the employee's premiums, the rules under traditional FMLA provide mechanisms for the employer to obtain payment (prepay, pay-as-you-go or catch-up).

If an employee chooses not to retain group health plan coverage while taking paid sick leave or expanded family and medical leave, the employee is entitled upon returning from leave to be reinstated on the same terms as prior to taking the leave, including family member coverage.

What if an Employee is Already Receiving Benefits or Already on Leave?

An employee is typically not eligible to receive paid leave under the EPSLA or the EFMLEA if receiving workers' compensation or temporary disability benefits. However, if the employee was able to return to light duty, but a qualifying reason prevents the employee from working, then the employee may be eligible for paid leave.

Whether an employee is eligible for paid leave under the EPSLA or the EFMLEA depends upon whether the employee is on a voluntary or mandatory leave of absence. If it is a voluntary leave of absence, the employee may qualify for paid leave by ending the leave of absence and taking the paid leave (assuming there is a qualifying reason). However, if the employee is on a mandatory leave of absence (e.g., furlough), the employee would not be eligible for paid leave (although the employee may be eligible for unemployment insurance benefits).

How Long Must an Employer Retain Records?

An employer is required to keep records of employee documentation and substantiation for four years.

Do Employees Have to Be Restored to Their Job After the Leave?

Generally, an employee is entitled to be restored the same or an equivalent position upon return from paid sick leave or expanded family and medical leave in the same manner that an employee would be returned to work after FMLA leave. However, employees subject to employment actions, such as layoffs, that would have affected the employee regardless of whether the leave was taken may not be protected. Employers must be able to demonstrate the employee would have been laid off even if s/he had not taken leave. For leave taken under the EFMLEA, an employer may deny restoration to key eligible employees (as defined under the FMLA), if such denial is necessary to prevent substantial and grievous economic injury to the employer's operations.

The job restoration provision does not apply to employers with less than 25 employees if:

- The employee took leave to care for his or her son or daughter whose school or place of care was closed or whose child care provider was unavailable;
- The employee's position no longer exists due to economic or operating conditions that (i) affect employment and (ii) are caused by a public health emergency (i.e., due to COVID-19 related reasons) during the period of the employee's leave;
- The employer made reasonable efforts to restore the employee to the same or an equivalent position; and
- If the employer's reasonable efforts to restore the employee fail, the employer makes reasonable efforts for a period of time to contact the employee if an equivalent position becomes available. The period of time is specified to be one year beginning either on the date the leave related to COVID-19 reasons concludes or the date twelve weeks after the employee's leave began, whichever is earlier.

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

Los Angeles: COVID-19 Supplemental Paid Sick Leave Ordinance Enacted

Published: April 15, 2020

On April 10, 2020, the City of Los Angeles published Ordinance No. 186590 to require certain employers to provide supplemental paid sick leave to qualifying employees when they are absent from work for reasons related to the COVID-19 pandemic. The ordinance became effective on April 10, 2020 and remains in effect until December 31, 2020 (unless the City takes action to extend it).

Who is Subject to the Ordinance?

Employers are subject to the ordinance if they have 500 or more employees nationally. The ordinance does not by its terms exclude employers that are subject to the paid sick leave and paid family and medical leave provisions of the Families First Coronavirus Response Act (which generally applies to employers with fewer than 500 employees). It is possible for an employer to be subject to both the ordinance and the Families First Act (for example, if a corporation has fewer than 500 employees but belongs to a controlled group of corporations that in aggregate has 500 or more employees nationwide).

The ordinance defines the term "employer" to mean any person or entity that directly or indirectly or through an agent or any other person (including through the services of a temporary service or staffing agency or similar entity) employs or exercises control over the wages, hours or working conditions of an employee. The ordinance states that a worker is presumed to be an employee, and the employer has the burden to demonstrate that a worker is a bona fide independent contractor and not an employee.

Which Employees Qualify?

To qualify for supplemental paid sick leave from a particular employer under the ordinance, an employee must meet two requirements: (1) The employee must have been employed by the employer from February 3, 2020 through March 4, 2020, and (2) the employee must perform work for the employer within the geographic boundaries of the City of Los Angeles. For example, an ongoing employee who normally works at the employer's place of business in Pasadena, but who teleworks from his/her home within the City of Los Angeles during the COVID-19 pandemic, might qualify for supplemental paid sick leave under the ordinance.

Supplemental Paid Sick Leave

To receive supplemental paid sick leave under the ordinance, an employee must make an oral or written request to the employer that he/she is taking time off from work because:

- a public health official or healthcare provider requires or recommends that the employee isolate or self-quarantine to prevent the spread of COVID-19; or
- the employee is at least age 65 or has a health condition (such as heart disease, asthma, lung disease, diabetes, kidney disease, or weakened immune system); or
- the employee needs to care for a family member who is not sick, in a situation where public health officials or healthcare providers have required or recommended isolation or self-quarantine for the family member; or
- the employee needs to provide care for a family member whose senior care provider (or school or childcare provider in the case of a child under age 18) temporarily ceases operations in response to a public health or other public official's recommendation.

Employers are prohibited by the ordinance from requiring a doctor's note or other documentation for the use of supplemental paid sick leave.

Supplemental paid sick leave is calculated under the ordinance as follows (subject to the limitations set forth in the bullet points below):

Employees who work a minimum of 40 hours per week or is classified as full-time by the employer: 80 hours of supplemental paid sick leave, calculated based on the employee's average two-week pay over the period of February 3, 2020 through March 4, 2020.

Employees who work less than 40 hours per week and are not classified as full-time by the employer: supplemental paid sick leave in an amount no greater than the employee's average two-week pay over the period of February 3, 2020 through March 4, 2020.

The leave under the ordinance is subject to the following important limitations:

- Supplemental paid sick leave cannot exceed $511 per day and $5,110 in the aggregate with respect to any employee.
- The employer's obligation to provide 80 hours of supplemental paid sick leave to an employee under the ordinance is reduced for every hour that the employer allowed the employee to take paid leave (not including previously accrued hours) on or after March 4, 2020 for any of the four reasons specified above, in an amount equal to or greater than the supplemental paid sick leave under the ordinance.
- Employees of joint employers are only entitled to the total aggregate amount of supplemental paid sick leave specified for employees of one employer.

Exemption

The ordinance states that an employer of an employee who is a "health care provider" (as defined by California Government Code section 12945.2) or "first responder" is exempt from the ordinance.

For purposes of this exemption, the ordinance states that a "first responder" is an employee of a state or local public agency who provides emergency response services, including a peace officer, a firefighter, a paramedic, an emergency medical technician, a public safety dispatcher or safety telecommunicator, an emergency response communication employee, or rescue service personnel.

It is not clear whether the ordinance's exemption applies to the employer or is limited to the employees who are health care providers or first responders.

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

IRS Guidance Issued on Tax Credits under the FFCRA

Published: April 16, 2020

The Internal Revenue Service ("IRS") issued guidance on the tax credits under the Families First Coronavirus Response Act ("FFCRA"). This guidance covers a variety of topics including how to calculate and claim the tax credit, how to determine the amount of the tax credit and documentation requirements to verify eligibility for the tax credits.

The FFCRA requires most private sector employers with less than 500 employees to provide paid sick leave and paid family leave to employees who are unable to work or telework due to COVID-19 specific reasons. Under the FFCRA, these small and midsize employers are eligible for refundable tax credits that reimburse them, dollar for dollar (up to a prescribed limit), for the cost of providing such leave, including the employer's cost of providing qualified health plan expenses to affected employees during the period beginning on April 1, 2020 through December 31, 2020. Although the FFCRA requires most government employers to provide paid leave, it does not entitle those governmental employers to tax credits for this leave. The following FAQs provide additional information.

How Does an Employer Claim the Tax Credit?

An eligible employer may claim tax credits for qualified leave wages. These credits are available for leave beginning on April 1 and ending on December 31. The employer will also be eligible to claim a tax credit for the cost of qualified health plan expenses provided to the employee through the same period. Employers will claim their credits on federal employment tax Form 941, Employer's Quarterly Federal Tax Return. Employers can use the tax credits they are earning by reducing their federal employment tax deposits.

If there are insufficient federal employment taxes to cover the amount of the tax credit, an employer may request advance payment of the tax credit by submitting an IRS Form 7200, Advance Payment of Employer Credits Due to COVID-19. The IRS expects to begin processing those requests during April 2020.

What is the Amount of the Tax Credit Available to Eligible Employers?

The credit covers 100% of the amount of FFCRA's Paid Sick Leave and Expanded Family and Medical Leave wages that have been paid to an employer's employees beginning on April 1. It also includes the amount of any qualified health plan expenses allocable to those wages. The FFCRA adds to the tax credits the amount of the Hospital Insurance tax, also known as Medicare tax, that the employer is required to pay on qualified leave wages. The rate for this tax is 1.45 percent of wages.

Must Employers Withhold Taxes from the FFCRA Wages Paid to Employees?

Yes. Qualified leave wages are wages subject to withholding of federal income tax and the employee's share of Social Security and Medicare taxes. Qualified leave wages are also considered wages for purposes of other benefits that the employer may provide, such as contributions to 401(k) plans.

Are FFCRA Wages Taxable to Employees?

Yes. The FFCRA did not include an exception for qualified leave wages from income.

Can Employers Make Salary Reduction Contributions from Qualified FFCRA Wages for Health Plan, 401(k) or Other Benefit Purposes?

Yes. Because the FFCRA does not distinguish qualified leave wages from other wages, the same rules apply. Therefore, to the extent that an employee has a salary reduction agreement in place, the FFCRA does not prohibit taking salary reduction contributions for any plan from qualified sick leave wages or qualified family leave wages.

Which Qualified Health Plan Expenses are Eligible?

Qualified health plan expenses for this purpose include fully insured and self-funded medical plans, HRAs, dental plan, vision plans, prescription drug plans and health FSAs. It does not include HSAs.

What can be Included when Calculating the Amount of Qualified Health Plan Expenses?

The amount of qualified health plan expenses generally includes both the portion of the cost paid by the employer plus the cost paid by the employee with pre-tax salary reduction contributions. The qualified expenses of each plan are aggregated for each eligible employee.

What is the Amount of Qualified Health Plan Expenses that an Employer who Sponsors a Fully Insured Health Plan Can Use Towards the Tax Credit?

An employer who is fully-insured may use any reasonable method to determine and allocate the plan expenses, including:

- the COBRA applicable premium (without the 2%);
- one average premium rate for all employees; or
- a substantially similar method that takes into account the average premium rate determined separately for employees with self-only and other than self-only coverage.

The IRS has provided that if an employer was to use the average premium rate for all employees (regardless of which tier the employee was covered under: i.e. single, family, employee and spouse), the employer's overall annual premium for the employees would be divided by the number of employees covered by the policy. This would then be divided by the average number of workdays during the year to determine the average daily premium per employee. A typical full-time employee would be treated as working 52 weeks x 5 days or 260 days. A part-time or seasonal employee would be adjusted as appropriate.

What is the Amount of Qualified Health Plan Expenses that an Employer who Sponsors a Self-Insured Health Plan Can Use Towards the Tax Credit?

An employer who sponsors a self-insured group health plan may use any reasonable method to determine and allocate the plan expenses, including

- the COBRA applicable premium for the employee (without the 2%), typically available from the administrator; or
- any reasonable actuarial method to determine the estimated annual expenses of the plan.

If the employer uses a reasonable actuarial method to determine the estimated annual expenses of the plan, then rules similar to the rules for insured plans are used to determine the amount of expenses allocated to an employee.

What Information is Required from Employees to Substantiate the Employer's Eligibility for Tax Credits?

An employer must receive a written request for such leave from the employee in which the employee provides:

- the employee's name;
- the date(s) the employee is requesting leave;
- the COVID-19 qualifying reason for leave; and
- a statement that the employee is unable to work/ telework due to COVID-19 reasons

Depending upon the reason for the FFCRA leave request, additional documentation may be required if leave is requested:

- due to federal/state/local quarantine, employee must provide name of government entity that issued the quarantine governing that employee;
- due to health provider advising self-quarantine, employee must provide name of the healthcare provider.
- to take care of an individual subject to quarantine, employee must either provide the name of the government entity or the health care provider who advised the quarantine of the individual.
- to care for son or daughter out of school/daycare, employee must provide the name of the child, the name of the school/place of care/child care provider, and a statement that no other suitable person is available to care for the child. Furthermore, if the child is over the age of fourteen, an additional statement must be provided explaining what special circumstances exist to request the leave.

Finally, employers also need to create and maintain records that include the following information:

- how the employer determined the amount of FFCRA wages paid to employee eligible for the credit, including records of work, telework and FFCRA leave;
- how the employer determined the amount of qualified health plan expenses that the employer allocated to the wages paid;
- copies of any completed IRS Form 7200s that the employer submitted for an advance of employer credits due to COVID-19; and
- copies of all completed IRS Forms 941 that the employer submitted to the IRS.

An employer should keep all records of employment taxes for at least 4 years after the date the tax becomes due or paid, whichever is later.

Employer Action

Employers should coordinate with their finance departments and tax advisors to fully understand available tax credits and the process for obtaining relief.

For the FAQ (which is regularly updated by the IRS), visit https://www.irs.gov/newsroom/covid-19-related-tax-credits-for-required-paid-leave-provided-by-small-and-midsize-businesses-faqs.

FAQs on COVID-19 and Health Coverage

Published: April 17, 2020

On April 11, 2020, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") issued FAQ Part 42, which includes implementation guidance on the health coverage aspects of the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), as well as other health plan issues related to COVID-19. In addition, the Department of Labor issued corrections to its regulation on the FFCRA to fix an inconsistency regarding concurrent use of employer-provided paid time off and paid expanded family medical leave under the FFCRA.

Briefly, the FAQs provide:

- For grandfathered group health plans, extending coverage as required under FFCRA will not affect grandfathered status.

- The coverage requirements related to COVID-19 diagnostic testing:
  - Are effective March 18, 2020 and expire at the end of the emergency period. Currently, the end of the emergency period is April 25, 2020 but may be extended (or shortened) by HHS.
  - Include COVID-19 antibody testing.
  - Extend to out-of-network providers and traditional and non-traditional places of care (e.g., a drive-through COVID-19 testing site).

- Relief from the 60-day advance notice requirement for mid-year plan design changes that affect the Summary of Benefits and Coverage ("SBC") when related to COVID-19 during the emergency period (including adding or enhancing telehealth benefits).

- An employee assistance program ("EAP") may offer benefits for COVID-19 diagnosis and testing without jeopardizing excepted benefit status while emergency declarations related to the pandemic are in effect.

Employers should ensure their group health plans comply with the coverage requirements under the FFCRA (as amended by the CARES Act).

Additional details are described below.

Background

The FFCRA, enacted on March 18, 2020, requires coverage for certain items and services related to diagnostic testing for COVID-19 without cost-sharing, pre-authorization, or medical management techniques.

The CARES Act, enacted on March 27, 2020 amends the FFCRA and expands the range of diagnostic items and services that a plan must cover without cost-sharing pre-authorization or medical management techniques. It also requires health plans and insurance carriers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount equal to the negotiated rate, or if the plan or carrier does not have a negotiated rate with the provider, the cash price as listed on the provider's public website. Finally, the CARES Act also provides temporary relief to qualified high deductible health plans ("HDHP") to provide telehealth or other remote health care services prior to satisfaction of the deductible without jeopardizing an individual's eligibility for a health savings account ("HSA").

Which Plans are Subject to FFCRA Coverage Requirements?

Group health plans sponsored by private employers, non-federal governmental plans and church plans are subject to the FFCRA coverage requirements. This includes fully insured, self-funded, grandfathered and non-grandfathered plans. Individual plans are also subject to this mandate including policies sold through, or outside of, the Marketplace and student health insurance coverage.

The coverage mandates do not apply to short-term limited duration insurance, excepted benefits, or group health plans that do not cover at least two current employees (e.g., a retiree-only plan).

Providing the required diagnostic items and services related to COVID-19 will not cause a plan to lose grandfathered status so long as no other changes are made that could otherwise cause a loss of this status.

How Long do Plans Have to Provide this Coverage?

Health plans must comply with the requirements under the FFCRA as of March 18, 2020 and must do so until the public health emergency declaration related to COVID-19 ends. The FAQs clarify that a public health emergency declaration lasts until the earlier of a declaration by HHS that the emergency no longer exists or the expiration of the 90-day period measured from the date the emergency was declared. Unless extended or terminated earlier, the public health emergency related to COVID-19 will end April 25, 2020.

What Items and Services Must Be Covered under FFCRA, as Amended by the CARES Act?

Health plans must provide coverage for the following items and services:

- An in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test that:
  - is approved, cleared or authorized by the Federal Food, Drug and Cosmetic Act ("FDCA);
  - the developer has requested (or intends to request) emergency use authorization under the FDCA, unless and until the emergency use authorization request is denied or if the developer does not submit a request within a reasonable timeframe;
  - is developed in and authorized by a state that has notified HHS of its intention to review tests intended to diagnose COVID-19; or
  - is another kind of test that HHS deems appropriate in guidance.

- Items and services furnished to an individual during health care provider office visits (which include in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described above, but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

The guidance clarifies:

- testing for COVID-19 antibodies will meet the definition of an "in vitro diagnostic product" and is covered, assuming it otherwise satisfies the requirements of the FFCRA (as amended by the CARES Act).

- the term "visit" is defined broadly to include both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered, including drive-through screening and testing sites where licensed healthcare providers are administering COVID-19 diagnostic testing.

The guidance also provides an example of how plans must cover other tests as part of the evaluation of an individual for COVID-19.

Example: If the individual's attending provider determines that other tests (e.g., influenza tests, blood tests, etc.) should be performed during a visit to determine the need of such individual for COVID-19 diagnostic testing, and the visit results in an order for, or administration of, COVID-19 diagnostic testing, the plan or issuer must provide coverage without cost sharing, when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice. This coverage must also be provided without imposing prior authorization or other medical management requirements.

Health plans are required to provide coverage for items and services related to a COVID-19 diagnosis without cost-sharing when furnished by out-of-network providers. Where there is no negotiated rate with an out-of-network provider, the plan must reimburse the provider at the cash price for the services as listed by the provider on a website. 0ne of the FAQs clarifies that the plan may negotiate with the out-of-network provider for a lower price than the listed cash price.

SBC Relief

Generally, if there is a mid-year material modification in any of the terms of the plan or coverage that would affect the content of the SBC, the plan must provide 60 days advance notice of the change. One of the FAQs discusses relief from this requirement, stating that the Departments will not take enforcement action against any plan or carrier that makes a modification to the SBC to provide greater coverage related to the diagnosis and/or treatment of COVID-19 without providing at least 60 days advance notice. This relief extends to plans and carriers that add benefits or reduce/eliminate cost sharing for telehealth or other remote care services mid-year. Plans and carriers should provide notice of the changes as soon as reasonably practicable, either by issuing an updated SBC or a separate notice describing the material modification.

The Departments will continue to take enforcement action against any health insurance issuer or plan that attempts to limit or eliminate other benefits, or to increase cost-sharing, to offset the costs of increasing the generosity of benefits related to the diagnosis and/or treatment of COVID-19.

Employee Assistance Plans Onsite Clinics as Excepted Benefits

An EAP is treated as an excepted benefit when it meets certain requirements, including that the EAP does not provide significant medical benefits. For this purpose, the amount, scope and duration of covered services are considered. EAPs generally must maintain excepted benefit status in order to avoid certain coverage mandates under the Affordable Care Act with which it cannot comply (e.g., providing coverage for certain preventive care items and services without cost-sharing).

One of the FAQs states that an EAP will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 while a public health declaration or national emergency declaration related to COVID-19 is in effect. Therefore, an EAP that offers benefits for diagnosis of, or testing for, COVID-19 may still qualify as an excepted benefit. This guidance may allow other arrangements offered by employers to qualify as an excepted benefit EAP when providing benefits to diagnose or test for COVID-19.

Another FAQ reiterates that an onsite clinic is an excepted benefit in all circumstances.

FAQ 42 may be found at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf

Notice of Ancillary Coverage Termination

Published: April 20, 2020

Due to the COVID-19 pandemic, many employers are being forced to terminate, lay-off and furlough employees. When employers exercise one of these options, it is important that they consider the ramifications to the former employees' ancillary benefits and take appropriate actions.

Employers that Offer Group Life Insurance Coverage

Where an employee is no longer employed, the employee's group life insurance coverage may end. Employers that have recently terminated, laid-off or furloughed employees may need to offer these former employees an option to convert the group term to an individual policy. This conversion option would allow an employee to continue life insurance on his or her own. Timing is important when converting a policy. Once terminated/laid-off/furloughed, employers must notify their former employees as soon as possible that they may be eligible to convert their coverage to an individual policy, as there may be a deadline to convert the coverage. Former employees should be directed to the plan's SPD or the certificate of life insurance coverage for deadlines, which may be quickly approaching depending on when the employees were terminated/laid-off or furloughed.

Employers that offer Voluntary Benefits

Employers may pay for voluntary benefits for their employees using either pre- or post-tax dollars deducted from employees' payroll. Employers should review their SPDs and/or employee handbooks regarding payment procedures for voluntary benefits. When employment ceases, so do employer contributions. Many times, former employees do not realize the employer has stopped paying. Employers that have recently terminated, laid-off or furloughed employees due to the COVID-19 pandemic should notify their former employees that they are no longer paying for their voluntary benefits. Further, employers should advise their former employees what steps they can take to continue coverage on their own.

If you have questions, please contact your account manager or account executive.

Qualified Disaster Relief Payments

Published: April 21, 2020

Employers may make tax-free qualified disaster relief payments to employees to reimburse or pay certain reasonable and necessary expenses incurred by the employee in connection with the COVID-19 pandemic. Below you will find information on the taxation, use, amount and substantiation of these payments.

Taxation

In general, amounts provided by employers to employees are taxable to those employees. However, Internal Revenue Code Section 139 provides an exception for "qualified disaster relief payments," generally available when there is a federally declared disaster. The IRS interpreted the President's March 13, 2020 declaration under the Robert T. Stafford Relief and Emergency Act with respect to the COVID-19 pandemic as constituting such a federally declared disaster.

Qualified disaster relief payments are excluded from gross income and from wages and compensation for purposes of employment taxes. Thus, they are not subject to income tax withholding, FICA, or FUTA, do not have to be reported by an employer making the payment on the receiving employee's Form W-2, and do not have to be reported as income by the affected employee. The payments are also nontaxable in most, but not all, states. The employer deducts the payments as wages.

What Can These Payments be Used For?

Qualified disaster relief payments may be used to pay or reimburse reasonable and necessary personal, family, living, or funeral expenses as incurred as a result of a qualified disaster. What this may be in light of COVID-19 is not specifically addressed, but basic necessities such as food, shelter, childcare, telecommuting, and medical expenses would likely qualify. Code Sec. 139 qualified payments do not include any amounts intended as wage replacement and amounts that were not incurred with respect to the declared disaster. There can be no "double dipping" (i.e., the expense cannot otherwise be compensated by insurance or otherwise – FFCRA paid leave will not also qualify under Code Sec. 139).

Amount of Payments

There is no IRS limit. Payments can vary by employee and there are no applicable nondiscrimination rules.

Substantiation

The IRS has informally indicated that recipients are not required to account for actual disaster relief payments in order to qualify for the Code Sec. 139 exclusion, provided that the amount of the payment can be reasonably expected to be commensurate with the expense incurred. It is uncertain whether individuals receiving payments may later be called upon to demonstrate that the expenses for which they received disaster relief payments were not subject to reimbursement through insurance or otherwise.

Employer Action

Qualified disaster payments were first instituted following 9/11. There is little guidance concerning them and there is no guidance specifically addressing Code Sec. 139 as it relates to COVID-19. Employers who wish to make qualified disaster payments should review Code Sec. 139 and consult with a CPA or other tax advisor with any questions.

Extension of Form 5500 Deadline

Published: April 22, 2020

The IRS has announced that ERISA pension and welfare benefit plans with a Form 5500 filing deadline falling on or after April 1, 2020 and before July 15, 2020 (whether it is their original deadline or their deadline was previously extended) will now automatically have until July 15, 2020 to file. This is especially helpful for plans with an April 15 extended due date who may not have been able to file due to the COVID-19 pandemic. It is important to note, however, that this extension does not provide any relief for calendar year 2019 plan filings which are initially due on July 31.

Background

Under ERISA, welfare benefit plans must electronically file the Form 5500 by the last day of the seventh month after the end of any plan year that had 100 or more plan participants on the first day of that plan year. Among other things, the Form 5558, Application for Extension of Time to File Certain Employee Plan Returns, when completed and mailed to the IRS office in Ogden, UT, extends that deadline to file a Form 5500 by two and a half months from the original due date. Since the Ogden IRS office is closed due to the COVID-19 pandemic, the Form 5558 cannot be filed at this time, resulting in the IRS providing this relief. However, for Forms 5500 due 5/31/2020 and 6/30/2020, the two-and-a-half-month extension (with 8/15/2020 and 9/15/2020 extended due dates, respectively) are currently only able to be automatically extended to this 7/15/2020 deadline relief.

It is important to watch these adjusted deadlines carefully:

Original Due Date	Extended Due Date With Form 5558	Automatically Extended Due Date
1/31/2020	4/15/2020	7/15/2020
2/29/2020	5/15/2020	7/15/2020
3/31/2020	6/15/2020	7/15/2020
4/30/2020	N/A	7/15/2020 (Form 5558 not required)
5/31/2020	8/15/2020	7/15/2020*
6/30/2020	9/15/2020	7/15/2020*
7/31/2020	10/15/2020	N/A

*pending guidance, but no Form 5558 is required to extend to 7/15/2020

Employer Action

Since the 7/15/2020 deadline extension applies automatically, plan sponsors do not need to file the Form 5558 to claim the extension. Even though the deadline was extended, plan sponsors are encouraged to file the Form 5500 by their original due date where possible. Plans that have filing deadlines outside of the window provided by this relief should monitor guidance to see whether any additional relief or additional extensions become available.

New Mandatory Preventive Items and Services

Published: April 23, 2020

Most plans will be required to cover new preventive items and services in 2021 and 2022, including several related to the human immunodeficiency virus ("HIV").

Additionally, the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") requires coverage for any COVID-19 related preventive care services within 15 days.

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. If a plan or carrier does not have in its network a provider who can provide the required preventive care item or service, the plan or carrier must cover the item or service when performed by an out-of-network provider, and may not impose cost-sharing with respect to the item or service.

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 issued.

New Preventive Items and Services

The newly covered items and services are as follows:

Effective for plan years beginning 2021

Abdominal aortic aneurysm screening: men: 1-time screening for abdominal aortic aneurysm with ultrasonography in men aged 65 to 75 years who have ever smoked.

Bacteriuria screening: pregnant women: Screening for asymptomatic bacteriuria using urine culture in pregnant persons.

Breast cancer preventive medication: Clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.

BRCA risk assessment and genetic counseling/testing: Primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.

Hepatitis B screening: pregnant women: Screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.

HIV preexposure prophylaxis (PrEP) for the prevention of HIV infection: Clinicians offer PrEP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

HIV screening: adolescents and adults ages 15 to 65 years: Clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened.

HIV screening: pregnant women: Clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.

Perinatal depression: counseling and intervention: Clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.

Gonorrhea prophylactic medication: newborns: Prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.

Effective for plan years beginning 2022

Hepatitis C virus infection screening: adults aged 18 to 79 years: Screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.

Rapid Coverage for COVID-19 Vaccine

Although plans usually have one year to cover services recommended by the USPSTF, the CARES Act provides that new preventive services related to COVID-19 (e.g., a vaccine) must be covered by a non-grandfathered group health plan within 15 days. At this time, no such vaccine is available; however, a vaccine may become available later this year or in 2021.

It appears that this requirement applies only to non-grandfathered plans, but further guidance may extend such coverage to grandfathered plans.

Employer Action

Employers sponsoring non-grandfathered group health plans should review the various preventive care requirements effective for their 2021 plan years. Such coverage must be provided in-network, without cost-sharing.

For fully insured health plans carriers are generally responsible for compliance and should include these benefits as applicable. For self-funded health plans, employer should discuss with TPAs to ensure coverage is in effect for plan years that begin on or after January 1, 2021.

Should a vaccine for COVID-19 become available, group health plans will want to move quickly to ensure coverage is provided in-network without cost-sharing.

For a complete list of preventive items and services, visit:

http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

COVID-19
Employer Obligations for Members of the Armed Services

Published: April 28, 2020

Due to the COVID-19 pandemic, there has been an increased need for the federal and state governments to call up members of the National Guard and/or the Reserves components of the federal armed forces for a variety of missions to help combat COVID-19. Employers need to be mindful of the rights and protections afforded to their employees who serve in the armed forces. Generally speaking, employers with employees who serve in the "Uniformed Services" are prohibited from discriminating against these employees and must protect their jobs when they return from military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as well as under state laws. This Bulletin focuses mainly on employer's obligations with respect to employee benefits for these employees.

Background

USERRA applies to all public and private employers in the United States, regardless of size, and protects certain employment and benefit rights for members of Uniformed Services. Uniformed Services include the Army, Navy, Marine Corps, Air Force, Coast Guard, and National Guard, among other commissioned corps. Their service includes both active and reserve duty (whether voluntary or involuntary) and time off for training or instruction.

In general, USERRA prohibits employers from discriminating against employees based upon their military service and requires employers to provide members of the Uniformed Services the following:

- the right to continue coverage under the employer's group health plans while the employee is absent from work due to Uniformed Service;
- guaranteed reemployment following completion of the employee's Uniformed Service;
- restoration of the seniority the employee had on the date of the leave, and additional seniority that the employee would have attained, if the employee had remained continuously employed; and

- reinstatement in group health plans if coverage was terminated as a result of Uniformed Service and the employee is reemployed following completion of Uniformed Service.

All employers are required to provide to employees entitled to the rights and benefits under USERRA, a notice of their rights, benefits and obligations. Employers may provide the notice "Your Rights Under USERRA" by posting it where employee notices are customarily place or by mailing or distributing the notice by email. The USERRA poster can be accessed at https://www.dol.gov/sites/dolgov/files/VETS/legacy/files/USERRA_Private.pdf

It is important to note that National Guard members may be called to service under either federal or state authority, but only Federal National Guard service is covered by USERRA. National Guard duty under state authority, commonly referred to as State Active Duty, is not covered by USERRA; however, members of the National Guard serving on State Active Duty may have similar employment protections under state law. This Bulletin will not address the specific state laws, but each of New York, New Jersey, Pennsylvania, California and Delaware have their own military laws which are similar to USERRA. Generally speaking, USERRA will preempt any state laws that provide lesser rights or benefits or impose additional eligibility criteria.

Military Leave

Under USERRA, employers must grant unpaid military leaves of absence to employees who request such leave in order to perform services in the Uniformed Services. With certain exceptions, they must grant a leave of absence for up to 5 years to any person who is absent from his or her job because of service in the Uniformed Services. Employees are required to provide their employers with advance notice of military service. The notice may be either written or oral, and may be provided by the employee or by an appropriate officer of the branch of the military in which the employee will be serving. No notice is required if military necessity prevents the giving of notice, or the giving of notice is otherwise impossible or unreasonable. Employers must allow, but not require, service members to use any vacation and/or personal leave that had accrued before the beginning of their military leave instead of unpaid leave.

Health Benefits

Employees serving in the Uniformed Services are entitled to COBRA-like continuation health coverage. If an employee has group health plan coverage through an employer, s/he must be permitted to continue the same coverage s/he had before being called to duty (including dental and vision) during military leave, including coverage for dependents if the plan offers dependent coverage. USERRA does not grant independent election rights to employees and their dependents; only the employee who performs Uniformed Service is granted the right to elect USERRA coverage for himself or herself, and for any covered dependents. This means that only the employee can elect coverage on behalf of dependents and dependents cannot elect coverage if the employee does not also elect the coverage. The employee may continue coverage for the lesser of 24 months beginning on the date of the military leave, or the period beginning on the date of the military leave and ending on the date the employee fails to return from service or apply for reemployment. If the military leave is less than 31 days, employers are not permitted to charge a premium that is higher than that paid by regular employees. If the leave is 31 days or more, employers may charge up to 102% of the full premium under the plan.

Can an Employer Terminate Coverage?

Yes, but only in certain circumstances. An employee's health plan coverage may be terminated upon the employee's departure from employment for Uniformed Service if the employee does not give advance notice of service and/or does not elect to continue coverage during his or her leave. However, the employee must be retroactively reinstated if the employee is excused from the advance notice requirement because it was impossible, unreasonable, or precluded by military necessity, and the employee later elects coverage and pays all amounts due. Plans may also adopt reasonable rules allowing cancellation of coverage if timely payment is not made.

Can an Employer Impose a Waiting Period in Connection with Reinstatement?

When uniformed service members return to employment, an employer is required to provide them and their dependents with health care benefits immediately. While an employer may not impose an exclusion or waiting period in connection with reinstatement of coverage upon reemployment following Uniformed Service, an employer is permitted, but not required, to allow an employee to choose to delay reinstatement of health plan coverage until a date that is later than the employee's reemployment date.

Can an Employee Make a New Election in a Cafeteria Plan?

Yes. Employees absent from employment by reason of military service will be treated as any other employees on leave. A service member's ability to discontinue or change coverage under a cafeteria plan will depend on whether the plan allows mid-year election changes. If under the terms of the plan, an unpaid leave by either the employee or the employee's spouse triggers the right to make mid-year election changes, an employee on military leave will be allowed to make such changes. If participation in a cafeteria plan is discontinued by reason of military leave, eligibility for cafeteria plan benefits following the leave must be restored.

Layoffs

If an employee is laid off with recall rights or on a leave of absence, s/he is an "employee" for purposes of USERRA. If an employee is laid off before or during his or her service in the Uniformed Services, and the employer would not have recalled him or her during that period, the employer is not required to reemploy him or her following his or her period of service simply because s/he is covered under USERRA. A service member can be furloughed or laid off upon return from Uniformed Services only if it is reasonably certain that s/he would have been furloughed or laid off had s/he not been absent for uniformed service. Reemployment rights under USERRA cannot put the employee in a better position than if s/he had remained in the civilian employment position.

Reemployment

If an employee satisfies the prerequisites to reemployment, the employee should be promptly reemployed in the job position that s/he would have attained with reasonable certainty if not for the absence due to Uniformed Service. "Prompt" reemployment generally depends on the length of time the person was away and can range from the next day after returning from duty if the deployment was relatively short, to up to fourteen days in the case of a multi-year deployment.

When reemploying a service member who might have been exposed to COVID-19, an employer must make reasonable efforts in order to qualify the returning employee for his or her proper reemployment position. This can include temporarily providing paid leave, remote work, or another position during a period of quarantine for an exposed reemployed service member or COVID-19 infected reemployed service member, before reemploying the individual into his or her proper reemployment position.

Employers are required to reemploy a returning service member in all cases except:

- if the employer's circumstances have changed, so as to make it impossible or unreasonable for the employer to reemploy the individual;
- if the returning service person is no longer qualified to reemployment despite reasonable efforts to requalify that person, and reemployment would impose an undue hardship; or
- if the position the employee held before service was for a brief, non-recurrent period and there is no reasonable expectation that employment would have continued indefinitely for a significant period.

Under USERRA, a reemployed employee may not be discharged without cause for 180 days after the date of reemployment if the person's period of military service was for 31 to 180 days, and for one year after the date of reemployment if the person's period of military service was for 181 days or more. Those who serve for 30 days or less are not protected from discharge without cause.

Employer Action

Although legislation is being introduced at a quick rate at both the federal level and state level, employers should pay attention to laws already in existence that protect leave for members of the Uniformed Services when called to combat emergency situations. Employers should also review their Plan Documents and Summary Plan Descriptions (SPDs) for policies and procedures regarding leaves. In addition, employers with employees who are subject to a collective bargaining agreement should review the agreement to determine what, if any, additional rights are included for those on military leave. Employers with employees in the Uniformed Services should consult with counsel to ensure they are in compliance with existing requirements under both federal and state law, where applicable.

For more information on USERRA, visit the following websites:
https://www.dol.gov/agencies/vets/programs/userra/resources
https://www.dol.gov/agencies/vets/programs/userra/USERRA%20Pocket%20Guide

San Francisco Enacts COVID-19 Public Health Emergency Leave Ordinance

Published: April 28, 2020

Late on April 17, 2020, Mayor Breed signed the Public Health Emergency Leave Ordinance (Ordinance) that was passed by the San Francisco Board of Supervisors earlier in the week. The Ordinance requires employers to provide paid Public Health Emergency Leave (PHE leave) to employees when they are absent from work for reasons related to the COVID-19 pandemic. The Ordinance became effective on April 17, 2020 and remains in effect until June 17, 2020 (unless extended) or the end of the public health emergency, whichever is earlier.

Shortly thereafter, the San Francisco Office of Labor Standards Enforcement (OLSE) published guidance in the form of FAQs on employers' and employees' rights and obligations under the Ordinance. The following summary incorporates the requirements of both the Ordinance and the OLSE guidance.

Covered Employers

Employers are required to provide PHE leave if they have 500 or more employees worldwide and have any employee who performs work in San Francisco. If the number of employees fluctuates, the population size of the employer is based upon the average number of employees per pay period during the preceding calendar year.

The Ordinance is intended to fill the gap left by the federal Families First Coronavirus Response Act (FFCRA), which generally requires employers with fewer than 500 employees to provide certain employees with paid sick leave and paid family and medical leave when they are unable to work or telework for reasons related to COVID-19. The Ordinance specifically does not apply to employers required to provide paid sick leave and paid family and medical leave under the FFCRA.

Eligible Employees

PHE leave is available under the Ordinance to any current employee who performs work within the geographic boundaries of San Francisco (even on a limited basis), including full-time, part-time, temporary, seasonal, salaried, and paid-by-commission employees. Eligibility for PHE leave is not affected by the employee's immigration or documented status, length of employment, or whether

currently scheduled to work (as long as there has not been a formal separation of employment such as a layoff). This means that furloughed employees, and employees of businesses that have temporarily closed or suspended operations, are eligible for PHE leave under the Ordinance. However, independent contractors are not eligible for PHE leave.

Employers are not required by the Ordinance to permit eligible employees to take PHE leave when they are working--or scheduled to work--outside of San Francisco.

Amount of PHE Leave

The amount of PHE leave payable to an eligible employee is calculated as follows:

Eligible Employee	Entitlement to Paid PHE Leave
An employee scheduled to work full-time (40 hours per week) as of February 25, 2020	80 hours
An employee scheduled to work part-time as of February 25, 2020	The average number of hours the employee was scheduled to work over two weeks during the six months ending on February 25, 2020 (including hours for which the employee took leave of any type), but not more than 80 hours
An employee who commenced work after February 25, 2020	The average number of hours the employee worked over two weeks between the date of hire and the date paid leave is taken (including hours for which the employee took leave of any type), but not more than 80 hours

In general, PHE leave must be provided in addition to any other paid time off available to the employee, including paid sick leave under the San Francisco Paid Sick Leave Ordinance.

An employer may not change any non-mandated paid time off policy on or after April 17, 2020 except to provide additional paid leave. For example, an employer may not reduce the amount of PTO under its internal non-mandated policy to offset PHE leave required to be paid under the Ordinance.

However, the amount of PHE leave an employer must provide to an employee is reduced by:

- every hour of paid time off that the employer allowed an employee to take in addition to previously accrued hours, on or after February 25, 2020, for any of the six reasons for taking PHE leave (as explained below), provided that the paid time off was consistent with the PHE leave requirements
- every hour of paid leave the employee takes pursuant to the April 16, 2020 California Supplemental Paid Sick Leave Executive Order applicable to food sector workers.

Reasons for Taking PHE Leave

Eligible employees may take PHE leave on or after Friday, April 17, 2020 (but not after the Ordinance expires, which is currently scheduled to occur on June 17, 2020), if the employee is unable to work or telework because of any the following reasons:

1. The employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19, including shelter-in-place orders. This includes employees who are members of a “vulnerable population” or “high-risk population” who are unable to work due to recommendations in a state or local order, including people who are at least 60 years old; people with certain health conditions such as heart disease, lung disease, diabetes, kidney disease, and weakened immune systems; and people who are pregnant or were pregnant in the last two weeks.
2. The employee has been advised by a health care provider to self-quarantine.
3. The employee is experiencing symptoms associated with COVID-19 and seeking a medical diagnosis.

4. The employee is caring for a family member who is subject to an order as described in (1) above, has been advised to self-quarantine as described in (2) above, or is experiencing symptoms as described in (3) above.
5. The employee is caring for a family member, if the family member's school or place of care has been closed, or the family member's care provider is unavailable, due to the public health emergency.
6. The employee is experiencing any other substantially similar condition specified by a local health officer or under federal law.

Special Exception: If an employee is a health care provider or emergency responder, the employer may limit that employee's use of PHE leave to the following situations:

- The employee is unable to work or telework because the employee has been advised to self-quarantine; or
- The employee is unable to work or telework because the employee is experiencing symptoms associated with COVID-19, is seeking a medical diagnosis, and does not meet the Centers for Disease Control and Prevention guidance for criteria to return to work for healthcare personnel with confirmed or suspected COVID-19.

Note that the Ordinance and OLSE guidance (linked below) contain detailed rules on the individuals who qualify as family members, health care providers, and emergency responders for purposes of PHE leave.

For any PHE leave, the employer may require the employee to identify the basis for requesting the leave, but the employer may not require disclosure of health information or other documentation (such as a doctor's note or letter from a childcare facility) for absences related to any of the above reasons.

Payment of PHE Leave

PHE leave must be paid in the same manner as paid sick leave under the San Francisco Paid Sick Leave Ordinance:

Employee Classification	Payment
Non-exempt employees	At the employee's "regular rate of pay" for the workweek in which the leave is taken, or at a rate calculated by dividing total wages paid (not including overtime premium pay) by total hours worked over a 90-day lookback period
Exempt employees	In the same manner as the employer calculates wages for other forms of paid leave time

Tips are not included in calculating the rate of pay for PHE leave. PHE leave may never be provided at less than the San Francisco minimum wage. Refer to the OLSE guidance for additional rules on calculating an employee's rate of pay during PHE leave.

Additional rules that apply to taking PHE leave:

- Employers can require employees to take PHE leave in increments of up to one hour (but not in larger increments, such as a half-day or full day)
- An employee may use PHE leave for all hours that s/he is scheduled to work in a particular day, including regular and overtime hours; however, all of the hours of PHE leave would be paid at the employee's regular sick leave rate of pay
- PHE leave may be taken regardless of whether and when the employee is scheduled to work; for example, an employee who is not scheduled to work for a particular week may still take PHE leave for that week
- An employer may limit an employee's use of PHE leave in a given work week to the average number of hours for which the employee is normally scheduled over a one-week period
- An employee may use PHE leave before using other accrued paid time off
- An employee may voluntarily choose to use other accrued paid time off provided by the employer before the employee uses PHE leave; however, the employer may not require the employee to use other accrued paid time off before using PHE leave

- An employer must provide payment for PHE leave taken by an employee by no later than the payday for the next regular payroll period after the PHE leave is taken.

Employers are not required by the Ordinance to pay any unused PHE leave to employees upon their termination of employment.

Notice and Posting

The OLSE has published a PHE leave notice (linked below) that employers must provide to employees as soon as possible in a manner calculated to reach all employees:

- by posting in a conspicuous place at the workplace,
- via electronic communication, and/or
- by posting in a conspicuous place in an Employer's web-based or app-based platform.

Every employer must provide the notice in English, Spanish, Chinese, and any language spoken by at least 5% of the employees who are, or prior to the Public Health Emergency were, at the workplace or job site.

The employer must also retain records related to PHE leave on the same basis as other records related to compliance with other San Francisco ordinances.

COVID-19

Returning to Work and Benefit Eligibility Considerations

Published: April 29, 2020

Employers with employees returning to work after a leave of absence, reduction in hours (e.g., furlough) or termination of employment (e.g., layoff) may have questions about the implications for medical benefit eligibility and the effect on the ACA's employer shared responsibility rules.

Eligibility

The answer to the benefit eligibility question will depend heavily on whether the employee was terminated from employment (a termination and rehire) or kept active as an employee (e.g., while on furlough) with continued benefit eligibility. Employers should first determine whether the plan document addresses furloughs, rehires, or unpaid leaves of absence. If the employer is interested in waiving waiting periods for rehired employees or otherwise extending coverage beyond what is described in the plan document, it should make sure to get the carrier's approval and amend the plan document if necessary.

Premium Payments

If employment was not terminated and the employee was kept active on health benefits, the employer may resume taking employees' premiums out of the employees' pay. The employer may recoup the cost of any missed contributions during the period the employee was furloughed without pay. Employers should check state wage and hour laws, as some states have limits on what can be deducted from an employee's pay.

Cafeteria Plan Considerations

Restoring Previous Elections

An individual rehired within 30 days may only make a new election if there has been an intervening event that would permit an election change. When more than 30 days have elapsed between an employee's termination and rehire, the cafeteria plan may (by design) allow a new election or require the old election to be reinstated.

Status Change with No Loss of Eligibility

If an employee has a reduction in hours but maintains eligibility under the plan, he or she should generally not be given the opportunity to drop or change a pre-tax salary reduction election to discontinue benefits. There must be both a status change such as a commencement of an unpaid leave of absence and the status change must affect eligibility under an employer plan (except for group term life insurance, dismemberment, or disability coverage). However, there are two exceptions:

- Benefits can be discontinued for nonpayment of premiums when an employee is on an unpaid leave.
- A cafeteria plan may allow an employee to prospectively revoke an election of coverage under a group health plan that provides minimum essential coverage or better coverage when there is a reduction in hours of service of a full-time employee that otherwise does not affect group health plan eligibility. Cafeteria plans are often not amended to address this circumstance.

ACA Considerations

Full-Time Status under the ACA

Some employers may be rehiring employees who were previously considered full-time employees under ACA rules. If the employee is rehired within 13 weeks (26 weeks for education organizations), the employee will be considered a continuing employee. This means that if the full-time employee was enrolled in coverage, s/he should be offered coverage no later than the first day of the month following resumption of services. If the employee is rehired after more than 13 weeks (26 weeks for educational organizations), the employee may be treated as a new employee and subject to a new waiting period (or a new initial measurement period if the employee is a part-time, variable hour, or seasonal employee). Part-time, variable hour, and seasonal employees rehired after the end of a stability period do not need to be offered coverage unless the employee worked enough hours during the previous measurement period to achieve full-time status for the subsequent stability period.

Hours of Service

Hours of service do not include hours incurred after the employee has terminated, or when payment is made or due under a plan maintained solely for the purpose of complying with applicable workers' compensation, unemployment compensation, or disability insurance laws. When counting an employees' hours to determine full-time employee status under the ACA look-back rules, hours of service include periods where the employee is entitled to pay due to vacation, holiday, illness, incapacity (including disability unless coverage was paid for after-tax and no employer contributions), and leaves of absence (including leave taken under the Families First Coronavirus Response Act).

For special unpaid leaves of absence (such as leave under the FMLA and USERRA), the employer has two options for crediting hours. One option is to exclude the period of special unpaid leave from the applicable measurement period. The other option allows employers to credit the employee with hours equal to the average hours worked during weeks not part of the unpaid leave.

Employers who furlough employees without terminating employment will need to make careful determinations as to whether employees need to be credited with hours of service under the applicable look-back period. The failure to correctly credit hours could cause the employer to misclassify employees as not full-time and cause penalties under the ACA employer shared responsibility rules. Careful records should be kept so that the employer knows each employee's status as full-time or not full-time during each month of 2020 in order to be prepared for ACA reporting that is done in early 2021. Employers may wish to go ahead and credit employees with hours service during the furlough period. While this would be one way to avoid penalty under employer mandate rules, the employer should get the carrier's approval before proceeding.

California Mandates COVID-19 Supplemental Paid Sick Leave for Food Sector Workers

Published: April 30, 2020

On April 16, California Governor Newsom signed Executive Order N-51-20 into law. The Order requires "Hiring Entities" with at least 500 employees nationwide to provide their "Food Sector Workers" with two weeks of COVID-19 Supplemental Paid Sick Leave when those workers are absent from work for certain reasons related to the COVID-19 pandemic. The Order became effective immediately and remains in effect until the expiration of all statewide stay-at-home orders.

The Order is intended to partially fill the gap left by the federal Families First Coronavirus Response Act, which generally requires employers with fewer than 500 employees to provide certain employees with paid sick leave and paid family and medical leave when they are unable to work or telework for reasons related to COVID-19. The Order uses the terms "Hiring Entity" (instead of "employer") and "Food Sector Worker" (instead of "employee"), which indicates an obligation to furnish COVID-19 Supplemental Paid Sick Leave to independent contractors and other non-traditional workers, in addition to traditional employees.

Definitions

A "Food Sector Worker" is defined as a person who meets all three of the following criteria:

1. A person who either:
    - works in one of the following food supply chain industries or occupations:
        - Agriculture occupations (as defined by California Industrial Welfare Commission's Wage Order 14-2001 section 2(D), linked below); or
        - Industries preparing agricultural products for market, on the farm (as defined by California Industrial Welfare Commission's Wage Order 13-2001 section 2(H), linked below); or
        - Industries handling products after harvest (as defined by California Industrial Welfare Commission's Wage Order 8-2001 section 2(H), linked below); or
        - Canning, freezing, and preserving industry (as defined by California Industrial Welfare Commission's Wage Order 3-2001 section 2(B), linked below); or
    - works for a Hiring Entity that operates a food facility (as defined by

California Health and Safety Code section 113789(a)-(b), linked below); or
- delivers food from a food facility (as defined under California Health and Safety Code section 113789(a)-(b)) for or through a Hiring Entity;

2. The person is exempt (as an "essential critical infrastructure worker") from California's stay-at-home order in Executive Order N-33-20 (linked below) or any other statewide stay-at-home order; and

3. The person leaves home or other place of residence to perform work for or through the Hiring Entity.

A "Hiring Entity" is a private entity, including any delivery network company or transportation network company, that has 500 or more employees in the United States. The Hiring Entity must use the rules under the federal Families First Coronavirus Response Act to determine the number of its employees.

Paid Sick Leave

Amount of Leave

The amount of COVID-19 Supplemental Paid Sick Leave payable to a Food Sector Worker is calculated as follows:

Food Sector Worker	Entitlement to COVID-19 Supplemental Paid Sick Leave
Food Sector Worker • who is considered by the Hiring Entity to work "full-time"; or • who worked (or was scheduled to work) an average of at least 40 hours per week in the two weeks preceding the date that the person took leave	80 hours
Food Sector Worker who does not satisfy the above criteria	If the Food Service Worker has a normal weekly schedule: • The total number of hours that the person is normally scheduled to work over two weeks for or through the Hiring Entity If the Food Service Worker works a variable number of hours: • 14 times the average number of hours that the person worked each day for or through the Hiring Entity in the six months preceding the date that the person took leave (or the entire period worked for the Hiring Entity, if less than six months)

If a Food Sector Worker is taking COVID-19 Supplemental Paid Sick Leave at the time all statewide stay-at-home orders expire, the person must be allowed to continue and complete the full amount of leave.

Reasons for Taking Leave

To receive COVID-19 Supplemental Paid Sick Leave, a Food Sector Worker must make an oral or written request to the Hiring Entity for the leave because s/he is unable to work for one of the following reasons:

- The Food Sector Worker is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;

- The Food Sector Worker is advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19; or

- The Food Sector Worker is prohibited from working by the Hiring Entity due to health concerns related to the potential transmission of COVID-19.

Payment of Leave

COVID-19 Supplemental Paid Sick Leave is paid at the highest of the following rates of pay:

- The Food Sector Worker's regular pay rate for the last pay period;

- The California minimum wage; or
- The local minimum wage that applies to the Food Service Worker.

The dollar amount payable to a Food Sector Worker as COVID-19 Supplemental Paid Sick Leave is capped at $511 per day and $5,110 in the aggregate.

A Hiring Entity is not required to provide COVID-19 Supplemental Paid Sick Leave to a Food Sector Worker if, as of the effective date of the Executive Order (i.e. April 17, 2020), it provides the Food Sector Worker with a supplemental benefit (such as paid leave) that is payable for the reasons listed above, and the benefit amount is equal to or greater than the COVID-19 Supplemental Paid Sick Leave that the Food Sector Worker would otherwise be entitled to receive.

The total number of hours of COVID-19 Supplemental Paid Sick Leave that a Food Sector Worker is entitled to receive is in addition to any California Paid Sick Leave (linked below) available to the person. In addition, a Hiring Entity may not require a Food Sector Worker to use any other paid or unpaid leave, paid time-off, or vacation time provided by the Hiring Entity before the Food Sector Worker uses – or in lieu of – COVID-19 Supplemental Paid Sick Leave.

Notice and Posting

The California Labor Commissioner has published a model notice (linked below) that Hiring Entities must post in a conspicuous location in the workplace. If a Hiring Entity's Food Sector Workers do not frequent a workplace, the notice requirement can be satisfied by delivery through electronic means, such as e-mail. The notice can be found by visiting https://www.dir.ca.gov/dlse/COVID-19-Food-Sector-Workers-poster.pdf.

New Guidance Offers Relief and Extends Deadlines for Benefit Plans

Published: May 5, 2020

The Department of Labor's Employee Benefit Security Administration (EBSA), along with the Treasury Department (collectively, "the Departments"), issued several pieces of guidance over the last week affecting employer-sponsored benefit programs.

Briefly, the guidance provides the following:

- Employee Relief. Participants have an extension until at least June 29, 2020 of deadlines related to COBRA notification, elections and premium payment; special enrollment requests; and to make timely claims.

- Employer Relief. Employers have relief related to deadlines for furnishing required notices to plan participants and flexibility around electronic delivery of these notices.

- Revised Model COBRA Notices. A new General Notice and Election Notice are available, along with a new FAQ addressing COBRA and Medicare interaction.

The guidance brings helpful relief for employers, but it is important to pay attention to the timing extensions under the final rule, as these may create additional administrative burdens.

Final Rule

The final rule requires all group health plans, disability, and other employee welfare benefit plans to disregard the period from March 1, 2020 until 60 days after the announced end of the National Emergency (the "Outbreak Period") when determining the following periods and dates:

- COBRA
  - The date for a plan sponsor to provide a COBRA election notice.
  - The 60-day election period for a qualified beneficiary to elect COBRA continuation of coverage.
  - The date for making monthly COBRA premium payments.
  - The date for individuals to notify the plan of a qualifying event or disability determination.

- Special Enrollment Rights. The date for a participant to request a special enrollment right for group health plan coverage which is otherwise 30 days from the loss of other coverage or acquisition of a dependent (60 days for loss of Medicaid or SCHIP or for a gain of premium assistance).

- Claims for Benefits. The date within which individuals may file a benefit claim. This appears to apply to health FSAs and HRAs and well as to other ERISA-covered benefits.

- Appeals of Denied Claims. The date within which claimants may file an appeal for an adverse benefit determination.

- External Review.
  - The date the claimant may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination.
  - The date within which a claimant may file information to perfect a request for external review.

The National Emergency ends on a date as announced by the Departments (no earlier than April 30, 2020, in which case the Outbreak Period ends on June 29, 2020, the 60th day after the end of the National Emergency).

Employers should note:

- The end of the Outbreak Period has not yet been announced. Further guidance will likely be issued to reflect that date once it is established. To the extent there are different Outbreak Period end dates for different locations in the country, the Departments will issue additional guidance regarding application of this relief.

- These requirements have retroactive application and apply to any applicable events on or after March 1, 2020, until the Outbreak Period ends.

- With respect to COBRA, there are administrative (and likely financial) burdens on employers with respect to the extended timeframe for qualified beneficiaries to elect COBRA and make timely premium payments.

The final rule provides helpful examples using a hypothetical Outbreak Period end date of April 30, 2020. Note that the actual end of the Outbreak Period will be later than what is reflected in these examples.

1. **Electing COBRA**

   Mary works for Employer X and participates in X's group health plan. Due to the National Emergency, Mary experiences a qualifying event for COBRA purposes as a result of a reduction of hours and has no other coverage. Mary is provided with a COBRA notice on April 1, 2020. What is the deadline for Mary to elect COBRA?

   Normal Deadline: 60 days after notice is provided – May 31, 2020

   Extended Deadline: The Outbreak Period is disregarded. Mary has until 60 days after the end of the Outbreak Period (June 29, 2020) – August 28, 2020.

2. **COBRA Premium Payment**

   On March 1, 2020, Karen was receiving COBRA under a group health plan. More than 45 days had passed since Karen had elected COBRA. Monthly premium payments are due by the first of the month. The plan does not permit qualified beneficiaries ("QBs") longer than the 30-day grace period to make premium payment. Karen made a timely February payment, but did not make the March payment or any subsequent payment during the Outbreak Period. As of July 1, Karen has made no premium payments for March, April, May or June. Does Karen lose coverage, and if so, for which months?

   Normal Deadline: Karen would have lost coverage if premium not paid by March 31, 2020.

Extended Deadline: Premiums are timely if made within 30 days after the end of the Outbreak Period. Premium payments for 4 months (March through June) are all due by July 29, 2020 to be considered timely and preserve coverage. Karen is eligible to receive coverage under the terms of the plan during this interim period even though some of the premium payments are not received until July 29, 2020. Since the due date for Karen's premiums would be postponed and payment for premiums would be retroactive during the initial COBRA election period, Karen's insurer or plan may not deny coverage, and may make retroactive payments for benefits and services received by the participant during this time.

3. COBRA Premium Payment

Same facts as Example 2. By July 29, Karen has made a payment equal to 2 months' premiums. For how long does COBRA continue?

Normal Deadline: Karen would have lost coverage if premium not paid by March 31, 2020.

Extended Deadline: Karen has COBRA coverage for March and April 2020 only. Karen is not entitled to COBRA for any months after April 2020. Benefits and services that occurred prior to April 30, 2020 are covered. The group health plan is not obligated to cover benefits or services that occurred after April 30, 2020.

4. Special Enrollment Period

Betsy is eligible for, but previously declined participation in her employer-sponsored group health plan. On March 31, 2020, Betsy gave birth and would like to enroll herself and the child in her employer's plan; however, open enrollment does not begin until November 15. When may Betsy exercise her special enrollment rights?

Normal Deadline: 30 days after the qualifying event – April 30, 2020.

Extended Deadline: The Outbreak Period is disregarded. Betsy and her child qualify for special enrollment into her employer's plan as early as the date of the child's birth (March 31, 2020). Betsy has until 30 days after the end of the Outbreak Period (June 29, 2020) – July 29, 2020 to exercise her special enrollment right, provided she pays her share of the premium for any period of coverage.

5. Group Health Plan Claims

Darla is a participant in a group health plan. On March 1, 2020, Darla received medical treatment for a condition covered under the plan, but a claim relating to the treatment was not submitted until April 1, 2021. Under the plan, claims must be submitted within 365 days of the participant's receipt of medical treatment. Was Darla's claim timely?

Normal Deadline: Darla's claim should have been submitted by March 1, 2021 to be considered timely under the plan.

Extended Deadline: The Outbreak Period is disregarded. Darla has 365 days from the end of the Outbreak Period to file a claim. Darla's claim is timely if filed by June 29, 2021.

6. Internal Appeal – Disability Plan

Erin received a notification of an adverse benefit determination from her disability plan on January 28, 2020. The notification advised that Erin has 180 days within which to file an appeal. What is Erin's appeal deadline?

Normal Deadline: Erin's appeal deadline would be July 26, 2020.

Extended Deadline: The Outbreak Period is disregarded. Erin's last day to file an appeal is 148 days (180 minus 32 days following January 28 to March 1) after June 29, 2020 – November 24, 2020.

For a copy of the final rule, visit https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09399.pdf.

Disaster Relief Notice 2020-01

In addition to the relief afforded under the final rule (described above), EBSA is also extending deadlines to furnish certain required notices or disclosures to plan participants, beneficiaries, and other persons. A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document that must be furnished between March 1, 2020 and 60 days after the announced end of the Outbreak Period if the plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances.

Good faith acts include use of electronic alternative means for communicating with plan participants and beneficiaries who the plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.

This relief appears to apply to the following notices, disclosures, and documents:

- Summary Plan Descriptions
- Summaries of Material Modification/Material Reduction
- Summary Annual Reports
- Claim Notices/Explanations of Benefits
- Plan Documents
- COBRA Notices (except as described above)
- Medical Child Support Notices
- Notice of Special Enrollment Rights
- CHIPRA Notice
- Wellness Program Disclosures
- Women's Health Cancer Rights Act Notice
- Grandfathered Plan Notice
- Marketplace Notice (Notice to Employees of Coverage Options)
- Summaries of Benefits and Coverage

The guidance also confirms:

- The Form 5500 extension (previously announced by the IRS) for filings due from April 1 – July 15, 2020. Form 5500 filings with a due date in this range are now due July 15, 2020. At this time, no relief has been issued for 2019 calendar year plans, with Form 5500 filings due July 31, 2020.

- That Form M-1 filings (associated with Multiple Employer Welfare Arrangements, "MEWAs") are provided the same relief (i.e., M-1 filings due between April 1 and July 15, 2020, are now due July 15, 2020).

Finally, the Notice highlights general fiduciary compliance and the approach to enforcement, stating that:

- the guiding principle for plans must be to act reasonably, prudently, and in the interest of the covered workers and their families who rely on their health, retirement, and other employee benefit plans for their physical and economic wellbeing. Plan fiduciaries should make reasonable accommodations to prevent the loss of benefits or undue delay in benefit payments in such cases and should attempt to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes.

- the approach to enforcement will emphasize compliance assistance and include grace periods and other relief where appropriate, including when physical disruption to a plan or service provider's principal place of business makes compliance with pre-established timeframes for certain claims' decisions or disclosures impossible.

COBRA Model Notices

EBSA also released new Frequently Asked Questions and revised COBRA model notices. The revised model notices were issued to ensure qualified beneficiaries understand the interaction between COBRA and Medicare. The FAQs further highlight this interaction and state:

- in the event group health plan coverage ends due to a termination of employment, a Medicare-eligible individual may be able to enroll in Medicare beginning the earlier of (a) the month after employment ends or (b) the month after group health plan coverage ends based on currently employment status.

- that when an individual has both Medicare and COBRA coverage, Medicare is generally the primary payer and COBRA pays second.

For a copy of the revised Model COBRA General and Election notices, visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

Employer Action

Employers should:

- review the revised timeframes under the final rules and work with COBRA vendors, carriers, and third-party administrators ("TPAs") to ensure compliance. To the extent needed, employers should secure stop loss approval.

- take advantage of the relief around furnishing certain required notices, disclosures, and documents as needed, and provide as soon as reasonable.

- be aware that if a Form 5500 (or M-1 filing) is due between April 1, 2020 and July 15, 2020, the due date has been automatically extended to July 15, 2020.

- update COBRA General and Election notices, if necessary.

County of Los Angeles Enacts COVID-19 Supplemental Paid Sick Leave Ordinance

Published: May 12, 2020

On April 28, 2020, the Board of Supervisors for the County of Los Angeles voted to approve an interim urgency ordinance that requires certain employers to provide supplemental paid sick leave to qualifying employees when they are absent from work for reasons related to the COVID-19 pandemic. The City of Los Angeles previously passed a similar ordinance, but the County ordinance expands the coverage for supplemental paid sick leave to employees outside the City's geographic boundaries.

The ordinance became effective on April 28, 2020 and remains in effect until December 31, 2020 (unless the Board of Supervisors takes action to extend it).

Employers Subject to the Ordinance

Employers are subject to the ordinance if they have 500 or more employees nationally. However, the ordinance does not apply to employers that are federal, state or local government agencies.

Qualifying Employees

To qualify for supplemental paid sick leave under the ordinance, an employee must meet the following requirements:

a. The employee was employed by the employer on April 28, 2020 (i.e. the effective date of the ordinance); and

b. The employee performs work for the employer within an unincorporated area of the County of Los Angeles (refer below for a link to a listing of these areas); and

c. The employee is not a food sector worker, as defined in the California Governor's Executive Order N-51-20.

In addition, certain employees may be exempt from receiving supplemental paid sick leave under the ordinance, as discussed in the section on "Exemptions" below.

Supplemental Paid Sick Leave

Employers are required under the ordinance to begin providing supplemental paid sick leave to qualifying employees on March 31, 2020.

To receive supplemental paid sick leave under the ordinance, an employee must make a written request to the employer (for example, via email or text) that the employee cannot work or telework because of one of the following reasons:

1. A public health official or healthcare provider requires or recommends that the employee isolate or self-quarantine to prevent the spread of COVID-19; or

2. The employee is subject to a federal, state or local quarantine or isolation order relating to COVID-19 (for example, the employee is at least age 65 or has a health condition such as heart disease, asthma, lung disease, diabetes, kidney disease, or weakened immune system); or

3. The employee needs to care for a family member who is subject to a federal, state or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine related to COVID-19; or

4. The employee needs time off work because the employee needs to provide care for a family member whose senior care provider (or school or childcare provider) ceases operations in response to a public health or other public official's recommendation.

For purposes of the ordinance, a "family member" means the employee's spouse, child (including a biological, adopted or foster child, stepchild, legal ward, and certain other individuals), and parent (including a biological, foster or adoptive parent, legal guardian, and certain other individuals).

Employers may require documentation for the use of supplemental paid sick leave as allowed under the Families First Coronavirus Response Act and related rules and regulations from the U.S. Department of Labor. However, an employee may begin using supplemental paid sick leave before obtaining the requested documentation.

Supplemental paid sick leave is calculated under the ordinance as follows (subject to the limitations set forth in the bullet points below):

Employee	Supplemental Paid Sick Leave
An employee who works at least 40 hours per week or is classified as a full-time employee by the employer	80 hours of supplemental paid sick leave, calculated based on the employee's highest average two-week pay over the period of January 1, 2020 through April 28, 2020
An employee who works less than 40 hours per week and is not classified as a full-time employee by the employer	An amount no greater than the employee's average two-week pay over the period of January 1, 2020 through April 28, 2020

Supplemental paid sick leave under the ordinance is subject to the following important limitations:

- Supplemental paid sick leave cannot exceed $511 per day and $5,110 in the aggregate with respect to any employee.

- The employer's obligation to provide supplemental paid sick leave to an employee under the ordinance is reduced for every hour that the employer allowed the employee to take "Voluntary COVID-19 Leave" on or after March 31, 2020 for any of the four reasons specified above, in an amount equal to or greater than the supplemental paid sick leave required under the ordinance. "Voluntary COVID-19 Leave" is additional paid leave for COVID-19 related purposes that is above and beyond an employee's regular or previously accrued leaves (such as sick or personal leave).

- Employees of joint employers are only entitled to the total aggregate amount of supplemental paid sick leave specified for employees of one employer.

An employer may not require an employee to use any other paid or unpaid leave, paid time off, or vacation time provided by the employer, before the employee uses supplemental paid sick leave (or in lieu of supplemental paid sick leave) under the ordinance. In addition, the total number of hours of supplemental paid sick leave that an employee is entitled to receive under the ordinance is in addition to any paid sick leave available to the employee under California Labor Code section 246.

Exemptions

An employer may exclude an employee from receiving supplemental paid sick leave under the ordinance if the employee is an "emergency responder" or a "health care provider."

An "emergency responder" is an employee who provides emergency response services, including a peace officer, firefighter, paramedic, emergency medical technician, public safety dispatcher or safety telecommunicator, emergency response communication employee, rescue service personnel; and employees included in the definition of emergency responder in regulations issued by the U.S. Department of Labor.

A "health care provider" is an employee who provides emergency response services, including medical professionals; employees needed to keep hospitals and similar health care facilities well supplied and operational; employees involved in research, development, and production of equipment, drugs, vaccines, and other items needed to combat the COVID-19 public health emergency; and employees included in the definition of health care provider in regulations issued by the U.S. Department of Labor.

IRS Issues Relief for Cafeteria Plans in Response to COVID-19

Published: May 15, 2020

On May 12, 2020, in response to the COVID-19 pandemic, the Internal Revenue Service ("IRS") issued two notices, Notice 2020-29 and Notice 2020-33, providing welcome relief and guidance to employers sponsoring Section 125 cafeteria plans ("Section 125 plans"), health flexible spending accounts ("health FSAs"), dependent care assistance programs ("DCAPs"), and qualified high deductible health plans ("HDHPs").

Briefly, the guidance:

- Permits mid-year election changes during the 2020 calendar year for health coverage, health FSAs, and DCAPs as a result of the COVID-19 pandemic.
- Extends claims periods for employees to apply unused amounts remaining in a health FSA or DCAP for expenses incurred for those same qualified benefits through December 31, 2020.
- Clarifies that the relief for HDHPs to cover expenses related to testing for and treatment of COVID-19 and the temporary exemption for telehealth services apply retroactively to January 1, 2020.
- Increases the limit of unused health FSA carryover amounts to $550 from $500.
- Clarifies reimbursement rules associated with Individual Coverage Health Reimbursement Arrangements ("ICHRAs").

IRS Notice 2020-29: Cafeteria Plan and HDHPs

Elections under a Cafeteria Plan

Generally, pre-tax elections made under a Section 125 plan are irrevocable except as permitted under the circumstances described in the election change regulations (such as if the employee experiences a change in status or there are significant changes in the cost of coverage) and incorporated in an employer's written cafeteria plan document.

Notice 2020-29 provides temporary flexibility with respect to the irrevocable election rules due to the challenges facing employers and participants due to the COVID-19 pandemic.

Under this relief, an employer may amend its Section 125 plan to allow employees who are eligible to make salary reduction contributions under the plan to make the following prospective election changes during the 2020 calendar year:

1. Make a new election for employer-sponsored health coverage, where the employee had initially declined to elect such coverage.

2. Revoke an existing election for employer-sponsored health coverage and make a new election to enroll in different health coverage sponsored by the employer (including changing enrollment from self-only coverage to family coverage).

3. Revoke an existing election for employer-sponsored health coverage, provided that the employee must attest in writing that he or she is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer.

4. With respect to a health FSA election, revoke an election, make a new election, or decrease or increase an existing election.

5. With respect to a DCAP election, make a new election, or decrease or increase an existing election.

An employer is not required to adopt any of the election change options offered by Notice 2020-29 and may choose to adopt only some of the options. To address Section 125 plans that may have permitted mid-year election changes prior to issuance of this guidance, the relief may apply retroactively to January 1, 2020 consistent with this guidance.

Additionally, an employer is not required to permit participants to make unlimited election changes. It may determine the extent to which election changes are permitted and applied, as long as such changes apply prospectively and comply with the Section 125 nondiscrimination rules.

To prevent the potential for adverse selection as a result of adopting these new permitted election changes, an employer may consider limiting elections to circumstances where the employee's coverage will be increased or improved as a result of the election.

The relief relating to employer-sponsored health coverage applies to employers who sponsor both fully insured health coverage as well as those who sponsor self-funded health coverage. It is important to note that nothing in the IRS guidance requires carriers or self-funded health plans (including stop loss insurance) to permit mid-year enrollment and/or coverage changes for COVID-19 related reasons. Prior to implementing these new mid-year election changes under the cafeteria plan rules (specifically, Option #1, #2 and/or #3 above), it is important to understand whether the carrier (or plan terms) will allow for such changes mid-year.

The relief relating to health FSAs applies to all health FSAs, including limited purpose health FSAs. Additionally, with respect to health FSAs and DCAPs, an employer may limit mid-year elections to amounts no less than those amounts that have already been reimbursed.

Written Attestation Required When Coverage Is Dropped.

If an employer permits an employee to revoke an existing election for employer-sponsored health coverage under Option #3 above, the employer must receive written attestation from the employee that the employee is either already enrolled, or immediately will enroll, in other comprehensive health coverage not sponsored by the employer. The employer may rely on such written attestation provided by the employee, unless the employer has actual knowledge that the employee is not, or will not be, enrolled in other comprehensive health coverage not sponsored by the employer.

Notice 2020-29 offers the following as an example of an acceptable written attestation:

> Name: _____ (and other identifying information requested by the employer for administrative purposes).
>
> I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan).
>
> Signature: _____

Extended Claims Periods for Health FSAs and DCAPs

Notice 2020-29 also provides that an employer may amend its Section 125 plan to provide for an extended period during which a participant may apply unused amounts remaining in a health FSA or DCAP to pay or reimburse medical care expenses or dependent care expenses incurred through December 31, 2020 when the plan year or grace period ends in 2020.

For example, an employer who sponsors a Section 125 plan with a health FSA that has a plan year that runs from January 1 to December 31, with a grace period ending on March 15 immediately following the end of each plan year, may amend the Section 125 plan to permit participants to apply unused amounts in the health FSA as of March 15, 2020, to reimburse the participant for qualified expenses incurred through December 31, 2020. It should be noted that Section 125 plans with a plan year ending on or after October 31, 2020 will not need this relief, as they will continue to be able to provide a grace period of up to two months and 15 days, which would permit the reimbursement of qualified expenses incurred after December 31, 2020.

Generally, a health FSA may either provide for a grace period or a carryover amount but may not have both. This relief is available both to Section 125 plans that have a grace period and those that provide for a carryover.

Notice 2020-29 provides the following examples to illustrate how a Section 125 plan with a July 1 plan year and a $500 carryover would implement the extended period for incurring claims allowed:

Example 1

An employer provides a health FSA under a Section 125 plan that allows a $500 carryover for the plan year ending June 30, 2020. In accordance with the relief provided for in Notice 2020-29 and Notice 2020-33, the employer may amend the Section 125 plan to adopt a $550 carryover (see below for a discussion regarding Notice 2020-33) beginning with the 2020 plan year, and may also amend the plan to adopt a temporary extension that allows for claims incurred on or before December 31, 2020, to be paid with respect to health FSA balances remaining from plan year ending June 30, 2020.

Employee A has a remaining balance of $2,000 in his health FSA for the plan year ending June 30, 2020. Employee A has elected to contribute $2,000 to his health FSA for the plan year beginning July 1, 2020. He incurs $1,900 in medical care expenses between July 1, 2020 and December 31, 2020. The health FSA may reimburse Employee A $1,900 from the $2,000 remaining in his health FSA as of June 30, 2020, leaving $100 remaining in the health FSA from the plan year ending June 30, 2020. Because the plan provides for a carryover, Employee A may use the remaining $100 in his health FSA through June 30, 2021, to reimburse claims incurred during the plan year ending June 30, 2021. Employee A may be reimbursed up to $2,100 (representing the $2,000 contributed to the health FSA for the July 1, 2020 through June 1, 2021 plan year, plus the $100 carryover from the plan year ending June 30, 2020) for qualified expenses incurred between January 1,

2021 and June 30, 2021. Employee A may also carry over up to $550 of any remaining balance of the $2,100 to the plan year beginning July 1, 2021. A grace period will not be available to Employee A for the plan year ending June 30, 2021.

Example 2

Assume the same facts as Example 1, but here Employee B has $1,250 remaining in her health FSA as of June 30, 2020. Employee B has elected to contribute $1,200 to her health FSA for the plan year beginning July 1, 2020. Employee B incurs $600 in qualified medical expenses between July 1, 2020 and December 31, 2020. Employee B's health FSA may reimburse her $600 from the $1,250 balance in her health FSA as of June 20, 2020, leaving the remaining $650. Under the terms of the health FSA, Employee B may use $500 of her remaining $650 balance to reimburse for claims she incurs during the 2020 plan year. The remaining $150 will be forfeited. Employee B may be reimbursed for up to $1,700 (representing the $500 that was carried over from the plan year ending June 30, 2020, plus the $1,200 she had elected to contribute for the plan year beginning July 1, 2020) for qualified expenses incurred between January 1, 2021 and June 30, 2021. Employee B may carry over up to $550 of any remaining unused portion of the $1,700 to the plan year beginning July 1, 2021, after claims have been processed for the plan year ending June 30, 2021. As with the previous example, a grace period will not be available to Employee B for the plan year ending June 30, 2021.

Coordination with HDHPs

The extension of the period for incurring claims that may be reimbursed by the health FSA is an extension of coverage by a health plan that is not an HDHP for purposes of determining whether an eligible individual qualifies to make contributions to an HSA (except in the case of an HSA-compatible health FSA, such as a limited purpose health FSA). Therefore, an individual who had unused amounts remaining at the end of a plan year or grace period ending in 2020 and who is allowed an extended period to incur expenses (until December 31, 2020) under a health FSA will not be eligible to contribute to an HSA during the extended period (except in the case of an HSA-compatible health FSA, including a health FSA that is amended to be HSA-compatible). Employers considering this relief should understand the effect that extending the benefit may have on HSA eligibility. It is possible that extending a traditional health FSA it could have the effect of disqualifying individuals from HSA eligibility. It would appear that, to preserve HSA eligibility, the FSA many need to be amended to be HSA-compatible (for example, converting the health FSA for all participants to a limited purpose health FSA for the duration of the extension). Further guidance in this area would be helpful.

Plan Amendments

An employer who amends its Section 125 plan to provide mid-year election changes or an extended period to apply unused amounts remaining in the health FSA or DCAP must adopt a plan amendment reflecting such changes to the plan.

Amendments must be adopted on or before December 31, 2021 and may be effective retroactively to January 1, 2020. The employer must also inform all employees who are eligible to participate in the Section 125 plan of relevant changes to the plan.

HDHPs

The IRS guidance makes the following clarifications to previous guidance:

- Expenses related to treatment for and testing of COVID-19 applies with respect to reimbursements of expenses incurred on or after January 1, 2020.
- For this purpose, treatment and testing of COVID-19, required to be provided without cost-sharing, includes the panel of diagnostic testing for influenza A and B, norovirus and other coronaviruses, and respiratory syncytial virus ("RSV").

Additionally, the guidance clarifies that telehealth or other remote services provided on or after January 1, 2020 with respect to plan years beginning on or before December 31,

2021 will not be disqualifying for purposes of HSA eligibility. Therefore, if an otherwise HSA eligible individual received telehealth services before satisfaction of the deductible in February 2020 (before the safe harbor became effective), the individual would not be disqualified from making HSA contributions.

IRS Notice 2020-33: Health FSA Carryover and ICHRAs

Maximum Carryover Increased to $550 for 2020 Plan Years

The IRS simultaneously issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a maximum of $500 to $550. This increase reflects a change from the static $500 carryover amount to 20% of the currently indexed heath FSA contribution limit. For 2020, 20% of the current $2,750 limit on health FSA contributions is $550. Thus, the maximum unused amount from a health FSA plan year that begins in 2020 that can be carried over to the following plan year (2021) is $550.

For plan years beginning in 2020, with respect to either (1) adding a carryover for a health FSA plan year or (2) increasing the maximum carryover to $550, the rules state an amendment must be adopted on or before December 31, 2021.

With respect to plan years beginning in 2021 (or later), an amendment to increase the carryover amount may be adopted at any time on or before the last day of the plan year. Employers should notify plan participants of the change.

Individual Insurance Policies and ICHRAs

Additionally, Notice 2020-33 clarifies that a health plan may reimburse individual insurance policy premium expenses that had been incurred prior to the beginning of a plan year for coverage provided during the plan year. This relief is intended to assist employers who are implementing ICHRAs, which are employer-sponsored health plans designed to reimburse employees for substantiated premiums for individual health insurance coverage and other medical care expenses). Notice 2020-33 provides that an ICHRA with a calendar year plan year may immediately reimburse a substantiated premium for health insurance coverage that begins on January 1 of that plan year, even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

Employer Action

Employers should coordinate with their third-party administrators (and carriers as applicable) and:

- Review the new available mid-year election change designs for 2020 plan years and determine whether to implement them. Carrier approval should be obtained prior to implementing mid-year election changes that affect medical, dental and vision coverage. This includes stop loss carrier approval.
- Determine whether to offer the extended claims period for health FSA and DCAP expenses for 2020. Employers should be mindful of potential issues that arise with respect to HSA eligibility if traditional health FSA coverage is extended.
- If currently offering the health FSA carryover, determine whether to increase the dollar limit to $550 for plan years that begin in 2020.
- Appropriately amend the Section 125 plan and notify plan participants of the changes in a timely manner.

Annual Out-of-Pocket Maximum Adjustments Announced for 2021

Published: May 18, 2020

On May 8, 2020, the Department of Health and Human Services ("HHS") published its Annual Notice of Benefit and Payment Parameters for 2021. This guidance is a final rule that addresses certain provisions of the Affordable Care Act ("ACA"). The final rule follows a proposed rule issued in January. Generally, these changes apply to plan years beginning on or after January 1, 2021. For purposes of employer-sponsored health plans, the final rule includes:

- Caps on out-of-pocket dollar limits for 2021 non-grandfathered group health plans.
- Clarification on the policy regarding how drug manufacturer support, including coupons, may accrue towards the annual limitation on cost sharing.

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 2021 as follows:

- $8,550 for self-only coverage; and
- $17,100 for coverage other than self-only.

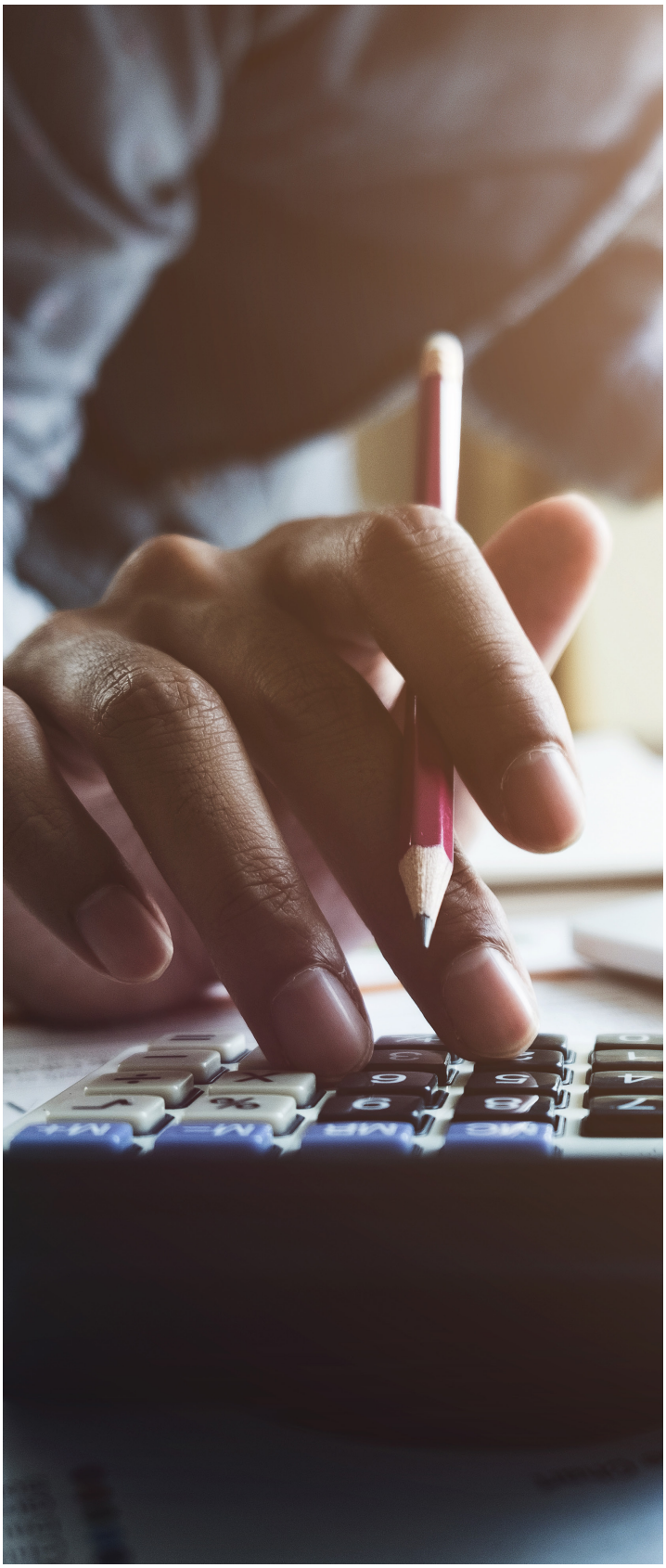
Note that different out-of-pocket limits apply to high-deductible health plans, for purposes of making contributions to a health savings account (HSA). The 2021 HSA thresholds will likely be announced in June 2020.

Change to Drug Manufacturer Support Policy

The final rule also clarifies the policy regarding how drug manufacturer support, including coupons, may accrue towards the annual limitation on cost sharing. The prior rule, which allowed issuers to exclude coupons from an enrollee's annual limit on out-of-pocket costs only in certain circumstances, caused confusion. The new policy provides that issuers will be permitted, but not required, to use any form of direct support offered by drug manufacturers to enrollees for specific prescription drugs to count amounts paid toward reducing out-of-pocket costs toward the annual limitation on cost sharing, to the extent consistent with state law.

What Else Should you Know?

This is a final rule. While these regulations will be effective on July 13, 2020, the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2021.



Proper Use of Premium Credits

Published: May 18, 2020

In light of the current pandemic, some carriers are offering premium credits attributable to a portion of the premiums paid in months where COVID-19 limited the benefit available to participants. While this is good news, the availability of such premium credits creates fiduciary issues with respect to plan assets under ERISA. This summary is intended to highlight possible issues and mitigate potential ERISA fiduciary exposure.

The proper usage of the premium credits will depend on the proportion of premium that the employer and the employee paid, respectively.

Generally, the proportion attributable to the employer paid premium can be kept by the employer.

However, the proportion that relates to employee premium should be given back to employees. This can be accomplished as follows:

- Reducing future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.
- Providing cash payments to current participants. This is administratively burdensome and results in tax consequences to participants (i.e., premium credits are taxable income).

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

With respect to ancillary products (such as dental and vision benefits), the employee often pays 100% of the premium, in which case 100% of the premium credit would be passed on to employees.

Using the principles outlined in 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.

Even though this is not an MLR rebate, the same principles should apply. If you would like further information about the proper usage of an MLR rebate, please reach out to your Account Executive.

New York Enacts Paid Sick Leave Beyond the Pandemic Emergency

Published: May 21, 2020

On March 18, 2020 Governor Cuomo signed legislation implementing COVID-19 emergency sick leave benefits for New York employees that remain in effect through any COVID-19 mandatory isolation or quarantine order by the State, New York State Department of Health, local Board of Health, or other authorized government. On April 3, 2020 Governor Cuomo signed legislation amending New York labor law (the "Act") to create a statewide sick leave benefit, unrelated to COVID-19, that will take effect January 1, 2021.

Key features of the New York sick leave benefit include:

- Employers with less than 100 employees 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 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 will begin to accrue hours toward sick leave beginning on September 30, 2020 (180 days after implementation of the Act) or date of hire, whichever is later.
- Employees may begin taking sick leave under the Act as of January 1, 2021.

Coverage

All employers in New York will be subject to the Act. An employer's size determines the minimum number of sick leave hours that must be provided and is based on the number of employees each calendar year measured from January 1 through December 31. Any collective bargaining agreement entered into on or after the effective date of the Act must provide at least comparable sick time benefits to its members.

Benefits

The minimum amount of sick time that must be made available to employees beginning January 1, 2021 is as follows:

Employer Size	Hours of Sick Time Per Calendar Year
Less than 5 employees	40 hours unpaid
Less than 5 employees and net income greater than $1 million in prior tax year	40 hours paid
5 to 99 employees	40 hours paid
100 or more employees	56 hours paid

For benefit purposes, an employer may use the calendar year or establish any consecutive twelve-month period.

Employers may establish a reasonable minimum increment for the use of sick leave not to exceed four hours. While on sick leave, employees will be paid their regular compensation or the applicable minimum wage, whichever is greater. Any unused sick time may be carried over to the following calendar year; however, an employer is not obligated to provide more paid sick time per calendar year than indicated above (i.e., 40 or 56 hours depending on employer size) or to compensate an employee for any unused sick time upon termination of employment.

Employers with sick or time off policies that meet or exceed the state sick leave provisions are not required to provide any additional sick leave pursuant to the Act. Employers must maintain payroll and time-off records for a period of six years.

The Act will not preempt a New York city (e.g., New York City) with a population of one million or more from enacting or enforcing municipal leave laws that meet or exceed the statewide sick leave provisions.

Accruals

Employees will accrue at least 1 hour of sick leave for every 30 hours worked beginning on the employee's date of hire or September 30, 2020, the effective date of the Act's non-COVID-19 sick leave provisions. Alternatively, employers may credit the full annual amount of leave at the beginning of the calendar year.

Reasons for Leave

Beginning January 1, 2021, employees may request leave verbally or in writing for their own or a family member's:

- Mental or physical illness, injury, or health regardless of whether a diagnosis has been made or the individual requires medical care at the time the leave is requested,
- Diagnosis of mental or physical illness, injury or health condition,
- Preventive care, or
- Precaution, care and services related to acts of domestic violence.

Family Members

Sick leave may be requested for an employee's child, spouse, domestic partner, parent, sibling, grandchild, grandparent as well as the child or parent of an employee's spouse or domestic partner.

A parent includes a biological, foster, step or adoptive parent, legal guardian or a person who stood in loco parentis when the employee was a minor child. Employees may take sick leave to care for a biological, adopted, or foster child as well as a legal ward or a child of an employee standing in loco parentis.

Employee Rights

Upon request by an employee, an employer must provide the employee with a summary of the amount of sick leave accrued and used in the current or prior calendar year. Employers may not retaliate against an employee for taking sick leave and must restore the employee to their same position, pay and at the same terms and conditions of employment prior to taking sick leave.

Employer Action

While employers continue to manage the business impacts of COVID-19 and hopefully begin to prepare for employees returning to work, longer term planning for the fall of 2020 should include ensuring your business will comply with the New York sick leave provisions that take effect January 1, 2021. Additional guidance is anticipated later in the year.

2021 Inflation Adjusted Amounts for HSAs

Published: May 22, 2020

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2021. Most limits increased from 2020 amounts.

Annual Contribution Limits

For calendar year 2021, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,600**. For calendar year 2021, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$7,200**.

High Deductible Health Plans

For calendar year 2021, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,400 for self-only coverage** or **$2,800 for family coverage** (unchanged from 2020), and the **annual out-of-pocket expenses** (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $7,000 for self-only coverage** or **$14,000 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.

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.

Massachusetts DFML Releases Draft Updated Regulations

Published: May 29, 2020

The Massachusetts Department of Family and Medical Leave ("DFML") recently released draft updated regulations. The DFML has posted information on the formal comment period including information on how public hearings will be conducted. The DFML will be conducting a hearing on June 11th via WebEx. If the state of emergency in Massachusetts is rescinded in whole or in part to allow in-person public hearings on June 11, there will be two in-person hearings held. Please check the DMFL website prior to the hearing dates for more information.

This bulletin highlights the significant proposed new definitions and updates to existing definitions as well as other proposed regulatory changes. Employers are encouraged to read the draft updated regulations in their entirety.

New Definitions

- **Accrued Paid Leave:** leave earned by or otherwise provided to a covered individual pursuant to a benefit plan or policy offered by an employer or covered business entity including, but not limited to, sick leave, annual leave, vacation leave, personal leave, compensatory leave or paid time off.

- **Active Duty:** full-time duty in the active military service of the United States and full-time National Guard duty.

- **Application for Benefits:** a request for family or medical leave benefits pursuant to 458 CMR 2.08.

- **Complete Application:** an application for benefits that contains all of the required information from the covered individual pursuant to 458 CMR 2.08(2) and all of the information required from the employer pursuant to 458 CMR 2.08(6). The application for benefits is deemed complete when the DFML receives the information required under 458 CMR 2.08(6) or 10 business days after the DFML requests the information required under 458 CMR 2.08(6) from the employer, whichever is sooner.

- **Former Member of the Armed Forces:** an individual who was a member of the Armed Forces, including a member of the National Guard or Reserves, and was discharged or released under conditions other than

dishonorable at any time during the five-year period prior to the first date the covered individual completes an application for benefits to care for the former member of the Armed Forces.

- **Good Cause:** a demonstration by a party that a failure to comply with a requirement of M.G.L. c. 175M and 458 CMR 2.00 was due to circumstances beyond the party's control.

- **Job Protected Leave:** the period of time described in 458 CMR 2.16(1), immediately following the first date on which an employee commences the taking of any type of leave that is associated with a qualifying reason regardless of whether an application for benefits has been submitted to the DFML in connection therewith or whether that leave is paid or unpaid. Employees who do not file an application for benefits with the DFML but use any other type of leave paid or unpaid and associated with a qualifying reason will have their leave run concurrently with the leave period provided in M.G.L. c. 175M.

- **Municipality, District, Political Subdivision or its Instrumentality:** includes municipal departments such as school departments, police departments, fire departments or public works departments.

- **Private Plan Administrator:** the third-party administrator of an employer's or covered business entity's private paid family and/or medical leave plan.

Updated Definitions

- **Base Period:** amends the first sentence of the definition to the last four completed calendar quarters immediately preceding the date an application for benefits is filed with the DFML for a qualified period of paid family or medical leave.

- **Chronic Conditions:** would now require at least two periodic visits per calendar year for treatment by a health care provider, or by a nurse under direct supervision of a health care provider; adds that substance abuse disorders are not serious health conditions, unless inpatient hospital care is required or unless complications develop.

- **Covered Contract Worker:** the definition has been expanded to include a self-employed individual: who performs services as an individual entity in Massachusetts; who resides in Massachusetts; and who is not classified as an independent contractor pursuant to M.G.L. c. 151A, § 2.

- **Employer:** the definition has been expanded to allow a municipality, district, political subdivision or its instrumentalities to become a covered employer under this chapter by notifying the DFML of Family and Medical Leave pursuant to 458 CMR 2.06(6) and completing the procedure established by the DFML.

- **Intermittent Leave:** the definition now requires that leave be taken in increments of 15-minute intervals.

Other Proposed Regulatory Changes

Covered Contract Workers

A new section has been added to clarify that self-employed individuals or covered contract workers properly classified in accordance with M.G.L. c. 151A, § 2 are not considered part of an employer's workforce.

Contribution Penalties

An employer or covered business entity that fails to properly access the allowable deduction from an employee or covered contract worker, or is assessed a charge against payroll for failure to remit required contributions, or that is required to repay the DFML the cost of benefits paid to covered individuals for whom it failed to make contributions cannot charge back employees or covered individuals for the penalty.

Private Plan Updates

Application

Clarifies that an employer or covered business entity seeking an exemption must submit a Request for Exemption through the Massachusetts Department of Revenue's MassTaxConnect system. Employers and covered business entities seeking an exemption that do not have pre-existing accounts on the MassTaxConnect system must register and establish an account in order to request an exemption. An employer or covered business entity may not apply for an exemption on behalf of only a portion of its covered workforce. If approved, the employer or covered business entity is exempt from remitting contributions and any filing requirements.

Coverage under a private plan begins for all employees and covered contract workers no later than the first day of the first quarter immediately following the date of approval. Applications for exemptions will be accepted and reviewed on a rolling basis and will be effective no earlier than the quarter immediately following the date of approval. Exemptions from contributions will be effective for up to one year and may be renewed annually.

Requirements for Exemption

Three additional requirements have been added for an employer or covered business entity to be approved for an exemption from the requirement to remit contributions:

1. provide for an appeals process with the private plan administrator before a covered individual can exercise its right of appeal with the DFML,

2. provide notice to the covered individual as part of any determination under the private plan as to their rights under the private plan as well as the rights afforded by the law, and

3. for purposes of determining the benefit amount, a private plan must calculate the weekly benefit amount based on the wages earned with the employer or covered business entity at the time of an application for benefits.

Review of Denied Exemption

An employer or covered business entity that is denied an exemption from the requirement to remit contributions and that believes in good faith that its private plan meets or exceeds the requirements for exemption may request supplementary review by the DFML. A request for review of a denied exemption is a form of discretionary relief and the determination of the DFML is not subject to further administrative appeal. An employer or covered business entity must submit the review request electronically using the Massachusetts DFML of Revenue's MassTaxConnect system. An employer or covered business entity must submit the review request on or before the last day of the quarter prior to the effective date of the request for an exemption.

Retained Rights for Covered Individuals under Private Plans

Three additional sections have been added regarding rights for individuals under private plans. The private plan administrator and employer or covered business entity is required to provide the DFML all application for benefits documentation that is retained by the private plan administrator or employer within five business days of the request by the DFML in connection with an appeal of a denial of family or medical leave benefits by the employee or covered contract worker. Any determination by the DFML in connection with the appeal of the denial of family or medical leave under the private plan is binding on the private plan administrator and employer or covered business entity. Covered individuals covered under a private plan are not entitled to file an application for benefits with the DFML.

Private Plan Termination or Non-renewal

The proposed amendments clarify that the effective date of the termination of a private plan is the first day of the first quarter immediately following the date of the termination or non-renewal. An employer or covered business entity that does not renew an approved private plan must continue to provide paid leave benefits to covered individuals under the same terms and conditions of the private plan for the

entire duration of the leave for requests for leave filed with the private plan administrator with a start date commencing prior to the effective date of termination or non-renewal. In the case of intermittent leave, the private plan must maintain coverage until the end of the employee or covered contract worker's benefit year.

Covered individuals of an employer or covered business entity that does not renew an approved private plan are eligible to apply for benefits on the first day of the first quarter immediately following the date of termination or non-renewal. The employer or covered business entity that terminates or non-renews its private plan exemption will be required to report prior wages and qualified earnings to the Massachusetts Department of Revenue for the four quarters immediately preceding the termination date of the exemption.

Application for Benefits

The proposed amendments clarify that a covered individual may file an application for benefits with the DFML no more than 60 calendar days before the anticipated start date of family or medical leave. An employee or covered contract worker must provide at least 30 calendar days' notice to their employer or covered business entity of the anticipated start date of family leave or medical leave. Notice must be provided as soon as practicable if a delay is beyond the employee or covered contract worker's control.

Notice of an employee's or covered contract worker's need for family and medical leave must be made to the employer or covered business entity or prior to an application to the DFML for family or medical leave benefits. The DFML will not accept an application for benefits unless notice to the employer or covered business entity or was made in accordance with the regulations.

A covered individual filing an application for benefits must provide the DFML with:

1. proof that the employee or covered contract worker's employer or covered business entity has been notified of the intended leave,
2. the full name of the covered individual taking the leave and/or the full name of the family member for whom the covered individual will be caring for or bonding with under the requested leave;
3. the anticipated start date of the leave,
4. the anticipated length of the leave,
5. the type of leave, and
6. the individual's expected return date.

A surprising addition to this section is the DFML allowing an employer, covered business entity, or its designee to apply for benefits on behalf of a covered individual. In order to do so, employers, covered business entities, or leave administrators must be approved by the DFML and agree to adhere to all the application requirements and timelines.

Determinations

The DFML clarifies that in order for it to approve a benefit, the following will be considered:

1. confirmation that the covered individual provided the required notice to their employer or covered business entity,
2. the financial eligibility test,
3. certification, including a certification by a health care provider, supporting the necessity for leave
4. whether the covered individual's request for family or medical leave associated with the application for benefits was approved or denied by the employer or covered business entity and the reason(s) for the approval or denial,
5. whether the covered individual has actually taken or plans to take the leave associated with the application for benefits, and
6. any other relevant information deemed necessary.

Weekly Benefit Amount

Reductions

The proposed amendments clarify that the weekly benefit amount and/or leave allotment for a period is reduced by the amount of wages, wage replacement, or leave that a covered individual on family or medical leave receives for that period from:

1. any government program or law, including unemployment benefits under M.G.L. c. 151A, or workers' compensation under M.G.L. c. 152, other than for permanent partial disability incurred prior to the family or medical leave application for benefits claim;
2. under other state or federal temporary or permanent disability benefits law;
3. any benefits received on behalf of an employer or covered business entity through a private plan,
4. any wages received from another employer or covered business entity or through self-employment, or
5. a permanent disability policy or program of an employer or covered business entity.

Further, the weekly benefit amount may be reduced where the covered individual has an outstanding tax obligation or has an obligation for child support.

Initial Seven-Day Wait Period

This section clarifies that there is an initial seven-day wait period for each application for benefits, with the exception of medical leave during pregnancy or recovery from childbirth if supported by documentation by a health care provider that this medical leave is immediately followed by family leave, in which case the seven-day wait period for family leave is not required.

Substitution of Employer-Provided Paid Leave

This section clarifies that accrued paid leave provided by an employer or covered business entity runs concurrently with any available leave under paid family and medical leave. Covered individuals that choose to use accrued paid leave provided by their employer or covered business entity or through an extended sick leave program rather than receive a paid benefit are not compensated with paid leave benefits for a period of time for which they received compensation through the use of accrued paid leave or leave through an extended sick leave program.

Employer Reimbursement

An employer or covered business entity that makes payments to a covered individual during a period of family or medical leave that are equal to or greater than the amount required will be reimbursed out of any benefits due to the covered individual or to become due from the DFML. However, the DFML will not reimburse an employer or covered business where the covered individual has received a benefit from the DFML for the same period.

Employer Action

Employers should read and understand the significant proposed changes to the Massachusetts Paid Family and Medical Leave Final Regulations. Employers are encouraged to provide feedback to the DFML during the comment period and virtual hearing. Employers should continue to work with employment counsel, leave administrators and payroll processors to ensure their leave policies and procedures are compliant when the updated final regulations are confirmed. In addition, employers should monitor the state's PFML website for additional guidance and regulations. USI will continue to monitor and advise on any new developments.

Resources

For the draft markup of revised PFML regulations: https://www.mass.gov/doc/51420-draft-markup-of-revised-paid-family-and-medical-leave-pfml-regulations/download

For the Massachusetts Department of Family and Medical Leave: https://www.mass.gov/orgs/department-of-family-and-medical-leave

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

Published: June 02, 2020

On March 26, 2020, New Jersey Governor Murphy signed Senate Bill 2304 which expands the Temporary Disability Benefits (TDB) and Family Leave Insurance (FLI) programs effective immediately. The law also provides for job protection under the New Jersey Family Leave Act (NJFLA) and expands New Jersey's Earned Sick Leave Law (ESLL). On April 14, 2020, the Governor also signed into law, Senate Bill 2374, which amends the NJFLA and FLI to provide job protected, paid leave to care for family members quarantined due to COVID-19, and amends the NJFLA to provide for job-protected unpaid leave to care for children due to school closures.

TDB and FLI

In response to the COVID-19 pandemic, the law expands the definition of a "serious health condition" to include an illness caused by a public health emergency. Workers now have access to TDB and FLI if they are unable to work because they are diagnosed with or suspected of exposure to a communicable disease or taking care of a family member in the same situation. The bills do not specifically refer to COVID-19, therefore, this expansion applies to COVID-19 and any public health emergencies declared by the Governor or Commissioner of Health or other public health authority. The latest legislation also expands the definition of an employee's own disability under the TDB to recognize the impact of an illness or exposure to a communicable disease including the need to quarantine.

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

Earned Sick Leave

The legislation expands New Jersey's ESLLs to permit the use of earned sick time for quarantine or isolation recommended or ordered by a health care provider or public health official as a result of suspected exposure to a communicable disease or to care for a family under the same situation. Please review our March 31, 2020 Bulletin "New Jersey Expands Disability and Leave Benefits to Address COVID-19" and our May 8, 2018 Bulletin "New Jersey Enacts Paid Sick Leave Law" for a summary of the ESLL.

Family Leave Act

Generally, the NJFLA provides an eligible employee with up to 12 weeks of unpaid, job protected leave for the birth of a child of the employee, adoption or placement of a child in foster care, or the care of a family member with a serious health condition.

In response to the current pandemic, S2374 expands the NJFLA's categories of leave. Specifically, NJFLA leave must be provided:

- to care for or bond with a child, as long as the leave begins within 1 year of the child's birth or placement for adoption or foster care;
- to care for a family member, or someone who is the equivalent of family, with a serious health condition (including a diagnosis of COVID-19), or who has been isolated or quarantined because of suspected exposure to a communicable disease (including COVID-19) during a state of emergency; or
- to provide required care or treatment for a child during a state of emergency if their school or place of care is closed by order of a public official due to an epidemic of a communicable disease (including COVID-19) or other public health emergency.

The new law also provides that an employer may request certification issued by a "school, place of care for children, public health authority, public official or health care provider" for any school or childcare closure, mandatory quarantine or any other measure that gives rise to the leave.

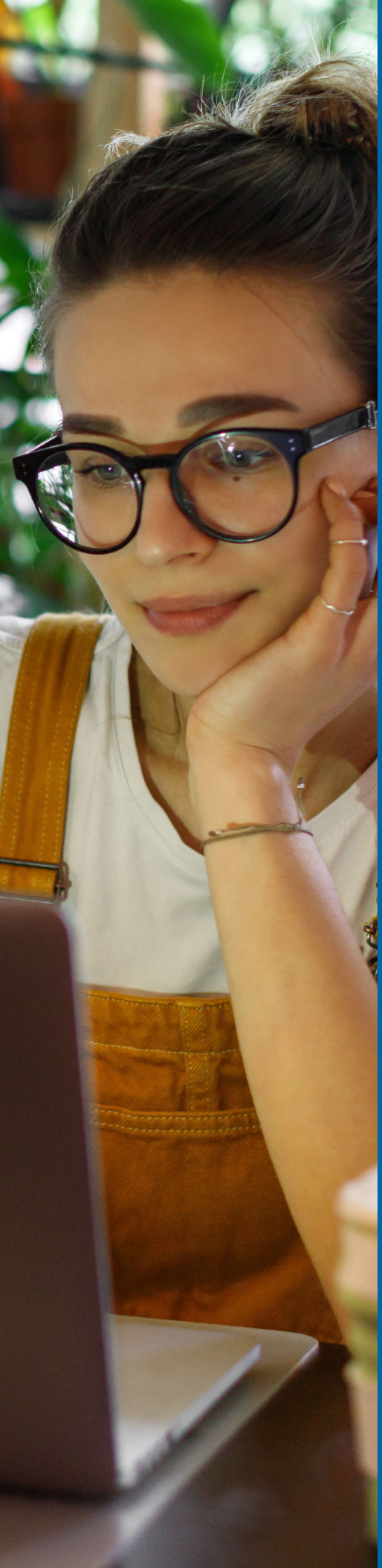
The leave may also be taken intermittently, as long as prior notice is provided to the employer as soon as possible, and a reasonable effort is made to schedule leave so as not to disrupt the operations of the employer and where possible, provide a regular schedule of the day(s) when intermittent leave will be taken.

The new law also indicates that family leave cannot be denied to highly paid employees when the leave is due to a state of emergency declared by the Governor or when indicated as necessary by a public health authority, and "for an epidemic of a communicable disease, a known or suspected exposure to a communicable disease, or effects to prevent the spread of a communicable disease."

NJFLA has been amended so that the rights to reinstatement to employment provided also apply to those taking leaves for public health emergencies as provided for in the legislation.

Employer Action

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



2020 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 24, 2020

The Patient-Centered Outcomes Research (PCOR) fee filing deadline is July 31, 2020 for all self-funded medical plans and HRAs for plan years ending in 2019. Year-end federal legislation reinstated the PCOR fee through September 30, 2029. The IRS issued Notice 2020-44 announcing the adjusted fee amount for this year as well as limited transition relief.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2018 – January 31, 2019	$2.45/covered life/ year	July 31, 2020
March 1, 2018 – February 28, 2019	$2.45/covered life/ year	July 31, 2020
April 1, 2018 – March 31, 2019	$2.45/covered life/ year	July 31, 2020
May 1, 2018 – April 30, 2019	$2.45/covered life/ year	July 31, 2020
June 1, 2018 – May 31, 2019	$2.45/covered life/ year	July 31, 2020
July 1, 2018 – June 30, 2019	$2.45/covered life/ year	July 31, 2020
August 1, 2018 – July 31, 2019	$2.45/covered life/ year	July 31, 2020
September 1, 2018 – August 31, 2019	$2.45/covered life/ year	July 31, 2020
October 1, 2018 – September 30, 2019	$2.45/covered life/ year	July 31, 2020
November 1, 2018 – October 31, 2019	**$2.54/covered life/ year**	July 31, 2020
December 1, 2018 – November 30, 2019	**$2.54/covered life/ year**	July 31, 2020
January 1, 2019 – December 31, 2019	**$2.54/covered life/ year**	July 31, 2020

Employers with self-funded health plans ending in 2019 should use the 2nd Quarter Form 720 to file and pay the PCOR fee by July 31, 2020. The information is reported in Part II. At this time, no extension to the July 31, 2020 due date is currently available; however, we will update you if an extension is announced.

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

Transition Relief

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

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

For plan years that end on or after October 1, 2019 and before October 1, 2020, in addition to the established counting methods, a plan may use any reasonable method for calculating the average number of covered lives.

Plan sponsors of applicable self-insured health plans must file Form 720 annually to report and pay the PCORI fee; a QSEHRA is an applicable self-insured health plan for this purpose.

Short Plan Years

The PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable
self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

EEOC Antibody Testing Guidance in Return to Work Decisions

Published: June 25, 2020

The Centers for Disease Control ("CDC") and the Equal Employment Opportunity Commission ("EEOC") are cautioning employers from using antibody testing as part of a return to work strategy. This guidance is based on information known to date and could be revised in the future should antibody testing become more reliable. For now, antibody testing should not be used in return to work strategies.

It should be noted that group health plans must cover COVID-19 testing, and other services resulting in the order for a COVID-19 test, without cost-sharing (i.e., no copays or deductibles), through the end of the emergency period (currently July 25, 2020, unless extended or shortened). An antibody test in this context would be covered at 100%. Generally, such a test would relate to the items and services furnished during a healthcare provider office visit for the evaluation of an individual for COVID-19 and is not part of a return to work strategy.

The following provides additional background.

Antibody Test for COVID-19

An antibody test for COVID-19 may tell an individual whether they had a previous infection. Although these tests should not be used at this time to determine if an individual is immune, these tests can help determine the proportion of a population previously infected with COVID-19 and provide information about populations that may be immune and potentially protected. According to the CDC, an antibody test may not show the presence of a current infection because it may take 1-3 weeks after infection to make antibodies.

As of June 16th, 2020, only 19 tests have Emergency Use Authorization, with most still requiring lab-based processing. To date, no antibody test has received FDA approval.

CDC Antibody Testing Guidelines

On May 23, 2020, the CDC released interim guidance for COVID-19 antibody testing in clinical and public health settings. Due to the limitations of the test, false-positive test results, lack of FDA approval status, and the need for additional

data, the CDC directs that antibody testing should not be used to make decisions about returning persons to the workplace. Further, antibody tests should not be used to make decisions about grouping persons residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities.

EEOC Antibody Testing Guidelines

Citing the CDC guidelines noted above, on June 17, 2020, the EEOC updated Frequently Asked Questions (FAQs) regarding COVID-19 and the Americans with Disabilities Act ("ADA"), Rehabilitation Act, and other EEO laws. In FAQ A.7, the EEOC makes it clear that under the ADA an employer may not require antibody testing before permitting employees to re-enter the workplace.

According to the EEOC, an antibody test constitutes a medical examination under the ADA. At this time, the antibody test does not meet the ADA's "job related and consistent with business necessity" standard for medical examinations or inquiries for current employees.

The EEOC points out that an antibody test differs from a viral test to determine if someone has an active case of COVID-19. The EEOC has stated in previous guidance that a COVID-19 viral test is permissible under the ADA (FAQ A.6).

Employer Action

In light of the CDC and EEOC guidance, employers should not use antibody testing as a part of a return to work strategy. Employers should review their return to work strategies with employment counsel to ensure compliance with the ADA, state and local law.

IRS Issues Proposed Rule Expanding Medical Expenses

Published: June 26, 2020

Under a proposed rule issued by the Internal Revenue Service ("IRS"), certain direct primary care fees and health care sharing ministries membership expenses may be considered eligible medical expenses under Code Section 213(d).

The rule is in proposed format and would not take effect until taxable years beginning on or after the date final regulations are published. Taxpayers may not rely upon the proposed rule.

Briefly, the proposed rule (if finalized):

- would recognize direct primary care fees and health care sharing ministry membership expenses as expenses for medical care under IRC section 213(d); and

- permit for reimbursement of applicable fees and membership expenses through certain employer-sponsored health reimbursement arrangements ("HRAs").

The proposed rule acknowledges there may be an impact on eligibility to contribute to a Health Savings Account ("HSA") when an individual (a) has coverage in a direct primary care arrangement that provides medical items and services before satisfaction of the minimum required deductible, or (b) is a member of a health care sharing ministry.

The proposed rule describes how these fees and membership expenses may be treated in an HRA sponsored by an employer. However, it does not address whether they would be reimbursable through a health flexible spending account ("Health FSA"). Under existing rules, to the extent the fees or membership expenses are viewed as insurance premiums, they would not be eligible Health FSA expenses. Further clarification on this point would be helpful.

As described below, the IRS is requesting comments on various aspects of the proposed rule.

Direct Primary Care Arrangements

Under the proposed rule, a direct primary care arrangement is a contract between an individual and one or more primary care physicians under which the physician or physicians agree to provide medical care for a fixed annual or periodic fee without billing a third party.

For this purpose, a "primary care physician" is an individual who is a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine.

The IRS seeks comments on various issues, including whether:

- to expand the definition of direct primary care arrangement to include contracts between an individual and nurse practitioner, clinical nurse specialist or physician's assistant providing primary care services; and
- clarification is needed as to arrangements that would not fall within the definition of direct primary care under the proposed rule (for example, a contract between a dentist and patient to provide dental care would not be direct primary care under this definition).

Health Care Sharing Ministries

Briefly, membership in a health care sharing ministry entitles members to share their medical bills through the ministry and potentially receive payments from other members to help with their medical bills.

Under the proposed rule, amounts paid for membership in a health care sharing ministry that shares expenses for medical care may be payments for medical insurance under section 213(d)(1)(D). They are not payments for medical care.

As defined by the proposed rule, a health care sharing ministry is an organization:

- which is described in section 501(c)(3) and is exempt from taxation under section 501(a);
- members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the state in which a member resides or is employed;
- members of which retain membership even after they develop a medical condition;
- which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999; and
- which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

The IRS requests comments on the definition of a health care sharing ministry.

How Could these Fees be Reimbursed Through an HRA?

Under the proposed rule an HRA, including an HRA integrated with traditional group health plan coverage, an individual coverage HRA (ICHRA), a qualified small employer HRA (QSEHRA) or an excepted benefit HRA, may be designed to:

- reimburse expenses for medical care including reimbursements for direct primary care arrangement fees; and/or.
- reimburse for a membership in a health care sharing ministry.

Issues for Employers Sponsoring High Deductible Health Plans with HSAs

The proposed rule highlights that in many instances, a direct primary care arrangement would constitute a health plan or insurance that provides coverage before satisfaction of the minimum deductible is met and provides coverage that is not limited to preventive care. Therefore, an individual generally may not be eligible to contribute to an HSA when covered by a direct primary care arrangement. There may be limited circumstances where the direct primary care arrangements will not be disqualifying (e.g., only provides preventive care).

In addition, because a health care sharing ministry is considered medical insurance that is not permitted insurance, membership in the health care sharing ministry would make an individual ineligible for purposes of contributing to an HSA.

Employer Action

The rules are in proposed format and will not take effect until a final rule is issued. For now, employers should await release of final regulations and review for any changes from the proposed regulations. Employers may begin considering whether, once final regulations are issued, to permit reimbursement of these fees or membership expenses through HRAs.

While not specifically addressed in the IRS guidance, there are ERISA issues that arise if employers are contributing, through HRA dollars, toward direct primary care services or health care sharing ministries and whether funding such contributions create an ERISA covered plan. Further guidance from the Department of Labor would be helpful to address this issue.

Massachusetts Releases 2021 MCC Amounts

Published: June 29, 2020

The Commonwealth Health Insurance Connector Authority (Health Connector) recently published Administrative Bulletin 05-20 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 2021 and provides those respective dollar amounts.

Administrative Bulletin 05-20 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2021.

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 need MCC to avoid significant penalties.

Deductible Limits – 956 CMR 5.03(2)(B)

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 05-20 sets the 2021 maximum MCC deductibles as $2,700/$5,400. If the plan has a separate prescription drug deductible, the amounts cannot exceed $330/$660 and the total maximum deductible applies.

OOPMS – 956 CMR 5.03(2)(C)

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 2021, the OOPM will be $8,550/$17,100.

2020 Compliance Bulletins
State Based

NORTH CAROLINA

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North Carolina DOI Activates Premiums Deferral Mandate

On March 30, 2020, based on President Trump's "Major Disaster Declaration" due to the COVID-19 pandemic, North Carolina Commissioner of Insurance, Mike Causey, issued an amended order that activated a "State of disaster automatic stay of proof of loss requirements; premium and debt deferrals," as described in NCGS §58-2-46. The Order was accompanied by Bulletin Number 20-B-06 issued to all North Carolina licensed insurance companies and applies from March 27, 2020 to April 26, 2020 (the "Order Period"). In addition, the North Carolina Department of Insurance issued FAQs related to the Order on April 1, 2020.

This Order effectively requires insurance companies issuing group health policies and stop-loss policies in North Carolina to extend periods for which covered, adversely affected employers in any North Carolina county receive limited relief for payments of premiums. These North Carolina insurance companies must give such employers the option to defer premium payments due during the Order Period for 30 days from the last day the premium payment may be made under the terms of the relevant policy.

With respect to group health benefit plans, after the 30-day deferral period has expired, the sponsoring employer must pay all premiums in arrears to the insurer. Failure to do so can result in lapse of coverage as of the date premiums were paid up, in which case an insurance company can cancel the relevant policy, and the employer will be responsible for all medical expenses incurred since the effective date of the lapse in coverage.

Thus, for example, an employer is fully paid up for group health insurance premiums through February 29, 2020. For coverage ending March 31, 2020, an employer that is required to make a premium payment due April 15, 2020, under the terms of the relevant group health policy, shall be allowed to defer such premium to the insurance company until May 15, 2020. If the employer fails to pay by May 15, 2020, coverage will lapse retroactive to February 29, 2020, and the employer shall be responsible for paying medical expenses incurred by covered participants after that date.

A 30-day deferral period also applies to any statute, rule, or other policy provision that imposes a time limit on any North Carolina insurer, insured, claimant, or customer to perform any act during the Deferral Period including the transmittal of information, with respect to insurance policies. Additionally, the 30-day deferral period shall apply to any time limitations imposed on insurers under the terms of a policy or contract or provisions of law related to North Carolina residents.

Blue Cross Blue Shield of North Carolina has provided information on its understanding of the Order. Besides the mandated premium payment extension, it is providing a 30-day extension, as needed, for deadlines related to:

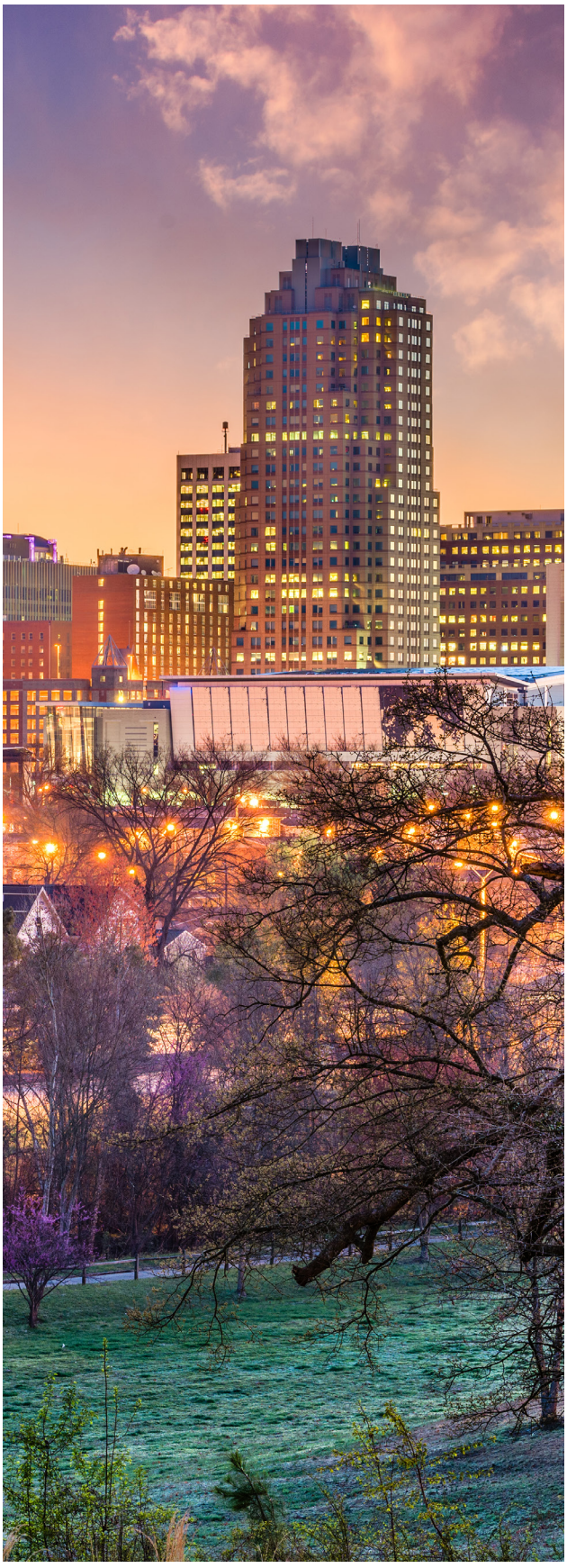
- Claims submissions
- Appeals filing
- Authorization requests of medical services
- Additions of newborn and adopted children to a policy

It has also stated that the following provisions will also apply:

- Defer utilization management review of hospital cases
- Extend HIPAA and COBRA eligibility deadlines

Employers with a group health insurance plan with another carrier should confirm eligibility for the 30-day premium deferral, as well as any other implications the Order may have on other aspects of their plans. As indicated by the Department:

Policyholders must pursue the option to defer and should contact their insurance companies to request a deferral of their premium payments.



Seattle Hotel Employee Protections Ordinances Proposed Rules

The City of Seattle Office of Labor Standards ("OLS") proposed administrative rules to implement the four Hotel Employee Protections Ordinances passed in 2019. One of the laws, the Improving Access to Medical Care for Hotel Employees Ordinance (SMC 14.28) ("MC Ordinance"), requires employers 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.

The legal challenge to the MC Ordinance was not successful at the federal district court level but an appeal of that decision is still possible.

The rulemaking provides helpful guidance as it relates to the MC Ordinance. This summary provides information on the proposed rule for the MC Ordinance only and not the other three, which are non-healthcare related laws. The public has until June 5, 2020 to comment on the proposed rules. The proposed rule is not final and additional guidance is expected.

Definitions

The MC Ordinance defined an ancillary hotel business as a business that:

- Routinely contracts with the hotel for services in conjunction with the hotel's purpose;
- Leases or sublets space at the site of the hotel for services in conjunction with the hotel's purpose; or
- Provides food and beverages to hotel guests and to the public with an entrance within the hotel's premises.

The proposed rule adds the following clarifications to the meaning of ancillary hotel business:

- **Business** – means the portion the business enterprise that provides services to guests or at the site of the hotel.
- **Services** – refers to the provision of a direct, specific benefit to a guest as opposed to an indirect benefit that serves the general welfare of guests. The sale of goods is not a service.
- **Routinely contracts** – a business that has an isolated and/or short-term business relationship will not be considered to "routinely contract" with the hotel. A business will not be considered to "routinely contract" if the business relationship is in existence for less than one year.
- **Site of the hotel** – includes any building, structures, or grounds that are kept, used, maintained, advertised, or held out to the public to be a part of the hotel.
- **Entrance within the hotel premises** – means when the entrance opens into the hotel premises and is promoted and used by the business's guests as an access point into the business.

The MC Ordinance defined a hotel's purpose as services in conjunction with the hotel's provision of short-term lodging including:

- Food or beverage services;
- Recreational services;
- Conference rooms;
- Convention services;
- Laundry services; and
- Parking.

The proposed rule adds the following clarifications to the meaning of hotel's purpose:

- Recreational services include but are not limited to indoor and outdoor fitness and leisure activities

- Convention services are related to the coordination and facilitation of a gathering of persons that meet for a common purpose including but not limited to

  - event planning and coordination;
  - provision of food and beverage; and
  - facility set up and tear down.

The proposed rulemaking adds definitions for the following terms:

- **Annual open enrollment** – a period during which an individual may enroll or change health coverage.

- **Dependents** – any person for whom the employee is allowed an exemption under the "qualifying child" or "qualifying relative" tests of the internal revenue code ("IRC"), 26 USC §151-153.

- **Domestic partner** – Washington State Registered Domestic Partner.

- **Ordinary income** – compensation paid in case, direct deposit, or check.

- **Plan year** – the calendar, policy, or fiscal year of benefits coverage as established by an employer's group health plan.

- **Special enrollment period** – a period during which an individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, health coverage outside of the initial and annual enrollment periods.

- **Tax-favored health programs** – flexible spending arrangements ("FSA"), health reimbursement arrangements ("HRA"), health savings accounts ("HSA"), or substantially similar programs.

- **Workweek** – fixed and regularly recurring period of one hundred sixty-eight hours or seven consecutive twenty-four-hour periods that may begin on any day of the week and any hour of the day.

Covered Employees

Covered employees must work an average of 80 hours per month at a large hotel in the City of Seattle.

- Employers are required to make a reasonable estimate of the average monthly work hours of an employee for the calendar year or, if employed less than one year, over the course of the period of employment.

- An employer's estimate will be deemed unreasonable if it results in an underestimation of the actual average hours worked by the employee.

- Employers will be required to make retroactive healthcare expenditures as ordinary income in the event that they underestimate average work hours.

- Employers will be prohibited from recovering excess expenditures in the event that they overestimate average work hours.

- Employers will not be required to make a monthly healthcare expenditure for employees who separate from employment prior to the end of a calendar month.

Waivers Due to Other Coverage

The proposed rule clarifies the following requirements for the Ordinance Voluntary Waiver Form ("Ordinance Waiver"):

- employers must use the Ordinance Waiver provided by the OLS;
- the Ordinance Waiver may not be altered or substituted in any form;
- it must be provided in the employee's primary language;
- it must be voluntarily completed in full by the employee without pressure or coercion from the employee's coworkers or the employer, including supervisors, managers, or their agents;
- it is invalid if not complete; and
- employers are prohibited from stating, suggesting, or implying that an employee is required to sign the form.

Employers may use an electronic version of the Ordinance Waiver with the following additional conditions:

- the text must be identical to the Ordinance Waiver;
- the signature, electronic signature, or other authorization must be on the same screen as the text of the form;
- the employee must be able to see the entirety of the form at the same time and on the same screen on which they provide their electronic signature or authorization
- the website containing the form may not state or imply that the employee is required to sign the form.

An Ordinance Waiver is valid for one year after which an employee may choose to sign another Ordinance Waiver. Employees may revoke their voluntary waiver in writing during any period of annual open enrollment or due to a qualifying life event. Employers must retain copies of all waivers and written revocations for three years.

Expenditure Rate

The prescribed expenditure rates are based on the presence or absence of spouses, domestic partners, or dependents regardless of whether those individuals are covered by the group health plan. That means an employee is entitled to the expenditure for the employee and spouse even if the employee is enrolled as self-only. If the employer is unable to obtain information to determine the appropriate rate, the employer may make expenditures at the employee only rate until otherwise notified by the employee. Employer's must notify all covered employees each year of the following:

- the rate for which the employee is eligible;
- the process to notify the employer of a change that would affect the rate;
- the form of the healthcare expenditure that the employer will use;
- information regarding access of information, administrator contact, carryover, grace period, and forfeiture if any expenditures fund a tax favored health plan.

Employers must make the full expenditure for each covered employee. Only employer payments count towards satisfaction of the required expenditures. Required expenditures are in addition to any amount otherwise required by federal, state, or local law. Healthcare expenditures shall include administrative costs paid to a third party for the purpose of providing health care services or coverage but not administrative costs incurred by the employer and not paid to a third party.

Covered employees must receive the benefit of the healthcare expenditure every month that they are covered regardless of the timing of the employer payment to a third party for coverage.

Self-Funded Plans

Employer sponsored self-funded group health plans may satisfy the healthcare expenditures based on "average per-capita monthly expenditures." These expenditures:

- include the average cost of healthcare services paid by the employer for each employee and participating spouses, domestic partners, and/or dependents
    - can be based on all employees participating in the plan at all work locations, even if outside Seattle; or
    - can be based only on covered employees participating in the plan (as defined above).
- can be based on a monthly premium equivalent rate that is actuarially certified
    - if not actuarially certified then the required expenditures must be verified by end of year audit by the third month after the end of the plan year.
- do not include any premium payments by employees or refunds or credits given to an employer at the end of the plan year.

Covered employees may waive the expenditure by using the Expenditure Voluntary Waiver Form ("Expenditure Waiver") provided by OLS and with the same requirements as those for the Ordinance Waiver. In the event that an employee declines the expenditure but refuses to sign the Expenditure Waiver, the employer must have proof that the employee received the waiver form and evidence that the employee declined the expenditure. Otherwise, the employer must provide the healthcare expenditure to the employee. An employee's waiver of the expenditure does not waive the employer's obligation or ability to offer health insurance to that employee.

Employer Action

The MC Ordinance will be effective July 1, 2020 or the next scheduled annual open enrollment period for health coverage (if offered) after July 1, 2020. For a calendar year plan this would be the open enrollment for the January 1, 2021 plan year.

However, there is a delayed effective date for certain ancillary hotel business. For an ancillary hotel business with 50-250 employees that contracts, leases or subleases with a hotel as of September 16, 2019, the requirements take effect upon the later of July 1, 2025 or the earliest annual open enrollment period for health coverage (if offered) after July 1, 2025.

While an appeal of the recent court ruling may be likely, the 9th Circuit has upheld various city ordinances that have imposed a spending requirement related to health care.

Covered employers should:

- Await additional guidance including finalization of the proposed rules.
- Sign up on the City's website (link below) for the newsletter and other updates on this topic.
- Review existing expenditures (if any) on health care.
- Identify Covered Employees and begin to address how to provide expenditures (e.g., through a group health plan, payment of compensation, etc.).
- Monitor developments, including any legal challenges to the Ordinance.

Washington Expands Workplace Protections for High-Risk Employees

On April 13, 2020, Washington Governor Inslee issued a proclamation providing additional workplace protections for high-risk workers to safeguard them from exposure to COVID-19 without jeopardizing their employment. The proclamation took effect immediately and applies to all public and private employers through June 12, 2020 (may be extended). Additional guidance implementing this directive would be helpful to assist employers.

Notably, the proclamation includes protections around health plan coverage for high-risk individuals who are unable to work.

High-Risk Individuals

The proclamation applies to employees identified as "high-risk individuals" as defined by the Centers for Disease Control and Prevention ("CDC"). High-risk individuals include:

- age 65 years or older
- people with health conditions such as
  - chronic lung disease
  - moderate to severe asthma
  - obesity
  - diabetes
- people who are immunocompromised due to conditions such as
  - HIV
  - cancer treatment
  - organ transplantation

Required Protections

The proclamation provides employees that are part of the high-risk population additional workplace protections. Employers are required to use all available options to protect high-risk employees from exposure to COVID-19, including:

- telework
- alternative or remote work locations
- social distancing
- reassignment

If the above are not feasible, employers must:

- Allow employees to use any accrued, employer-provided leave under the employer's policy in any sequence at the discretion of the employee.
- Not interfere with the employee's utilization of unemployment insurance benefits (use of accrued leave cannot be required prior to applying for unemployment).
- Maintain all health insurance benefits while an employee is not able to work even if the employee has exhausted all paid leave benefits.
- Reinstate employees to existing positions when they can return to work even if the employee is replaced while unable to work.

With respect to continuing group health plan benefits while a high-risk employee is unable to work, there is an argument that such a state order may be preempted under ERISA, particularly as it relates to self-insured ERISA governed group health plans. Further clarification on this issue would be helpful. Fully insured health plans are subject to state mandates, including this proclamation.

Employers and unions may not enforce any provisions of their collective bargaining agreements that are contrary to the protections afforded by the proclamation. Employers are not prohibited from taking job actions such as reductions in force when no work reasonably exists, but employers are prohibited from taking any actions that may adversely affect the employee's eligibility for unemployment insurance benefits.

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

Employer Action

With respect to group health plan coverage benefits:

- Employers with fully insured group health plans will want to continue coverage in accordance with the proclamation for high-risk employees who are unable to work and confirm any eligibility exceptions with carriers.

- While there is an argument the extended coverage under the proclamation may be preempted by ERISA, employers with self-funded group health plans should consider extending coverage as directed by the Governor. Confirm any eligibility exceptions with stop loss carriers.

Employers with employees in Washington will want to carefully review all aspects of the proclamation and current employment practices.

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