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2020: Third Quarter

Compliance Digest

Compliance Bulletins Released July-September

2020 Compliance Bulletins

July

August

September

Departments Issue FAQ Part 43 on COVID-19

Published: July 6, 2020

On June 23, 2020, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") issued FAQ Part 43, which includes certain guidance on the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), as well as other COVID-19 health plan issues.

Briefly, FAQ 43:

- Confirms the type of testing and services required to be covered by group health plans and reinforces that plans must provide coverage for COVID-19 diagnostic testing without cost sharing;
- Excludes workplace and surveillance testing for COVID-19 from the coverage mandate;
- Allows plan sponsors to revoke COVID-19 plan changes upon the expiration of the public health emergency through modified notice requirements;
- Temporarily allows large employers to offer coverage for telehealth or other remote care services to employees who are not otherwise eligible for the employer's group health plan;
- Allows grandfathered plans to maintain their grandfathered status despite COVID-19-related changes being made and then subsequently revoked after the public health emergency has ended; and
- Allows employers to waive a standard for obtaining a reward under a health contingent wellness program due to COVID-19 circumstances.

Additional details are described below.

Items and Services that must be Covered under FFCRA (As Amended by the Cares Act)

Health plans must provide coverage for the following items and services without cost-sharing (including deductibles, copayments, and coinsurance), prior authorization or other medical management techniques for the duration of the public health emergency period (currently set to end July 25, 2020, unless extended or shortened by HHS):

- 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 ("EUA") under the FDCA, unless and until the EUA 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 healthcare provider office visits (including telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described above, 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 provides links to appropriate websites a plan or carrier may use to determine which COVID-19 tests are required to be covered without cost sharing.

In addition, FAQ 43 clarifies:

- Health plans must provide coverage for certain items and services when medically appropriate for the individual as determined by the individual's provider.
- Health plans are also required to cover COVID-19 diagnostic testing for at-home testing, when ordered by the individual's provider and it is medically appropriate and meets the current accepted standards of medical practice.
- Health plans must cover multiple diagnostic tests for an individual, when medically necessary.

Coverage of Testing for Employment Purposes or Surveillance is not Required

Group health plans are not required to cover COVID-19 testing for surveillance or employment purposes, including "return to work" situations. The FFCRA only requires coverage of items and services for diagnostic purposes.

Out of Network Providers and Balance Billing

As previously covered in the FAQ Part 42, 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 ("OON") providers. Where there is no negotiated rate with an OON provider, the plan must reimburse the provider at the cash price for the services as listed by the provider on a website (or a negotiated lower price than the listed cash price).

The FAQ clarifies:

- Participants and beneficiaries should not be balance billed for an applicable COVID-19 test.
- The reimbursement rate requirements apply only the diagnostic testing for COVID-19. Balance billing may be allowed for all other services, subject to applicable state laws and other plan provisions.

With respect to individuals who receive a COVID-19 test in an emergency department of a hospital that is OON, the group health plan must reimburse the OON provider of the COVID-19 test an amount equal to the cash price for the services as listed by the provider on a website (or a negotiated lower price than the listed cash price). For any other OON services provided in an emergency setting, a non-grandfathered plan must comply with minimum payments standards under the Affordable Care Act ("ACA").

Summary of Benefits & Coverage ("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. In prior guidance, the Departments allowed for plans to provide a notice of the COVID-19 related changes as soon as reasonably practicable.

The guidance clarifies that if a plan reverses the changes related to COVID-19 once the public health emergency is no longer in effect, the Departments will consider the plan to have satisfied its obligation to provide advance notice, provided the plan had previously notified the participants that the changes were temporary (such as through the COVID-19 public health emergency). The plan may also notify participants within a reasonable timeframe in advance of the reversal of the changes.

Expanding Access to Telehealth and Other Remote Care Services for Non-Benefit Eligible Employees

Although typically prohibited under the ACA's market reforms, the Departments are providing temporary relief allowing large employers to offer telehealth and other remote care services to employees and their dependents who are not otherwise eligible for any group health plan offered by the employer. For this purpose, a large employer is an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

This relief applies for the duration of any plan year that begins before the end of the public health emergency period (currently July 25, 2020). The Departments will require these arrangements to comply with the following requirements:

- Prohibition on discrimination based on a pre-existing condition or health status;
- Prohibition on rescissions of coverage; and
- Parity in mental health and substance use disorder benefits.

Grandfathered Health Plans

In the guidance, the Departments provide that if a plan added benefits, or reduced or eliminated cost sharing pursuant to the Departments' safe harbor outlined in FAQs Part 42, Q9 and Q14, only for the period in which the COVID-19 public health emergency is in effect, the plan will not lose its grandfathered plan status solely because the changes are later reversed and the terms of the plan that were in effect prior to the emergency period are restored.

Wellness Programs

The Departments provided guidance allowing for employers to waive a standard for obtaining a reward under a health contingent wellness program if the participants face difficulty meeting the standard as a result of COVID-19 as long as the waiver is offered to all similarly situated individuals.

Resources

For a copy of FAQs Part 43, visit: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf

Supreme Court Rules in Favor of LGBTQ Protections in Title VII

Published: July 8, 2020

On June 15, 2020, the Supreme Court held in Bostock v. Clayton County that firing an employee because of the employee's sexual orientation or gender identity is a form of sex discrimination under Title VII of the Civil Rights Act. Title VII generally applies to employers in both the private and public sector that have 15 or more employees.

Briefly, Title VII, in part, prohibits employers from discrimination as to employment or benefits based on sex. Even before the Supreme Court's decision, the Equal Employment Opportunity Commission ("EEOC"), the agency responsible for enforcement of Title VII, has generally taken view that discrimination because of an employee's gender identity or orientation is discrimination based on sex.

While the Court's decision specifically dealt with terminating employees, it has implications for benefit plan provisions, as Title VII prohibits discrimination with respect to compensation, terms, conditions or privileges of employment due to an individual's race, color, religion, sex or national origin. This includes discrimination with respect to fringe benefits (i.e., medical, hospital, life insurance and retirement benefits).

Employers sponsoring health and welfare programs should assess whether their health programs may discriminate against employees who are gay or transgender. This may include exclusions for medically necessary medical services associated with health care for transgender participants (e.g., surgical benefits, hormone therapy, mental health care). Employers should consult with legal counsel and proceed with caution if implementing plan designs or eligibility rules based on sexual orientation or gender identity. In addition, state insurance and employment laws may also prohibit such discrimination.

Section1557 Nondiscrimination Final Rule

Published: July 8, 2020

On June 12, 2020, the Department of Health and Human Services ("HHS") issued a final rule which narrows the interpretation and application of the nondiscrimination rules under Section 1557 of the Affordable Care Act ("ACA") by removing protections on the basis of gender identity, further specifying who is subject to Section 1557 and removing certain notice requirements.

Generally, the 1557 rules prohibit discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability. Section 1557 has been in effect since 2010. Regulations issued in 2016 extended 1557 rules to most insured group health and some self-funded group health plans. These rules were challenged, and a nationwide injunction prohibited HHS from enforcing nondiscrimination rules related to gender identity and pregnancy. Aspects of the 2016 rules have been vacated and these final rules issued.

Briefly, the final rules:

- Clarify that Section 1557 applies to entities principally engaged in healthcare, as well as to the healthcare activities of other entities to the extent those activities are funded by HHS. This effectively narrows those entities subject to these rules. Specifically,
    - A health insurance carrier is not principally engaged in the business of providing health care and its operations would only be pulled under these rules for the portion that receives federal financial assistances. For example, a carrier that offers policies outside of the Exchange Marketplace that do not receive federal financial assistance would not be subject to this rule.
    - An employer-sponsored health plan will not be subject to Section 1557 provided no federal funding is received from HHS and the employer is not principally engaged in the business of providing health care.
- Remove the notice requirements that required health companies to distribute nondiscrimination notices and "taglines" translation notices in at least fifteen languages within all "significant communications" to patients and customers.

- Repeal provisions of the prior regulations that defined sex discrimination to include discrimination based on sexual orientation and gender identity.

Notably, the final rules narrowly interpret sex discrimination to exclude discrimination based on gender identify or termination of pregnancy. The rule was issued three days before the Supreme Court held that sex discrimination under Title VII of the Civil Rights Act includes discrimination based on an individual's sexual orientation or gender identity. A lawsuit challenging the final rule has been filed and it will be interesting to see whether the definition of discrimination under these Section 1557 rules will stand considering the Supreme Court's ruling.

Employer Action

Under the final rule, most employer sponsored health plans (including their insurance carriers and TPAs) will not be subject to the 1557 nondiscrimination rules. However, in light of the Supreme Court's recent decision and other state and federal employment laws, employers should proceed with caution around exclusions or limitations in health benefit programs (or other employee benefit plans) based on sexual orientation or gender identity. Employers intending to restrict certain services to only a single gender based on a participant's gender at birth or otherwise excluding transgender services from their group health plans should consult with counsel to understand potential ramifications.

For the fact sheet, visit https://www.hhs.gov/sites/default/files/1557-final-rule-factsheet.pdf

FFCRA Benefit Eligibility Updates for Summer Program Closures

Published: July 13, 2020

With the summer season officially upon us, the Department of Labor's Wage and Hour Division ("the Department") has issued Field Assistance Bulletin ("FAB") 2020-4 to clarify when benefits under the Families First Coronavirus Response Act ("FFCRA") may be available due to a summer camp or enrichment program being closed due to coronavirus-related reasons.

The FAB builds on earlier FFCRA guidance (FAQ 93) affirming that an employee may be entitled to leave when a summer camp or program is closed or unavailable due to COVID-19 including when the employee can demonstrate:

- taking affirmative steps such as submitting an application or paying a deposit to enroll the child in the summer camp or program prior to the announced closing of the camp or program,
- the child had previously attended the summer camp or program and remains eligible for the 2020 summer season, or
- other means showing the child's enrollment or planned enrollment in a camp or program.

Background

The FFCRA provides eligible employees of covered employers (less than 500 employees) up to 12 weeks of expanded family and medical leave who are unable to work (or telework) because the employee is caring for his or her son or daughter whose school or "place of care" has been closed or whose childcare provider is unavailable due to COVID-19 related reasons.

During the first two weeks of unpaid leave, the employee may use FFCRA paid sick leave, at 2/3 of the employee's regular rate of pay (up to $200 per day per employee), when the employee is unable to work (or telework). After the first two weeks, up to an additional 10 weeks of paid expanded Family and Medical Leave Act ("FMLA") leave at 2/3 of an employee's regular rate of pay (up to $200 per day per employee), for an employee who has been employed for at least 30 calendar days. Relief from these paid leave requirements may be available for certain small businesses (fewer than 50 employees), if providing the paid leave would jeopardize the business' viability.

Field Assistance Bulletin 2020-4

FAB 2020-4 helps determine whether a summer camp or program would have qualified as a child's "place of care" for the summer had it not closed for COVID-19 reasons which would entitle an employee to paid sick or expanded family and medical leave benefits under the FFCRA. A "place of care" is a physical location in which care is provided for the employee's child while the employee works and includes summer camps and summer enrichment programs.

To qualify for FFCRA childcare benefits, an employee must provide the employer verbally or in writing with information supporting the need for leave, a statement that the employee is unable to work and documentation showing the need to care for a child whose school or summer program is closed that includes:

- the name of the child,
- the name of the school or "place of care," and
- a statement that no other suitable person is available to care for the child.

An employee can document the summer camp or program would have qualified as the child's "place of care" for summer 2020 by demonstrating:

- the employee took affirmative steps such as submitting an application or paying a deposit to enroll the child in the summer camp or program prior to the announced closing of the camp or program, or
- the child's past attendance and current eligibility in 2020 at the summer camp or program.
  - For example, a child age 13 who attended a summer enrichment program in 2019 would not be eligible for the same program in 2020 because the program is offered to children up to age 12.

The Department recognizes there may be other circumstances that employers may need to consider such as when a young child would have first been eligible for a camp or program in 2020 and therefore, cannot demonstrate prior enrollment. A parent's mere interest in a camp or program is generally not sufficient to qualify for FFCRA benefits.

Employer Action

The Department acknowledges in the FAB that there is no "one-size-fits-all" rule. Employers should work with employees to determine if evidence exists that an employee may be entitled to leave when a summer camp or program is closed or unavailable due to COVID-19 related reason before denying a leave request.

IRS Issues FFCRA W-2 Reporting Guidance

Published: July 17, 2020

The IRS issued Notice 2020-54 to help employers properly report 2020 emergency paid sick leave and expanded family medical leave wages paid to employees under the Families First Coronavirus Response Act ("FFCRA"). Employers with less than 500 employees who provided benefits under either leave program will need to separately identify and report FFCRA wages on Form W-2 Box 14 based on the reason the leave was taken as follows:

- Emergency paid sick leave for an employee's COVID-19 health related issues,
- Emergency paid sick leave taken by the employee for a family member's COVID-19 health related issues or to care for a child whose place of care is unavailable due to COVID-19, and
- Emergency paid family and medical leave to care for a child whose place of care is unavailable due to COVID-19.

Emergency Paid Sick Leave

FFCRA provides up to 80 hours of paid sick leave (at the greater of the employee's regular rate of pay or minimum wage) to employees who are unable to work (or telework) for one of the following COVID-19 reasons:

1. The employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19.
2. The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
3. The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
4. The employee is caring for an individual who is subject to an order as described (1) or has been advised as described in (2).

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

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

Employers will identify and report FFCRA sick leave wages on Form W-2 Box 14 (or in a separate statement) as follows:

- Sick leave wages for reasons 1-3 shown above with a notation such as "sick leave wages subject to $511 per day limit."

- Sick leave wages for reasons 4-6 shown above with a notation such as "sick leave wages subject to $200 per day limit."

Expanded Family and Medical Leave

The FFCRA provides eligible employees up to 12 weeks of expanded family and medical leave who are unable to work (or telework) because the employee is caring for his or her son or daughter whose school or place of care has been closed or whose childcare provider is unavailable due to COVID-19 related reasons. During the first two weeks of unpaid leave, the employee may use FFCRA paid sick leave, at 2/3 of the employee's regular rate of pay (up to $200 per day), when the employee is unable to work (or telework). After the first two weeks, up to an additional 10 weeks of expanded family and medical leave may be paid at 2/3 of an employee's regular rate of pay (up to $200 per day), for an employee who has been employed for at least 30 calendar days.

Employers will report expanded family and medical leave wages on Form W-2 Box 14 (or in a separate statement) with a notation such as "emergency family leave wages."

Employer Action

Employers should work closely with their payroll vendor and tax advisor to ensure proper reporting of any wages paid to employees under the FFCRA. If employers will be identifying the FFCRA wages in a separate statement (rather than on Form W-2 Box 14) and the employee receives a paper Form W-2, then the statement must be included with the Form W-2 provided to the employee. If the employee receives an electronic Form W-2, then the statement must be provided in the same manner and at the same time as the Form W-2.

IRS Announces 2021 ACA Affordability Indexed Amount

Published: July 23, 2020

The IRS recently announced in Revenue Procedure 2020-36 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.83% for plan years that begin in 2021. This is an increase from the 2020 percentage amount (9.78%).

Background

Rev. Proc. 2020-36 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2021

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2021 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

The W-2 safe harbor

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.83% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

Rate of pay safe harbor

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.83% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

Federal Poverty Level (FPL) safe harbor

Coverage is affordable if it does not exceed 9.83% of the FPL.

For a 2021 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $104.53 (48 contiguous states), $130.66 (Alaska), or $120.25 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2021 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

Supreme Court Affirms Expansion of ACA Contraception Exemptions

Published: July 24, 2020

The Supreme Court recently ruled in a 7-2 decision to uphold regulations that expand the Affordable Care Act ("ACA") contraception exemptions.

The ACA requires all non-grandfathered group health plans to cover, without cost sharing, certain preventive care items and services, including contraceptive services. Religious employers are exempt from the contraceptives mandate. Certain religious non-profits and closely held for profit organizations with religious objections may qualify for an accommodation.

The regulations at issue in this Supreme Court decision permit non-governmental employers, institutions of higher education, and individuals with seriously held religious or moral objections to cease providing coverage for some, or all, contraceptive services.

With the Court's decision, employers with religious or moral objections to providing some, or all, of the mandated contraceptives under the ACA may qualify for an exemption. However, as discussed in this article, additional challenges to these regulations are expected.

Supreme Court Decision

The Supreme Court held that the religious and moral objection exemption rules promulgated by the Departments were a valid exercise of their authority under the ACA. Further, there were no procedural issues the Departments violated in issuing the contraception exemption rules under the Administrative Procedures Act. The Court reversed the Third Circuit's decision and remanded the case for the Third Circuit to dissolve the nationwide injunction consistent with the Court's ruling.

In both concurring and dissenting opinions, various justices indicated it is likely these cases will continue to be fought in the lower courts on other legal grounds. In fact, shortly following the Supreme Court's decision, the New Jersey and Pennsylvania Attorneys General indicated they will argue that the Department's regulations are arbitrary and capricious under the Administrative Procedures Act, an issue not addressed in the lower court decisions.

Employer Action

The Supreme Court's decision may permit more employers to exclude some or all contraceptives from their group health plans based on religious and/or moral objection. However, this is unlikely to be the final word on this issue. As these cases are likely to continue in the lower courts, employers who are considering removing coverage for contraceptives based on the Supreme Court's decision should discuss implications with counsel. In addition, state insurance laws may limit an employer's ability to exclude such coverage from a fully insured plan.

Proposed Rule to Increase Flexibility for Grandfathered Plans

Published: July 27, 2020

The Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") recently released a notice of proposed rulemaking regarding grandfathered group health plans and grandfathered group health insurance coverage. If finalized, the proposed rule would amend current rules to:

- provide greater flexibility for certain grandfathered group health plans to make changes to fixed-amount cost-sharing requirements without causing a loss of grandfather status.

- ensure that high deductible health plans ("HDHPs") are able to comply with minimum cost-sharing requirements so enrolled individuals are eligible to contribute to health savings accounts ("HSAs").

The Departments note that there is no authority for non-grandfathered plans to become grandfathered, and therefore the proposed rule does not provide any opportunity for a plan or coverage that has lost its grandfather status to regain that status.

Background

In general, section 1251 of the Affordable Care Act ("ACA") provides that certain group health plans and health insurance coverage existing as of March 23, 2010, the date of enactment of the ACA, (referred to collectively in the statute as grandfathered health plans) are not subject to all of the ACA's mandated provisions. In November 2015, the Departments issued final regulations that identified certain types of changes that, if made to a grandfathered plan or coverage, would result in a loss of grandfather status. These types of changes generally include an increase in fixed-amount cost-sharing above certain thresholds, decrease in employer contributions, and elimination of substantially all benefits to diagnose or treat a condition.

In response to a 2017 Executive Order, the Departments issued a request for information regarding grandfathered group health plans and grandfathered group health insurance coverage ("2019 RFI"). These proposed regulations are based on the feedback received from stakeholders who submitted comments in response to the 2019 RFI.

Proposed Regulations

Alternative Inflation Adjustment

Under the 2015 final regulations, group health plans and group insurance coverage would lose grandfather status if there is any increase in:

- Fixed-amount cost-sharing requirement other than a copayment (e.g., deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the "maximum percentage increase." For this purpose, the "maximum percentage increase" means medical inflation, expressed as a percentage, plus 15%.

- Fixed-amount copayments (when measured from March 23, 2010) above the greater of $5 plus medical inflation or the "maximum percentage increase."

The proposed regulations include a revised definition of "maximum percentage increase" to provide an alternative method of measuring "maximum percentage increase" based on the premium adjustment percentage (rather than medical inflation) which is used to calculate other ACA inflation adjusted variables such as the annual employer mandate penalties under IRC Section 4980H and the maximum annual limit on cost-sharing. This alternative standard would not supplant the current standard; rather, it would be available to the extent it yields a greater result than the current standard, and it would apply only with respect to increases in fixed amount cost-sharing requirements that are made effective on or after the effective date of the final rule.

Under the proposed rule, the maximum percentage increase means the greater of:

- medical inflation, expressed as a percentage, plus 15 percentage points; or

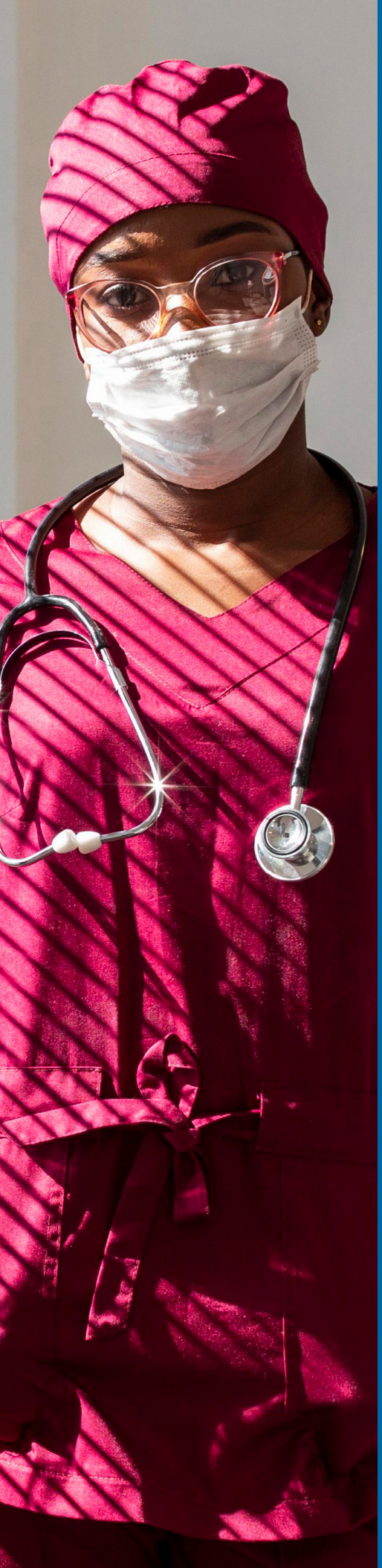
- the portion of the premium adjustment percentage, that reflects the relative change between 2013 and the calendar year prior to the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points.

HDHPs

The proposed regulations clarify that grandfathered group health coverage that is an HDHP may increase fixed-amount cost-sharing requirements, such as deductibles, to the extent necessary to maintain their status as an HDHP without losing grandfather status. This change would ensure that participants and beneficiaries enrolled in that coverage remain eligible to contribute to an HSA. The proposed rule notes the annual cost-of-living adjustment to the required minimum deductible for an HDHP has not yet exceeded the maximum percentage increase that would otherwise cause an HDHP to lose grandfather status.

Employer Action

The Departments are issuing the proposed rule with a request for public comment by August 14, 2020. For now, employers with grandfathered group health plans should await release of final regulations and review any changes from the proposed regulations. The amendments to the 2015 final rules that are included in these proposed rules would apply to grandfathered group health plans and grandfathered group health insurance coverage beginning 30 days after the publication of any final rules. The proposed rule should not be relied upon until finalized.



National Public Health Emergency Extension Benefit Plan Impact

Published: July 28, 2020

On July 23, 2020, the Secretary of Health and Human Services ("HHS"), Alex Azar, declared the Public Health Emergency, scheduled to end on July 25, 2020, will once again be extended for an additional 90 days and as a result, numerous temporary benefit plan changes remain in effect.

Important Definitions

Emergency Period. HHS Secretary Azar issued a Public Health Emergency, beginning January 27, 2020. This Emergency Period is now set to expire October 23, 2020 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period runs from March 1, 2020 until 60 days after the announced end of the National Emergency which should likely mean no earlier than December 22, 2020.

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

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

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

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

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

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

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

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

Group health plans, disability, and other employee welfare benefit plans will disregard the period from March 1, 2020 until the end of the Outbreak Period when determining the following:

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

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

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

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

Employer Action

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

New Annual Assessment for New Jersey Individual and Large Group Health Insurance

Published: August 4, 2020

New Jersey Governor Phil Murphy signed Assembly Bill 4389 into law on Friday, July 31. The New Jersey law, effective January 1, 2021, imposes a 2.5% tax on the net premiums collected for individual and large group health plans and is estimated to generate nearly $220 million annually. The funds will be used make insurance more affordable for working and middle-class consumers.

Background

Section 9010 of the Affordable Care Act imposed a health insurance tax ("HIT") on insurers beginning in 2014. The HIT is an annual fee that applies to insurers that offer fully insured health coverage in the individual market, group market and public programs. While Congress imposed a one-year moratorium on the HIT for 2017, the HIT resumed in 2018 and was subsequently repealed beginning in 2021. Assembly Bill 4389 was introduced on July 9, 2020, to replace the HIT upon its expiration in January. On July 31, Governor Murphy signed the Bill into law.

The New Jersey Health Insurer Assessment ("HIA")

The new legislation requires insurance carriers to report to the Department of Banking and Insurance the net value of premium they write during the past year for individual and large group health plans. Premium from small group plans, Medicaid and Medicare policies, nonprofit dental plans and certain self-funded group employer coverage are not included in the assessment. Insurers will be required to pay a 2.5% assessment on the value of these premiums. The money collected will be used to increase affordability and greater access to health insurance for the uninsured through a number of means including subsidies, reinsurance and other efforts. The intent is to offer additional financial help to NJ residents when the state launches its own Marketplace in the fall.

Employer Impact

New Jersey rates for 2021 health plans will be announced by the carriers shortly. There is growing concern about the 2021 rates which will include the HIA, given the impact of COVID-19 on individuals and businesses of all sizes. We are likely to see this increase passed through to employers in a time when they are already struggling in the pandemic. We will continue to monitor this situation and keep you apprised.

Initial California Healthcare Reporting Guidance Released

Published: August 20, 2020

The California Franchise Tax Board has released preliminary guidance on mandatory reporting of healthcare coverage of California residents for calendar year 2020. The guidance applies to (1) employers and other entities that sponsor self-funded group medical plans, and (2) insurance carriers for fully insured group medical plans. The reports for calendar year 2020 must be furnished to California residents by January 31, 2021, and filed with the Franchise Tax Board electronically (or, in some cases, with paper forms) by March 31, 2021, using the same Forms 1095-C and 1095-B that are already required under the Affordable Care Act.

Background

California Senate Bill No. 78, which was signed into law on June 27, 2019, requires all California residents to have minimum essential coverage ("MEC") for every calendar month beginning on or after January 1, 2020. Unless the resident is otherwise exempt, a tax penalty applies to those residents who fail to comply with the state's individual healthcare mandate for one or more months of the calendar year.

SB 78 imposes two separate reporting obligations on employers and other plan sponsors:

- **Furnishing reports to covered individuals.** SB 78 requires employers and other entities that sponsor an employment-based health plan to furnish proof of healthcare coverage (using IRS Form 1095-C or 1095-B) to all California residents covered by the plan. The form will enable residents to prove they had MEC during the calendar year, thereby helping them avoid penalties under the state's individual healthcare mandate. The deadline for furnishing the form to residents for calendar year 2020 is January 31, 2021.

- **Reporting to the Franchise Tax Board.** SB 78 also requires employers and other plan sponsors to file reports (using IRS Form 1095-C or 1095-B) with the Franchise Tax Board regarding all state residents covered by the plan. These reports will enable state tax authorities to determine whether a resident is subject to a penalty under the state's individual healthcare mandate. The deadline for filing reports with the Franchise Tax Board for calendar year 2020 is March 31, 2021.

Important exceptions: If the group medical plan is fully insured, and an insurance carrier has provided MEC reports (using IRS Form 1095-B) to state residents covered under the plan and to the Franchise Tax Board, then the employer or other plan sponsor does not have to provide a duplicate MEC report to those same state residents or to the Franchise Tax Board. In addition, an employer or other entity sponsoring a group medical plan is permitted under state law to enter into a contract with a third-party service provider (such as an insurance carrier or third-party administrator) to provide the required MEC reports to state residents covered under the plan and/or to the Franchise Tax Board.

Employers and other plan sponsors that fail to file the required reports with the Franchise Tax Board are subject to a penalty of $50 per individual.

Preliminary Guidance on Mandatory Reporting

The Franchise Tax Board has released the following information to assist employers, insurance carriers and other plan sponsors in fulfilling their reporting obligations under California's individual healthcare mandate:

- An official government website
- Draft versions of two government publications (California Publications 3895C and 3895B)
- Document entitled "FTB (Franchise Tax Board) File Exchange System – MEC (Minimum Essential Coverage) IR (Information Reporting) Registration and Enrollment Guide 2020"

Refer below for hyperlinks to these materials.

In most cases, an employer or other entity that sponsors a self-funded group medical plan will prepare IRS Form 1095-C (including Parts I, II, and III) to identify the employees and family members covered under the plan during the calendar year (along with other information). The Franchise Tax Board requires the employer or other sponsor of a self-funded plan to file all Forms 1095-C relating to California residents (along with the Form 1094-C transmittal form) with the Board as part of the mandatory reporting obligation.

In some cases, an employer with a self-funded group medical plan will prepare IRS Form 1095-B to identify the individuals covered under the plan during the year. This

procedure may be followed for COBRA qualified beneficiaries who were not employed by the employer at any time during the year, or for retirees covered under a self-funded retiree medical plan who were not employed by the employer at any time during the year. The Franchise Tax Board requires the employer or other sponsor of a self-funded plan to file all Forms 1095-B relating to California residents (along with the Form 1094-B transmittal form) with the Board as part of the mandatory reporting obligation.

The following chart summarizes the preliminary guidance from the Franchise Tax Board for reporting by employers and other plan sponsors on Forms 1095-C and 1095-B:

	Form 1095-C	Form 1095-B
What is the deadline for furnishing forms to state residents for calendar year 2020	January 31, 2021	January 31, 2021
What is the deadline for filing forms with the Franchise Tax Board for calendar year 2020?	March 31, 2021	March 31, 2021
Can the employer or other plan sponsor submit the required forms to the Franchise Tax Board on paper?	Yes, if the employer or other plan sponsor is required to file fewer than 250 Forms 1095-C with the Franchise Tax Board for 2020	Yes, if the employer or other plan sponsor is required to file fewer than 100 Forms 1095-B with the Franchise Tax Board for 2020
Is the employer or other plan sponsor required to submit the required forms to the Franchise Tax Board electronically?	Yes, if the employer or other plan sponsor is required to file 250 or more Forms 1095-C with the Franchise Tax Board for 2020	Yes, if the employer or other plan sponsor is required to file 100 or more Forms 1095-B with the Franchise Tax Board for 2020
Can the employer or other plan sponsor obtain a hardship waiver from the electronic filing requirement?	Yes, by applying to IRS on Form 8508	Yes, by applying to IRS on Form 8508

For employers or other plan sponsors required to file electronically, the California MEC Information Reporting Program is similar to the federal Affordable Care Act Information Returns (AIR) Program. Organizations need to register online (starting October 5, 2020), submit an enrollment form, and complete a testing cycle, before transmitting actual taxpayer data to the Franchise Tax Board.

Employer Action

All group medical plans – whether fully insured or self-funded – covering California residents, the employer or other plan sponsor should (as a best practice) include information about the state's individual healthcare mandate and penalty as part of the new-hire enrollment materials and annual open enrollment materials distributed to California residents.

Fully insured group medical plans - covering California residents, the employer or other plan sponsor should confirm with the insurance carrier on an annual basis that the carrier has furnished MEC reports to state residents and has filed MEC reports with the Franchise Tax Board. The employer or other plan sponsor is not required to furnish duplicate MEC reports to state residents or file duplicate MEC reports with the Franchise Tax Board.

Self-funded group medical plans (including self-funded retiree medical plans) - covering California residents, the employer or other plan sponsor should coordinate with the third-party administrator or other vendor regarding whether the third party will be furnishing MEC reports to state residents and filing MEC reports on behalf of the plan with the Franchise Tax Board. If the third party accepts that responsibility, the employer or other plan sponsor will still need to cooperate with the third party in making sure that the reporting obligation is fulfilled (for example, by providing whatever electronic or paper signature may be necessary).

Resources

- California SB 78, http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB78
- California Franchise Tax Board website on healthcare reporting by employers, https://www.ftb.ca.gov/about-ftb/newsroom/health-care-mandate/businesses.html
- California Publication 3895C (draft version), https://www.ftb.ca.gov/file/business/report-mec-info/2020-3895c-publication-draft.pdf
- California Publication 3895B (draft version), https://www.ftb.ca.gov/file/business/report-mec-info/2020-3895b-publication-draft.pdf
- California Franchise Tax Board File Exchange System/MEC IR Registration and Enrollment Guide for 2020, https://www.ftb.ca.gov/file/business/report-mec-info/ftb-file-exchange-system-mec-ir-registration-and-enrollment.pdf

FFCRA Paid Leave Regulations Partially Invalidated by District Court

Published: August 21, 2020

On August 3, 2020, the U.S. District Court for the Southern District of New York invalidated four separate provisions in temporary regulations previously issued by the U.S. Department of Labor ("DOL") regarding emergency paid leave under the Families First Coronavirus Response Act ("FFCRA"). It appears the Court's decision may apply with respect to certain counties in New York. However, it is not clear whether the ruling applies nationally or retroactively. In addition, the DOL is likely to appeal the decision which may create additional uncertainty.

Background

The FFCRA requires employers with less than 500 employees to provide emergency paid sick leave and paid expanded family and medical leave to eligible employees for certain reasons related to COVID-19. The FFCRA also provides tax credits to reimburse employers that provide paid leave to employees.

In response to passage of the FFCRA, the DOL issued temporary regulations to implement the paid leave requirements. The temporary regulations provide guidance to employers on employee eligibility for paid leave, identify when paid leave can be intermittent, define eligible and excludable employees, clarify documentation and recordkeeping requirements, and address other issues under the FFCRA.

According to separate IRS guidance on the FFCRA, employers are required to comply with the DOL's temporary regulations in order to qualify for tax credits to reimburse them for paid leave that they provide under the FFCRA.

Lawsuit

The State of New York filed a lawsuit against the DOL, claiming that the temporary regulations exceed the DOL's authority under the law because the regulations restrict the use of paid leave beyond what the FFCRA statutory requirements permit. The District Court agreed with the State of New York, and ruled against the DOL on the following four provisions in the temporary regulations:

- The requirement that work be available to an employee in order to qualify for paid leave

- The definition of health care provider that could be denied leave
- Employer ability to deny intermittent leave
- Allowing an employer to require documentation prior to the use of paid leave

Work Availability

The temporary regulations state that eligible employees can qualify for paid leave under the FFCRA only if they have work available from their employer, and they are unable to perform the work because of reasons related to COVID-19. In other words, employees are not eligible for paid leave under the FFCRA if their employer does not have work available for them.

The court concluded that the FFCRA does not include a "work availability" requirement, and therefore ruled that the inclusion of such a requirement in the temporary regulations is invalid.

Definition of Health Care Provider

The temporary regulations define a "health care provider" broadly to include almost all employees working at a hospital, doctor's office or other medical facility. The employer is permitted under the temporary regulations to exclude "health care providers" from eligibility for paid leave under the FFCRA, unless the "health care provider" has the employer's consent.

The court ruled that the definition was too broad because it includes employees whose roles are completely removed from the provision of healthcare services.

Intermittent Leave

The temporary regulations allow employees to take paid leave under the FFCRA intermittently only if the employer gives its consent to the employee and only in certain situations.

The court ruled that the requirement that the employer agree or approve an employee's request for intermittent leave is unreasonable, and therefore invalid.

Documentation Requirements

The temporary regulations require employees to provide their employer with documentation of the need for leave prior to taking paid leave under the FFCRA.

The court ruled that the documentation requirements in the final rule exceed what is permitted by the statute, and therefore are invalid.

FFCRA Tax Credits

The FFCRA also provided refundable payroll tax credits to help employers fund paid leave to employees. In general, the tax credits are available for leaves approved by the FFCRA. Additional issued guidance clarified that employers would be allowed to deny paid leave to an employee that could not provide documentation needed to claim the tax credits. The court's ruling in this case does not clarify any impact on the availability of tax credits relative to the regulations that are invalidated. In other words, it is not certain that employers that follow the ruling and make paid leave more widely available to their employees will be eligible for the related tax credits.

Additional guidance is needed from the IRS on the impact of the ruling on FFCRA tax credits.

Employer Action

The court ruling does not state whether it applies outside of the six counties that comprise the Southern District of New York (i.e., New York, Bronx, Westchester, Putnam, Rockland, Orange, Dutchess, and Sullivan counties). Additionally, the court does not state whether the ruling has a retroactive effect. If an employer had previously denied leave or excluded employees from eligibility based on the invalidated rule, it is not clear whether the employer is required to provide paid leave retroactively.

Employers should continue to monitor the DOL and IRS for additional guidance on paid leave and related tax credits under the FFCRA. Employers should discuss implications of this decision with their employment counsel, particularly if operating in the New York counties listed above. We will continue to provide guidance as this issue develops.

DOL Provides Guidance Regarding FFCRA and SCA/DBRA Interaction

Published: August 24, 2020

On August 3, 2020, the U.S. Department of Labor's Wage and Hour Division published two FAQs for employers that have a service contract with the federal government covered by the Service Contract Act ("SCA") or a federal construction contract covered by the Davis-Bacon and related Acts ("DBRA"). The FAQs help explain when fringe benefits must be provided to employees taking paid leave under the Families First Coronavirus Response Act ("FFCRA").

According to the FAQs from the DOL, the health and welfare rate (i.e., the monetary equivalent of health and welfare benefits) under SCA and DBRA is not included in the regular rate of pay for purposes of FFCRA.

The guidance establishes that fringe benefits would NOT need to be paid unless the employee is taking FFCRA leave concurrently with leave provided under SCA/DBRA or Executive Order 13706 (EO 13706). Specifically, if the employee is using existing paid vacation, sick leave, holiday hours or sick leave dictated by EO 13706 concurrently with FFCRA leave, then a health and welfare fringe payment would be required.

The DOL guidance is available at www.dol.gov/agencies/whd/pandemic/sca-questions

District Court Blocks Enforcement of HHS Final Rule on ACA Section 1557

Published: September 3, 2020

On August 17, 2020, a U.S. district court decided in the case of Walker v. Azar to block enforcement of final regulations from the U.S. Department of Health and Human Services ("HHS") relating to section 1557 of the Affordable Care Act, to the extent that the regulations fail to define sex discrimination as including discrimination based on sexual orientation and gender identity. This means discrimination on the basis of sexual orientation and gender identity is prohibited by section 1557.

Background

ACA section 1557 prohibits hospitals, doctors' offices, insurance carriers and other entities that receive financial assistance from the federal government relating to a health program or activity (such as Medicare or Medicaid) from discriminating on the basis of sex and other factors set forth in Title IX of the Civil Rights Act. Employers outside of the healthcare industry are generally exempt from the nondiscrimination requirements of ACA section 1557, although other federal and state civil rights laws may apply to them. Regulations issued in 2016 ("2016 regulations") expanded these nondiscrimination requirements to prohibit discrimination on the basis of sexual orientation and gender identity.

On Friday, June 12, 2020, HHS issued final regulations (the "2020 regulations", published in the Federal Register on June 19, 2020) on the nondiscrimination requirements of ACA section 1557. The 2020 regulations repeal provisions of the 2016 regulations that defined sex discrimination as including discrimination based on sexual orientation and gender identity. Enforcement of the 2016 regulations had previously been blocked by another U.S. district court in the case of Franciscan Alliance, Inc. v. Burwell (N.D. Tex. 2016) because of the Religious Freedom Restoration Act. That litigation appears to be ongoing.

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

Walker v. Azar Case

The U.S. District Court for the Eastern District of New York decided in Walker v. Azar that HHS should have voluntarily reconsidered the 2020 regulations once the U.S. Supreme Court released its decision in the Bostock case. The court's ruling states, "Since HHS has been unwilling to take that path voluntarily, the Court now imposes it." The U.S. district court issued a preliminary injunction preventing the 2020 regulations from repealing the more expansive definition of sex discrimination found in the 2016 regulations thereby maintaining the prohibition on discrimination on the basis of sexual orientation and gender identity.

Employer Action

Hospitals, doctors' offices, insurance carriers, and other entities that are subject to the ACA section 1557 nondiscrimination requirements should proceed with caution around exclusions or limitations in health benefit programs (or other employee benefit plans) based on sexual orientation or gender identity. They should consult with their legal counsel before restricting certain services to only a single sex based on a participant's sex at birth, or otherwise excluding transgender services from a group health plan.

FAQs Address School Reopening and FFCRA Leave

Published: September 9, 2020

The Department of Labor's Wage and Hour Division ("the Department") added three new FAQs to clarify when benefits are available under the Families First Coronavirus Response Act ("FFCRA") as the school year begins.

The FFCRA provides eligible employees of covered employers (less than 500 employees) up to 12 weeks of expanded family and medical leave when they are unable to work (or telework) because they are caring for a son or daughter whose school or "place of care" has been closed or whose childcare provider is unavailable due to COVID-19-related reasons. During the first two weeks of unpaid leave, the employee may use FFCRA paid sick leave at 2/3 of the employee's regular rate of pay (up to $200 per day per employee) when the employee is unable to work (or telework). After the first two weeks, up to an additional 10 weeks of paid expanded Family and Medical Leave Act ("FMLA") leave at 2/3 of an employee's regular rate of pay (up to $200 per day per employee) is available for an employee who has been employed for at least 30 calendar days. Relief from these paid leave requirements may be available for certain small businesses (fewer than 50 employees) if providing the paid leave would jeopardize the business' viability.

The new FAQs clarify that FFCRA paid leave benefits are available in the following two scenarios:

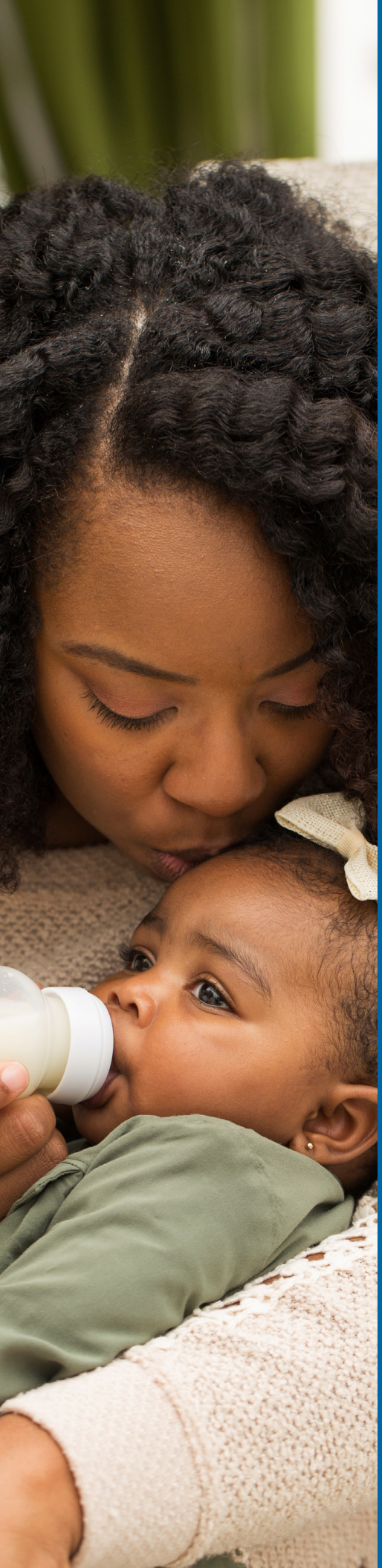
- School operates on an alternate day (or other hybrid-attendance) basis. For days when a child is not permitted to attend school in person and must instead engage in remote learning, as long as the need for the leave to actually care for the employee's child during that time and only if no other suitable person is available to do so (FAQ 98).

- School begins with remote learning only. When a school is beginning under a remote learning program out of concern for COVID-19. (FAQ 100).

However, FAQ 99 states that FFCRA paid leave benefits are not available when a child's school has the option of in-person attendance or remote learning, but the employee opts for remote learning. The Department takes the position that, in this scenario, the child's school is not "closed" due to COVID-19-related reasons.

Employer Action

Employers should be aware of these new FAQs and work with employees to determine when FFCRA paid leave benefits may be available during the school year.



New York Paid Family Leave 2021 Contributions and Benefits

Published: September 10, 2020

The New York State Department of Financial Services has announced the contribution rate and benefit schedule under the New York Paid Family Leave ("PFL") law effective January 1, 2021 as follows:

- The contribution rate increases to 0.511% of weekly wages, up to a maximum annual contribution of $385.34.
- The maximum weekly benefit increases to 67% of average weekly wages payable for 12 weeks and will be capped at $971.62.

Additional details are provided below.

Contributions

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the annualized New York State Average Weekly Wage ("AWW"). For 2021, the contribution percentage has been set at 0.511% (includes a 0.005% risk adjustment for COVID-19 quarantine claims) and the New York State AWW in effect will be $1,450.17. Therefore, based on these amounts the maximum annual employee contribution for 2021 will be $385.34. A comparison to the 2020 contribution amounts is as follows:

	2021	2020	Percentage change
Contribution Percentage	0.511%	0.27%	89.3%
NYS Average Weekly Wage	$1,450.17	$1,401.17	3.5%
Annualized NYS Average Weekly Wage	$75,408,84	$72,860.84	3.5%
Maximum Annual Contribution	$385.34	$196.72	96.1%

Benefits

Beginning January 1, 2021, the PFL benefit will increase to the final phased-in maximum 67% of an employee's Average Weekly Wage (up to the New York State AWW) payable for 12 weeks. Therefore, the maximum weekly benefit for 2021 will be $971.61 (the maximum annual benefit in 2021 increases to $11,659.32). A comparison to the 2020 benefit levels is as follows:

	2021	2020	Percentage change
Benefit Percentage	67%	60%	12.0%
Weeks Payable	12	10	20.0%
Maximum Weekly Benefit	$971.61	$840.70	15.6%
Maximum Annual Benefit	$11,659.32	$8,407.00	15.6%

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a 52-consecutive week period is limited to 26 weeks.
- The Superintendent of the NYS Department of Financial Services has the discretion to delay the scheduled PFL benefit increase if it is determined the increase may negatively impact employees, employers, insurers and the overall economic climate. For 2021, the Superintendent has determined the 2021 PFL benefit increase is appropriate and therefore, will be implemented as scheduled and noted above. This is the final year of the scheduled PFL increases that became effective in 2018.

Employer Action

Employers should prepare for the 2021 New York PFL contribution and benefit increases that begin in January. Paid Family Leave coverage will typically be added as a rider on an employer's existing disability insurance policy although benefits can be provided through a self-funded plan approved by the state Workers' Compensation Board.

Medicare Part D Notification Requirements

Published: September 14, 2020

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

Employers should send these notices no later than October 15, 2020 if they haven't done so already.

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

What are the Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

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

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

Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters (notices last updated by CMS for use on or after April 1, 2011).

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

To Whom Should the Participant Notice Be Sent?

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

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

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

If the disclosure notice is provided to all plan participants annually, prior to the ACEP each year (October 15th or next working day), CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

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

How Should the Participant Notice Be Sent?

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

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

Mail

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

Electronic Delivery

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

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

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

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

Open Enrollment Materials

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

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

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

Personalized Notices

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

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

CMS Notification

When and How Should Notification be Given to CMS?

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

- Within 60 days after the beginning date of the plan year (March 1, 2021 for a 2021 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

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

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

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

How is Creditable Coverage Determined?

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

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

Actuarial Determination

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

Simplified Determination

Some plans will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.
A prescription drug plan is deemed to be creditable if:

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

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

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

EEOC Updates COVID-19 Guidance

Published: September 21, 2020

On September 8, 2020, the Equal Employment Opportunity Commission ("EEOC") posted an updated "What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws" ("WYSK"). The updated WYSK modifies two existing Q&As and adds 18 new Q&As that have been adapted from two other EEOC technical assistance resources: "Pandemic Preparedness in the Workplace and the Americans with Disabilities Act" and a March 27, 2020 publicly available EEOC webinar.

The updated guidance provides helpful clarifications. The following highlights some of the new information as it relates to screening employees for COVID-19. Employers should carefully review the WYSK and other EEOC guidance in their entireties.

- The ADA requires that any mandatory medical test of employees be "job related and consistent with business necessity." Applying this standard to the current circumstances of the COVID-19 pandemic, employers may take screening steps to determine if employees entering the workplace have COVID-19 because an individual with the virus will pose a direct threat to the health of others. Generally, the ADA does not interfere with employers following recommendations by the CDC or other public health authorities regarding whether, when, and for whom COVID-19 testing or other screening is appropriate. Testing administered by employers consistent with current CDC guidance will meet the ADA's "business necessity" standard. (WYSK Q/A-6)

- Employers may ask all employees who will be physically entering the workplace if they have COVID-19 or symptoms associated with COVID-19 and ask if they have been tested for COVID-19. Symptoms associated with COVID-19 include, for example, fever, chills, cough, and shortness of breath. The CDC has identified a current list of symptoms which can be found at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. An employer may exclude those with COVID-19, or symptoms associated with COVID-19, from the workplace because, as EEOC has stated, their presence would pose a direct threat to the health or safety of others. (WYSK Q/A-8)

- An employer may not ask an employee who is physically coming into the workplace whether they have family members who have COVID-19 or symptoms associated with COVID-19. The Genetic Information Nondiscrimination Act (GINA) prohibits employers from asking employees medical questions about family members. GINA, however, does not prohibit an employer from asking employees whether they have had contact with anyone diagnosed with COVID-19 or who may have symptoms associated with the disease. Moreover, from a public health perspective, only asking an employee about his contact with family members would unnecessarily limit the information obtained about an employee's potential exposure to COVID-19. (WYSK Q/A-10)

In addition to the above, the updated WYSK includes guidance on maintaining the confidentiality of medical information associated with an employee who has COVID-19 or symptoms associated with the disease, as well as reasonable accommodations.

DOL Reaffirms and Revises FFCRA Leave Regulations, Updates FAQs

Published: September 23, 2020

Six weeks after a federal district court vacated four provisions in the Families First Coronavirus Response Act ("FFCRA") temporary regulations, the Department of Labor ("DOL") has responded by reaffirming two of those provisions (along with its detailed reasoning for doing so) and revising the other two provisions. The DOL also updated its FFCRA FAQs to reflect these clarifications.

Background

The FFCRA requires employers with fewer than 500 employees to provide emergency paid sick leave and paid expanded family and medical leave to eligible employees for certain reasons related to COVID-19. The FFCRA also provides tax credits to reimburse employers that provide paid leave to employees.

In response to the passage of the FFCRA, the DOL issued temporary regulations to implement the paid leave requirements. The temporary regulations provide guidance to employers on employee eligibility for paid leave, identify when paid leave can be intermittent, define eligible and excludable employees, clarify documentation and recordkeeping requirements, and address other issues under the FFCRA.

On August 3, 2020, the U.S. District Court for the Southern District of New York ("Court") invalidated four separate provisions of these temporary regulations:

1. the requirement that FFCRA paid sick leave and expanded family and medical leave are available only if an employee has work from which to take leave;

2. the requirement that an employee may take FFCRA leave intermittently only with employer approval;

3. the definition of an employee who is a "health care provider," whom an employer may exclude from being eligible for FFCRA leave; and

4. the statement that employees who take FFCRA leave must provide their employers with certain documentation before taking leave.

Modifications to FFCRA Temporary Regulations

On September 16, 2020, in response to this Court decision, the DOL published clarifications and revisions to its FFCRA temporary regulations. For the first two provisions that were invalidated by the Court, the DOL reaffirms its original position and offers a fuller explanation of its approach. For the second two invalidated provisions, the DOL revises the text of its temporary regulations to address the Court's concerns.

In addition, the DOL updated several of the questions and answers in its published FFCRA FAQs and added three new ones to reflect these changes.

In the three new FAQs (101, 102 and 103), the DOL makes clear that it considers the Court decision to have vacated the four provisions on a nationwide basis (not just as to the parties or to certain New York counties). The DOL also states that its revised explanations and regulations are effective September 16, 2020 through December 31, 2020 (the expiration of the FFCRA's paid leave provisions).

Work Availability Requirement - Reaffirmed

The DOL reaffirms that paid sick leave and expanded family and medical leave may be taken only if the employee has work from which to take leave, and that the qualifying reason for taking FFCRA leave must be the sole ("but for") reason that the individual is not working. For example, if an employer closes an employee's worksite or the employee is furloughed, the individual is already not working; even if the individual experiences an otherwise qualifying FFCRA reason, it is not the sole reason the individual is not working.

The DOL cited multiple rationales for this rule, including that one of the FFCRA's purposes – discouraging employees from going to work if there is a possibility they could transmit COVID-19 to others – is not served if individuals receive pay to stay home despite there being no work to go to anyway. Additionally, the DOL pointed out there are other programs to assist individuals who are experiencing unemployment because there is no work available.

To counter concerns that an employer could feign a lack of work to avoid granting FFCRA leave, the DOL reiterates that the employer's determination as to "the availability or unavailability of work must be based on legitimate, non-discriminatory and non-retaliatory business reasons."

The DOL does modify the temporary rule slightly to clarify that the work availability requirement applies to all qualifying reasons to take paid sick leave and expanded family and medical leave, not just some of them.

Employer Approval Required for Intermittent Leave - Reaffirmed

The DOL reaffirms that, where intermittent FFCRA leave is permitted by the Department's regulations (while teleworking or for childcare-related reasons), an employee must obtain his or her employer's approval to take paid sick leave or expanded family and medical leave intermittently.

In the preamble to the revised temporary regulation, and in updated FAQs 21 and 22, the DOL clarifies the meaning of "intermittent" leave. For example, an employee does not need employer approval to take paid FFCRA leave only on the alternating days of the week when his or her child is not permitted to attend school in-person. This is not considered intermittent leave, because the alternating schedule is determined by the school, not the employee, and each day of school closure constitutes a separate reason for FFCRA leave that ends on the next day the school is open to the child.

This is in contrast to the situation where a child's school is closed for an entire week due to COVID-19 reasons, and an employee wishes to take paid FFCRA leave on Monday, Wednesday, and Friday, but work on Tuesday and Thursday, while another family member watches the child. This would be a request for intermittent leave, and therefore requires employer approval, because the employee is asking to take leave for only certain portions of the school closure.

Definition of Health Care Provider - Revised

Employers are allowed to exclude employees who are "health care providers" from eligibility for FFCRA leave, in order to prevent disruptions to the health care system's capacity to respond to the COVID-19 public health emergency that could result from these individuals being absent from work.

The Court objected that the original definition of "health care provider" was based on the identity of the employer, rather than the role of the employee, meaning an employer engaged in the health care field could exclude all of its employees from FFCRA leave eligibility, even those who had no role whatsoever in the provision of health care.

In response, the DOL significantly revised the definition of a "health care provider" in this context to focus on the skills, roles, duties and capabilities of the employees. The new basic definition of a "health care provider" is:

- an employee who falls under the FMLA's definition of "health care provider;" including physicians, nurse practitioners, and others who make medical diagnoses, and
- an individual who is "employed to provide diagnostic services, preventive services, treatment services, or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care."

FFCRA FAQ 56 was updated with this revised definition and illustrative examples. The new definition of "health care provider" includes:

- employees who provide direct diagnostic, preventive, treatment, or other patient care services, such as nurses, nurse assistants, and medical technicians
- employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services
- employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition

Furthermore, "a person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility."

Documentation and Notice Requirements - Revised

The DOL revised the temporary rule to clarify that the information an employee must give his or her employer to support the need for emergency paid sick leave or expanded family and medical leave does not have to be given prior to taking the leave, but rather can be provided to the employer "as soon as practicable, which in most cases will be when the [e]mployee provides notice" to the employer of the need for the FFCRA leave.

The DOL also made a revision to clarify that an employee taking expanded family and medical leave under FFCRA must give notice to his or her employer as soon as practicable, which generally will be prior to the need to take leave if the reason for the leave is foreseeable.

FFCRA FAQs 16, 21, and 22 were updated to reflect these clarifications.

Employer Action

Employers subject to the FFCRA should comply with these revised rules beginning September 16, 2020.

In particular, employers involved in the health care field who have exempted employees from FFCRA leave should review the new definition of "health care provider" with legal counsel and make adjustments to their policies and practices as necessary.

It is always possible another legal action may be filed to challenge the reaffirmed and/or new FFCRA temporary rules, although they are only scheduled to be in effect through the end of the year. We will continue to monitor and provide guidance on developments in this area.

2020 Compliance Bulletins
State Based

COLORADO

NEW HAMPSHIRE

WASHINGTON

New Colorado Paid Leave Requirements

On July 14, 2020, the Healthy Families and Workplaces Act ("HFWA") was signed into law. It requires employers to provide paid sick leave to all Colorado employees under various circumstances:

1. COVID-19-Related Leave. Effective immediately until December 31, 2020, employers who are not subject to the federal Emergency Paid Sick Leave Act ("EPSLA") in the Families First Coronavirus Response Act ("FFCRA") must comply with the provisions of the EPSLA for Colorado employees.

2. Sick Leave. Beginning January 1, 2021 (January 1, 2022 for employers with less than 16 employees), the HFWA requires all employers in Colorado to provide paid sick leave to their employees, accrued at one hour of paid sick leave for every 30 hours worked, up to a maximum of 48 hours.

3. Public Health Emergency (PHE) Leave. Effective in the event of a public health emergency, various events related to the cause entitle employees to supplemental paid sick leave. PHA: (a) an act of bioterrorism, a pandemic influenza, or an epidemic caused by a novel and highly fatal infectious agent, for which: (i) an emergency is declared by a federal, state, or local public health agency; or (ii) a disaster emergency is declared by the governor; or (b) a highly infectious illness or agent with epidemic or pandemic potential for which a disaster emergency is declared by the governor.

COVID-19-Related Leave

Employers with 500 or more employees must comply with the paid sick leave provisions of the EPSLA, briefly described as follows:

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

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

Note, as this requirement applies to employers who are not subject to FFCRA, federal tax credits are not available to reimburse the cost of providing this leave.

Sick Leave

Reasons for Leave

Employees may use accrued paid sick leave to be absent from work for the following purposes:

- The employee has a mental or physical illness, injury, or health condition; needs a medical diagnosis, care, or treatment related to such illness, injury, or condition; or needs to obtain preventive medical care;
- The employee needs to care for a family member who has a mental or physical illness, injury, or health condition; needs a medical diagnosis, care, or treatment related to such illness, injury, or condition; or needs to obtain preventive medical care;
- The employee or family member has been the victim of domestic abuse, sexual assault, or harassment and needs to be absent from work for purposes related to such crime; or
- A public official has ordered the closure of the school or place of care of the employee's child or of the employee's place of business due to a public health emergency, necessitating the employee's absence from work.

Benefit Amount

Employees are compensated at the same hourly rate or salary and with the same benefits, including health care benefits. Overtime and bonuses are not counted.

Substantiation

For paid sick leave of four or more days, the employer may require reasonable documentation that the absence qualifies for sick leave benefits.

Accrual and Use of Leave

Each employee earns one hour of sick leave for every 30 hours worked, up to 48 hours of sick leave. An exempt employee is assumed to work 40 hours per week (or, if less, the number of hours in a normal workweek). An employer may front load the accrual at the beginning of the year or loan the accrual to an employee.

A successor employer must provide all leave to the employees it hired that they accrued with the original employer.

An employee:

- Begins accruing paid sick leave when the employee's employment begins;
- May use paid sick leave as it is accrued (i.e., there is no waiting period); and
- May carry forward and use in subsequent calendar years paid sick leave that is not used in the year in which it is accrued.

The leave can be taken in increments no smaller than one hour.

Employers are not required to pay the employee for any unused sick leave upon termination of employment.

For a rehired employee, sick leave is not forfeited unless more than six months has lapsed between the termination and rehire dates.

Employee Notice

When possible, the employee should inform the employer of the expected duration of the absence in advance and should make a reasonable effort to schedule the use of paid sick leave in a way that does not disrupt the operations of the employer.

PHA Leave

In addition to the paid sick leave accrued by an employee, the HFWA requires an employer to provide its employees an additional amount of paid sick leave during a public health emergency.

PHE leave is 80 hours (for employees who normally work less than 40 hours per week, the greater of the time the employee is scheduled to work in a 14-day period or the amount of the time the employee actually works on average in a 14-day period).

The reasons for PHE leave are an employee's need to:

1. Self-isolate due to diagnosis of a communicable disease causing a public health emergency;

2. Self-isolate due to experiencing symptoms of a communicable disease causing a public health emergency;

3. Seek or obtain medical diagnosis, care, or treatment if experiencing symptoms of a communicable disease causing a public health emergency;

4. With respect to a communicable disease causing a public health emergency, when a public official or health authority or the employer determines that the employee's presence on the job would jeopardize the health of others due to exposure or symptoms.

5. Seek preventive care concerning communicable disease causing a public health emergency.

6. Care for a family member who is experiencing items 1-5 above.

7. Care for a child family member whose childcare provider or school is unavailable due to a public health emergency, including when remote instruction is available.

Employers may count an employee's unused accrued sick leave under the regular provisions toward this supplemental paid sick leave.

Employees must notify the employer of the need to take leave as soon as practicable when the need is foreseeable and the workplace is not closed.

An employee may use PHE leave until four weeks after the official termination or suspension of the public health emergency.

Documentation is not required to take this leave.

General Provisions

Employer Notice

An employer may have reasonable procedures for the employee to provide notice when the need to take leave is foreseeable. However, an employer cannot deny leave on the basis of noncompliance with these procedures.

Employers are required to notify employees of their rights under the HFWA by providing employees with a written notice of their rights and displaying a poster detailing employees' rights under the HFWA.

Record Retention

Employers must retain records documenting, by employee, the hours worked, paid sick leave accrued, and paid sick leave used and make such records available to the Division of Standards and Statistics.

Confidentiality

The HFWA treats an employee's information about the employee's or a family member's health condition or domestic abuse, sexual assault, or harassment case as confidential and prohibits an employer from disclosing such information or requiring the employee to disclose such information as a condition of using paid sick leave.

Other Types of Leave

Employers, including public employers, that provide comparable paid leave to their employees and allow employees to use that leave as permitted under the HFWA are not required to provide additional paid sick leave to their employees.

Union Issues

Employees covered by a collective bargaining agreement would not be entitled to paid sick leave under the HFWA if the collective bargaining agreement expressly waives the requirements of the HFWA and provides an equivalent benefit to covered employees.

Employers that are signatories to a multiemployer collective bargaining agreement comply with the requirements of the bill by making contributions to a multiemployer paid sick leave fund, plan, or program based on the hours each of its employees accrues.

Anti-Retaliation

The HFWA prohibits an employer from retaliating against an employee who uses the employee's paid sick leave or otherwise exercises the employee's rights under the HFWA.

Enforcement

The director of the Division of Standards and Statistics will implement and enforce the HFWA and adopt rules necessary for such purposes.

Employer Action

- Employers not subject to the FFCRA's sick leave should immediately comply with the comparable provisions under the HFWA for Colorado employees.
- Employers should watch for further guidance and prepare for compliance on January 1, 2021.
  - Employers should arrange for continued coverage under their health plans during these types of leave.

New Fee Will Affect Premiums in New Hampshire

On August 5, 2020, the Centers for Medicare & Medicaid Services ("CMS") and the Department of the Treasury announced the approval of New Hampshire's request to implement a section 1332 State Relief and Empowerment waiver to promote stability in the state's individual health insurance market. The state will implement a state-based reinsurance program that runs from January 1, 2021 through December 31, 2025. The program is expected to reduce premiums in the individual market by approximately 16%. Part of the funding for the program will include a per member per month ("PMPM") assessment to be paid by health insurance and stop loss insurance carriers. For 2021, the assessment is $2.43 PMPM.

Employers sponsoring both insured and self-funded health plans with stop loss insurance will be directly affected as these costs likely will be reflected as an increase in group health insurance premiums and stop loss costs.

2021 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2021 health care expenditures required by the Improving Access to Medical Care Hotel Employees Ordinance, Seattle Municipal Code (SMC) 14.28.

Covered employers must make healthcare expenditures to or on behalf of covered employees (hourly employees who work an average of 80 hours or more per month for a covered employer) to improve their access to medical care. The amounts of the healthcare expenditure are adjusted each calendar year. Covered employers include those that own, control or operate either a Seattle hotel or motel with 100 or more guest rooms or an "ancillary hotel business" of 50 or more employees worldwide

For the 2021 calendar year (January 1 to December 31, 2021), the adjusted rates are:

- $437 per month for an employee with no spouse, domestic partner, or dependents
- $743 per month for an employee with only dependents
- $874 per month for an employee with only a spouse or domestic partner
- $1,310 per month for an employee with a spouse or domestic partner and one or more dependents

The Ordinance is effective July 1, 2020 or the next scheduled annual open enrollment period for health coverage (if offered) after July 1, 2020. 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, 20193, 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.

Employer Action

- Covered Employers subject to the Ordinance should prepare to comply with the law.
- If compliance is required with a plan year that begins in 2021 plan year, the adjusted rates should be used to determine appropriate expenditures.
- Include the adjusted rates of the expenditure as part of the annual notification required to covered employees.
- Monitor OLS FAQs and website for further information.

Mandated Long-Term Care Insurance Coming to Washington

This article has been updated to reflect new legislation (SSB 6267) that modifies HB 1087 to clarify the ability for individuals with existing long-term care insurance to opt-out of the premium assessment.

The State of Washington enacted H.B. 1087 (amended by SSB 6267) to establish the Long-Term Services and Supports Trust Program ("the Program") that creates a long-term care insurance benefit for certain qualified individuals. The Program will be funded by a new payroll tax.

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

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

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

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

An exempt employee (a person who has been granted a premium assessment exemption by the ESD, further discussed below) may never be a qualified individual.

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

Employees Exempt from the Program - New

An employee who attests they have long-term care insurance is permitted to apply for an exemption from the premium assessment. Under SSB 6267, an exempt employee is permanently ineligible for receiving benefits through the Program.

Employees who are 18 years old or older may apply for the exemption through ESD. ESD must accept applications for exemptions from October 1, 2021, through December 31, 2022, and is not required to verify the employee has long-term care insurance.

An exempt employee must provide written notification to all current and future employers of an approved exemption. If an exempt employee fails to notify an employer of an exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification is provided.

Employers must not deduct premiums after being notified by an employee of an approved exemption and must retain written notifications of exemptions received from employees. An employer who deducts premiums after being notified by the employee of an exemption is solely responsible for refunding any premiums deducted after the notification to the employee. The employer is not entitled to a refund from ESD for any premiums remitted to ESD that were deducted from exempt employees.

Next Steps

ESD and other agencies responsible for the administration of the Program will begin rulemaking to implement the long-term care trust fund and benefit. That guidance should help clarify the Program. Notably, it will be important for employers to understand the process for remitting premiums to the state beginning in 2022 and how employees apply for an exemption.

Seattle Hotel Employee Protections Ordinances Final Rules FAQ

The City of Seattle Office of Labor Standards ("OLS") finalized administrative rules to implement the four Hotel Employee Protections Ordinances passed in 2019. The rules are collectively referred to as the "Seattle Human Rights Rules Chapter 190" and were effective July 1, 2020.

One of the ordinances, 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 following Q&A provides pertinent details on the MC Ordinance requirements affecting Large Hotels and ancillary hotel businesses and is based on FAQs provided by OLS. This summary does not address the safety, security, and job retention rules that impose additional requirements on hotel employers. The complete FAQ from OLS also contains additional information related to collective bargaining agreements, retaliation prohibitions, and enforcement.

1. What is the Improving Access to Medical Care for Hotel Employees Ordinance?

This law requires covered employers to make healthcare expenditures to or on behalf of covered employees based on family/household size to increase their access to medical care. Healthcare expenditures can be made through monthly ordinary income payments, payments towards employer-sponsored health insurance, or payments to other things like health savings accounts, flexible savings accounts, and health reimbursement arrangements.

2. Which employers are covered employers and must follow this law?

This law applies to:

- Employers that own, control, or operate a Seattle hotel or motel with 100 or more guest rooms (referred to as a Large Hotel or Covered Hotel); and
- Ancillary hotel business employers with 50 or more employees worldwide.

An Ancillary Hotel Business is a business that has one or more of the following relationships with a Large Hotel:

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

3. Which employees are protected by this law?

The law applies to hourly employees who work an average of 80 hours or more per month for a covered employer. Hourly employees are those employees who are entitled to Seattle's Minimum Wage, Seattle Municipal Code 14.19. Employees can waive coverage by completing a Voluntary Ordinance (ORD) Waiver.

4. How does an employer determine whether an employee works an average of 80 hours or more per month?

An employer must make a reasonable estimate of the average monthly hours that the employee will work over the course of the calendar year, or over the course of the period of employment if the employee will be working for a period shorter than a year (e.g. temporary or seasonal work).

5. What are considered "hours" for the purpose of the calculation of an employee's average hours?

The law defines "hours" as:

- Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and
- Each hour for which the employee is paid, or entitled to payment, by the employer for a period during which no duties are performed due to vacation, illness, legally required paid leave, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

Employers are required to make retroactive payments resulting from underestimation of hours and may not recover overpayments resulting from an overestimation of hours.

6. How much is a covered employer required to spend on healthcare expenditures for each covered employee?

There are four monthly rates. The rate applicable to an individual employee is determined by the employee's family composition (regardless of actual enrollment). For 2020, the applicable rates are:

- Employee with no spouse, domestic partner or dependents (single employee) – $420;
- Employee with only dependents (any number) – $714;
- Employee with only a spouse or domestic partner – $840; and
- Employee that has both a spouse/domestic partner and dependents – $1,260.

These rates are adjusted each year based on a "medical inflation rate."

7. Does this law require an employer to provide health coverage to its employees?

No. This law does not mandate that an employer provide health coverage to its employees or regulate health insurance plans. These kinds of requirements are regulated by federal law.

8. Does an employee choose how the employer makes the expenditure?

No. The employer has the discretion as to which method(s) of the monthly healthcare expenditure they choose to make. Regardless of chosen method, the employer must satisfy the entire expenditure owed to the employee. If the payment toward one method does not cover the entire obligation, the employer must make up the difference via a different expenditure method. An employer is not obligated to make a final monthly required healthcare expenditure to or on behalf of an employee who separates from employment prior to the end of a calendar month.

9. Are there any circumstances in which a covered employer will be deemed to have satisfied its obligation to provide an expenditure, but not have made any payments?

There is one limited situation where this can occur. An employer will be deemed to have satisfied its obligation with respect to an employee if:

- The employer makes an offer of coverage through a group health plan that fully satisfies the monthly expenditure rate for the employee;

- The employee contribution is not more than 20% of the single employee healthcare expenditure rate (in 2020, $84/month) towards the employer-sponsored health insurance plan; and

- The employee voluntarily waives the offer of healthcare expenditure in writing using the OLS Voluntary Expenditure (EXP) Waiver Form.

NOTE: Employers must use OLS's EXP Waiver Form. This is a waiver of healthcare expenditures and is separate and distinct from a waiver of an offer of employer-sponsored health insurance.

10. What makes a Voluntary Expenditure (EXP) or Ordinance (ORD) Waiver valid?

The employee must fully understand their rights under the law and the waiver must be voluntarily completed by the employee without pressure or coercion from coworkers, the employer, or anyone connected to the employer. Employees must have the right to cancel the voluntary waiver during any annual open enrollment or due to a qualifying life event.

An electronic signature is acceptable on the EXP and ORD Waiver form so long as:

- The form is an exact replica of the official OLS EXP or ORD Waiver,

- The entire form is visible at the sign time the employee signs it (the information is not broken up into multiple click-through screens and/or the signature is not on a separate page), and

- No language on the website suggests the employee must sign the form.

Employers must keep a copy of the signed form for record retention requirements.

For a copy of the EXP Waiver Form (in English), visit https://www.seattle.gov/Documents/Departments/LaborStandards/Expenditure%20Waiver_14.28_Fillable.pdf.

For a copy of the ORD Waiver Form (in English), visit: https://www.seattle.gov/Documents/Departments/LaborStandards/Ordinance%20Waiver_14.28_Fillable.pdf.

11. What is the difference between the ORD Waiver and the EXP Waiver?

The ORD Waiver is appropriate when an employee is waiving their protections under the ordinance because they have coverage from another source, such as a spouse's employer's group health plan. The employee must identify the source of the other coverage on the ORD Waiver form.

The EXP Waiver is appropriate when the employee does not want to receive the expenditures in the form chosen by the employer, such as when an employee wishes to waive an offer of coverage at open enrollment.

Example. The employer plans to comply with the ordinance by covering married employees and their spouses and an employee only wants individual enrollment. The employer can request an EXP waiver from the employee to waive the required expenditure amount for a married employee. The employer may still offer self-only coverage to the employee.

12. What is the notice and posting requirements?

Employers must display one of two notice of rights posters that OLS will make available for electronic download on its website. One of the posters is for employees of hotels and one is for employees of ancillary hotel businesses. Employers must display the poster at any workplace or job site their employees work, in a visible and accessible location, in English and in the primary languages of employees at that workplace.

Additionally, on an annual basis, an employer must notify covered employees, including those who have previously waived their rights to the ordinance, of:

- The rate for which the employee is eligible,

- How an employee should notify the employer of a change that would impact the employee's rate,

- Which healthcare expenditure form(s) the employer will use to satisfy its obligations under the law, and

- If an employer uses payments into a tax-favored health plan to meet some or all of its obligations: information about the tax-favored health plan, how to access information about the plan, how to contact the plan administrator (if applicable), any carryover requirements, grace periods, and whether funds revert back to the employer at any time

13. Which kinds of third-party payments qualify?

A third-party payment is a sum of money paid to a third-party that is made for the purpose of providing healthcare services to the employee or to the employee's spouse, domestic partner, or dependents (if applicable). These kinds of third-party payments include, but are not limited to:

- Payments to an insurance carrier for health insurance coverage,

- Payments into a trust health plan, and

- Payments into a tax-favored health program that allows for reimbursement for out-of-pocket costs for healthcare services (HRA/FSA/HSA – see IRS Publication 969)

14. How does an employer with a self-funded plan determine if its expenditures meet or exceed the required rate for a given employee?

An employer may use the "monthly premium equivalent rate" (also known as a "premium budget rate") to estimate its average per-capita monthly expenditures. The "monthly premium equivalent rate" is the expected "average per-capita monthly expenditure." An employer that obtains an actuarial certification that verifies that its "monthly premium equivalent rate" is an accurate and reasonable estimate of its "average per-capita monthly expenditures" may rely upon its estimate for the purposes of determining whether it has met its healthcare expenditure obligation for a given employee. An employer that does not obtain an

actuarial certification must conduct an audit at the end of the plan year to verify that covered employees received the expenditure owed.

15.Where can I get more information?

- For the OLS website, including the posted notices and waiver forms (available in English and other languages), visit: https://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections/improving-access-to-medical-care-for-hotel-employees-ordinance

- For the complete FAQ from OLS, visit: https://www.seattle.gov/laborstandards/resources-and-language-access/resources/q-and-a

- For a copy off the MC Ordinance (SMC 14.28), visit: http://seattle.legistar.com/View.ashx?M=F&ID=7788303&GUID=380D112A-B3B6-45F9-A77A-EF9A5234D352

16.What are the next steps?

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. 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, 20193, 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.

Covered employers should:

- Post required notices available here: https://www.seattle.gov/laborstandards/ordinances/hotel-employee-protections

- Sign up on the City's website 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

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