MY BENEFIT ADVISOR

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Key ACA Taxes Repealed, but the PCOR Fee Is Back

Published: January 3, 2020

In a bipartisan effort, the U.S. Congress agreed on a spending package to fund the federal government which included important changes to federal laws affecting employer-sponsored group health and welfare benefit plans. The legislation was signed into law by the President on December 20, 2019.

The law repeals the following taxes under the Affordable Care Act ("ACA"):

- 40% tax on high cost health plans (a.k.a., the "Cadillac Plan Tax") after December 31, 2019.
- 2.3% medical device tax on sales after December 31, 2019.
- Annual Health Insurer Tax ("HIT") for calendar years beginning after December 31, 2020.

In an interesting turn of events, the new law reinstates the Patient-Centered Outcomes Research (PCOR) fee through September 30, 2029 for insured and self-funded health plans. Prior to enactment of this new law, many plans had paid their final PCOR fee as July 31, 2019 or were scheduled to pay their final assessment on July 31, 2020. With reinstatement of the fee, insured and self-funded plans will continue with these payments into 2029 and (in some cases) 2030. More guidance will be issued from the IRS as to future PCOR fee amounts and process.

The following chart illustrates the upcoming PCOR fee payments and deadlines.

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

The new law does not address "surprise billing," which can occur when healthcare services are provided by out-of-network doctors or specialists working at an in-network facility. The new law also does not address prescription drug pricing or health cost transparency. Congress may revisit these issues in 2020.

Employer Action

- Employers can breathe a sigh of relief as the Cadillac Plan Tax will no longer take effect on January 1, 2022. The repeal of the medical device tax and HIT tax will also provide some cost relief to employer sponsored plans.
- With the PCOR fee reinstated for ten more years, employers should continue to prepare for compliance. While insurance carriers will pay the fee for fully insured plans, employers are responsible for paying the PCOR fee for self-funded health plans, including health reimbursement arrangements ("HRAs").
    - It is expected that employers sponsoring self-funded health plans (including HRAs) will continue to use IRS Form 720 to file and pay the PCOR fee with an expected due date of July 31 of the calendar year immediately following the last day of the plan year.
    - The IRS is expected to issue an inflation adjusted amount to use for the next reporting period.

Overtime Pay Consequences of Common Employee Benefits

Published: January 21, 2020

On December 16, 2019, the Wage and Hour Division of the U.S. Department of Labor (DOL) published final regulations on "regular rate of pay" for overtime pay purposes under the Fair Labor Standards Act ("FLSA"). The final regulations address common employer-provided benefits as well as other workplace practices, which were not specifically addressed in previous DOL guidance.

Common Employer-Provided Benefits Addressed in DOL Final Regulations

The following benefits are excluded from "regular rate of pay" for overtime pay purposes:

- Employer contributions to an employee's health savings account (HSA) with a custodian or trustee, when such contributions are communicated to employees.

- Employer contributions to a benefit plan, where the primary purpose of the plan is to provide payment of benefits to employees on account of:
  - death,
  - disability,
  - illness,
  - hospitalization,
  - accident, or
  - legal services.

- Employer's cost to provide parking benefits to employees (e.g., parking spaces near the business premises of the employer).

- Reimbursements to employees for the following expenses incurred for the employer's convenience or benefit:
  - cell phone,
  - non-mandatory credentialing exam fees, or
  - organization membership dues.

- Payments for occasional periods when no work is performed, including:
  - family medical leave,
  - military service,
  - voting,
  - attending child custody or adoption hearings,
  - attending funeral services, or
  - any other paid leave required under state or local law.

The following benefits are excluded from "regular rate of pay" for overtime pay purposes, provided employee eligibility for the benefit does not depend on hours worked, services rendered, job performance, or other criteria based on the quality or quantity of the employee's work:

- Benefits from a self-funded employee benefit plan, including a self-funded health reimbursement arrangement (HRA).

- Employer's cost for the following conveniences furnished to the employee:
  - on-the-job medical care,
  - on-site treatment provided by specialists such as chiropractors, massage therapists, physical therapists, or personal trainers, or
  - counselors or Employee Assistance Programs.

- Employer's cost for providing wellness programs, such as:
  - health risk assessments,
  - biometric screenings,
  - vaccination clinics (e.g., flu vaccination),
  - nutrition classes or weight loss programs,
  - smoking cessation programs,
  - stress reduction or mental health wellness programs,
  - exercise programs,
  - coaching to help employees meet health goals, or
  - financial wellness programs or financial counseling.

- Employer's cost of providing gym access, gym memberships, and fitness classes furnished as a convenience to the employee.

- Tuition benefits, whether paid to the employee, an education provider, or a student loan program.

- Adoption assistance, including financial assistance, legal services, and information and referral services.

- Emergency childcare services provided by the employer in the case of unforeseen circumstances (e.g., when schools or daycare centers are closed for bad weather).

- De minimis gifts or prizes (e.g., coffee mugs or t-shirts) provided to employees in connection with a contest or raffle.

The following benefits are included in "regular rate of pay" for overtime pay purposes:

- Cash payments to an employee made in-lieu of receiving health insurance provided through employer contributions to a section 125 cafeteria plan.
- Commuter subsidies paid by the employer (other than employer-provided parking spaces and parking benefits).
- Childcare services provided by the employer on a routine basis.
- Surrogacy assistance from the employer, which tends to consist solely of payment or reimbursement of medical expenses (typically outside of a medical plan).
- Employer's payment of an employee's accumulated educational debt.

The DOL final regulations also address other important employer practices, such as pay for forgoing holidays, compensation for bona fide meal periods, call-back pay, and discretionary bonuses. The DOL acknowledges in the final regulations that it is impossible to address all of the various compensation and benefits arrangements that may exist between employers and employees, both now and in the future. The above list is therefore not intended to be exhaustive.

Employer Action

Employers should review the DOL's final regulations on "regular rate of pay" for overtime pay purposes under the FLSA and review their common employer-provided benefits to ensure compliance with the final regulations. For further assistance in evaluating the effect of the final regulations on their overtime pay practices, employers should contact their employment-law attorney or resource.

Family and Medical Leave Tax Credit Extended

Published: January 22, 2020

In the spending bill passed into law on December 20, 2019, the employer tax credit for paid family and medical leave was extended for one additional year. This tax credit was created under the Tax Cuts and Jobs Act of 2017 and was initially available for 2018 and 2019 only. The credit is now available through the end of 2020.

Background

The tax credit is available to certain employers as to FMLA-qualifying circumstances (whether under FMLA or not) for employees earning $78,000 or less for whom paid family and medical leave is provided. Nothing in the rules requires the employer to be subject to FMLA to receive the tax credit. Thus, it is available to employers with less than 50 employees. Notably, paid leave must be provided to both full-time and part-time employees in order to claim the credit; if part-time employees are excluded from a paid leave policy, this credit is not available.

Frequently Asked Questions

The following frequently asked questions provide additional detail of the Paid Family and Medical Leave Tax Credit.

Q1. What is the amount of credit?

The credit is generally 12.5% of the amount of wages paid to qualifying employees (although it increases by .25% for every percentage point an employee's FMLA wages exceed 50% of their normal wages, capped at 25%).

The credit is also capped with respect to each employee to the normal hourly wage rate of such employee for each hour
(or fraction thereof) of actual services performed for the employer multiplied by the number of hours (or fraction thereof) for which family and medical leave is taken. In the case of any employee who is not paid on an hourly wage rate, the wages of such employee are prorated to an hourly wage rate under regulations to

be established by the Secretary of the Treasury.

Q2. What form does this credit take?

The credit is in the form of a general business credit.

Q3. Which employers are eligible for the credit?

To take the credit, an employer must have in place a written policy that provides not less than 50% of the wages normally paid to such employee and:

- in the case of a qualifying employee who is full-time (customarily employed for at least 30 hours per week), provides not less than 2 weeks of annual paid family and medical leave; and
- in the case of a qualifying employee who is a part-time employee (customarily employed less than 30 hours per week), provides an amount of annual paid family and medical leave that is not less than a prorated amount. Note that many existing programs do not offer paid leave to part-time employees and thus would not qualify for the credit (unless there is no part-time workforce).

If an otherwise eligible employer (whether or not subject to FMLA) provides paid family and medical leave outside of what is required under FMLA to an eligible employee, there are protections it must ensure in order to take advantage of the tax credit. In that case, the otherwise eligible employer must provide paid family and medical leave in compliance with a written policy which ensures that the employer:

- will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy; and
- will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy.

All entities in the same controlled group under Code Sec. 52(a) and (b) (more than 50% common ownership) are treated as a single employer.

Q4. Which employees qualify?

An employee for whom a credit is available is any employee who:

- has been employed for at least one year; and
- had compensation of no more than $78,000 for 2020.

Q5. What circumstances qualify?

"Family and medical leave" means leave for any one or more of the following purposes whether the leave is provided via FMLA or by a policy of the employer:

- because of the birth of a son or daughter of the employee and in order to care for such son or daughter.
- because of the placement of a son or daughter with the employee for adoption or foster care.
- in order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition.
- because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.
- because of any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- to care for a servicemember as to an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember.

Vacation leave, personal leave, and medical or sick leave for any other purpose is not counted.

The IRS has clarified that an employer may take credit for paid leave provided under its short-term disability program.

Any leave which is paid by a state or local government or required by state or local law is not considered in determining the amount of paid family and medical leave provided by the employer.

Q6. What is the maximum amount of leave?

The amount of family and medical leave that may be taken into account is up to 12 weeks.

Q7. When is the effective date of the credit?

This credit was initially created for only 2018 and 2019 but has been extended through 2020.

A taxpayer may elect to have this section not apply for any taxable year.

Employer Action

Existing guidance for claiming the paid family and medical leave tax credit should carry forward through 2020.

Parking Tax Relief for Tax-Exempt Employers

Published: January 23, 2020

The Taxpayer Certainty and Disaster Tax Relief Act of 2019 was signed into law on December 20, 2019. The law repeals a provision under the Tax Cuts and Jobs Act that required tax-exempt organizations to include their costs for providing qualified transportation fringe benefits to employees in unrelated business income.

This relief is limited to non-profits. The elimination of the employer's deduction for qualified transportation fringe benefits for all other employers remains in effect.

California Individual Mandate, Penalty, and Reporting

Published: January 29, 2020

Beginning January 1, 2020, all California residents are required to have minimum essential coverage ("MEC") for every calendar month thereafter. A penalty applies to those residents who fail to comply with the individual mandate, unless they are considered exempt.

The new state law also requires employers (and other entities) that sponsor an employment-based health plan to file reports (similar to IRS Form 1095-C or 1095-B) with California's Franchise Tax Board on all California residents covered by the plan. These reports will enable covered employees and family members to avoid the individual mandate penalty. The initial deadline for filing reports with the Franchise Tax Board will be March 31, 2021, with respect to calendar year 2020.

The new reporting obligation for employers is subject to an important exception: if the group health plan is fully insured, and an insurance carrier is filing reports (similar to IRS Form 1095-B) with the Franchise Tax Board on covered employees and family members, then the employer does not have to file a report with the Franchise Tax Board on those same covered individuals.

California's Individual Mandate

The new state law creates a "minimum essential coverage individual mandate" under which California residents must be enrolled in and maintain MEC for each month beginning on or after January 1, 2020. The mandate does not apply, however, for any month in which an individual:

- Has a certificate of exemption for hardship or religious conscience issued by Covered California (which is California's insurance marketplace)
- Is a bona fide resident of another state or a U.S. possession
- Is an expatriate living outside of the U.S. who meets certain federal tax requirements
- Is a member of an Indian tribe

- Is not a citizen or national of the U.S., and is not lawfully present in the U.S.
- Is enrolled in limited or restricted scope coverage under the Medi-Cal program or another similar state program
- Is incarcerated (other than incarceration pending the disposition of charges)
- Is a member of a health care sharing ministry

For purposes of the mandate, MEC includes coverage under an employer-sponsored group health plan offered in connection with employment to an employee and related individuals (unless the plan is considered an "excepted benefit" such as limited scope dental or vision benefits that are offered separately). Other sources of MEC will also enable California residents to comply with the mandate.

California residents who fail to comply with the mandate for one or more months of the year will be liable for an "individual shared responsibility penalty" that is payable as part of their state income tax return. The penalty for the full year is equal to 2.5 percent of the individual's adjusted gross household income, but not less than $695 (adjusted for inflation), and not more than the state average premium for a bronze-level individual insurance policy from Covered California. California residents should contact their tax advisor for assistance in evaluating their personal situation, including whether they qualify to have the penalty waived if certain requirements are met.

Employer Reporting Obligation

The following entities providing MEC to a California resident during a calendar year are required to file a report (the "MEC report") with both the covered individuals and the Franchise Tax Board:

- An employer or other sponsor of an employment-based health plan
- An insurance carrier offering health coverage
- Covered California with respect to individual health insurance policies
- The State Department of Health Care Services and county welfare departments with respect to coverage under a state program
- Any other provider of MEC, including the University of California with respect to student health insurance coverage

Employers and other entities sponsoring an employment-based health plan are permitted under the new state law to enter into contracts with third-party service providers, including insurance carriers, to provide the required MEC reports.

The deadline for furnishing the MEC report to covered individuals residing in California is January 31 of the following year, while the deadline for filing the MEC report with the Franchise Tax Board is March 31 of the following year. MEC reports must be in a form to be specified by the Franchise Tax Board (but similar to IRS Form 1095-C or 1095-B).

Important exception: If an insurance carrier is filing a MEC report with the Franchise Tax Board on California residents covered under a group insurance policy, then the employer or other sponsor of the group health plan is not required to file a MEC report with the Franchise Tax Board on those same covered individuals.

Employers and other entities that fail to file the required MEC report with the Franchise Tax Board are subject to a penalty of $50 per covered individual.

Applicable Dates

- **January 1, 2020** – California's individual mandate becomes effective for state residents
- **January 31, 2021** – Deadline for providing MEC reports to individuals residing in California for calendar year 2020
- **March 31, 2021** – Deadline for filing MEC reports with the Franchise Tax Board for calendar year 2020

Employer Action

Employers that sponsor a group medical plan for employees and family members residing in California may want to include information about the California minimum essential coverage individual mandate and the individual shared responsibility penalty as part of its 2020 new-hire enrollment materials and annual open enrollment materials.

During late 2020 and each year thereafter, employers with a fully insured group medical plan covering employees and family members in California should confirm with their insurance carriers that the carriers are filing MEC reports with the Franchise Tax Board. If they are, then the employer is not required to file its own MEC reports with the Franchise Tax Board on those same covered individuals.

During late 2020 and each year thereafter, employers with a self-insured group medical plan should make arrangements to file MEC reports with the Franchise Tax Board either directly or with the assistance of a third-party vendor.

Additional guidance on MEC reporting is expected.

New Jersey Legislative Updates

Published: February 11, 2020

New Jersey Update Summary

New Jersey Issues Final Earned Sick Leave Law Regulations.

On January 6, 2020, the New Jersey Department of Labor & Workforce Development issued regulations regarding the enforcement of New Jersey's Earned Sick Leave Law (which took effect in October 2018). The regulations include many comments and responses that provide insight into the law's interpretation.

New Jersey Clarifies 2019 Individual Mandate Reporting.

The State of New Jersey has again updated the information related to employer reporting beginning in 2020 under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Employers (including out-of-state employers) who provided health coverage to New Jersey residents enrolled in self-funded group health plans must issue participant statements by March 2, 2020 and remit to the state by March 31, 2020 the same Forms 1095-C provided to the IRS for calendar year 2019. Employers with fully insured plans may generally rely on the insurance carrier to issue statements and file required information with the state. New Jersey has established the statement issuance date and filing deadline to coincide with recent IRS guidance for ACA reporting compliance.

New Jersey Amends the NJ WARN Act.

On January 21, 2020, New Jersey Governor Murphy signed legislation that greatly expands the reach and enhances the benefits under the Milville-Dallas Airmotive Plant Job Loss Notification Act (the NJ WARN Act). The law becomes effective July 19, 2020. Employers with employees in New Jersey should consult with employment counsel to ensure compliance with the Act when considering layoffs, closing a facility or transferring employees to a new location.

New Jersey Issues Final Earned Sick Leave Law Regulations

Late in October 2018, New Jersey's Earned Sick Leave Law (ESLL) took effect. Under the ESLL, employees can accrue one (1) hour of earned sick leave for every 30 hours worked, up to 40 hours a year. In November 2018, the State held a public hearing at which it discussed some proposed rules to help employers and employees better understand the provisions set forth in the ESLL.

Finally, on January 6, 2020, the New Jersey Department of Labor & Workforce Development (the "Department") issued regulations regarding the enforcement of the ESLL, including 118 separate comments and responses Although the final regulations contain minimal changes, the Department's responses to the public's concerns provide insight into how the Department interprets the law.

Please review our Compliance Update "New Jersey Enacts Paid Sick Leave" issued May 8, 2018 for a summary of the ESLL:

https://emersonreid.dmplocal.com/dsc/collateral/050818_P_ERC_New_Jersey_Enacts_Paid_Sick_Leave_Law_BRO.pdf

The following will discuss the final regulations issued this year.

Substantive Change: Benefit Year

In the final regulations, the Department clarified that an employer can establish multiple "benefit years" for employees rather than require each employer to establish a single benefit year for all employees. A benefit year is now defined as "the period of 12 consecutive months established by an employer in which an employee shall accrue and use earned sick leave." In the comments, the Department explains that an employer may utilize an employee's anniversary year as the benefit year for purposes of the ESLL.

Issues Addressed in Comments

In the Department's 118 comments and responses, a few clarifications were made on certain provisions of the ESLL. Below is a high-level overview of a few of these comments and is not intended to be an exhaustive analysis.

Collective Bargaining Agreements (Comments 1, 7, 73, 80, 94, 99)

The Department clarifies that employees represented by a union may accept earned sick leave benefits greater than or less than those provided in the ESLL or waive those rights as part of the collective bargaining process. The Department also interprets the ESLL as applying to the parties of an expired collective bargaining agreement immediately if not replaced by a new collective bargaining agreement.

Paid Time Off Policies (Comments 8, 9, 12, 65, 68, 72, 92)

When an employer is using a PTO policy to satisfy the ESLL's requirements, the Department explains that to comply with the law, an employer's PTO policy must: (a) permit an employee to use all of the PTO for reasons covered by the ESLL; (b) provide for accrual or advancement in accordance with the SLL's requirements; (c) allow employees to use the time off in accordance with the ESLL; (d) provide for payment of sick time in accordance with ESLL; and (e) provide for payout or carryover in compliance with the ESLL. Employers using the PTO policy to satisfy the ESLL must also comply with all ESLL Requirements for all PTO hours including documentation, notice provisions, and prohibitions against retaliation.

FMLA (Comment 10)

The Department explains that the terms of the federal Family and Medical Leave Act (FMLA) do not conflict with ESLL. The ESLL prohibits an employer from requiring an employee to use available earned sick leave.

New Jersey Issues Final Earned Sick Leave Law Regulations

Non-Discretionary Bonuses (Comment 5, 67)

The Department states that non-discretionary bonuses must be included in the calculation of ESLL compensation. The Department did not explain how employers can include these bonuses in calculating the rate of pay for the ESLL.

Temporary Staffing Firms (Comments 54, 83)

The final regulations clarify that in the case of a temporary staffing agency placing an employee with client firms, earned sick leave shall accrue based on the total time worked on assignment with the temporary agency, not separately for each client firm to which the employee is assigned.

120-Day Waiting Period (Comment 2)

The final regulations confirm that an employee, shall not be eligible to use earned sick leave until the 120th calendar day after the employment commences.

40 Hour Maximum (Comment 7)

The Department clarified that an employer shall not be required to permit an employee to use more than 40 hours of earned sick leave in any benefit year, regardless of how many hours have been carried over.

Employer Action

The final regulations and guidance do cover many other specific topics; therefore, it is advisable to review the comments and responses in their entirety. Employers should evaluate their ESLL and PTO policies with labor counsel to ensure compliance.

New Jersey Clarifies 2019 Individual Mandate Reporting

The State of New Jersey has again updated the information related to employer reporting beginning in 2020 under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Employers (including out-of-state employers) who provided health coverage to New Jersey residents enrolled in self-funded group health plans must issue participant statements by March 2, 2020 and remit to the state by March 31, 2020 the same Forms 1095-C provided to the Internal Revenue Service (IRS) for calendar year 2019. Employers with fully insured plans may generally rely on the insurance carrier to issue statements and file required information with the state. New Jersey has established the statement issuance date and filing deadline to coincide with recent IRS guidance for Affordable Care Act ("ACA") reporting compliance.

Background

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

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

Who Must Issue and File Required Forms

Forms are required to be issued to all primary enrollees no later than March 2, 2020 and filed with the state no later than March 31, 2020 on behalf of all part-year and full-year New Jersey residents for 2019. A part-year resident is an individual who lives in the state for at least 15 days in any month in 2019.

Certain employers and other providers of minimum essential health insurance coverage such as insurance carriers, multiemployer plans, government entities, etc. must file the forms with the New Jersey Division of Taxation no later than March 31, 2020. Currently, there is no plan to offer an extension. Filers or their representative must register and use MFT Secure Transport Services, the same system used to file Forms W-2, as the state will not accept mailed paper forms. Employers should only send Forms 1095-C to the state for individuals subject to NJ's individual mandate. While the state will accept 1095 data files containing records for individuals who are not New Jersey residents, employers should be cognizant that privacy and other laws may limit or prohibit sending sensitive information.

What Forms are Required by Whom

- Employers with Fully Insured Coverage: The insurance carrier will be required to file form 1095-B with the state for each covered member of the plan. Employers are not required to file with the state. The carrier should furnish Form 1095-B to NJ residents.

- Employers with Self-Insured Coverage: Employers should furnish Form 1095-C to covered members who are New Jersey residents. This likely overlaps with the federal requirement to furnish these Forms. Employers will file with the state Form 1095-C and must complete Parts I and III. The employer may file a Form 1095-B for any plan member who was not an employee during all of 2019. Small employers (less than 50 employees) will report coverage using form 1095-B.

- Employers Participating in a Multiemployer Arrangement: The plan sponsor will file Form 1095-B (or 1095-C) for each covered employee.

New Jersey Clarifies 2019 Individual Mandate Reporting

Employer Action

- Employers with fully insured plans should confirm that the insurer will issue Forms 1095-B to New Jersey primary enrollees by March 2, 2020. It's important to note that the IRS issued guidance relaxing the ACA reporting rules for insurance carriers who are no longer required to automatically issue Forms 1095-B to plan participants, although carriers must still file Forms 1095-B with the IRS.

- Employers with fully insured plans should confirm that the insurer will file the Forms 1095-B with the state no later than March 31, 2020.

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

- As New Jersey will not require that separate forms be prepared for adult children who were covered under their parents' group health plan, the state suggests that employees provide a copy of Form 1095-B or 1095-C to their adult children who reside in New Jersey. It is unclear at this time whether these adult children will need to submit proof of coverage when filing their New Jersey state tax returns in order to prove minimum essential coverage.

New Jersey Amends the NJ WARN Act

On January 21, 2020, New Jersey Governor Murphy signed legislation that greatly expands the reach and enhances the benefits under the Milville-Dallas Airmotive Plant Job Loss Notification Act (the "NJ WARN Act" or "Act"). The law becomes effective July 19, 2020. Employers with employees in New Jersey should consult with employment counsel to ensure compliance with the Act when considering layoffs, closing a facility or transferring employees to a new location.

Background

The NJ WARN Act requires private NJ employers generally in business for three or more years with 100 or more full-time employees (including out-of-state employees) to provide a notice at least 60 days in advance of a mass layoff, temporary or permanent facility closing (except in certain circumstances), or transfer of employees to another location.

Under the existing law, full-time employees are entitled to severance pay equal to one week of pay for each full year of employment when an employer fails to provide the requisite NJ WARN Act notice in a timely fashion.

Changes to the NJ Warn Act

The following are key changes to the NJ WARN Act effective July 19, 2020:

- The Act no longer distinguishes between full-time and part-time employees when determining the size of an employer subject to the Act and to whom a notice and severance benefits must be provided.

- Severance benefits of one week of pay for each full year of employment must be paid to each affected employee even when an employer issues the NJ WARN Act notice within the required timeframe.

- Notice must be issued to each affected employee at least 90 days in advance of a mass layoff, facility closing or transfer of employees to another location. Employers will be required to pay an additional four weeks of pay if they fail to provide employees with the full 90-day notice.

- The definition of a "mass layoff" changes and will consist of 50 or more qualifying terminations. All the employer's facilities/locations are considered when determining the number of employees who may be affected.

- Employees covered by a Collective Bargaining Agreement ("CBA") will receive the greater of any CBA severance benefit, or the benefit as required under the NJ WARN Act.

- The law provides certain protections for NJ workers upon a change of ownership or filing for bankruptcy protection.

- The definition of employer now includes a person who is involved in the decision-making process responsible for the employment action that gives rise to a mass layoff subject to notification, which could subject certain individuals to personal liability for NJ WARN Act failures.

Employer Action

New Jersey employers should review their internal policies and severance practices with counsel to understand the changes and ensure compliance with the NJ WARN Act.

Medicare Part D
CMS Notification Reminder

Published: February 18, 2020

Employers sponsoring a group health plan need to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

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

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

An employer with a calendar year plan (January 1 – December 31, 2020) must complete this reporting no later than Saturday, February 29, 2020.

Additional guidance on completing the form, including screen shots, is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

Deadline Extended for 2019 Forms 1095-C

Published: February 19, 2020

On December 2, 2019, the IRS issued Notice 2019-63, which provides:

- An extension of time, until **March 2, 2020**, for employers to provide Forms 1095-C to their full-time employees and other individuals; and
- An extension of relief from penalties for the 2019 reporting year for employers and other entities that make good-faith efforts to comply with the reporting requirements.

Notice 2019-63 does not, however, extend the deadline to provide completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) to the IRS (as described in Q/A-2 below). Nor does it provide any relief from providing Forms 1095-C to full-time employees ("FTEs"). This means that all Applicable Large Employers ("ALEs") must continue to provide Form 1095-C to any employee that was full time for any month of 2019.

However, the Notice provides an alternative furnishing method for Form 1095-B (and in some cases Form 1095-C), with relief from the 2019 Section 6055 reporting penalty, for:

- Insurance carriers that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019;
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019; and
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-C to covered individuals who were not full-time employees in any month of calendar year 2019.

Briefly, the alternative furnishing method allows carriers (and in some cases employers) to avoid 2019 Section 6055 penalties associated with a failure to furnish the applicable form to covered individuals by posting information to a website and timely providing the completed applicable Form upon request.

The following FAQs provide additional details.

Q1: What Was Extended?

2019 Forms 1095-C must be furnished to FTEs and other individuals by Monday, **March 2, 2020** (rather than by January 31, 2020).

This extension of time also applies to insurance carriers providing 2019 Forms 1095-B to individuals covered under an insured plan, and to employers providing 2019 Forms 1095-B to individuals covered under a self-funded health plan (but see Q/A-3).

The Notice states that the new deadline of March 2, 2020, will not be further extended by the IRS.

Q2: Were The Deadlines For Reporting To The Irs Extended?

No, the 2019 Form 1094-C and all supporting Forms 1095-C (and the 2019 Form 1094-B and all supporting Forms 1095-B) must be filed with the IRS by Tuesday, March 31, 2020, if filing electronically (or by Friday, February 28, 2020, if filing by paper). These deadlines **were not extended** as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C with the IRS must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: With The Indiviudal Mandate Reduced To Zero After December 31, 2018, Is There Any Relief When Furnishing A Form 1095-B?

Yes, but it is generally limited to Forms 1095-B (except as described in Q/A-4 below).

Because the individual shared responsibility penalty is reduced to zero for 2019, an individual does not need the information on Form 1095-B in order to compute his or her federal tax liability or file an income tax return with the IRS. (But see Q/A-7 below regarding individual healthcare mandates in certain states.)

The IRS will not assess a 2019 Section 6055 reporting penalty against reporting entities for failing to furnish Form 1095-B to covered individuals in cases where the following two conditions are met (Alternative Furnishing Method):

1. **Website posting.** The reporting entity posts a notice prominently on its website stating that responsible individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that they can use to contact the reporting entity with any questions.

2. **Provide form within 30 days.** The reporting entity furnishes a 2019 Form 1095-B to any responsible individual upon request within 30 days of the date the request is received.

Insurance carriers (and employers with self-funded plans) that take advantage of this relief must still provide the 2019 Form 1094-B and all 2019 Forms 1095-B to the IRS by the required deadline. In other words, while the carrier (or employer) will not be penalized by the IRS for not supplying covered individuals with Forms 1095-B with respect to their coverage (subject to the two conditions set forth above), the carrier (or employer) must still create Forms 1095-B and provide them to the IRS by the required deadline.

There is no relief from the penalties associated with a failure to file completed forms with the IRS.

Q4: Will The Alternative Furnishing Method Apply To Ales With A Self-Funded Health Plan?

No, except in one situation.

ALEs are still required to provide Forms 1095-C to employees who were full-time for any month of calendar year 2019. Nothing has changed with respect to this requirement, aside from extending the deadline to March 2, 2020. ALEs offering self-funded group health plan coverage must continue to furnish Forms 1095-C to their FTEs, with all applicable parts (I, II and III) of Form 1095-C completed.

Some ALEs who offer self-insured health plan coverage to individuals who are not FTEs (e.g., part-time employees) may consider using the alternative furnishing method with respect to Form 1095-C.

Furnishing Form 1095-C to Individuals Who Were NOT Full-Time Employees

The Notice does provide relief to ALEs required to furnish 2019 Forms 1095-C to individuals covered under a self-funded group health plan **who were not FTEs for any month of calendar year 2019.** In this limited instance, ALEs may use the alternative furnishing method and will not face 2019 Section 6055 penalties, provided the ALE meets two conditions (outlined in Q/A-3):

- Post a prominent notice on website stating the Form 1095-C (or 1095-B) is available by request; and
- Provide the Form 1095-C (or Form 1095-B) within 30 days of a request.

In most cases, the individuals targeted for this relief are those who receive Form 1095-C with Code 1G in line 14 of Part II. Examples of covered individuals who are not full-time employees for any month of the calendar year, but who may receive coverage under the employer's self-funded group health plan, include:

- Part-time employees covered under the plan.
- A spouse or child receiving COBRA coverage.
- A former employee receiving COBRA coverage who had a COBRA qualifying event in 2018 or earlier.
- Individuals covered under a self-funded retiree medical plan who retired in 2018 or earlier.

Even if an ALE takes advantage of this alternative furnishing method with respect to an individual covered by the self-insured group health plan who was not a full-time employee in any month of 2019, the employer must still submit completed Forms 1094-C and 1095-C to the IRS by the required deadline.

Q5: Is The Good Faith Penalty Relief Extended?

Yes, penalty relief is extended for employers and other reporting entities that report incorrect or incomplete information on Form 1094-C or Forms 1095-C, when these entities can show that they made good-faith efforts to comply with the information reporting requirements for 2019. This relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

Q6: What If The Submissions Are Late?

Employers that do not comply with the due dates for providing a return or statement to an individual or the IRS are subject to penalties (except as described in Q/A-3 and Q/A-4). Employers and other reporting entities should still furnish and file the forms, and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q7: Our Employees Reside In States With An Individual Healthcare Mandate. Are There Other Things To Consider?

A handful of states (including the District of Columbia) have enacted individual healthcare mandates that apply to residents. As part of this requirement, carriers and employers must provide statements to residents and reporting to the states to demonstrate minimum essential coverage and enable covered employees and other individuals to avoid state

penalties. States have either adopted (or are expected to adopt) the federal forms, 1095-B and 1095-C, to satisfy this requirement. While there may be limited federal relief with respect to furnishing these forms, carriers and employers may want to continue to provide these forms to covered employees and other individuals who are subject to a state mandate.

The following is a list of states (including the District of Columbia) with an individual healthcare mandate and effective dates for compliance.

State or Jurisdiction	Effective Date of Individual Healthcare Mandate	Employer Reporting Begins in 2020	Employer Reporting Begins in 2021
California	January 1, 2020		X
New Jersey	January 1, 2019	X	
Rhode Island	January 1, 2020		X
Vermont	January 1, 2020		X (however, employers may not be required to report coverage to the state)
Washington, DC	January 1, 2019	X	

Massachusetts established an individual mandate in 2007. Reporting to individuals is provided via Form 1099-HC. Employers with at least 6 employees who are residents of the state must file an HIRD. As the Massachusetts requirement predates these recent healthcare mandates and uses different reporting forms, it is not included on this list.

Q8: What About Future Relief?

The Notice asks for comments as to whether an extension of the due date to furnish Forms 1095-C (and Forms 1095-B) and continued extension of the good faith relief will be necessary for future years and why. There is information in the Notice on how taxpayers may submit comments.

Q9: Have Revised Forms 1094/1095-C And 1094-1095-B Been Released For 2019?

Yes. The IRS recently released draft Forms 1094/1095-C and 1094/1095-B information returns and instructions for calendar year 2019, but they have very few changes from the prior year's versions. Since they were released so late, there was much that there might be significant modifications to the forms and reporting requirements, perhaps related to the fact that beginning January 1, 2019, the penalty for an individual not maintaining MEC was reduced to zero. However, at least based on the 2019 draft forms and instructions, this is not the case. There were relatively few changes made from the prior year, as detailed below.

- **Draft 2019 Form 1094-C:** No changes.
- **Draft 2019 Form 1095-C:** No changes to the form itself.

  Identifying the "Plan Start Month" in Part II remains optional for 2019, although it may become mandatory for 2020.

The Instructions for Recipient on the back of the form had a few changes to reflect the elimination of the individual mandate penalty, and to underscore that information reported on the form is relevant to determining if an individual qualifies for subsidies through the Marketplace/Exchange. Changes include:

- deleting a statement that the information is reported on the form "to assist you in completing your income tax return"
- adding a statement that "[i]f you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit"Draft

2019 Instructions for Forms 1094-C and 1095-C:

In addition to routine updates to the furnishing and filing deadlines, and the dates used in examples, the following changes were made:

- deleting a reference that individuals reported to have MEC under a self-insured plan "are not liable for the individual shared responsibility payment for the months that they are covered under the plan"
- adding a statement that "[e]ligibility for certain types of minimum essential coverage can affect a taxpayer's eligibility for the premium tax credit"
- updating the calendar year penalty caps for the failure of an ALE to (1) file correct information returns, or (2) provide correct payee statements, to $3,339,000 each (from $3,275,500 in 2018)
- updating the applicable percentage for affordability safe harbors and the Qualifying Offer Method to 9.86% for plan years beginning in 2019 (from 9.56% in 2018)

Changes to the draft 2019 Forms 1094-B, 1095-B, and applicable instructions are similar to the changes described above.

Q10: What Should Employers Do Next?

Employers should consider the following:

- Employers should take note of the extended deadline, March 2, 2020, to furnish 2019 Forms 1095-C to full-time employees and other individuals.
- Final versions of the 2019 Forms 1094-C and 1095-C, along with relevant instructions, should be released soon. Hopefully, the final versions include additional guidance on the relief announced in this Notice.
- ALEs should complete Form 1095-C (including all relevant parts) and timely furnish the statements to full-time employees. ALEs should also timely transmit form 1094-C along with all Forms 1095-C to the IRS.
- Employers with fully insured plans should be aware that their carriers may not issue Forms 1095-B directly to covered employees for 2019. Individuals asking for a copy should be directed to the carrier. Employers should anticipate that covered employees residing in a state with an individual healthcare mandate may need to contact the carrier to obtain a Form 1095-B before filing a state income tax return.
- ALEs with self-funded health plans that extend coverage to individuals other than full-time employees should decide whether to continue to furnish Forms 1095-C as done in prior years, or to take advantage of the new alternative furnishing method with respect to those covered individuals, USI has identified a few administrative reasons why ALEs may be reluctant to adopt this new furnishing method for 2019:
  - While the Notice offers limited relief with respect to furnishing a Form 1095-C to covered individuals who were not full-time employees for any month of calendar year 2019, the ALE must ensure that Form 1095-C (including Part III) is completed and submitted to the IRS on behalf of these individuals. As the information must be included in the final submission, it is unclear whether taking advantage of the Section 6055 penalty relief makes any practical or administrative sense.

- Employers looking to take advantage of this relief will need to post the required notice on a website and provide the completed Form 1095-C within 30 days of a request. Failure to do so could subject to the employer to associated penalties.

- Given the timing of Notice 2019-63, vendors or other third parties that assist in preparation and distribution of 2019 Forms 1094-C and 1095-C may not be able to accommodate this new process.

- Employers with employees who reside in states with an individual healthcare mandate will want to work with vendors to ensure forms are provided and reported to the state in a timely and complete manner.

- While good faith penalty relief was extended under the Notice, be aware that the IRS is actively assessing fines associated with failures to file Forms 1094-C and 1095-C with the IRS by the deadline (as described in Q/A-2 above). Timely reporting remains an area of active IRS enforcement.

For reference, please review our December __, 2019 Bulletin with additional information on the reporting requirement:

https://emersonreid.dmplocal.com/dsc/collateral/120919_P_ERC_Deadline_Extended_for_2019_Forms_1095_C_BRO(1).pdf

2020 Federal Poverty Guidelines Announced

Published: February 25, 2020

HHS recently announced the 2020 Federal Poverty Level (FPL) guidelines which, among other things, establish the FPL safe harbor for purposes of the Affordable Care Act (ACA) employer mandate. For 2020, the FPL safe harbor is $103.99/month in the lower 48 states, $129.99/month for Alaska, and $119.64/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of affordability. As the FPL guidelines were announced after the start of the calendar year, plans beginning on January 1, 2020 use $101.79/month for the lower 48 states ($127.14 Alaska and $117.19 Hawaii), which is 9.78% of the applicable 2019 FPL. The increased threshold applies to plan years beginning on or after February 1, 2020.

Background

Large employers may be subject to the employer penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Marketplace. The FPL is relevant to this penalty in two ways:

1. Affordability Safe Harbor

For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. Subsidy Eligibility

An individual is only eligible for a subsidy in the Marketplace if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

Indexed Amounts

The following are the 2020 HHS poverty guidelines:

2020 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/ household	Poverty guideline
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120
For families/households with more than 8 persons, add $4,480 for each additional person.	

2020 Poverty Guidelines for Alaska	
Persons in family/ household	Poverty guideline
1	$15,950
2	$21,550
3	$27,150
4	$32,750
5	$38,350
6	$43,950
7	$49,550
8	$55,150
For families/households with more than 8 persons, add $5,600 for each additional person.	

2020 Poverty Guidelines for Hawaii	
Persons in family/ household	Poverty guideline
1	$14,680
2	$19,830
3	$24,980
4	$30,130
5	$35,280
6	$40,430
7	$45,580
8	$50,730
For families/households with more than 8 persons, add $5,150 for each additional person.	

Affordability Safe Harbor and Subsidy Eligibility 2019 Results

Based on new 2020 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $12,760 for a single individual for every state (and Washington D.C.) except Alaska or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is $103.99 (9.78% of $12,760/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is $12,760 – $51,040 for a single individual and $26,200 – $104,800 for a family of four for every state (and Washington D.C.), except Alaska or Hawaii.

DOL Penalties Increase for 2020

Published: February 26, 2020

The Department of Labor (DOL) published the annual adjustments for 2020 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2020

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

Description	2019 Penalty	2020 Penalty
Failure to file Form 5500	Up to $2,194 per day	Up to $2,233 per day
Failure of a MEWA to file reports	Up to $1,597 per day	Up to $1,625 per day
Failure to provide CHIP Notice	Up to $117 per day per employee	Up to $119 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$117 per day per violation (per participant/beneficiary)	$119 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,156 per failure	Up to $1,176 per failure
Failure to furnish plan documents (including SPDs/SMMs)	$156 per day $1,566 cap per request	$159 per day $1,594 cap per request
Genetic information failures	$117 per day (per participant/beneficiary)	$119 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$2,919 minimum	$2,970 minimum
Failure to meet genetic information requirements – not de minimis failures	$17,515 minimum	$17,824 minimum
Cap on unintentional failures to meet genetic information requirements	$583,830 maximum	$594,129 maximum

Employer Action

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

Coronavirus: Health Coverage and Employee Leaves of Absence

Published: March 11, 2020

This article has been updated from its original publication date. (Rev 04/01)

As the new coronavirus (COVID-19) continues to spread, many employees are wondering whether there is coverage under their medical plan and whether they can take a leave of absence. The following provides some high-level information intended to address these inquiries. This information is up to date as of March 31, 2020, is general in nature, and subject to change.

Health Coverage

According to the CDC, individuals who feel sick with fever, cough, or difficulty breathing, and have been in close contact with a person known to have COVID-19, or live in or have recently traveled from an area with ongoing spread of COVID-19 should call their healthcare professional. The healthcare professional will work with the state's public health department and CDC to determine if the individual needs to be tested for COVID-19. Keep in mind that tests associated with COVID-19 have not been readily available to date.

Is the Test Covered?

1. **General Coverage.** Under the Families First Coronavirus Response Act (the "FFCRA") testing for COVID-19 must be covered. This applies to all group health plans (e.g., skinny plans (preventive care only), reference-based pricing arrangements, and even grandfathered plans.
   Coverage for conditions related to COVID-19 may be subject to deductibles, coinsurance, etc.

   The plan document terms should be consulted.

2. **State Law.** Some states, including Alaska, California, New York, Oregon, and Washington, have gone further than the FFCRA. It is likely that other states have adopted (or will adopt) similar rules after this article was set for publication. This includes Colorado, Florida, Georgia, Hawaii, Maryland, Pennsylvania, and Utah.

These rules generally apply to fully insured health plans, including small and large group plans.

Self-funded group health plans subject to ERISA are not required to comply with state mandates. Employers with self-funded group health plans should work with their benefits consultants and third-party administrators to determine whether to adopt plan changes to align with the state action. In some situations, the carrier (or TPA) is asking employers with self-funded health plans to "opt-in to" (or to "opt-out of") of the enhanced benefit options.

3. **HSA-compatible QHDHPs.** A qualified high deductible health plan ("QHDHP"), in part, is a health plan with a minimum deductible ($1,400 for self-only coverage and $2,800 for coverage other than self-only for 2020). An individual with a QHDHP and no other disqualifying coverage may be eligible to establish and contribute to a health savings account ("HSA").

   Generally, a QHDHP may not provide benefits for any year until the individual meets the deductible for that year. However, there is a safe harbor that permits coverage for preventive care prior to meeting the deductible. The definition of preventive care is limited and includes:

   - ACA mandated preventive items and services;
   - periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations);
   - routine prenatal and well-child care;
   - immunizations for adults and children;
   - tobacco cessation and obesity weight-loss programs;
   - certain screening devices as listed in IRS Notice -2004-23; and
   - items and services associated with certain chronic conditions as identified in IRS Notice 2019-45.

   However, except as it relates to certain identified chronic conditions, preventive care does not include any service or benefit intended to treat an existing illness, injury or condition.

   At this point, it is not clear whether testing and treatment for COVID-19 is considered preventive care and therefore not subject to the deductible. Absent guidance from the IRS, QHDHPs should consider applying the deductible toward expenses associated with COVID-19 to preserve HSA-eligibility. Further guidance from the IRS would be helpful.

Other Benefits and Protections

1. **Disability benefits. Will a COVID-19 diagnosis trigger a short-term disability benefit?** Per the CDC, reported illnesses associated with COVID-19 range from mild symptoms to severe illness. Therefore, each employee will need to be evaluated on a case-by-case basis, depending on the individual's condition and the definition of disability under the terms of the plan. For example, someone who is asymptomatic but asked to stay home may not be eligible for disability benefits while someone who is hospitalized would be eligible.

   Employees in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico have access to state mandated disability leave.

2. **Leave**. Employers should evaluate whether employees with COVID-19 qualify for paid leave. Arizona, California, Connecticut, Washington D.C., Maryland, Massachusetts, Michigan, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington have different forms of paid leave laws (sick, family, and/or medical). In addition, paid leave may be available under a city law, employer policies, collective bargaining agreements, etc.

   Employees of employers with less than 500 employees may qualify for family medical leave due to childcare issues and/or sick leave under the FFCRA due to illness or quarantine.

   Employers should also evaluate whether employees with COVID-19 qualify for unpaid FMLA leave due to the employee's own serious health condition. Further, an employee may qualify for unpaid FMLA leave due to a family member's serious health condition.

Whether an employee on a non-FMLA leave is eligible to continue benefits will depend on the benefit plan and applicable law.

Employer Action

We can help with benefit related inquiries, but COVID-19 raises many other issues such as employment-related issues in which case employers should reach out to counsel.

For more information on COVID-19:

CDC dedicated website,
https://www.cdc.gov/coronavirus/2019-ncov/index.html

COVID-19 Federal Guidance and Proposed Legislation

Published: March 18, 2020

Treatment of expenses with Qualified High Deductible Health Plans

Since many states and health insurance carriers have implemented rules and policies to cover COVID-19 treatment and testing without cost-sharing, there has been concern that such first-dollar coverage would adversely impact individuals covered by qualified high deductible health plans (QHDHPs) with health savings accounts (HSAs). The IRS has issued guidance that provides relief in this situation. The guidance allows QHDHPs to provide medical care services and items associated with testing for and treatment of COVID-19 without a deductible or with a deductible below the minimum statutory threshold ($1,400 for self-only coverage and $2,800 for family coverage). The guidance also clarifies that where a QHDHP provides reimbursement for such expenses before the minimum statutory deductible is satisfied, individuals covered under the QHDHP will not be disqualified from HSA eligibility. This relief provided by the IRS does not change prior guidance regarding QHDHP requirements other than regarding testing and treatment of COVID-19 and does not expand the definition of preventive care. Should a vaccine for COVID-19 become available, it would be considered preventive care for QHDHP purposes because the guidance reminds us that vaccinations continue to be considered preventive care for the purpose of determining whether a health plan is a QHDHP.

COVID-19: Proposed Federal Legislation

The House passed legislation, called the Families First Coronavirus Response Act (the CRA), on March 14, 2020 that, if passed, would mandate testing for COVID-19, make changes to the Family and Medical Leave Act and make changes to paid sick leave policies. These provisions, if enacted, would only be temporary; taking effect within 15 days of enactment and continue through the end of 2020. The legislation will now move on to the Senate and the Senate Majority Leader has indicated that Republicans may support the House bill without further amendments. President Trump has also indicated he will sign this legislation.

With respect to testing, the CRA requires all employer-sponsored health plans to provide coverage for testing and other services that relate to COVID-19 without cost sharing, prior authorization and other medical management requirements.

The CRA provides that the tests and services include FDA cleared or authorized in vitro COVID-19 diagnostic tests, as well as items and services provided to an individual during health care provider office visits, urgent care center visits and emergency room visits that result in ordering or administering an in vitro diagnostic product.

With respect to employees taking leave, the CRA expands the FMLA requirements for leave and creates a federal paid sick leave law for U.S. employers with less than 500 employees ("Covered Employers"). The CRA provides refundable payroll tax credits for employers providing these leaves under the CRA due to COVID-19 through the end of 2020.

The CRA does not require an employee to meet the usual FMLA requirements, including working for 12 months, working for 1.250 hours or working in a location with at least 50 employees in a 75-mile radius. The CRA requires Covered Employers to temporarily expand FMLA protections and benefits to employees employed at least 30 calendar days that need leave because of reasons relating to COVID-19. The reasons for the leave are set forth as follows:

1. Where a public health official or health care provider recommends or orders leave for the employee because the employee's presence on the job would jeopardize the health of others; because of the exposure of the employee to COVID-19 or the employee exhibits symptoms of COVID-19 where the employee cannot perform their job and comply with the recommendation or order.

2. To care for a family member of the employee where a public health official or health care provider determines the family member's presence in the community would jeopardize the health of other individuals in the community because of the family member's exposure to COVID-19 or the family member's symptoms of COVID-19.

3. To care for the employee's child under the age of 18 if school or the child's place of care has been closed, or the childcare provider of such child is unavailable because of COVID-19.

The CRA also provides for paid leave for affected employees, requiring Covered Employers to pay the employee at two-thirds of the employee's regular rate of pay. The CRA does not require the first two weeks of leave be paid; employees can substitute PTO or other accrued leave for unpaid or partially paid periods, but Covered Employers cannot require this. The CRA does, however, provide for the possibility of regulations that could limit employers that the expanded FMLA provisions would apply to. These regulations could exclude certain health care providers and emergency responders from the definition of eligible employee; and could exempt businesses with under 50 employees if the CRA might jeopardize the viability of the business. With respect to job protection, the CRA does not require all Covered Employers to give such protection to all affected employees. A Covered Employer with less than 25 employees does not have to restore an affected employee to his or her position if the position ceases to exist, but such Covered Employer would be subject to other requirements such as including reinstatement to an equivalent position if one becomes available within a one year period.

The CRA would also require all Covered Employers (including those with less than 25 employees) to provide paid sick leave to all employees, even if employed less than 30 days. Covered Employers would be required to provide 80 hours of sick leave to full-time employees; and provide part-time employees with the number of hours averaged over a 2-week period. Such sick leave must be in addition to the sick leave the Covered Employer already provides. The CRA also includes a posted notice requirement regarding paid sick leave. Employees who would be eligible for the paid sick leave include those who need time off to:

a. self-isolate because the employee was diagnosed with COVID-19;
b. obtain a diagnosis or care if the employee is experiencing symptoms of COVID-19;
c. comply with an official order or recommendation because the employee was exposed to COVID-19 or has symptoms, or to care for or assist a family member in connection with (a) or (b) above; or

d. care for a child whose school or pace of care closes or whose childcare provider is unavailable.

New York Responses to COVID-19

Published: March 19, 2020

Emergency Sick Leave Legislation

On March 18, 2020 Governor Cuomo signed legislation (the "Act") that implements emergency sick leave benefits and job protection to employees who are subject to a mandatory or precautionary order of quarantine or isolation issued by a governmental entity ("Quarantine Period"). The Act is effective immediately.

In order for benefits under the Act to apply, an employee must (1) exhibit symptoms, or (2) have been diagnosed with a medical condition and be unable to work, even remotely, during the Quarantine Period. Benefits under this Act may not be payable if an employee returns from a country the Centers for Disease Control and Prevention issued a level two or three travel health notice and the travel was not business related. In that case, employees may use employer-provided accrued sick time or unpaid leave.

Generally speaking, the benefits under the Act are based on the size of the employer as of January 1, 2020. Employers with 1-10 employees and a net income of less than $1 million in the prior tax year are only required to provide unpaid sick leave during the Quarantine Period. The minimum requirements are as follows:

Employer Size	Minimum Sick Leave Requirements
Up to 10 employees with net income greater than $1M in the prior tax year	5 days of paid sick leave and unpaid leave thereafter
11 – 99 employees	5 days of paid sick leave and unpaid leave thereafter
100 or more employees and public employers	14 days of paid sick leave

Employers with up to 100 employees must allow employees to be eligible for NY Paid Family Leave and NYS Disability benefits after they have exhausted their paid sick leave under the Act. The Act expands the definitions of "disability" and "family leave" under NYPFL and NYS DBL to allow for disabilities and leaves due to a Quarantine Period.

The leave provided under the Act may not be credited against an employee's prior accrued leave and, upon returning to work after a leave taken pursuant to the Act, employees must be restored to their positions. Benefits may be payable concurrently upon the first full day of an unpaid Quarantine Period; however, the maximum weekly benefit an employee may receive is $840.70 for paid family leave benefits and $2,043.92 for disability benefits.

The federal government passed legislation including sick leave provisions which will need to be coordinated with benefits under the Act.

Employer Action

Employers should carefully review the Act's provisions, work closely with counsel and communicate with employees to ensure they receive any benefits under the Act to which they may be entitled. Employers subject to the New York City Paid Sick and Safe Leave Act must also ensure requirements of that ordinance are also being met. Employers subject to the NYC Paid Sick and Safe Leave Act must continue to comply with its requirements.

Although included in the Act, this summary does not include the Governor's comprehensive paid sick leave proposal contained in his executive budget, as it will not become effective until January 1, 2021. Further details will be provided at a later date.

Insurance Response

On March 2, 2020, Governor Cuomo issued a directive to New York health insurance carriers to take certain actions related to the COVID-19 outbreak and to remind insurers of their responsibilities under current law. The directive, issued in a Circular Letter by the Department of Financial Services, impacts fully insured plans in the small and large group markets and does not apply to self-insured plans.

At the time of this writing, the major insurance carriers have indicated that testing and other services related to COVID-19 will be covered with no member cost-sharing for insured plans. Employers should review the carrier's guidance with respect to their plans. Although the directive does not apply to self-insured plans, employers with self-insured plans can work with carriers and their third-party administrators and stop-loss carriers to implement similar actions.

Below are key points from the directive, many of which are simply reminders to carriers of what is already in place. It should be noted that the insurance industry and state and federal reactions to the outbreak continue to evolve and are subject to change.

- Carriers should devote resources to informing insureds of available COVID-19 benefits, including updating websites and staffing nurse helplines to handle the increased volume. All inquiries should be responded to in a timely fashion.

- Laboratory tests for COVID-19 are an essential health benefit and must be covered for small group health plans and will typically be available for large group health plans. Carriers are advised to waive any cost-sharing for COVID-19 laboratory tests received at an in-network provider office visit, urgent care center or for any emergency room visit. If in-network providers are unable to conduct testing, carriers must cover testing out-of-network.

- Carriers are reminded that New York laws prohibits carriers from excluding a service that is otherwise covered under a health insurance policy because the service is delivered via telehealth. Carriers are directed to ensure that their telehealth programs with participating providers are robust and will be able to meet any increased demand, as patients may be encouraged to seek treatment using telehealth services in lieu of office visits, due to the contagious nature of COVID-19.

- Carriers are directed to verify their provider networks are adequate to handle the increase in need for health services in the event more COVID-19 cases are diagnosed in New York, or to provide access to out-of-network providers at in-network cost-sharing rates.

- Utilization review decisions must be made in the timeframes required by law. Carriers should not use preauthorization requirements as a barrier to access necessary treatment for COVID-19 and should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate.

- If a vaccine become available, carriers should cover the immunization immediately with no patient cost-sharing.

- New York insurance law requires carriers that cover prescription drugs must provide access to non-formulary prescription drugs through a standard and expedited review process when the insured is suffering from a health condition that may seriously jeopardize the individual's health.

- Inpatient hospital services cannot be subject to an annual or lifetime limit since it is considered an essential health benefit.

- Pre-hospital emergency medical services are to be covered for the treatment of an emergency condition when such services are provided by an ambulance service.

- Carriers must hold harmless insureds who receive surprise medical bills for services related to testing and treatment of COVID-19.

We will continue to monitor developments around COVID-19 and will continue to update you.

California Insurance Response to COVID-19

Published: March 19, 2020

On March 5, 2020, the California Department of Insurance and California Department of Managed Health Care each issued guidance stating that commercial health insurance carriers and health maintenance organizations (HMOs) are immediately required to reduce cost-sharing (including copays, deductibles and coinsurance) to zero for all medically necessary screening and testing for coronavirus disease 2019 (COVID-19) (the "Guidance"). The Departments want to ensure that cost does not affect consumers' access to medically necessary screening and testing for COVID-19.

The Guidance applies to all commercial health insurance carriers and HMOs in California. It is not clear whether the Guidance applies to health insurance policies issued or delivered outside of California, but covering California residents. Self-insured group health plans are not required to comply directly with the Guidance.

Below are highlights from the Guidance of the requirements imposed on the carriers and HMOs as well as reminders about existing state laws:

- Immediately reduce cost-sharing to zero for all medically necessary screening and testing for COVID-19, including hospital, emergency department, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19.
- Notify all contracted providers about the waiver of cost-sharing for medically necessary COVID-19 screening and testing.
- Ensure the advice nurse line and customer service representatives clearly communicate this information to covered individuals who contact them about COVID-19 screening or testing.
- Prominently display a statement on their public website that cost-sharing is waived for medically necessary COVID-19 screening and testing, as well as guidance on how to access care.

- With respect to the carriers, inform the call center staff to advise covered individuals to call their provider's office or advice nurse line for instructions about how best to access care for COVID-19 screening and testing, prior to any in-person visit to a clinic or emergency department.

- All medically necessary emergency care must be covered without prior authorization, whether the care is provided by an in-network or out-of-network provider.

- Utilization review timeframes for approving requests for urgent and non-urgent services must be complied with. Insurance carriers and HMOs are strongly encouraged to waive prior authorization requests for services related to COVID-19 or, at a minimum, to respond to those requests quicker than the normal required timeframes.

- As more COVID-19 cases develop on California, ensure provider networks are adequate to handle an increased need for health care services, including offering access to out-of-network services where appropriate.

- Ensure covered individuals are not liable for unlawful balance billing from providers, including balance bills related to COVID-19 screening and testing.

- Work with providers to use telehealth services to deliver care when medically appropriate, to limit a covered individual's exposure to others who may be infected with COVID-19.

- Increase the capacity of contracted providers and facilities.

- In the event of a shortage of a particular prescription drug, waive prior authorization and step therapy requirements if the provider recommends a different drug to treat the condition.

We will continue to monitor developments around COVID-19 and will continue to update you.

Families First Coronavirus Response Act:
Signed into Law

Published: March 20, 2020

We recently advised you of proposed federal legislation responding to the COVID-19 pandemic. On March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act (the "CRA"). Subsequent to our March 18, 2020 Bulletin, the House made several technical corrections, narrowing some aspects of the original version of the bill, which is the version ultimately signed by President Trump.

As enacted, the legislation:

- Mandates all employer-sponsored health plans cover COVID-19 testing.

- For U.S. private employers with less than 500 employees and all public agency employers with 1 or more employees ("Covered Employers"), the Act:
  - Provides up to 12 weeks of leave under FMLA for eligible employees who have been employed for at least 30 days and unable to work (or telework) due to a need to care for a son or daughter under 18 years of age when their school or place of care has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID-19.
  - Creates a federal paid sick leave law providing for employer-paid leave of up to 80 hours to employees for COVID-19 issues.

The CRA does provide for the possibility of regulations that could limit employers to which the expanded FMLA provisions would apply. Such regulations may provide for the possible exclusion of certain health care providers and emergency responders from the definition of eligible employee or an exemption for businesses with under 50 employees if compliance might jeopardize the viability of the business.

The CRA's provisions mandating group health plan coverage for COVID-19 testing is effective immediately. The FMLA changes and paid sick leave take effect no later than April 2, 2020 and remain in place until the end of 2020.

Below are some important highlights from the final legislation.

Testing

The CRA requires all **employer-sponsored health plans** to provide coverage for testing and other services related to COVID-19 without cost sharing, prior authorization or other medical management requirements. The tests and services include FDA cleared or authorized in vitro COVID-19 diagnostic tests as well as items and services provided to an individual during health care provider office visits, urgent care center visits and emergency room visits that result in ordering or administering an in vitro diagnostic product.

Expanded FMLA

The CRA requires Covered Employers to temporarily expand (April 2, 2020 through December 31, 2020) FMLA protections and benefits to employees who have been employed 30 calendar days and need leave as a result of a school closure or closure of a childcare provider due to the public health emergency related to COVID-19. Employees are not required to meet the usual FMLA requirements, including working for 12 months, working for 1.250 hours or working in a location with at least 50 employees in a 75-mile radius. The final legislation narrowed the available leave and removed leave protections associated with an employee's own exposure or symptoms related to COVID-19 or that of a family member. Note, however, that traditional FMLA remains available, so employees can still take unpaid leave for their own serious health condition or that of a family member.

This new expanded FMLA leave includes both unpaid and employer paid leave. The first 10 days of the COVID-19 FMLA leave are unpaid (this is a change from the proposed legislation which allowed 14 days of unpaid leave). During this period of unpaid leave, an employee may elect to substitute any accrued vacation leave, personal leave, or medical or sick leave. After the 10-day unpaid leave period, Covered Employers must pay employees at two-thirds of the employee's regular rate of pay. The final legislation provides that the amount of such paid leave should not exceed $200 per day and $10,000 in the aggregate.

The final legislation includes a special rule that permits Covered Employers of employees who are health care providers or emergency responders to elect to exclude such employees from the application of these requirements.

While the job restoration provisions of FMLA generally apply with respect to this new COVID-19-related leave, there is relief afforded to Covered Employers with fewer than 25 employees. Specifically, such employers need not restore an affected employee to his or her position if the position ceases to exist, though such an employer will be subject to other requirements, including reinstatement to an equivalent position if one becomes available within a one--year period.

Paid Sick Leave

Covered Employers must also provide paid sick leave in connection with COVID-19. The CRA's paid sick leave provisions apply to all employees, even those employed less than 30 days, and apply to all Covered Employers. Under the final legislation, an employer may (but is not required to) exclude employees who are health care providers or emergency responders from the sick leave requirement.

An employee is eligible for paid sick leave under the CRA to the extent that the employee is unable to work (or telework) due to a need for leave because:

a. the employee is subject to a federal, state, or local quarantine or isolation order related to COVID-19.

b. the employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

c. the employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

d. the employee is caring for an individual who is subject to an order as described in (a) or has been advised as described in (2).

e. 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.

f. 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.

Covered Employers are required to provide 80 hours of sick leave to full-time employees, and provide part-time employees with the number of hours averaged over a 2-week period. The sick leave must be provided in addition to the sick leave the Covered Employer already provides.

The amount an employee is paid during this sick leave is based on the employee's required compensation and the employees' number of hours normally scheduled to work (with a special calculating rule for employees with varying hours). Generally, this means paid sick time is paid at the employee's regular rate of pay (or minimum wage, whichever is greater). However, the final legislation added a special rule permitting employers to use two-thirds of the employee's required compensation with respect to sick leave associated with family members ((d)-(e) above).

Further, the final bill includes a maximum amount of paid leave as follows:

- $511/day ($5,110 in the aggregate) for sick leave associated with (a), (b) or (c) above (generally the employee's own care).

- $200/day ($2,000 aggregate) for sick leave associated with (d), (e) or (f) above (care for a family member or other designated illness).

The CRA also includes a posted notice requirement related to paid sick leave. A model notice should be made available within 7 days of enactment (by March 23, 2020).

Potential Tax Credits

Beginning on a date to be determined between now and April 2, 2020 and ending on December 31, 2020, the CRA provides refundable payroll tax credits for employers providing paid family leave or paid sick leave wages required under the CRA due to COVID-19. The final rule includes credit for an employer's qualified health plan expenses allocable to wages associated with the respective leaves.

A refundable payroll tax credit is allowed for 100% of wage payments made under expanded FMLA, which, subject to further guidance, may include "qualified health plan expenses" allocable to such wages. However, for each employee, the credit is capped at $200 per day and $10,000 in the aggregate (or 50-day total limit).

A refundable payroll tax credit is also allowed for private employers for 100% of payments made for qualified paid sick leave wages, which, subject to further guidance, may include "qualified health plan expenses" allocable to such wages. However, this credit is limited in several ways:

- Wages taken into account are generally capped at $511 per day per employee.

- Wages taken into account are capped at $200 per day per employee for employees caring for a family member or for a child whose school or place of care has been closed.

- Only 10 days, in aggregate, may be taken into account.

Employer Action

- Testing: all employers should contact their carriers or TPAs to immediately implement coverage of COVID-19 testing with no cost-sharing, no prior authorization requirement, and no medical management requirements. Employers should also evaluate the extent to which plans must cover other items and services furnished in connection with the COVID-19 testing.

- Expanded FMLA: Covered Employers should review FMLA documentation and modify to reflect temporary COVID-19 requirements under the CRA. They should consider working with (if not already) an FMLA administration vendor to coordinate compliance with the CRA. Communications should be provided to employees explaining the new FMLA benefits for COVID-19 related leaves. They should also work with their payroll department or vendor to establish procedures for calculating and paying out for paid leave after first 2 weeks.

- Paid Sick Leave: Covered Employers should consider working with (if not already) a leave administration vendor to coordinate compliance with the CRA. They should post the DOL model notice (available March 23) and distribute an explanation on eligibility for paid sick leave. They should also work with their payroll department or vendor to establish procedures for calculating and paying out for paid sick leave.

- Tax Credits: Covered Employers should work with their payroll department or vendor to track payments under expanded FMLA or paid sick leave and work with them on how to calculate and claim tax credits through payroll tax filings.

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

Benefit Considerations in Light of Employee Terminations/Layoffs

Published: March 20, 2020

This article has been updated from its original publication date. (Rev 03/30)

Due to the COVID-19 pandemic, many employers are being forced to terminate, lay-off and/or reduce hours for employees. While this brings up a host of employment law issues that should be discussed with counsel, it also brings up various issues related to employers' benefit programs. Below is an overview of benefit-related issues that require attention.

Plan Eligibility

Most benefit programs require employees to be actively at work and/or to maintain a certain number of hours in order to be eligible for coverage. The terms of eligibility should be set forth in the plan's Summary Plan Description ("SPD"). If an employee does not maintain the required number of hours to be eligible for benefits, or is not actively at work, generally, a loss of benefits coverage results unless the employee is under protected leave, such as the Family Medical Leave Act. In some cases, plans and policies may include language that allows an employee to continue benefits as an active employee even when the employee is not meeting eligibility criteria on a short-term basis, such as during a layoff or unpaid non-FMLA leave. This type of continuation may be mandated by state law or through designed plan terms.

It is not advisable for an employer to simply leave an employee on its benefit plan if the employee is not actively at work or not meeting the hours requirement. The terms of the plan document govern the benefit plan and employers must follow these written terms to avoid ERISA fiduciary liability. It is also important to note that insurance carriers, including stop-loss carriers, may not cover claims incurred by individuals who were not satisfying the eligibility rules of the plan.

Employers should carefully review the termination provisions for each benefit program sponsored to understand when there is a loss of coverage as a result of a reduction in hours or layoff. Employers may also reach out to carriers to discuss and get approval for more generous coverage if appropriate.

COBRA

Employers that offer health plan coverage who have at least 20 employees are required to offer COBRA continuation coverage when there is a loss of coverage as a result of a termination of employment or a reduction in hours. COBRA applies to both fully and self-insured medical plans, dental plans, vision plans, EAPs, telehealth, many onsite clinics, health reimbursement arrangements (HRAs)and health flexible spending arrangements (FSAs) where the account is underspent (more contributions are made than reimbursements issued). Most of the time, the qualifying event (i.e., termination or reduction of hours) occurs and coverage will terminate at the end of the month in which the qualifying event occurred. Sometimes, plans may terminate coverage at the time of the qualifying event. If the qualifying event is termination of employment or reduction in hours, COBRA coverage extends for 18 months. States may have continuation coverage laws that lengthen this period of coverage (e.g., California and New York). COBRA coverage must be extended to all qualified beneficiaries (i.e., employee, spouse, children) who had health plan coverage on the day before the qualifying event. Employers should take note of notification obligations, payment and timing rules for COBRA.

Employers are permitted to charge a premium of 102% of the cost of coverage for COBRA, however they may charge less at their discretion. Employers should be careful, however, not to discriminate in setting the premiums. Employers can even subsidize some or all of the premium associated with COBRA coverage and may want to consult a benefits attorney to help set up a repayment plan with employees upon return to work. Employers should be careful where premium payments favor highly compensated individuals with a self-insured plan, as there could be potential discrimination issues which would cause the payment of the COBRA premiums to be treated as taxable income to those highly compensated individuals. Additionally, it is important to note that an individual has the opportunity to enroll in other coverage upon a loss of coverage such as a spouse's group plan or the Marketplace or other individual coverage. If the employer subsidizes the COBRA coverage for an employee for a few months, at the end of those months, there is some confusion as to whether the employee would have an opportunity to drop the COBRA coverage and enroll in another plan. While healthcare.gov appears to provide for an employee to be eligible for a special enrollment period in this situation, existing regulations do not support this. The employee could, of course, choose not to pay COBRA premiums at that time, which would terminate the COBRA coverage, but it will not result in a special enrollment event for the employee.

Premium Payments

If employees continue to stay on an employer's benefits plan while not actively at work, collecting premiums can be difficult. If an employee fails to pay, coverage can be terminated. There are several ways an employee may pay premiums while on a leave. Employers should review their SPDs and Employee Handbooks for policies and procedures. Generally speaking, employers can allow employees to catch up on their premium payments once they return to work, but state laws should be reviewed for limits of what can be deducted from pay. Of course, if the employee never returns to work, it may be difficult for the employer to recoup payments. Employers can also have employees pre-pay premiums before the start of the leave, but employers must be careful not to collect for too long of a period because they could violate the cafeteria plan regulations that prohibit deferred compensation. Finally, employers can require employees to pay their portion of premiums during their leave. In this case, these payments would be on an after-tax basis. If an employee is on paid leave, employers can collect premium amounts as they usually do through payroll deductions.

Full-Time Employees under the ACA

Applicable Large Employers, ALEs, (at least 50 employees) must identify their full-time employees (FTEs) for purposes of the Employer Mandate using either the monthly measurement method or look-back measurement method. Generally speaking, an individual with at least 130 hours of service in a month is considered an FTE. Whether an individual is considered an FTE or not is important for both penalty exposure and annual Forms 1094-C and 1095-C reporting. When an employer uses the look-back measurement method and employees are terminated and rehired, or when their hours are reduced, special rules come into play.

Termination and Rehire

When an employee is terminated and later rehired, the employee may be considered a new employee if the employee did not have any hours of service with the employer (including any commonly owned entities) for a period of at least 13 consecutive week (26 consecutive weeks for educational organizations). If the employee is treated as a new employee, upon rehire, the employer would not be subject to a penalty for the first three months of employment for the rehired FTE as long as affordable and minimum value coverage is offered at the end of the 3-month period.

If an employer is using the look-back measurement method and, under these rehire rules, the employee is a new variable hour, seasonal or part-time employee, the employer may impose a new initial measurement period to determine FTE status. If an employer is using the monthly measurement method and the employee is not a new hire under these rules, the employee is treated as a continuing employee. The employer has to offer coverage to an FTE who is a continuing employee by the later of the first day the employee is credited with an hour or service, or the first day of the calendar month following resumption of service. With the look-back measurement method, a continuing employee retains the status s/he had with respect to the applicable stability period. This status is reinstated upon the employee's resumption of services under the timeframes described above. Failure to offer a continuing FTE coverage within this timeframe could result in a penalty.

Reduction in Hours

A reduction in hours will affect FTE determinations differently depending on which measurement method an employer uses. Using the monthly measurement method, FTEs are determined by counting the employee's hours of service for each calendar month. If the employee averages at least 30 hours of service per week or 130 hours of service per month, the employee is an FTE for that month. Using the look-back measurement method, employees identified in the Standard Measurement Period as FTEs earn that status for a subsequent Stability Period regardless of what happens to their hours in the Stability Period as long as the employee remains the employee of the employer. If an employee has a reduction in hours in the Stability Period (usually during the plan year), it does not affect his or her status as an FTE.

When terminating employees, laying them off or reducing their hours, employers should keep good records and be aware of how it will affect their 2020 ACA reporting. Employers should also review SPD provisions regarding waiting periods when making decisions whether to waive those waiting periods when employees return to work.

California's Additional Response to COVID-19

Published: March 26, 2020

California has announced several more developments with respect to health insurance carriers and health maintenance organizations in California in addition to those we provided to you in our March 19, 2020 Bulletin. Below is a summary of these additional responses.

Payments of Insurance Premiums – Possible Relief

Recognizing that insureds may not be able to pay insurance premiums due to circumstances beyond their control, the California Department of Insurance has requested that all insurance carriers provide their insureds with at least a 60-day grace period to pay insurance premiums, to avoid cancellation of policies. This is not an order, rather it is a request that is directed to all admitted and non-admitted insurance carriers that provide any insurance coverage in California, including life, health, auto, property, casualty, and other types of insurance.

New Special Enrollment Period in Covered California

The California Department of Insurance and the California Department of Managed Health Care have ordered California's state marketplace, Covered California, to create a special enrollment period through June 30, 2020, for eligible uninsured individuals to obtain individual health insurance coverage. This same special enrollment period also applies to individual health insurance policies purchased outside of Covered California. As a reminder, individuals who qualify for Medicare or Medi-Cal are not eligible for individual health policies.

Coverage during this special enrollment period will be effective on the first day of the month following the date the premium payment is postmarked or delivered to the plan, whichever is earlier. For example, if an individual pays his/her premium on March 25, 2020, the effective date of coverage would be April 1, 2020.

The special enrollment period provides relief for employees who were not eligible for or chose not to enroll in their employer's group health plan, by enabling them to obtain insurance for healthcare expenses incurred in treating COVID-19 (as well as other healthcare services), as long as they reside in California and otherwise qualify for an individual insurance policy.

The order from the California Department of Insurance also applies to "health plans and health insurers offering coverage outside the health insurance benefits exchange." It is not entirely clear whether the order extends to employer-sponsored group plans and are hopeful the Department of Insurance will provide further guidance.

Filing Requirement for Insurance Carriers for Medically Necessary Treatment of COVID-19

The California Department of Insurance is requiring all health insurers operating in California to submit a notification describing how they are communicating with potentially impacted insured and summarizing the actions the insurer has taken (or is taking) to ensure the health care needs of insureds are met. This requirement does not apply with respect to self-insured group health plans. The notification must include information that demonstrates the insureds have access to medically necessary health care during the COVID-19 outbreak, including, but not limited to:

- Relaxing limits on waiting periods between refills so that insureds can maintain at least a 30-day supply of medication on hand (with the exception of refills for certain drug classes such as opioids, benzodiazepines and stimulants).
- Permitting conversion of 30-day prescriptions with multiple refills into one larger prescription (for example, allowing a prescription written as a 30-day supply with 2 refills to be filed as a single 90-day supply).
- Relaxing fill or refill supply limits imposed by the insurer, where the provider has indicated that a larger fill or refill is appropriate for the patient.
- Waiving delivery charges for home delivery of prescription medication.
- Assuring access by streamlining or eliminating processes for requesting prior authorization, step therapy exceptions, and exceptions for obtaining off-formulary drugs when a drug is unavailable due to supply chain disruptions or similar issues.
- Maximizing the use of telehealth in all appropriate settings by waiving or expediting any network provider credentialing, certification, or pre-authorization requirements.
- Permitting telehealth use by all types of providers, particularly providers of medical/surgical services and providers of mental health and substance abuse disorder services.
- Facilitating telehealth as an infection control measure through waiver of applicable cost-sharing for services provided by telehealth, even for services where cost-sharing might apply for in-person services or treatment.
- If care cannot be provided within the insurer's network, arranging for available and accessible providers outside the network, with the patient responsible only for an amount equal to in-network cost sharing.
- Adopting contingency plans if network providers (especially hospitals) are unable to provide care due to excessive demand related to the COVID-19 emergency, and effecting transfers to the nearest facility (in- or out-of-network) with the capacity to provide medically appropriate care.

HMO Voluntary and Mandatory Procedures

The California Department of Managed Health Care has published three All Plan Letters for HMOs (2020-07, 2020-08, and 2020-09) which contain guidance on social distancing, the provision of health care services during self-isolation orders and reimbursement for telehealth. Highlights of the guidance are as follows:

- HMOs should allow enrollees to receive at least a 90-day supply of maintenance drugs, unless the enrollee's provider has indicated a shorter supply of a drug is appropriate for the enrollee.
- HMOs should suspend prescription drug refill limitations where the enrollee's provider has indicated a refill is appropriate for the enrollee.

- HMOs should waive delivery charges for home delivery of prescription medications.

- For services provided via telehealth, the HMO must not require cost-sharing by the enrollee that is greater than the cost-sharing that would apply had the service been provided in-person. In addition, HMOs should (but are not required to) waive cost-sharing for care delivered via telehealth, even if cost-sharing applies whenever the provider delivers care in-person.

- If an HMO has pre-authorization (or pre-certification) requirements that contracted providers must meet before the HMO will cover care delivered via telehealth, the HMO should either expedite its review process or relax those pre-authorization (or pre-certification) requirements to allow the HMO to more quickly approve providers to offer services via telehealth.

- HMOs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, provided that the service is the same regardless of the method of delivery. For example, if an HMO reimburses a mental health provider $100 for a 50-minute therapy session conducted in-person, the HMO must reimburse the provider $100 for a 50-minute therapy session done via telehealth.

- HMOs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service had been rendered via video, provided the method by which the service is rendered (telephone or video) is medically appropriate for the enrollee.

- HMOs may choose to delay elective surgeries and other non-urgent procedures during this time, provided that the referring or treating provider (or, if applicable, the health professional providing triage or screening services) has determined that a longer waiting time will not have a detrimental effect on the enrollee's health.

- If an HMO does not have sufficient personnel to mail hard-copy notices and other information to enrollees and providers as required by law, the HMO may instead communicate with enrollees and provides electronically or by telephone.

Employer Action

Employers should consider sending a communication to employees residing in California who are not enrolled in the employer's group medical plan, informing them about the special enrollment period to obtain individual health insurance in California. Employers should also forward communications they receive from insurance carriers and HMOs summarizing their responses to changes in coverage to covered employees and COBRA qualified beneficiaries. Employers that are experiencing financial difficulties in paying their monthly group insurance premiums can contact their Account Executive for assistance in coordinating payment deadlines with their insurance carriers.

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

Resources

- Notice from the California Department of Insurance on the 60-Day Grace Period for Insurance Premium Payments (March 18, 2020), http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/upload/nr030-BillingGracePeriodNotice03182020.pdf
- California Department of Insurance press release discussing special enrollment in Covered California (March 20, 2020), http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/release031-2020.cfm
- California Department of Managed Health Care's All Plan Letters 2020-07, 2020-08, 2020-09, and 2020-10, https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
- Special enrollment at Covered California for the COVID-19 pandemic, https://www.coveredca.com/individuals-and-families/getting-covered/special-enrollment/
- California Department of Insurance COVID-19 State of Emergency Notification Filing Requirements, http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/CDI-Emergency-Notification-Filing-Requirements-COVID-19-3-18-2020.pdf

Initial Guidance on Payroll Tax Credits under the Families First Coronavirus Response Act

Published: March 27, 2020

On March 20, 2020, the Internal Revenue Service, Department of Treasury and Department of Labor announced that employers with less than 500 employees will be able to take advantage of two new refundable payroll tax credits which were created to immediately and fully reimburse them, dollar-for-dollar, for the cost of providing COVID-19 leave to their employees. These tax credits are provided under the Families First Coronavirus Response Act ("FFCRA"), signed by President Trump on March 18, 2020. The intent behind these tax credits is to enable employers to keep their workers on their payrolls and ensure they are not forced to choose between their paychecks and the public health measures necessary to combat the virus.

Briefly, the guidance provides:

- Employers will receive 100% reimbursement for paid leave;
- The credit includes health insurance costs;
- There will be no payroll tax liability for employers;
- Self-employed individuals are entitled to an equivalent credit; and
- Reimbursement will be quick and easy to obtain.

Eligible Employers

Eligible employers under the FFCRA are businesses and tax-exempt organizations with less than 500 employees that are required to provide emergency paid sick leave and emergency paid family and medical leave under the FFCRA. They will be able to claim these tax credits based on qualifying leave they provide to employees between April 1, 2020 and December 31, 2020. Credits are also available to self-employed individuals based on similar circumstances.

Paid Sick Leave Credit

Where an employee is unable to work or telework because the employee is quarantined, and/or where the employee is experiencing COVID-19 symptoms and seeking a medical diagnosis, eligible employers may receive a refundable sick leave credit for sick leave at the employee's regular rate of pay, up to $511 per day and $5,110 in total, for a total of 10 days.

For an employee who is unable to work or telework (1) because of the need to care for an individual subject to quarantine, (2) in order to care for a child whose school is closed or childcare provider is unavailable for reasons related to COVID-19, and/or (3) because the employee is experiencing substantially similar conditions as specified by the Department of Health and Human Services, eligible employers may claim a credit for two-thirds of the employee' regular rate of pay, up to $200 per day ad $2,000 in total, for up to 10 days. It is important to note that eligible employers are also entitled to an additional tax credit determined based on costs to maintain health insurance coverage for the eligible employee during the leave period.

Child Care Leave Credit

Eligible employers are also able to receive a refundable child care leave credit for an employee who has been employed at least 30 days and is unable to work or telework due to a need to care for a child whose school is closed, or child care provider is unavailable for reasons related to COVID-19. The credit shall be equal to two-thirds of the employee's regular pay, capped at $200 per day and $10,000 in total. Up to 10 weeks of qualifying leave can be counted towards the child care leave credit. Eligible employers are also entitled to an additional tax credit determined based on costs to maintain health insurance coverage for the eligible employee during the leave period.

Payment Process

In general, when employers pay their employees, they must withhold federal income taxes and the employees' share of Social Security and Medicare taxes from their employee's paychecks. Employers have to deposit these federal taxes, together with their share of Social Security and Medicare taxes, with the IRS and file quarterly payroll tax returns with the IRS.

Eligible employers who pay qualifying sick or child care leave will be able to retain an amount of the payroll taxes equal to the amount of qualifying sick and child care leave that they paid, rather than deposit them with the IRS. The payroll taxes that are available for retention include withheld federal income taxes, the employee share of Social Security and Medicare taxes, and the employer share of Social Security and Medicare taxes with respect to all employees. In the event there are not enough payroll taxes to cover the cost of qualified sick and child care leave paid, employers will be able to file a request for an accelerated payment from the IRS. The IRS expects to process these requests in two weeks or less. Further details regarding this process are expected soon.

Examples:

- If an eligible employer paid $5,000 in sick leave and is otherwise required to deposit $8,000 in payroll taxes, including taxes withheld from all its employees, the employer could use up to $5,000 of the $8,000 of taxes it was going to deposit for making qualified leave payments. The employer would only be required under the law to deposit the remaining $3,000 on its next regular deposit date.
- If an eligible employer paid $10,000 in sick leave and was required to deposit $8,000 in taxes, the employer could use the entire $8,000 of taxes in order to make qualified leave payments and file a request for an accelerated credit for the remaining $2,000.

Equivalent child care leave and sick leave credit amounts are available to self-employed individuals under similar circumstances. These credits will be claimed on their income tax return and will reduce estimated tax payments.

Exemption for Small Businesses

Businesses with under 50 employees may be exempt from the leave requirements relating to school closings or childcare unavailability due to COVID-19 where the requirements would jeopardize the ability of the business to continue, as indicated in the FFCRA. This relief will be available based on simple and clear criteria that make it available in circumstance involving jeopardy to the viability of an employer's business as a going concern. Emergency guidance and rulemaking will be released by the Department of Labor with details on this exemption.

Enforcement

The Department of Labor will be issuing a temporary non-enforcement policy that provides a period of time for employers to come into compliance with FFCRA. Under this policy, enforcement action will not be brought against any employer for FCCRA so long as the employer has acted reasonably and in good faith to comply with the FFCRA. The Department will focus on compliance assistance during the 30-day period.

Employer Action

Employers should be on the lookout for formal regulations from the IRS and Department of Labor with respect to this recent guidance and should discuss these new tax credits with payroll and tax advisors.

We are monitoring developments on the tax credits and will continue to keep you updated.

Special Enrollment Considerations During the COVID-19 Pandemic

Published: March 30, 2020

Several insurance carriers are communicating their intent to open a "special enrollment period" in connection with the COVID-19 pandemic. This special enrollment period would allow employees, who had previously failed to enroll in coverage for themselves, their spouses, and/or their children, to enroll in employer sponsored coverage. Carriers will permit employers to opt-in or opt-out of special enrollment periods. Below are considerations employers should review when determining whether to use these special enrollment periods.

- Without relief from the Department of Treasury, this type of special enrollment period would likely not be considered a status change event under Section 125 of the Internal Revenue Code. Until further guidance is issued, if an employer offers this special enrollment period, employees and dependents enrolling in coverage during one of these periods should remit contributions on an after-tax basis. Also note that, if an employer pays the cost of an accident or health insurance plan for its employees, including for an employee's spouse and dependents, the employer's payments are not considered wages and are not subject to Social Security, Medicare, and FUTA taxes, or federal income tax withholding.

- If employers offer this special enrollment period, plan documents, summary plan descriptions and other participant communications should be reviewed and updated to reflect this special enrollment period. Further, employers should consider communicating potential tax implications with participants.

- This type of special enrollment period may have a financial impact on an employer's health plan. Employers should weigh the consequences of possible adverse selection that may result from offering this type of special enrollment period with the potential benefits to their employee populations by making such coverage available.

- It should be noted that not all stop-loss carriers may allow for this special enrollment period, They may not agree to cover newly enrolled participants during this period, which may result in significant financial liability to the employers. Employers with self-insured plans should review their stop-loss policies and will likely need to have written authorization from stop-loss carriers

COVID-19 Stimulus Package: The CARES Act

Published: March 30, 2020

On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") into law. It provides support to individuals and businesses that are trying to cope with the coronavirus disease 2019 ("COVID-19") pandemic. We will likely continue to see additional legislation enacted in response to the COVID-19.

The majority of the 800 pages of legislation are aimed at providing relief for individuals and businesses that have been negatively impacted by the pandemic. This Bulletin will focus is on the parts of the CARES Act that are directed towards employee benefit plans and employee leaves of absence.

Briefly, the legislation:

- Expands coverage of COVID-19 testing and preventive services.
- Clarifies that plans and carriers will pay either the negotiated rate or the cash price, as listed on a provider's website, for COVID-19 testing.
- Allows high deductible health plans ("HDHPs") that are compatible with health savings accounts ("HSAs") with plan years before December 31, 2021 to cover telehealth visits prior to satisfaction of the minimum deductible.
- Provides that over-the-counter medicines and drugs are "qualified medical expenses" and may be reimbursed through a health FSA, HRA or HSA on a tax-favored basis without a prescription and expands the definition of "qualified medical expenses" to include menstrual products.
- Includes changes to paid sick leave and family leave provisions created under the Families First Coronavirus Response Act ("FFCRA").

The following provides highlights of the final enacted legislation with respect to employee benefit plans and employee leaves of absence and is not an exhaustive summary.

Coverage of Testing

The CARES Act builds on the insurance coverage provisions included in the FFCRA.

The FFCRA requires all employer-sponsored health plans to provide coverage for testing and other services related to COVID-19 without cost sharing, prior authorization, and other medical management requirements.

The tests and services include:

- In vitro COVID-19 diagnostic products that are cleared or authorized by the FDA, including their administration, and
- Items and services furnished to an individual during health care 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.

The CARES Act broadens coverage for COVID-19 tests and services under private plans beyond FDA-approved testing to also include coverage, without cost-sharing, for in vitro COVID-19 diagnostic products for which the developer has requested, or intends to request, emergency use authorization from the FDA, or that a state (which has told HHS it is reviewing such test) has authorized.

The CARES Act provides guidance that leaves open coverage for any "other test that the Secretary determines appropriate."

Reimbursement Rate for Testing

The CARES Act requires that group health plans (or insurers) reimburse providers at the negotiated cost of testing, where applicable, and for out-of-network providers, the group health plan (or insurers) must reimburse the provider at the cash price of the diagnostic testing, as reflected on the website. Providers are required to publicize the price of testing on a publicly available website. Providers who fail to publicize the price of testing will be subject to a fine not to exceed $300 per day.

Preventive Services

The CARES Act provides that if a preventive measure, defined as an "item, service, or immunization that is intended to prevent or mitigate COVID-19" (e.g., a COVID-19 vaccine) becomes available, group health plans must cover such preventive measure with no-cost sharing. The item or service must meet criteria under current U.S. Preventive Services Task Force ("USPSTF") guidelines or have a recommendation from the CDC with respect to an individual for whom the services are intended.

HSAs, FSAs and HRAs

The CARES Act provides much needed clarity with respect to Health Savings Accounts ("HSAs" and telemedicine. For plan years beginning on or before December 31, 2021, the CARES Act includes a safe harbor for high deductible health plans ("HDHPs") that permits pre-deductible coverage for telehealth and remote care services. As a result, HDHPs can allow all services provided through telemedicine or other remote care services to be covered prior to meeting the health plan deductible without jeopardizing an individual's HSA eligibility.

The CARES Act also repeals a rule enacted under the Affordable Care Act that prohibited over-the-counter medicines and drugs, other than insulin, from being qualified medical expenses without a prescription. For expenses incurred after December 31, 2019, participants may utilize HSAs, health flexible savings accounts ("FSAs,") or health reimbursement arrangements ("HRAs") to cover over-the-counter medicines and drugs (e.g., ibuprofen, cold medicines), without a prescription.

The CARES Act further provides that HSAs, health FSA, and HRAs, may be used to purchase certain menstrual care products (e.g., pads and tampons) on a tax-favored basis. These products will be treated as qualified medical expenses under the new legislation. This change applies to expenses incurred after December 31, 2019.

Paid Sick Leave and Expanded Family Medical Leave

The CARES Act provides a few clarifications and makes some relatively small changes to the paid sick leave and extended family leave provisions under FFCRA. The CARES Act:

- Provides for the exclusion of certain US government employers and executive branch employees for good cause;
    - Creates a new rule to define when a rehired employee may be considered an "eligible employee employed for at least the last 30 calendar days" under FFCRA. Under the CARES Act, a rehired employee, who would otherwise qualify as an "eligible employee employed by the employer" includes an employee who:
    - Was laid off by the employer on March 1, 2020 or later;
    - Had worked for the employer for at least 30 days in the last 60 calendar days prior to the lay-off; and
    - Has been rehired by the employer.
- Clarifies the amount of the paid leave benefit is "per employee" (e.g., $511/day/per employee).

The CARES Act includes provisions that are meant to improve the ability of employers to obtain advances on anticipated tax credits for employers for costs associated with paid sick and family leave. The Act allows employers to receive an advance tax credit from the IRS rather than having to be reimbursed on the back end. The CARES Act also provides penalty relief for failure to deposit tax amounts in anticipations of the credits.

Additional guidance from the IRS and DOL providing instructions on the process to obtain the tax credits and addressing additional questions and details on the expanded FMLA and paid sick leave provisions under FFRCA is expected in April.

Employer Action

Employers should:

i. ensure coverage for associated testing for COVID-19 is provided without cost-sharing or other limitation.

ii. confirm the health plan will pay either the plan's negotiated rate for the test, or the providers listed cash price. It appears this would limit a plan from imposing cost-sharing or balance billing in the event an individual received testing from an out-of-network provider; however, we await further guidance.

iii. consider waiving any copays associated with telehealth plans for plan years that begin before December 31, 2021 when offering an HDHP/HSA arrangement as such first dollar coverage is not disqualifying for a limited time.

iv. update documents and announce to employees that over-the-counter medicines and drugs can be reimbursed through tax favored accounts without a prescription and the expanded tax-free treatment of menstrual products.

v. review the FFCRA paid sick leave and expanded family leave requirements and note the changes made by the CARES Act.

We are monitoring developments and will continue to update you.

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

Published: March 31, 2020

On March 26, 2020, New Jersey Governor Murphy signed legislation that expands the Temporary Disability Benefits (TDB) and Family Leave Insurance (FLI) programs effective immediately. The law also provides for job protection under the New Jersey Family Leave Act (NJFLA) and expands the Earned Sick Leave Law.

Temporary Disability Benefits and Family Leave Insurance Programs

The law expands the definition of a "serious health condition" in response to the COVID-19 pandemic to include an illness caused by a public health emergency. Workers now have access to TDB and FLI if they are unable to work because they are diagnosed with or suspected of exposure to a communicable disease or they are taking care of a family member in the same situation. The bill does not specifically refer to COVID-19, therefore, this expansion applies to COVID-19 and any public health emergencies declared by the Governor or Commissioner of Health or other public health authority.

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

Earned Sick Leave

New Jersey's Earned Sick Leave ("ESLL") laws are expanded to allow the use of earned sick time for quarantine or isolation recommended or ordered by a health care provider or public health official as a result of suspected exposure to a communicable disease or to care for a family under the same situation.

Family Leave Act

The legislation modifies New Jersey's Family Leave Act so that the rights to reinstatement to employment provided also apply to those taking leaves for public health emergencies as provided for in the law.

Employer Action

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

DOL Guidance on Families First Coronavirus Response Act

Published: March 31, 2020

The Department of Labor ("DOL") has issued multiple forms of guidance including Fact Sheets, Questions and Answers, Posters, and a Field Assistance Bulletin to clarify and address the Families First Coronavirus Response Act (the "FFCRA"). Below is a summary of the highlights of the guidance. It should be noted that guidance from the DOL continues to be released.

Paid Leave under the FFCRA

Private employers with under 500 employees (and public employers) are required to provide two new types of leave to employees under the FFCRA. Please review our previous Bulletins for in depth information on these types of leave. Briefly, the employer must provide:

- 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 or telework 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 the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor; and

- Up to an additional 10 weeks of paid expanded Family and Medical Leave Act ("FMLA") leave at 2/3 the employee's regular rate of pay where an employee, who has been employed for at least 30 calendar days, is unable to work due to a bona fide need for leave to care for a child whose school or child care provider is closed or unavailable for reasons related to COVID-19.

When is the Effective Date of the New Leave Requirements?

The effective date is April 1, 2020, rather than April 2, 2020 as widely understood. The new requirements apply to leave taken between April 1, 2020 and December 31, 2020 and are not retroactive.

Paid leave provided for any qualifying reasons taken before April 1, 2020 does not count against the employee's leave entitlement under the FFCRA.

Once an employer shuts down its business for any reason (and whether or not the employer intends to reopen), employees will not be eligible for paid sick leave or expanded FMLA but may be eligible for unemployment insurance benefits. If an employee was already on paid sick leave or expanded FMLA when an employer shuts down its business, the employer must pay the employee for any paid leave used before the employer closed. Furloughed employees are not entitled for paid sick or expanded FMLA, but may be eligible for unemployment insurance benefits.

How do you Determine How Many Employees an Employer Has?

As stated above, the new leave requirements only apply to private employers with less than 500 employees. Employers should use the number of employees on the day the employee's leave would start to determine whether the employer has fewer than 50 employees for purposes of providing expanded FMLA and paid sick leave. Employers should:

- Count only employees within the United States.
- Include employees on leave and employees placed with the employer by a temporary agency.
- Controlled group rules do not apply. If one entity has an ownership interest in another entity, it is a separate employer unless it meets the (a) "joint employment" test, where two or more businesses exercise some control over the work or working conditions of the employee; or "integrated employer" test, where the factors to be considered are (i) common management, (ii) interrelation between operations, (iii) centralized control of labor relations, and (iv) degree of common ownership/financial control.

What Does "Employed for at least 30 Calendar Days" Mean for Expanded FMLA?

An employee will be considered employed by an employer for at least 30 calendar days if the employee was on the employer's payroll for the 30 calendar days immediately prior to the day the leave would begin. Where temporary employees have been working for an employer and are subsequently hired on a full-time basis, any days previously worked as a temporary employee may count toward the 30-day eligibility period.

When does the Small Business Exemption Apply to Exclude a Small Business from the FFCRA?

Employers with less than 50 employees are exempt from providing (a) paid sick leave due to school or place of care closures or childcare provider unavailability for COVID-19 related reasons and 9b) expanded FMLA due to school or place of care closures or childcare provider unavailability for COVID-19 related reasons when doing so would jeopardize the viability of the small business as a going concern. To claim this exemption, an authorized officer of the business must determine that:

- the provision of the paid leave would result in the small businesses' expenses and financial obligations exceeding available business revenues and cause the small business to cease operating at a minimal capacity;

- the absence of the employee(s) requesting paid leave would entail a substantial risk to the financial health or operational capabilities of the small business because of their specialized skills, knowledge of the business, or responsibilities; or

- there are not sufficient workers who are able, willing, and qualified, and who will be available at the time and place needed, to perform the labor or services provided by the employee(s) requesting paid leave, and these labor or services are needed for the small business to operate at a minimal capacity.

Who is a "Health Care Provider" who may be Excluded from Paid Leave under the FFCRA by their Employer?

For the purposes of employees who may be exempted from paid sick leave or expanded FMLA by their employer under the FFCRA, a health care provider is anyone employed at any doctor's office, hospital, health care center, clinic, post-secondary educational institution offering health care instruction, medical school, local health department or agency, nursing facility, retirement facility, nursing home, home health care provider, any facility that performs laboratory or medical testing, pharmacy, or any similar institution, employer or entity. The definition is extremely broad and includes any individual employed by an entity that contracts with any of the foregoing and anyone employed by any entity that provides medical services, produces medical products or is otherwise involved in the making of COVID-19 related medical equipment, tests and drugs.

Who is an "Emergency Responder" who may be Excluded from Paid Leave under the FFCRA by their Employer?

An emergency responder for purposes of being excluded from paid sick leave or expanded FMLA by their employer under the FFCRA is an employee who is necessary for the provision of transport, care, health care, comfort and nutrition of such patients, or whose services are otherwise needed to limit the spread of COVID-19. This includes, but is not limited to, military or national guard, law enforcement officers, fire fighters, emergency medical services personnel, etc.

How do you Count Hours for Part-Time Employees?

For purposes of paid sick leave under the FFCRA, a full-time employee is an employee who is normally scheduled to work 40 or more hours per week (the expanded FMLA does not distinguish between full and part-time employees). Part-time employees are entitled to leave for their average number of work hours in a two-week period. Hours of leave for both part-time and full-time employees are calculated based on the number of hours the employee is normally scheduled to work. If the normal number of hours is unknown, or if the employee's schedule varies, employers can use a six-month average to calculate average daily hours. In the event an employee hasn't been employed for at least six months, employers should use the number of hours they agreed upon with the employee to work upon hiring. If no agreement exists, employers may calculate the number of hours of leave based on the average hours per day the employee was scheduled to work over the entire term of his or her employment. Overtime hours must be counted, subject to 80-hour cap for sick leave.

What Does "Unable to Work Including Telework" Mean?

An employee is unable to work if his or her employer has work for the employee and one of the COVID-19 qualifying reasons set forth in the FFCRA prevents the employee from being able to perform that work, either under normal circumstances at their normal worksite or by means of telework. Employees may telework when their employers permit them or allow them to perform work at home or at a location other than their normal workplace. Normal wages must be paid for telework. If an employer and employee agree that an employee will work his or her normal number of hours, but outside his or her normally scheduled hours (for example, early morning or late night), then an employee is able to work, and leave is not necessary. If an employee becomes unable to telework because of one of the qualifying reasons for paid sick or expanded FMLA, the employee is entitled to take paid leave. Employers may allow intermittent paid sick and expanded FMLA while teleworking (unless an employee is teleworking, paid sick leave must be taken in full-day increments). Employers and employees are encouraged to collaborate to achieve flexibility and meet mutual needs.

How Much Should Employees be Paid for Taking Leave?

The answer to this depends on the employee's normal schedule and reason why leave is taken.

Employees are paid as follows:

- For paid sick leave based upon an employee's need for leave due to (1) federal, state, or local quarantine or isolation order related to COVID-19; (2) having been advised by a health care provider to self-quarantine due to concerns related to COVID-19; or (3) experiencing symptoms of COVID-19 and seeking medical diagnosis, the employee will receive for each applicable hour the greater of:
  - the regular rate of pay;
  - the federal minimum wage in effect under the FLSA; or
  - the applicable state or local minimum wage.

  The maximum is $511 per day, or $5,110 total over the entire paid sick leave period.

- For paid sick leave due to: (1) caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; (2) caring for the employee's child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons; or (3) experiencing any other substantially-similar condition that may arise, as specified by HHS, the employee is entitled to compensation at 2/3 of the greater of the amounts above.

  Under these circumstances, the employee is subject to a maximum of $200 per day, or $2,000 over the entire 2-week period.

- For expanded FMLA, the employee can take paid sick leave for the first 10 days of that leave period, or the employee may substitute any accrued vacation leave, personal leave, or medical or sick leave under the employer's policy. For the following 10 weeks, the employee will be paid at an amount no less than 2/3 of the regular rate of pay for the hours he or she would be normally scheduled to work capped at $200/day or $10,000 in the aggregate. The regular rate of pay used to calculate this amount is at or above the federal minimum wage, or the applicable state or local minimum wage.

The regular rate of pay used to calculate paid leave is the average of the employee's regular rate over a period of up to six months prior to the date on which leave is taken. If an employee has worked less than six months for the employer, the regular rate is the average of the employee's regular rate of pay for each week worked for the employer. Commissions and tips should be incorporated into these calculations.

Employers can pay employees in excess of FFCRA requirement, but they cannot claim (and will not receive tax credit for) those amounts in excess of the FFCRA's statutory limits.

Do Employers Have to Continue Health Coverage If an Employee is on Paid Sick or Expanded FMLA?

Yes, employees are entitled to continued group health coverage during these paid leaves on the same terms as if they continued to work.

Can there Be Multiple Qualifying Reasons for Leave?

Yes.

For paid sick leave, the 80 hours of paid sick leave is for one or more qualifying reasons; it is not 80 hours of paid sick leave per qualifying reason.

An employee may qualify for both paid sick leave and expanded FMLA, but cannot receive more than a total of 12 weeks of paid leave. Paid sick leave covers the first 10 workdays of expanded FMLA leave, which is otherwise unpaid. After the first 10 workdays, the employee will receive 2/3 of his or her regular rate of pay.

However, the employee will not receive more than $200 per day or $12,000 for the 12 weeks that include both paid sick leave and FMLA leave when on leave to care for a child whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons.

Can an Employee use its Employer's Preexisting Leave Entitlements and FFCRA Paid Leave Concurrently?

No. If an employee is eligible to take paid sick or expanded FMLA under the FFCRA, as well as paid leave that is already provided by the employer, unless the employer agrees, the employee must choose one type of leave to take and may not simultaneously take both, unless the employer agrees to allow the employee to supplement the amount s/he receives from paid sick leave or expanded FMLA, up to his or her normal earnings, with preexisting leave. If an employee chooses to use existing leave the employer has already provided, the employer may supplement or adjust the pay mandated under the FFRCRA with paid leave, but an employer cannot force an employee to use existing leave.

Can an Employer Require Employees to Adjust the FFCRA With Paid Leave Employees Already Have?

No. Under the FFCRA only employees may decide whether to use existing paid vacation, personal, medical or sick leave from the employer's paid leave policy to supplement the amount the employee receives from paid sick leave or expanded FMLA.

Is all FMLA Leave now Paid Leave?

No. Traditional FMLA leave (e.g., FMLA leave available for the serious health condition of the employee or employee's family member rather than related to childcare issues associated with COVID-19) remains unpaid.

Does taking paid leave under the FFCRA count against other types of paid sick leave or FMLA leave?

Paid sick leave under the FFCRA is in addition to other leave provided under federal, state or local law, an applicable collective bargaining agreement or an employer's existing company policy. With respect to family medical leave, an employee may take a total of 12 workweeks of leave during a 12-month period under the FMLA, including the expanded FMLA under the FFCRA.

What Happens if an Employee Takes Paid Sick Leave While in a Waiting Period for Health Coverage?

If an employee elects to take paid sick leave while in a waiting period for his or her employer's health coverage, the employee's health coverage will still take effect after s/he completes the waiting period on the same day the coverage would otherwise take effect even though the employee was absent from work on paid sick leave during the waiting period.

Employee Notice to Employer for Leave

Where leave is foreseeable, an employee should provide notice of leave to the employer as is practicable. After the first workday of paid sick time, an employer may require employees to follow reasonable notice procedures in order to continue receiving paid sick time.

What Notice Must Employers Provide to Employees?

Employers must provide a notice to employees regarding the new leave provisions as follows:

- The notice must be posted in a conspicuous place where employees can see it. For teleworking employees, this includes emailing, direct mailing, or posting to a website.

- There is no requirement to provide it in other languages, but the DOL is working on translations.
- The notice does not need to be provided to former employees, laid off employees, or job applicants, but must be conveyed to new hires.
- All covered employers (including those not normally covered by FMLA) are required to post the notice even if the state requires greater protections.

The notice can be found at: https://www.dol.gov/sites/dolgov/files/WHD/posters/FFCRA_Poster_WH1422_Non-Federal.pdf

Do Employers Need to Keep Records of Employees who Take Leave?

Employers must require employees to provide appropriate documentation supporting the reason for the need for paid sick and expanded FMLA. This documentation includes:

- the employee's name, qualifying reason for requesting leave, statement that the employee is unable to work, including telework, for that reason, and the date(s) for which leave is requested.
- the source of any quarantine or isolation order, the name of the health care provider who has advised the employee to self-quarantine.
- a notice posted on a government, school or day care website, or published in a newspaper, or an email from an employee or official of the school, place of care or childcare provider.

If employers intend to claim a tax credit under the FFCRA for its payment of the sick leave wages, they should retain this documentation in their records and should consult IRS applicable forms, instructions, and information for the procedures that must be followed to claim a tax credit.

What is the DOL's Temporary Non-Enforcement Period?

Field Assistance Bulletin 2020-1 offers a non-enforcement period to employers making a reasonable and good faith effort to comply with the FFCRA from March 18 to April 17, 2020. The Bulletin provides that the DOL will not bring enforcement action against any public or private employer for violations of the FFCRA during this 30-day window as long as the employer has acted reasonably and in good faith. For purposes of this relief, an employer will be found to be acting reasonably and in good faith when all of the following are met:

- The employer fixes any violations (including making employees whole) as soon as possible;
- Violations of the FFCRA were not willful, meaning the employer did not know its acts were in violation or did not act with reckless disregard as to its prohibited conduct; and
- The employer commits in writing to comply with the FFCRA prospectively.

For a copy of the DOL's Questions and Answers, visit https://www.dol.gov/agencies/whd/pandemic/ffcra-questions

San Francisco HCSO & FCO 2019 Reporting Cancelled

Published: March 31, 2020

In response to the COVID-19 pandemic, the San Francisco Office of Labor Standards Enforcement (OLSE) has canceled the requirement for employers to submit the 2019 Annual Reporting Form for the San Francisco Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance (FCO). This form would otherwise have been due by April 30, 2020 or face penalties of up to $500 per quarter.

All other requirements of the HCSO and FCO remain in effect. Covered employers must continue to make health care expenditures on behalf of their covered employees, generally within 30 days of the end of each quarter. The deadline for expenditures in the first quarter of 2020 is April 30, 2020.

As a reminder, the official HCSO Notice should be posted in a conspicuous place at any workplace or job site where covered employees work. The updated 2020 Notice is available in 6 languages at:

https://sfgov.org/olse/sites/default/files/Document/HCSO%20Files/2020%20HCSO%20Poster.pdf

New York Issues Guidance on COVID-19 Quarantine Leave

Published: April 2, 2020

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

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

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

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

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

Payment for Leave

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

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

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

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

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

Eligibility

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

Coordination of Leave

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

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

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

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

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

Job Protection

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

DOL Issues Temporary Rule: Regulations Regarding FFCRA Leave

Published: April 8, 2020

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

Background

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

Emergency Paid Sick Leave

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

Expanded FMLA leave

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

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

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

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

How Much Time of the EFMLEA is Unpaid?

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

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

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

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

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

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

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

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

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

The DOL's FAQs also provide the following definitions:

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

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

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

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

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

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

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

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

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

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

How Long Must an Employer Retain Records?

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

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

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

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

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

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

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

Published: April 15, 2020

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

Who is Subject to the Ordinance?

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

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

Which Employees Qualify?

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

Supplemental Paid Sick Leave

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

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

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

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

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

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

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

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

Exemption

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

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

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

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

IRS Guidance Issued on Tax Credits under the FFCRA

Published: April 16, 2020

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

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

How Does an Employer Claim the Tax Credit?

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

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

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

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

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

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

Are FFCRA Wages Taxable to Employees?

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

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

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

Which Qualified Health Plan Expenses are Eligible?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employer Action

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

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

FAQs on COVID-19 and Health Coverage

Published: April 17, 2020

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

Briefly, the FAQs provide:

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

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

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

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

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

Additional details are described below.

Background

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

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

Which Plans are Subject to FFCRA Coverage Requirements?

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

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

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

How Long do Plans Have to Provide this Coverage?

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

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

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

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

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

The guidance clarifies:

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

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

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

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

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

SBC Relief

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

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

Employee Assistance Plans Onsite Clinics as Excepted Benefits

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

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

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

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

Notice of Ancillary Coverage Termination

Published: April 20, 2020

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

Employers that Offer Group Life Insurance Coverage

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

Employers that offer Voluntary Benefits

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

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

Qualified Disaster Relief Payments

Published: April 21, 2020

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

Taxation

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

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

What Can These Payments be Used For?

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

Amount of Payments

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

Substantiation

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

Employer Action

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

Extension of Form 5500 Deadline

Published: April 22, 2020

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

Background

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

It is important to watch these adjusted deadlines carefully:

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

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

Employer Action

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

New Mandatory Preventive Items and Services

Published: April 23, 2020

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

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

Background

Non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. If a plan or carrier does not have in its network a provider who can provide the required preventive care item or service, the plan or carrier must cover the item or service when performed by an out-of-network provider, and may not impose cost-sharing with respect to the item or service.

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

New Preventive Items and Services

The newly covered items and services are as follows:

Effective for plan years beginning 2021

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

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

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

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

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

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

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

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

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

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

Effective for plan years beginning 2022

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

Rapid Coverage for COVID-19 Vaccine

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

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

Employer Action

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

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

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

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

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

COVID-19
Employer Obligations for Members of the Armed Services

Published: April 28, 2020

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

Background

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

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

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

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

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

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

Military Leave

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

Health Benefits

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

Can an Employer Terminate Coverage?

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

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

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

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

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

Layoffs

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

Reemployment

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

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

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

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

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

Employer Action

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

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

San Francisco Enacts COVID-19 Public Health Emergency Leave Ordinance

Published: April 28, 2020

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

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

Covered Employers

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

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

Eligible Employees

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

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

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

Amount of PHE Leave

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

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

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

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

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

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

Reasons for Taking PHE Leave

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

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

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

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

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

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

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

Payment of PHE Leave

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

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

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

Additional rules that apply to taking PHE leave:

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

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

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

Notice and Posting

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

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

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

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

COVID-19

Returning to Work and Benefit Eligibility Considerations

Published: April 29, 2020

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

Eligibility

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

Premium Payments

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

Cafeteria Plan Considerations

Restoring Previous Elections

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

Status Change with No Loss of Eligibility

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

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

ACA Considerations

Full-Time Status under the ACA

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

Hours of Service

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

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

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

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

Published: April 30, 2020

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

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

Definitions

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

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

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

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

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

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

Paid Sick Leave

Amount of Leave

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

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

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

Reasons for Taking Leave

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

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

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

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

Payment of Leave

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

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

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

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

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

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

Notice and Posting

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

New Guidance Offers Relief and Extends Deadlines for Benefit Plans

Published: May 5, 2020

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

Briefly, the guidance provides the following:

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

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

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

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

Final Rule

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

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

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

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

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

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

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

Employers should note:

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

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

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

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

1. **Electing COBRA**

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

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

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

2. **COBRA Premium Payment**

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

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

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

3. COBRA Premium Payment

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

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

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

4. Special Enrollment Period

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

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

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

5. Group Health Plan Claims

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

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

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

6. Internal Appeal – Disability Plan

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

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

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

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

Disaster Relief Notice 2020-01

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

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

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

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

The guidance also confirms:

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

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

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

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

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

COBRA Model Notices

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

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

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

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

Employer Action

Employers should:

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

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

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

- update COBRA General and Election notices, if necessary.

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

Published: May 12, 2020

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

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

Employers Subject to the Ordinance

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

Qualifying Employees

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

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

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

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

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

Supplemental Paid Sick Leave

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exemptions

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

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

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

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

Published: May 15, 2020

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

Briefly, the guidance:

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

IRS Notice 2020-29: Cafeteria Plan and HDHPs

Elections under a Cafeteria Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

Written Attestation Required When Coverage Is Dropped.

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

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

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

Extended Claims Periods for Health FSAs and DCAPs

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

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

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

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

Example 1

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

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

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

Example 2

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

Coordination with HDHPs

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

Plan Amendments

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

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

HDHPs

The IRS guidance makes the following clarifications to previous guidance:

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

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

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

IRS Notice 2020-33: Health FSA Carryover and ICHRAs

Maximum Carryover Increased to $550 for 2020 Plan Years

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

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

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

Individual Insurance Policies and ICHRAs

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

Employer Action

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

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

Annual Out-of-Pocket Maximum Adjustments Announced for 2021

Published: May 18, 2020

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

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

Change to the Out-of-pocket Maximums

Under the final rule, non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for 2021 as follows:

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

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

Change to Drug Manufacturer Support Policy

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

What Else Should you Know?

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

Proper Use of Premium Credits

Published: May 18, 2020

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

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

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

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

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

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

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

Using the principles outlined in DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

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

New York Enacts Paid Sick Leave Beyond the Pandemic Emergency

Published: May 21, 2020

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

Key features of the New York sick leave benefit include:

- Employers with less than 100 employees will be required to provide up to 40 hours of paid sick time per calendar year, although unpaid sick leave is required for employers with fewer than five employees and income less than $1 million in the prior tax year.
- Employers with 100 or more employees will be required to provide 56 hours of paid sick time per calendar year.
- Employees will accrue 1 hour of sick time for every 30 hours worked and will begin to accrue hours toward sick leave beginning on September 30, 2020 (180 days after implementation of the Act) or date of hire, whichever is later.
- Employees may begin taking sick leave under the Act as of January 1, 2021.

Coverage

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

Benefits

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

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

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

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

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

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

Accruals

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

Reasons for Leave

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

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

Family Members

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

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

Employee Rights

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

Employer Action

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

2021 Inflation Adjusted Amounts for HSAs

Published: May 22, 2020

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

Annual Contribution Limits

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

High Deductible Health Plans

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

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

Catch-up Contribution

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

Massachusetts DFML Releases Draft Updated Regulations

Published: May 29, 2020

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

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

New Definitions

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

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

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

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

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

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

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

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

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

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

Updated Definitions

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

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

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

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

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

Other Proposed Regulatory Changes

Covered Contract Workers

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

Contribution Penalties

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

Private Plan Updates

Application

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

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

Requirements for Exemption

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

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

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

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

Review of Denied Exemption

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

Retained Rights for Covered Individuals under Private Plans

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

Private Plan Termination or Non-renewal

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

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

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

Application for Benefits

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

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

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

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

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

Determinations

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

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

Weekly Benefit Amount

Reductions

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

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

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

Initial Seven-Day Wait Period

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

Substitution of Employer-Provided Paid Leave

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

Employer Reimbursement

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

Employer Action

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

Resources

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

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

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

Published: June 05, 2020

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

TDB and FLI

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

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

Earned Sick Leave

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

Family Leave Act

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

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

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

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

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

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

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

Employer Action

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

2020 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 12, 2020

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

The plan years and associated amounts are as follows:

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

Employers with self-funded health plans ending in 2019 should use the 2nd Quarter Form 720 to file and pay the PCOR fee by July 31, 2020. The information is reported in Part II. Note that, at the time of publication of this Bulletin, the revised Form 720 has not been issued. It is expected soon and should be used to file and pay the PCOR fee by the July 31, 2020 due date. No extension is currently available; however, we will update you if an extension is announced.

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

Transition Relief

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

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

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

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

Short Plan Years

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

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

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.

Philadelphia Expands Emergency Paid Sick Leave Benefits

Published: October 12, 2020

On September 17, 2020, Philadelphia passed the Public Health Emergency Leave Bill, which broadens the scope of Philadelphia's Promoting Healthy Families and Workplaces sick leave law by providing paid "public health emergency leave" to individuals who work within the geographic boundaries of Philadelphia, including individuals working for companies with 500 or more employees. The bill is intended to expand paid sick leave benefits to individuals who are not otherwise covered by the Families First Coronavirus Response Act (FFCRA).

Overview

Under the paid sick leave bill, "covered individuals" will be entitled to up to 112 hours of paid "public health emergency leave." A covered individual may use public health emergency leave for situations that mirror the FFCRA, including when the individual is unable to work because he or she is:

- Subject to a federal, state or local quarantine or isolation order related to the public health emergency;
- Advised by a healthcare provider to self-quarantine due to concerns related to the public health emergency;
- Experiencing symptoms related to the public health emergency and seeking a medical diagnosis;
- Caring for an individual who is subject to a federal, state or local quarantine or isolation order related to the public health emergency, or has been advised by a healthcare provider to self-quarantine due to concerns related to the public health emergency;
- Caring for a child of such covered individual if their school or place of care has been closed, or the childcare provider of such child is unavailable due to precautions taken in accordance with the public health emergency response; and/or

- Experiencing any other substantially similar condition specified by the United States Secretary of Health and Human Services in consultation with the United States Secretary of the Treasury and the United States Secretary of Labor.

Individuals who are able to telework are not entitled to public health emergency leave under the bill.

Employer Coverage

The Public Health Emergency Leave Bill covers all "hiring entities," which are broadly defined as any employer, individual, corporation or other entity that employs or pays wages to a covered individual for services rendered in Philadelphia, regardless of the entity's size or number of employees.

Covered Individuals

The Public Health Emergency Leave Bill defines "covered individuals" to include all employees and workers or independent contractors who perform at least 40 hours of services a year within the geographic boundaries of Philadelphia.

Notably, any individual who is entitled to paid leave under the FFCRA is not also entitled to paid leave under the Public Health Emergency Leave Bill from the same hiring entity. The bill also carves out certain exceptions for employees who are subject to collective bargaining agreements.

Amount of Leave

A covered individual who works 40 hours or more per week is entitled to the greater of 80 hours of leave or the average amount of hours that individual worked over a 14-day period, up to a maximum of 112 hours. Exempt employees under the Fair Labor Standards Act (FLSA) are generally assumed to work 40 hours in each week.

A covered individual who works fewer than 40 hours per week is entitled to leave equal to the amount of average hours worked in a 14-day period.

The following calculation should be used to determine the average number of hours in a 14-day period for covered individuals whose hours vary from week to week:

- A number equal to the average hours the individual worked per day over the 6-month period ending on the date the public health emergency was declared, multiplied by 14, including any hours for which the individual took leave of any type; or

- If the covered individual did not work over such period, the reasonable expectation at the time of hiring of the average hours the individual would normally work in a typical 14-day period.

Rate of Pay

Hiring entities must provide paid leave at the covered individual's regular rate of pay, with the same benefits (including health care benefits) as the individual normally receives from the hiring entity.

Timing of Leave

A covered individual may use all or a portion of his or her leave at any time during the public health emergency and for up to one month following the conclusion of the public health emergency. Leave may run concurrently with other forms of leave provided by state or federal law, unless otherwise prohibited.

The leave requirement under the bill is effective immediately but is set to expire on December 31, 2020.

Notice Requirements

A covered individual seeking paid leave must provide his or her hiring entity with notice of the need for leave as practicable and as soon as feasible. A hiring entity may only request the individual to provide a self-certified statement that the leave is to be taken in accordance with the bill. Additional details are needed about the employer's right or obligation to substantiate requests for leave.

Hiring entities are required to provide employees and covered individuals with notice of their right to public health emergency leave within 15 days of the bill becoming law.

Employer Action

Employers with employees performing service in Philadelphia should work with labor and employment counsel to review their leave policies and procedures to ensure that they are compliant with the amendments to the Promoting Healthy Families and Workplaces law.

Workers' Compensation Covers COVID-19 in California

Published: October 13, 2020

On September 17, 2020, California Governor Newsom signed Senate Bill 1159 into law. The new state law, which has an immediate effect, applies if an employee in California has a COVID-19-related illness during the period beginning March 19, 2020 and ending December 31, 2022. During this period, the employee's COVID-19-related illness is presumed to arise out of and in the course of employment and will be covered by the state workers' compensation system if certain additional requirements are met (unless the presumption is controverted by other evidence).

California employers should contact their workers' compensation carrier for details about the additional requirements that apply under SB 1159 with respect to their workers' compensation program.

As a result of the new state law, an employee in California who has a COVID-19-related illness that meets certain requirements would look to the state workers' compensation system for hospital, surgical, medical treatment, and disability benefits, rather than to the employer-sponsored group health and welfare benefit plan.

Employer Action

Whenever an employee in California has a COVID-19-related illness, the employer should coordinate with its workers' compensation carrier, and the insurance carrier or third-party administrator for its group health and welfare benefit plan, to ensure that the employee obtains hospital, surgical, medical treatment, and disability benefits for the COVID-19-related illness from the appropriate source.

New Jersey Issues Pre-Tax Transportation Benefit Rules

Published: October 14, 2020

On March 1, 2019, New Jersey established a transit benefit ordinance that requires employers to offer employees pre-tax commuter transit benefits, consistent with certain qualified transportation fringe benefits, as defined in Section 132(f) of the Internal Revenue Code.

Effective August 17, 2020, the New Jersey Division of Wage and Hour Compliance adopted rules for the transportation fringe benefit ordinance. Below are some highlights of the rules:

- A New Jersey employer with 20 or more employees, whether employed in New Jersey or not, for each working day during each of 20 or more calendar workweeks in the current or immediately preceding calendar year will be required to offer pre-tax transit benefits.
- An eligible employee is an individual who performs all service or some service in New Jersey however; certain conditions may need to be met.
- An employer may use payroll deduction to provide the pre-tax transit benefit, provided that the payroll deduction has been authorized by the employee in writing or is included in a collective bargaining agreement.
- Employers must maintain records for six years demonstrating compliance with the transit ordinance.

Background

Qualified transportation fringe benefits under Section 132(f) of the Internal Revenue Code allow an employer to provide commuter and transit benefits to their employees that are tax-free up to a certain limit. This employer-provided voluntary benefit program allows employees to effectively reduce their monthly commuting or transit costs. In 2020, the monthly limit is $270 for any commuter benefit or transit pass. While such benefits are tax-free to employees, under the 2017 Tax Cuts and Jobs Act, employers are no longer allowed a federal income tax deduction for qualified transportation fringe benefits.

New Jersey Requirements

A New Jersey employer with 20 or more employees, whether employed in New Jersey or not, for each working day during each of 20 or more calendar workweeks in the current or immediately preceding calendar year must offer a "pre-tax transportation fringe benefit" to its employees consistent with benefits found in Section 132(f) of the Internal Revenue Code. "Employer" does not include the federal government provided that the employee is eligible for a transit benefit through his or her employment with the federal government that is equal to or greater than a pre-tax transportation fringe benefit.

Employers must offer employees the opportunity to utilize pre-tax earnings up to $270 for 2020 to purchase commuter highway vehicle and transit benefits. Employers may use payroll deduction to provide these benefits with written permission from the employee, or if allowed under the terms of a collective bargaining agreement.

An employee under the law is identified as anyone hired or employed by the employer and who reports to the employer's work location, and mirrors the definition used in the unemployment compensation law. Employment includes an individual's entire service performed within, or both within and without, New Jersey if:

1. the service is localized in New Jersey; or

2. the service is not localized in any state but some of the service is performed in New Jersey and:
   - the base of operations, or, if there is no base of operations, then the place from which such service is directed or controlled, is in New Jersey; or
   - the base of operations or place from which such service is directed and controlled is not in any state in which some part of the service is performed, but the individual's residence is in New Jersey.

Employees covered by a collective bargaining agreement ("CBA") in effect on March 1, 2019 are exempt until the expiration of the CBA. Federal government employees who are offered a transit benefit from their employer are also exempt.

Recordkeeping and Penalties

Employers must retain records for six years to demonstrate that each eligible employee was offered the opportunity to use pre-tax earnings to purchase a pre-tax transportation fringe benefit.

Employers found to be in violation may be subject to a penalty of $100 - $250 for the first violation and $250 for all violations thereafter. An administrative penalty will not be imposed for the first violation if the employer demonstrates to the satisfaction of the Department of Labor and Workforce Development within the cure period (90 days following receipt of the violation notice) that it is complying with the ordinance.

Employer Action

Employers should determine whether their current employee demographic would require these benefits to be offered to their employees. Employers currently offering pre-tax transportation fringe benefits to employees should review their current program to ensure compliance with the New Jersey regulations.

Renewal Considerations

Potential Liability Exposures Due to COVID-19-Related Extensions

Published: October 20, 2020

Employees have an extended timeframe to, in part, elect COBRA, make COBRA payments, add dependents, and appeal denials of benefits. As the timeframe may extend beyond the current plan year, in some cases with coverage going into effect retroactively for many months, there are concerns about what gaps in insurance coverage there could be. This may particularly be an issue with stop loss insurance.

Employers must disregard the Outbreak Period, March 1, 2020 until 60 days after the announced end of the National Emergency, for each of the following topics below. At this point, an end to the National Emergency has not been announced, and it should be noted that the announced end date of the National Emergency may not be the same date as the end of the Public Health Emergency period announced by HHS (currently October 23, 2020). For purposes of the below examples, February 28, 2021 is used as the end of the Outbreak Period, but it may end earlier than this date, in which case the following examples are subject to the change.

COBRA: applies to all health plans of employers with 20 or more employees.

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

Potential Issues

- An employee fails to make a COBRA premium payment for the month of July 2020 by the end of July (missing the July 1 deadline and grace period under traditional rules). Under new rules, as long as s/he makes the payment by March 30, 2021, his or her July 2020 coverage must be reinstated.
- COBRA is an employer law, not a carrier law. If a participant is seeking coverage retroactively this far in the past, there could likely be a large claim. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Special Enrollment Rights: applies to major medical plans.

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

Potential Issues

- An employee has a baby on April 15, 2020. She could request enrollment to the medical plan in March 2021 for an April 15, 2020 effective date. Her employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.

- Carriers of insured plans are directly subject to the HIPAA Special Enrollment Rule. However, stop loss carriers are not. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Claims for Benefits: applies to all ERISA-covered plans.

- The date within which individuals may file a benefit claim as described under the plan's terms.

Potential Issues

- An employee did not make a timely claim under traditional rules for a medical service provided in June 2020. S/he could make a claim in April 2021 for reimbursement of the June 2020 expense. The employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.

- Carriers of insured plans and some third-party administrators ("TPAs") are claims fiduciaries. Who will adjudicate the claim? Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Appeals of Denied Claims: applies to all ERISA-covered plans.

- The date within which claimants may file an appeal for an adverse benefit determination. For health and disability claims, a claimant has 180 days, for all other claims 60 days.

Potential Issues

- An employee's claim for benefits is denied in April 2020. S/he misses the opportunity to appeal, resulting in a lack of exhausting administrative remedies and, thus, the inability to pursue the matter further under traditional rules. Employee appeals in April 2021.

- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

External Review: applies to all non-grandfathered major medical plans.

- The date the claimant may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination.

- The date within which a claimant may file information to perfect a request for external review.

Potential Issues

- An employee's claim for benefits is denied in April 2020. Employee misses the opportunity to request for an external review. Employee appeals in January 2021.

- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

Below you will find a breakdown of how these rules apply to each line of coverage.

MEDICAL CARRIERS (FULLY INSURED)	
All issues may apply: • COBRA • Claims for Benefits* • Appeals of Denied Claims* • External Review (only non-grandfathered major medical plans)*	Carriers are directly subject to the HIPAA Special Enrollment Rule.
MEDICAL STOP LOSS CARRIERS/ SELF-FUNDED MEDICAL PLANS	
• COBRA • Special Enrollment Rights • Claims for Benefits • Appeals of Denied Claims • External Review (only non-grandfathered major medical plans).	If the TPA has been appointed a claims fiduciary, which one will adjudicate claims should there be a change in carrier? Review stop loss coverage to determine coverage protections.
DISABILITY (ADVICE TO PAY)	
• Claims for Benefits • Appeals of Denied Claims	Not as worrisome, as the employer pays the claims regardless.
LIFE INSURANCE, DISABILITY (INSURED)	
• Claim for Benefits* • Appeals of Denied Claims*	
DENTAL, VISION (INSURED)	
• COBRA • Claims for Benefits* • Appeals of Denied Claims*	Not as worrisome due to limited liability.
DENTAL, VISION (SELF-FUNDED)	
• COBRA • Claims for Benefits • Appeals of Denied Claims	Not as worrisome due to limited liability.

* Carriers are claims fiduciaries, but which one will adjudicate claims, should there be a change in carrier? Informal responses from the major medical carriers suggest that, in a fully insured arrangement, the medical carrier at the date of service is responsible for the claims, assuming the extended emergency period timeline is met, premiums were paid, affected claims were for a covered service, and plan requirements are otherwise met.

Employer Action

Employers should consider the following:

For a currently insured medical plan going self-funded (or vice versa):

- Current carrier should adjudicate and pay claims, but best practice would be to so confirm.

For a currently self-funded medical plan remaining self-funded and with the same stop loss carrier and/or TPA at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules.

For a currently self-funded medical plan remaining self-funded but switching stop loss carriers and/or TPAs at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules;
- Establish which administrator (current or new) will adjudicate the claims.

2020 MLR Rebate Checks Recently Issued to Fully Insured Plans

Published: October 21, 2020

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

If a rebate is available, carriers were required to distribute MLR checks to employers by September 30, 2020.

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

This does not apply to self-funded plans.

What Do I Do with this MLR Rebate Check?

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

This does not apply to self-funded plans.

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

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

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

What will the Rebate Amount Be?

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

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

Will there be any Communication?

Yes.

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

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

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

What will the Form of Rebate to the Employer be?

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

When will the Rebate be Issued?

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

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

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

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

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

ERISA-covered group health plans

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

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

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

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

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

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

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

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

When do Rebates Need to be Made to Participants?

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

What is the Form of Rebate to Participants?

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

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

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

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

To recap, here are some options to consider:

- Reduce future premiums for current plan participants: This is administratively easy with limited tax issues with respect to participants.
- Cash payments to current participants: This is administratively burdensome and results in tax consequences to participants.
- Cash payments to former participants: This is administratively burdensome and results in tax consequences to former participants.

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

What are the Federal Tax Implications to Employees?

Pre-Tax Premium Payments

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

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

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

After-Tax Premium Payments

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

What are the Tax Implications for Employers?

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

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

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

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

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

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

California Expands COVID-19 Supplemental Paid Sick Leave

Published: October 22, 2020

On September 9, 2020, California Governor Newsom signed into law Assembly Bill No. 1867 (AB 1867). The bill addresses supplemental paid sick leave related to COVID-19 by codifying the existing paid sick leave available to food sector workers and creating a new type of paid sick leave for workers not already eligible for paid sick leave as a food sector worker under California law or under the federal Families First Coronavirus Response Act (FFCRA).

COVID-19 Food Sector Supplemental Paid Sick Leave

Effective April 16, 2020, Governor Newsom's Executive Order N-51-20 required "Hiring Entities" with at least 500 employees nationwide to provide their "Food Sector Workers" with up to two weeks of COVID-19 Supplemental Paid Sick Leave when those workers were absent from work for certain reasons related to the COVID-19 pandemic.

AB 1867 formally incorporates (or "codifies") Executive Order N-51-20 into California's legal codes by adding a new section 248 to the California Labor Code. The codified law imposes substantially the same obligations as the Executive Order, and is effective through December 31, 2020, or the expiration of the FFCRA, whichever is later.

COVID-19 Supplemental Paid Sick Leave

AB 1867 also adds a new section 248.1 to the California Labor Code, which requires every "Hiring Entity" to extend COVID-19 Supplemental Paid Sick Leave to "Covered Workers" who are not already eligible for paid sick leave related to the COVID-19 pandemic under the FFCRA or as a food sector worker under California law.

The requirements of the new law are effective September 19, 2020, through December 31, 2020, or the expiration of the FFCRA, whichever is later. However, if a Covered Worker is taking COVID-19 Supplemental Paid Sick Leave at the time the state law requirement to provide such leave expires, the person must be allowed to continue and complete the full amount of leave.

The California Labor Commissioner has published additional guidance on Supplemental Paid Sick Leave in the form of FAQs.

Hiring Entities and Covered Workers

A "Hiring Entity" is either:

- private entity that has 500 or more employee nationwide, or
- a public or private entity that employs health care providers or emergency responders, and that has elected to exclude such employees from emergency paid sick leave under FFCRA.

A "Covered Worker" is an employee who leaves his or her home to perform work for a Hiring Entity. Excluded from this definition are food sector workers who are eligible for COVID-19 Supplemental Paid Sick Leave under Executive Order N-51-20 and California Labor Code section 248.

Amount of Leave

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

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

Reasons for Taking Leave

COVID-19 Supplemental Paid Sick Leave is payable by a Hiring Entity when a Covered Worker makes an oral or written request to the Hiring Entity and is unable to work for one of the following reasons:

- The Covered Worker is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- The Covered Worker is advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19; or

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

Payment of Leave

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

- The Covered Worker's regular pay rate for the last pay period;
- The California minimum wage; or
- The local minimum wage that applies to the Covered Worker.

However, for a Covered Worker who is an active firefighter scheduled to work more than 80 hours in the two weeks preceding the leave, the COVID-19 Supplemental Paid Sick Leave is paid at the regular rate of pay as if the worker had been scheduled to work those hours, pursuant to existing law or applicable collective bargaining agreement.

The dollar amount payable as COVID-19 Supplemental Paid Sick Leave to any Covered Worker (including an active firefighter) is capped at $511 per day and $5,110 in the aggregate.

The amount of COVID-19 Supplemental Paid Sick Leave payable to a Covered Worker may be reduced or offset as follows:

- If a Hiring Entity already provides the Covered Worker with a supplemental benefit (such as supplemental paid leave) that is payable for the reasons listed above, and provides compensation that is equal to or greater than the amount of compensation that the Covered Worker would otherwise be entitled to receive as COVID-19 Supplemental Paid Sick Leave, then the Hiring Entity receives credit for those hours toward COVID-19 Supplemental Paid Sick Leave.
- Additionally, if a Hiring Entity already provided supplemental paid leave between March 4, 2020 and September 19, 2020, for a reason listed above, but did not compensate the Covered Worker in an amount equal to or greater than the amount of compensation required for COVID-19 Supplemental Paid Sick Leave, the Hiring Entity may retroactively provide supplemental pay to the Covered Worker to satisfy its compensation obligations, and receive credit for those hours toward COVID-19 Supplemental Paid Sick Leave.

It is important to note that the total number of hours of COVID-19 Supplemental Paid Sick Leave that a Covered Worker is entitled to receive is not reduced or offset by any California Paid Sick Leave available to the person under California Labor Code section 246. Further, a Hiring Entity may not require a Covered Worker to use any other paid or unpaid leave, paid time-off, or vacation time provided by the Hiring Entity before the Covered Worker uses – or in lieu of – COVID-19 Supplemental Paid Sick Leave.

Notice and Posting

The California Labor Commissioner has published a model notice (linked below) that Hiring Entities must post in a conspicuous location in the workplace. The FAQs on Supplemental Paid Sick Leave state that if a Hiring Entity's Covered Workers do not frequent a workplace, the notice requirement can be satisfied by delivery through electronic means, such as e-mail.

Employers must also give covered employees notice of the available amount of supplemental paid leave either in the wage statement or a separate writing provided on designated pay dates.

New York City Amends Safe and Sick Leave

Published: October 23, 2020

On September 28, 2020, Mayor Bill de Blasio signed into law amendments to New York City's Earned Safe and Sick Time Act ("ESSTA") to more closely align with the New York State Paid Sick Leave Law ("PSL"). The changes became effective September 30, 2020 and employers must inform employees about the new provisions by October 30, 2020. Notable highlights and changes to the ESSTA include:

- The amount of safe and sick time leave will now more closely mirror the PSL and is based on employer size. Any additional time to which employees may be entitled under these amendments does not need to be provided until January 1, 2021. The new accrual schedule is as follows:
  - 100 or more employees: Employees earn, may use and carry over 56 hours of paid safe and sick leave per year.
  - 5-99 employees: Employees may earn, use and carry over 40 hours of paid safe and sick leave per year.
  - 5 or less employees and net income of $1 million in the prior calendar year: Employees earn, may use and carry over 40 hours of paid safe and sick leave per year.
  - Employers with 5 or less employees and net income less than $1 million in the prior year: Employees earn, may use and carry over 40 hours of unpaid sick leave.

- Employees continue to accrue safe and sick leave at a rate of one (1) hour for every 30 hours worked.

- Employers may limit the available safe and sick time to 40 or 56 hours (depending on the annual accrual) per year.

- New hires will be eligible for safe and sick time leave much sooner as the optional 120-day waiting period has been eliminated.

- Employees will no longer need to work 80 hours in a calendar year before being able to take safe and sick time leave in a calendar year.

- Leave under the ESSTA may now be taken for domestic violence situations.

- Employees must be paid their regular rate of pay or the appropriate minimum wage if greater.
- Employers must provide an accounting each pay period showing the amount of safe and sick time accrued and used by the employee during the pay period, as well as the employee's total balance of safe and sick time.
- Where reasonable cause exists to believe that an employer is engaged in a pattern or practice of violations of the ESSTA, the City may initiate a civil action and impose penalties of up to $15,000 with an additional award of up to $500 to each employee covered by an employer's official or unofficial policy or practice of not providing, or refusing to allow the use of, safe and sick time.

Employer Action

New York City employers should become familiar with the new requirements, ensure the payroll provider is able to provide the required sick and safe leave accounting with each pay period, and consult with employment counsel to ensure compliance with the amended law.

Employers must inform current employees about the required changes by October 30, 2020, must conspicuously post the new notice, and provide new hires with a statement of rights upon hire. The notice is to be provided in English or the employee's primary language if a translation has been made available by the City. The City is expected to update its model ESSTA notice to incorporate the new provisions. The notice can be found at https://www1.nyc.gov/site/dca/about/Paid-Safe-Sick-Leave-Notice-of-Employee-Rights.page

Final 2020 Forms 1094-C and 1095-C Issued and Deadline Extended for 2020 Forms 1095-C

Published: October 26, 2020

On October 2, 2020, the IRS issued Notice 2020-76, which provides:

- An extension of time, until March 2, 2021, for employers to provide Forms 1095-C to their full-time employees and other individuals; and
- A final extension of relief from penalties for the 2020 reporting year for employers and other entities that make good-faith efforts to comply with the reporting requirements.

Notice 2020-76 does not, however, extend the deadline to provide completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) to the IRS (as described in Q/A-2 below). Nor does it provide any relief from providing Forms 1095-C to full-time employees ("FTEs"). This means that all Applicable Large Employers ("ALEs") must continue to provide Form 1095-C to any employee that was full time for any month of 2020.

However, the Notice provides an alternative furnishing method for Form 1095-B (and in some cases Form 1095-C), with relief from the 2020 Section 6055 reporting penalty, for:

- Insurance carriers that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2020;
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2020 (generally employers with fewer than 50 employees with a self-funded plan); and
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-C to covered individuals who were not full-time employees in any month of calendar year 2020.

Briefly, the alternative furnishing method allows carriers (and in some cases employers) to avoid 2020 Section 6055 penalties associated with a failure to furnish the applicable form to covered individuals by posting information to a website and timely providing the completed applicable Form upon request. The following FAQs provide additional details.

Q1: What was extended?

2020 Forms 1095-C must be furnished to FTEs and other individuals by Tuesday, March 2, 2021 (rather than by January 31, 2021).

This extension of time also applies to insurance carriers providing 2020 Forms 1095-B to individuals covered under an insured plan, and to employers providing 2020 Forms 1095-B to individuals covered under a self-funded health plan (but see Q/A-3).

The Notice states that the new deadline of March 2, 2021 will not be further extended by the IRS.

Q2: Were the deadlines for reporting to the IRS extended?

No, the 2020 Form 1094-C and all supporting Forms 1095-C (and the 2020 Form 1094-B and all supporting Forms 1095-B) must be filed with the IRS by Wednesday, March 31, 2021, if filing electronically (or by Monday, March 1, 2021, if filing by paper). These deadlines were not extended as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C with the IRS must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: With the individual mandate reduced to zero after December 31, 2019, is there any relief when furnishing a Form 1095-B?

Yes, but it is generally limited to Forms 1095-B (except as described in Q/A-4 below).

Because the individual shared responsibility penalty is reduced to zero for 2019, an individual does not need the information on Form 1095-B in order to compute his or her federal tax liability or file an income tax return with the IRS. (But see Q/A-7 below regarding individual healthcare mandates in certain states.)

The IRS will not assess a 2020 Section 6055 reporting penalty against reporting entities for failing to furnish Form 1095-B to covered individuals in cases where the following two conditions are met (Alternative Furnishing Method):

1. **Website posting.** The reporting entity posts a notice prominently on its website stating that responsible individuals may receive a copy of their 2020 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that they can use to contact the reporting entity with any questions.

2. **Provide form within 30 days.** The reporting entity furnishes a 2020 Form 1095-B to any responsible individual upon request within 30 days of the date the request is received.

Insurance carriers (and employers with self-funded plans) that take advantage of this relief must still provide the 2020 Form 1094-B and all 2020 Forms 1095-B to the IRS by the required deadline. In other words, while the carrier (or employer) will not be penalized by the IRS for not supplying covered individuals with Forms 1095-B with respect to their coverage (subject to the two conditions set forth above), the carrier (or employer) must still create Forms 1095-B and provide them to the IRS by the required deadline.

There is no relief from the penalties associated with a failure to file completed forms with the IRS.

Q4: Will the alternative furnishing method apply to ALEs with a self-funded health plan?

No, except in one situation.

ALEs are still required to provide Forms 1095-C to employees who were full-time for any month of calendar year 2020. Nothing has changed with respect to this requirement, aside from extending the deadline to March 2, 2021. ALEs offering self-funded group health plan coverage must continue to furnish Forms 1095-C to their FTEs, with all applicable parts (I, II and III) of Form 1095-C completed.

Some ALEs who offer self-insured health plan coverage to individuals who are not FTEs (e.g., part-time employees) may consider using the alternative furnishing method with respect to Form 1095-C.

Furnishing Form 1095-C to Individuals Who Were NOT Full-Time Employees

The Notice does provide relief to ALEs required to furnish 2020 Forms 1095-C to individuals covered under a self-funded group health plan who were not FTEs for any month of calendar year 2020. In this limited instance, ALEs may use the alternative furnishing method and will not face 2020 Section 6055 penalties, provided the ALE meets two conditions (outlined in Q/A-3):

- Post a prominent notice on website stating the Form 1095-C (or 1095-B) is available by request; and
- Provide the Form 1095-C (or Form 1095-B) within 30 days of a request.

In most cases, the individuals targeted for this relief are those who receive Form 1095-C with Code 1G in line 14 of Part II. Examples of covered individuals who are not full-time employees for any month of the calendar year, but who may receive coverage under the employer's self-funded group health plan, include:

- Part-time employees covered under the plan.
- A spouse or child receiving COBRA coverage.
- A former employee receiving COBRA coverage who had a COBRA qualifying event in 2019 or earlier.
- Individuals covered under a self-funded retiree medical plan who retired in 2019 or earlier.

Even if an ALE takes advantage of this alternative furnishing method with respect to an individual covered by the self-insured group health plan who was not a full-time employee in any month of 2020, the employer must still submit completed Forms 1094-C and 1095-C to the IRS by the required deadline.

Q5: Is the good faith penalty relief extended?

Yes, penalty relief is extended for employers and other reporting entities that report incorrect or incomplete information on Form 1094-C or Forms 1095-C, when these entities can show that they made good-faith efforts to comply with the information reporting requirements for 2020. This relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

The guidance indicates this is the last year this good faith relief will be provided.

Q6: What if the submissions are late?

Employers that do not comply with the due dates for providing a return or statement to an individual or the IRS are subject to penalties (except as described in Q/A-3 and Q/A-4). Employers and other reporting entities should still furnish and file the forms, and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties. Failure to furnish a correct Form 1095-C may result in penalties of $280/form with an annual calendar year maximum of $3,392,000. As stated in Q5, there is good faith penalty relieve available with respect to incorrect or incomplete information on the applicable Forms. Additionally, penalties may be waived if the failure was due to reasonable cause and not willful neglect.

Q7: Our employees reside in states with an individual healthcare mandate. Are there other things to consider?

In response to the reduction of the Affordable Care Act's ("ACA") individual mandate, a handful of states have enacted individual healthcare mandates that apply to residents. Many of these state mandates require carriers and employers to provide statements to residents and reporting to the states to demonstrate minimum essential coverage and enable covered employees and other individuals to avoid state penalties. Some states (including California, the District of Columbia, and New Jersey) have adopted the federal forms, 1095-B and 1095-C, to satisfy this requirement. Therefore, carriers and employers with employees in these states will likely need to continue to provide these forms to covered employees and other individuals to comply with the state mandate.

Q8: What about future relief?

The Notice asks for comments as to whether an extension of the due date to furnish Forms 1095-C (and Forms 1095-B) and continued extension of the good faith relief will be necessary for future years and why. The Notice states that very few comments were submitted in the prior year, indicating that this relief may no longer be necessary. Unless the IRS receives comments that explain why this relief continues to be necessary, no relief related to the furnishing requirements under sections 6055 and 6056 will be granted in future years. There is information in the Notice on how taxpayers may submit comments.

Q9: When will the final 2020 Forms 1094-C and 1095-C be issued?

The final 2020 Forms 1094-C and 1095-C (and applicable instructions) were recently released by the IRS. Due to the COVID-19 pandemic and challenges to business operations, ALEs may have variations to their reporting for 2020 due to furloughs and/or layoffs. ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status s an ACA FTE or not an ACA FTE for each month during 2020 in preparation to complete, furnish and file these Forms for 2020. There are some notable changes to the Forms for 2020, specifically addressing individual coverage health reimbursement arrangements ("ICHRAs"). For employers that do not sponsor an ICHRA, much of the reporting remains the same.

- On Form 1095-C, Part II the "Plan Year Start Month" is a required field. An ALE must enter a two-digit number to reflect the plan year start month (e.g., for January 2020, use "01," for June 2020, use "06."). In previous years, this was optional.

- To accommodate reporting associated with ICHRAs:
  - In Part II, there is a new reference to the "Employee's Age on January 1" and "Line 17 Zip Code." If an ICHRA is not offered do not complete these fields.
  - In Part II, there are new Codes (used in Line 14) used to report offers of ICHRAs. The new Codes are 1L, 1M, 1O, 1P, 1Q, 1R, and 1S. If an ICHRA is not offered these new codes should not be used.

- There is also information in the instructions on how to calculate the amount reported on Form 1095-C, Line 15 for an ICHRA offer of coverage.

- Part III must be completed with respect to coverage through an ICHRA.

While small employers are not subject to reporting for purposes of the employer mandate, if offering a self-insured group health plan or ICHRA, reporting under Section 6055 to the IRS and to covered employees or other primary insured individuals who have coverage provided through a self-insured group health plan is required. If a non-ALE is offering an ICHRA, that coverage is considered a self-insured health plan and is subject to this reporting requirement. According to the instructions, a new code "G" must be entered on Form 1095-B, line 8 to identify an ICHRA.

Employer Action

Employers should consider the following:

- Employers should take note of the extended deadline, March 2, 2021, to furnish 2020 Forms 1095-C to full-time employees and other individuals.
- Employers should review the final versions of the 2020 Forms 1094-C and 1095-C, along with relevant instructions.
- Small employers offering ICHRAs should comply with the reporting.
- ALEs should complete Form 1095-C (including all relevant parts) and timely furnish the statements to full-time employees. ALEs should also timely transmit form 1094-C along with all Forms 1095-C to the IRS.
- Employers with fully insured plans should be aware that their carriers may not issue Forms 1095-B directly to covered employees for 2020. Individuals asking for a copy should be directed to the carrier. Employers should anticipate that covered employees residing in a state with an individual healthcare mandate may need to contact the carrier to obtain a Form 1095-B before filing a state income tax return.
- ALEs with self-funded health plans that extend coverage to individuals other than full-time employees should decide whether to continue to furnish Forms 1095-C as done in prior years, or to take advantage of the new alternative furnishing method with respect to those covered individuals. Below are several administrative reasons why ALEs may be reluctant to adopt this new furnishing method for 2020:
  - While the Notice offers limited relief with respect to furnishing a Form 1095-C to covered individuals who were not full-time employees for any month of calendar year 2020, the ALE must ensure that Form 1095-C (including Part III) is completed and submitted to the IRS on behalf of these individuals. As the information must be included in the final submission, it is unclear whether taking advantage of the Section 6055 penalty relief makes any practical or administrative sense.
  - Employers looking to take advantage of this relief will need to post the required notice on a website and provide the completed Form 1095-C within 30 days of a request. Failure to do so could subject to the employer to associated penalties.
  - Employers with employees who reside in states with an individual healthcare mandate will want to work with vendors to ensure forms are provided and reported to the state in a timely and complete manner.
- While good faith penalty relief was extended under the Notice, be aware that the IRS is actively assessing fines associated with failures to file Forms 1094-C and 1095-C with the IRS by the deadline (as described in Q/A-2 above). Timely reporting remains an area of active IRS enforcement.

HHS Announces Another Extension to the Public Health Emergency

Published: October 28, 2020

The Secretary of Health and Human Services ("HHS"), Alex Azar recently announced the administration will renew the Public Health Emergency, scheduled to end on October 22, 2020. This will once again extend the period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period HHS Secretary issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire January 21, 2021 (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. At this time, no end date has been announced. According to the regulations, a period of "up to one year" may be disregarded. Therefore, the latest the Outbreak Period may end is February 28, 2021.

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.

2021 Cost of Living Adjustments

Published: November 4, 2020

The IRS recently released cost of living adjustments for 2021 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

For plan years beginning in 2021, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) remains unchanged at **$2,750**.

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

Annual Maximum carryover

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a maximum of $500 to $550 for plans that have adopted the carryover option. This increase reflects a change from the static $500 carryover amount to 20% of the currently indexed heath FSA contribution limit.

For plan years beginning in 2021, 20% of the current $2,750 limit on health FSA contributions is $550. Thus, the maximum unused amount from a health FSA plan year that begins in 2021 that can be carried over to the following plan year (2022) is **$550**.

Qualified Transportation Fringe Benefits

For calendar year 2021, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) remains unchanged at $270.

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

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

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) remains unchanged at **$130,000** for 2021.

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

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2021 remains unchanged at **$185,000**.

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

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

The 2021 maximum annual out-of-pocket limits for all non-grandfathered (NGF) group health plans are **$8,550** for self-only coverage and **$17,100** for family coverage.

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

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2021, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed **$5,300** ($10,700 for family coverage).

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2021, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Code Section 54.9831-1(c)(3)(viii), the annual EB HRA contribution may not exceed **$1,800**.

Health Savings Accounts

As announced in May 2020, the inflation adjustments for health savings accounts (HSAs) for 2021 were provided by the IRS in Rev. Proc. 2020-32.

Annual contribution limitation

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

Qualifying high deductible health plan

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

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

Catch-up contribution

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

New Jersey Releases 2021 Disability and Family Leave Amounts

Published: November 5, 2020

New Jersey has announced the 2021 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs as follows:

Maximum TDI and FLI Weekly Benefit	$903
Alternative Earnings Test Amount for TDI and FLI	$11,000
Base Week Amount for TDI and FLI	$220
Taxable Wage Base (employers) for TDI	$36,200
Taxable Wage Base (employees) for TDI and FLI	$138,200
Employee Contribution Rate for TDI	0.47%
Employee Contribution Rate for FLI	0.28%

Temporary Disability Insurance 2021

Temporary Disability Insurance provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons. To be eligible for TDI, employees must have worked 20 weeks earning at least $220 per week ("Base Week Amount") or have earned a combined total of $11,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $903. TDI may be payable for up to 26 weeks in a 52-week period.

Employees and employers contribute to TDI. Employees contribute 0.47% of wages up to the 2021 Taxable Wage Base (Employee) of $138,200 equal to $649.54.

Employers contribute based on TDI experience anywhere from 0.10% and 0.75% of an employee's wages up to the 2021 Taxable Wage Base (Employer) of $36,200. The maximum annual contribution will range between $36.20 and $271.50.

Family Leave Insurance 2021

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member. Similar to TDI, to be eligible for FLI employees must have worked 20 weeks earning at least $220 per week ("Base Week Amount") or have earned a combined total of $11,000 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $903. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.28% of wages up to the 2021 Taxable Wage Base (Employee) of $138,200 equal to $386.96.

Comparison to 2020

	2021	2020	Percentage Change
Maximum TDI/FLI Weekly Benefit	$903	$881	2.5%
TDI Employee Contribution Rate	0.47%	0.26%	80.1%
TDI Maximum Annual Employee Contribution	$649.54	$350.74	88.0%
TDI Maximum Annual Employer Contribution	$36.20 to $271.50	$35.30 to $264.75	2.5%
FLI Employee Contribution Rate	0.28%	0.16%	75%
FLI Maximum Annual Employee Contribution	$386.96	$215.84	79.3%

Reminder: Massachusetts HIRD Reporting Due December 5, 2020

Published: November 10, 2020

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

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

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

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

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

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

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: https://www.mass.gov/service-details/other-health-insurance-and-masshealth-premium-assistance.

DOL Issues Updated MHPAEA Compliance Tool

Published: November 11, 2020

The Department of Labor's Employee Benefits Security Administration recently issued an update to its Mental Health Parity and Addiction Equity Act ("MHPAEA") Self-Compliance Tool. Under the 21st Century Cures Act, the Departments of Labor, Health and the Treasury (collectively, "the Departments") are required to issue this tool, which health plans may use to determine whether coverage offered to participants complies with MHPAEA rules. The first Self-Compliance Tool was published in 2018.

Background

MHPAEA applies to:

- Employers with more than 50 employees offering group health plan coverage, insured or self-funded, that includes any Mental Health or Substance Use Disorder ("MH/SUD") benefits.
- Non-grandfathered insured plans, including coverage in the small group health plan market.

Briefly, MHPAEA:

- Requires that if a plan provides MH/SUD benefits in any classification, those benefits are provided in every classification in which medical/surgical benefits are provided.
- Prohibits a plan from imposing a financial requirement or Quantitative Treatment Limit ("QTL") on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of the same type applied to substantially all medical/surgical benefits.
  - A financial requirement includes copays, deductibles, cost-sharing, coinsurance and out-of-pocket maximums.
  - A QTL means annual, episode and lifetime days and/or visit limits (e.g., number of treatments, visits or days of coverage).

- Prohibits a plan from imposing a Non-Quantitative Treatment Limits ("NQTL") on MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

Updates to the Self-Compliance Tool

The Self-Compliance Tool is intended to provide the user a basic understanding of the MHPAEA rules and assist in evaluating MHPAEA compliance. Like the earlier version, the updated tool has eight complex questions and step-by-step analysis. The 2020 amendments to the Self-Compliance Tool fall into four categories:

- Integration of recent MHPAEA guidance,
- Revised compliance examples,
- A new section explaining best practices for establishing an integrated compliance plan and provided examples of the types of records that a plan or carrier should be prepared to provide in the event of an investigation, and
- A new list showing warning signs that may indicate potential MHPAEA violations.

The Self-Compliance Tool can be found at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

Final Regulations Address Coverage for COVID-19 Vaccines

Published: November 16, 2020

On October 29, 2020, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") issued interim final regulations that amend regulations regarding coverage of preventive health services to implement Section 3203 of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"). While the rule addresses various aspects of a COVID-19 vaccine, this article highlights the impact to group health plans.

Briefly, non-grandfathered group health plans must cover, without cost-sharing (both in-network and out-of-network), qualifying coronavirus preventive services (including immunizations) within 15 business days following an applicable recommendation by the Advisory Committee on Immunization Practices ("ACIP") and adopted by the Centers for Disease Control and Prevention ("CDC").

Grandfathered plans, excepted benefits or short-term limited duration insurance are encouraged to provide this coverage to all enrollees without cost-sharing.

As of the writing of this article, an approved COVID-19 vaccine is not yet available. This guidance addresses how future vaccines and related treatment must be covered by health insurance plans. These regulations are immediately applicable and apply until the end of the Public Health Emergency for COVID-19 as determined by the Department of Health and Human Services (currently January 21, 2021, unless further extended).

Other highlights from the guidance follow:

- Qualifying coronavirus preventive services include the vaccine itself and an office visit (not billed separately) where the primary purpose is the delivery of the recommended COVID-19 immunization.

- With respect to a qualifying coronavirus preventive service and a provider with whom the plan or issuer does not have a negotiated rate for such service (such as an out-of-network provider), the plan or issuer must reimburse the provider for such service in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

Employer Action

For now, employer group health plan sponsors should take note of this information and continue to monitor. Once a vaccine is closer to release, plan sponsors should ensure their health insurance carrier and/or plan administrators are covering these required services without cost sharing to participants.

Final Group Health Plan Transparency Rules Issued

Published: November 18, 2020

On October 29, 2020, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued the final rule on transparency in health plan coverage. The final rule imposes significant new requirements on non-grandfathered group health plans to disclose information on pricing and cost-sharing under their plans. This latest guidance finalizes proposed regulations issued in 2019.

The final rules adopt a phased-in schedule for compliance beginning with plan years on or after January 1, 2022 and completing with plan years that begin on or after January 1, 2024.

These rules apply to non-grandfathered insured and self-insured major medical plans. They do not apply to:

- excepted benefits (e.g., dental, vision, health FSAs);
- health reimbursement arrangements ("HRAs") and other account-based plans (e.g., individual coverage HRAs, "ICHRAs"); or
- short-term limited duration insurance.

The stated goal of the final rule is to support a market-driven health care system by giving employees and other consumers the information they need to make informed decisions about their health care purchases. For example, the rule provides participants and beneficiaries with price and benefit information in advance of receiving care, which can enable them to evaluate their health care options and make cost-conscious decisions. The Departments are of the view that price transparency will, over time, potentially lower overall health care costs in the market.

Required Disclosures

Like the proposed rule, the final rule adopts two new disclosure requirements:

1. Public disclosure via three machine-readable files of:
   b. in-network provider rates for covered items and services,
   c. out-of-network allowed amounts and billed charges for covered items and services, and
   d. negotiated rates and historical net prices for covered prescription drugs.

2. Disclosure of cost-sharing information to participants and beneficiaries through an internet-based self-service tool or paper format (upon request).

Public Disclosure

Effective for plan years beginning on or after January 1, 2022, group health plans must disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information through three machine-readable files posted on an internet website, thereby allowing the public access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending. These files must be accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

In a change from the proposed rule, the final rule adopts a third machine readable file specifically for prescription drug pricing information which will include the negotiated rate and the historical net price.

Machine-readable files and the information required by the final rule must be updated monthly and the date the files were most recently updated should be clearly indicated.

In connection with the proposed rule, the Departments issued data elements for these machine-readable files. The Departments are likely to update these files for the final rule and provide a third set of data elements to reflect the new prescription drug file.

Disclosures to Participants and Beneficiaries

Group health plans must disclose upon the request of a participant or beneficiary who is enrolled in a group health plan (or their authorized representative) cost-sharing information including an estimate of the individual's cost-sharing liability for covered items or services furnished by a provider.

This disclosure is similar to an explanation of benefits ("EOB"), except that it is provided before medical treatment, not afterwards. This information should be made available on an internet website and, if requested, in paper form, thereby allowing the requesting party to obtain an estimate and better understand the individual's out-of-pocket expenses. This should allow users to more effectively shop for items and services before deciding on a provider.

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

- Estimated cost sharing. An estimate of the participant's or beneficiary's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan.

- Accumulated amounts. Accumulated amounts of cost-sharing that the participant or beneficiary has already incurred under the plan at the time the request is made. This would include a current statement of how much the participant has already paid toward their deductible and out-of-pocket limit.

- In-network rate negotiated rates. The plan would need to disclose the dollar amount they have agreed to pay in-network providers for a certain service or prescription drug.

- Out-of-network allowed amounts. The plan must provide the maximum amount that could be paid by the plan for a particular service or drug that is out-of-network.

- Items and services in bundled payment arrangements (if applicable). Cost sharing information for each item and each service within the bundle must be disclosed.

- Any coverage prerequisites (e.g., prior authorization or step therapy) before a participant can receive a service or item.

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

The final rule adopts a phased in approach to compliance:

- With respect to 500 items and services identified by the Departments, compliance is required for plan years beginning on or after January 1, 2023. The final rule lists out the 500 items and services to be provided by 2023 (along with a plain language description and CPT code). This list will be posted on a publicly available website. For now, the list may be found in the preamble to the final regulations, pages 90-116 (linked below).

- Full compliance is required for plan years beginning on or after January 1, 2024 (includes all items and services – not just the identified 500).

Who is Responsible for Compliance?

Generally, the plan sponsor is responsible for compliance with the final rules.

However, for a fully insured group health plan, the plan and carrier may enter into a written agreement where the carrier agrees to provide the disclosure information under this final rule. In this case, if the carrier fails to provide full or timely information, then the carrier but not the plan, has violated the transparency disclosure requirements.

Similar relief is not available to self-insured group health plans. While a self-insured health plan may contract with a third party to provide the required disclosure, the plan is ultimately responsible.

Employers sponsoring self-insured group health plans will need to ensure their third party administrators ("TPAs") or other vendors (e.g., Pharmacy Benefit Managers, "PBMs") can comply with the disclosure requirements under the final rule and should consider adding indemnification provisions to any service agreement in the event the third party fails to make timely or full disclosures.

The Departments adopt a good faith safe harbor for when a plan or carrier, acting in good faith, makes an error or omission so long as it corrects the information as soon as possible.

Employer Action

This summary provides a high-level overview of the very detailed final rule on the new transparency disclosure requirements. As the various deadlines related to the phased-in approach draw closer, employers should work with their insurance carriers and TPAs to ensure they can comply with these new requirements. This is particularly important if a self-funded plan uses TPAs or other carve-out vendors that are not otherwise affected by these rules as the plan is responsible for compliance.

Resources

- Final Rule: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf

- Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f

- Tables outlining data elements required for each readable file (prescription drug file not available)
  - Negotiated Rate File: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-negotiated-rate-file.pdf
  - Allowed Amounts File: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-allowed-amounts-file.pdf

- Draft Model Disclosure: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf

New PCOR Fee Announced

Published: December 4, 2020

Last week, the IRS released Notice 2020-84, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2020 and before October 1, 2021 is **$2.66.**

The PCOR filing deadline is **August 2, 2021** for all self-funded medical plans and some HRAs for plan years ending in 2020. Carriers are responsible for paying the fee for insured policies.

2021 Form 720, due August 2, 2021:

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

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in Summer 2021 of the fee and additional information for filing and paying the PCOR fee with the IRS.

Final Rule to Increase Flexibility for Grandfathered Plans

Published: December 22, 2020

The Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") announced a final rule that amends the requirements for grandfathered group health plans and grandfathered group health insurance coverage to preserve their grandfathered status. The final rules 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 final 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"). The proposed regulations were based on the feedback received from stakeholders who submitted comments in response to the 2019 RFI. The Departments issued these final rules that adopt the proposed amendments without substantive change.

Final Regulations

Alternative Inflation Adjustment

The final regulations amend the 2015 final regulations to provide that 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 final regulations also amend the 2015 final regulations to 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 final 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 final 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 ensures that participants and beneficiaries enrolled in that coverage remain eligible to contribute to an HSA. The final 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 final regulations apply to grandfathered group health plans and grandfathered group health insurance coverage beginning on June 15, 2021.

Massachusetts Requires Employers to Register PFML Administrator

Published: December 23, 2020

The Massachusetts Department of Family and Medical Leave ("DFML") is notifying employers in the state program to create an Employer Account in order to review and manage paid family and medical leave ("PFML") applications for their organizations' staff.

In order to register, employers will need to have their work email address, a user created password, and the employer's federal Employer Identification Number ("EIN"). Employers managing PFML applications for multiple employers with different EINs will need to create a different Employer Account and use a unique email address for each employer. Email addresses can only be associated with one Employer Account.

The Employer Account allows employers to:

- Review paid leave applications from employees;
- Get updates about the program by email; and
- Download documents and decision letters.

Employer Action

Massachusetts employers will need to click on the following link to create an Employer Account: https://www.mass.gov/how-to/creating-an-employer-account-to-review-paid-family-and-medical-leave-pfml-applications.

While the DFML has not announced a deadline to create an Employer Account, it appears that it would be prudent to complete this prior to January 1, 2021, if possible.

COVID-19 and Government Funding Legislation Signed into Law

Published: December 30, 2020

On December 27, 2020, the Consolidated Appropriations Act, 2021 was signed into law and provides for relief related to the COVID-19 pandemic, as well as government funding. The legislation is tremendous and totals more than 5,000 pages. There are many different issues addressed, but this article focuses on the following components of the law that affect health and welfare programs:

- Relief for Health FSAs and DCAPs
- No Surprise Billing
- Increased Transparency: Broker compensation, pharmacy cost and consumer transparency.
- Comparative Analysis Requirement of the nonquantitative treatment limitations ("NQTLs") used for medical and surgical benefits as compared to mental health and substance use disorder benefits to show compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA").
- Voluntary Extension of Families First Coronavirus Response Act ("FFCRA") Leave.

Below you will find additional detail on the above as well as other relevant aspects of the legislation.

Relief for Health FSAs and DCAPs

This relief comes very late in the year, which may pose significant administrative challenges. Employers will want to decide whether to allow any or all permissible changes and reach out to their FSA vendors.

Employers may, but are not required to, amend their cafeteria plan for any of the following:

- For a health FSA or DCAP:
  - **Carryover and grace period.** Participants (even in a DCAP) may carry over unlimited unused amounts (rather than up to $550) from the 2020 plan year to the 2021 plan year (and from the 2021 plan year to the 2022 plan year). Alternatively, employers may allow for a grace period for a plan year ending in 2020 or 2021 of up to 12 months after the end of such plan year (rather than 2½ months following the end of the plan year). Health savings account ("HSA") eligibility should be considered, if applicable. See note below.
  - **Mid-year election changes.** For plan years that end in 2021, participants may make prospective election modifications without regard to any change in status.

- For a health FSA:
  - An employee who ceases participation in the plan during calendar year 2020 or 2021 may continue to receive reimbursements from unused amounts through the end of that plan year (including any grace period, taking into account any modification of a grace period permitted above).

- For a DCAP:
  - If a dependent child aged out during the pandemic, a participant can continue to receive reimbursements for such child's dependent care expenses for (1) the remainder of the plan year (if the enrollment period ended before January 31, 2020) and, to the extent a balance remains at the end of the plan year, (2) the following plan year until the child turns age 14 (but only with respect to the unused amount).

The plan must be amended no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective. For a January 1, 2020 to December 31, 2020 plan year, this means an amendment must be adopted no later than December 31, 2021. In addition, the plan must be operated in a manner consistent with the terms of such amendment during the period beginning on the effective date of the amendment and ending on the date the amendment is adopted.

Employers with qualified high deductible health plans ("HDHPs") tied to HSAs will need to work closely with their vendors to preserve HSA eligibility if adopting the carryover or grace period changes to the health FSA. If adopting a carryover, the rules permit a carryover from a traditional health FSA to an HSA-compatible health FSA for those electing the HDHP option in the subsequent year. However, similar treatment does not apply with respect to a grace period. Employers wishing to provide an HSA-compatible health FSA grace period will need to do so for all participants, not just those with HDHP coverage.

No Surprise Billing

Providers are generally barred from balance billing participants in a number of situations. Under the "No Surprises Act," effective for plan years beginning on or after January 1, 2022, participants pay in-network cost-sharing only for:

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

Exception for Certain Non-Emergency Non-Ancillary Services Where Consent is Obtained

There is an exception to the prohibition against balance billing in the case of non-emergency services performed by an OON provider at certain in-network facilities. Balance billing may be permissible when the provider provides the patient with oral and written notification at least 72 hours in advance of the appointment (or, for appointments made within the 72 hour window, on the same day on which the appointment is made) that includes the following:

- Notification of the provider's OON status;
- A statement that consent to receive services from an OON provider is optional and that the services may be received from a provider that can do so under the in-network cost structure;
- A good faith estimate of the amount the patient will be charged if he or she consents; and
- In the case of an OON facility, a list of any in-network providers at that facility who can provide the same item or service.

The patient must sign the notice in order to consent to the treatment by the OON provider and they must be provided a signed copy.

It is important to note that this exception does not apply to ancillary services provided by an OON provider at an in-network facility. Ancillary services include:

- items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- items and services provided by assistant surgeons, hospitalists and intensivists;
- diagnostic services (including radiology and laboratory services), unless exempt by future rulemaking; and
- items and services provided by non-participating providers if there are no participating providers at the same facility who can furnish such items or services.

Payment Amount

The plan must pay the OON provider as follows:

1. If the care is provided in a state that has a law in place that would apply on its own terms to determine the amount the plan would owe to the provider, the state law applies.
2. If the care is provided in a state that participates in the All-Payer Model Agreement, the amount the state approves under that system applies.
3. For care provided in states with no applicable rule and for air ambulance services disputes, the law prescribes a detailed process to determine the appropriate rate.

If the plan or insurer does not initially deny payment, it is required to remit a "qualifying payment amount" which is a median payment amount for the same or similar service the plan or insurer pays in the same insurance market and geographic area. There is a 30-day window for open negotiation.

After this period, if the payment amount is disputed, an Independent Dispute Resolution ("IDR") process kicks in. The IDR entity is required to pay based on:

- the level of training, experience and quality and outcomes measurements of the provider or facility;
- the provider/facilities market share in the geographic region in which the item or service was provided;
- the acuity of the individual receiving the item or service and the complexity of furnishing it;
- whether the providing facility is a teaching facility; and
- demonstrations by the parties of the extent to which they engaged in good faith efforts to enter into network agreements.

The IDR entity does not consider the amount the provider invoiced (billed charges), the provider's "usual and customary charges," or the amount public payors pay for the item or service in the course of making its determination.

The IDR entity's decision is final and generally may not be appealed. The "losing party" must pay the IDR fees/costs. HHS will assess a fee on both parties to the IDR to cover the agency's administrative costs.

The Departments are directed to issue regulations by July 1, 2021. States may impose other OON provider obligations that go above and beyond the federal statutory requirements.

Enforcement

States are charged with enforcing these federal requirements and providers are subject to penalties of up to $10,000 per violation unless they opt out, in which case HHS has enforcement authority. The DOL also has enforcement authority if it identifies patterns of balanced billing violations under a group health plan.

Transparency

Broker Compensation Transparency

Effective December 27, 2021, brokers and consultants of ERISA covered group health plans, regardless of size, must enter into a written contract with a responsible plan fiduciary which includes the following information:

- A description of the services to be provided;
- If applicable, a statement that the broker/consultant plans to offer fiduciary services to the plan;
- A description of all direct compensation the broker expects to receive (in the aggregate or by service);
- A description of all expected indirect compensation (including vendor incentive payments, a description of the arrangement under which the compensation is paid, the payer of the compensation, and any services for which the compensation will be received);
- Separately, any transaction-based compensation (e.g., commissions or finder's fees) for services and the payers and recipients of the compensation; and
- A description of any compensation the broker/consultant expects to receive in connection with the contract's termination (and how any prepaid amounts will be calculated and refunded upon termination).

The above applies when the broker or consultant expects to receive at least $1,000 in direct or indirect compensation (whether paid to the broker, an affiliate, or subcontractor) and should occur reasonably in advance of each contract date and renewal date. The definition of a broker or consultant for this purpose is broad and includes parties who are not considered traditional brokers/consultants (e.g., pharmacy benefit managers, wellness vendors, and third-party administrators).

Plan fiduciaries must report brokers/consultants to the DOL if they do not comply with these requirements.

Pharmacy Cost Transparency

Group health plans and insurers will be required to annually report to the Departments on their pharmacy benefits and costs multiple data points, including:

- Number of enrollees
- States in which the plan is offered
- 50 most common brand prescription drugs dispensed by pharmacies for claims under the plan and the total claims paid for each drug
- 50 most costly drugs by total annual spending and the annual amount spent for each of the 50 drugs
- 50 drugs with the greatest year-over-year cost increase for the plan and the change in amounts paid by the plan
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness) and
  - Plan and enrollee spending on prescription drugs
- Average monthly premiums paid by the employer and the enrollees
- Impact on premiums and out-of-pocket costs associated with rebates, fees or other payments by drug manufacturers to the plan or the plan's administrators, and certain specifics about those rebates/payments.

These new disclosure requirements go into effect December 27, 2021.

Consumer Transparency

The law provides the following additional transparency rules for insurers and plan sponsors of group health plans:

- **ID Cards.** The amount of the in-network and OON deductibles and the out-of-pocket maximums that apply to the plan and the plan telephone number and website contact information must be disclosed on any physical or electronic plan and on insurance identification cards.
- **EOB.** A requesting health care provider or facility or a requesting plan participant, beneficiary, or enrollee must be provided an explanation in advance that states whether the provider or facility is in-network for the item or service to be provided, the contracted rate for that item or service, and a description on how an individual may obtain the item or service from an in-network provider.
- **Price Comparison Guidance.** Price comparison guidance must be offered by telephone and made available on an internet website of the plan or issuer that enables an enrolled individual to compare the amount of cost sharing for which he or she would be responsible for paying with respect to the furnishing of specific items or services by any provider.
- **Provider Directories.** A process must be established to update and verify provider directory information at least every 90 days; respond within 1 day to enrollee questions about providers' in-network status; and maintain on a public website a database of all in-network providers and facilities and directory information for each of them. The plan must pay any extra costs that would be incurred by an enrollee that relies on any inaccurate directory information.

Third party payers cannot prohibit sharing of the above information/data with business associates in accordance with HIPAA standards.

These new disclosure requirements apply to plan years beginning on or after January 1, 2022. It is not clear how these transparency rules will overlap and coordinate with the recent transparency regulations finalized by the Departments. Further guidance in this area would be helpful.

Comparative Analysis Requirement

To comply with MHPAEA, a group health plan or issuer must perform and document comparative analyses of the design and application of NQTLs with the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

2. The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

3. The evidentiary standards used for the factors identified in (2), when applicable, provided that every factor must be defined and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

5. The specific findings and conclusions reached by the group health plan or issuer with respect to the health insurance coverage, including any results of the analyses described here that indicate that the plan or coverage is or is not in compliance.

Further guidance is expected.

Voluntary Extension of FFCRA Leave

The FFCRA provided new types of leave to employees of employers with less than 500 employees, applicable to leave taken between April 1, 2020, and December 31, 2020.

Under the new law, the FFCRA still sunsets on December 31, 2020. However, employers may voluntarily extend leave through March 31, 2021, and receive associated tax credits. This does not restart the clock on any employee's leave.

Self-employed individuals have the option to use prior year net earnings in determining average daily self-employment income.

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Alaska Health Insurance Response to COVID-19

On March 6, 2020, the Alaska Division of Insurance issued Bulletin 20-04 requiring health insurers to waive all cost-sharing for testing for coronavirus disease 2019 (COVID-19) through April 30, 2020.

The Alaska Bulletin

The Alaska mandate applies to all state regulated health insurance plans for all patients that meet the testing criteria set forth by the Alaska Division of Public Health and the U.S. Center for Disease Control.

Carriers will be required to:

- waive any cost-sharing for laboratory diagnostic testing for respiratory syncytial virus (RSV), influenza, respiratory panel tests, and COVID-19.

- waive cost-sharing for office, urgent care center, emergency room visit with testing for the above conditions.

The waivers would be applicable at both in and out of network facilities. The Alaska Bulletin also encourages insurers to liberalize telehealth services and reminds them that group insurance cannot require services to be provided by any particular provider or facility.

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

Colorado Mandates Paid Leave for COVID-19 Testing

On March 11, 2020, the Colorado Department of Labor and Employment (CDLE) released emergency rules that temporarily require employers in certain industries to provide paid sick leave to employees with flu-like symptoms for the four-day period required for coronavirus disease 2019 (COVID-19) testing. This rule will remain in effect until April 10, 2020 and may be extended if the state of emergency declared by Governor Jared Polis continues.

Paid Leave for COVID-19 Testing

Under the CDLE emergency rules, employers in the following industries are required to provide paid sick leave for an employee with flu-like symptoms who is being tested for COVID-19:

- leisure and hospitality,
- food services,
- childcare,
- education (including related service such as cafeterias),
- home health care,
- nursing home facilities, or
- community living facilities.

The paid sick leave is only required for the four-day period needed for COVID-19 testing and ends if an employee receives a negative COVID-19 test result. Should an employee test positive and require quarantine, the emergency rules do not provide wage replacement for lost work time.

Employers that already provide paid sick leave compliant with the four-day leave requirement are not required to provide additional days of paid sick leave. However, employees that have already exhausted their paid leave allotted by the employer are entitled to additional paid sick days if they subsequently experience flu-like symptoms and are tested for COVID-19.

Rate of Pay

Pay during the mandated four-day period required for COVID-19 testing must be provided at the employee's regular rate of pay. This includes all forms of wages and compensation. For employees paid below minimum wage due to a tip credit, the employee's compensation must be increased to the applicable minimum wage. Where an employee's rate or pay or service hours varied prior to the absence for COVID-19 testing, the employer must determine the employee's rate of pay by averaging the employee's daily pay for the preceding month.

Other Initiatives

Governor Polis' executive order also included directives for the CDLE to:

1. engage in emergency rulemaking for temporary paid sick leave, and

2. identify additional supports and wage replacement.

Accordingly, other wage replacement options for those who test positive for COVID-19, including expanding eligibility for unemployment insurance, are under review by the CDLE.

We are monitoring developments around the COVID-19 and will continue to provide you with timely updates.

2020 Louisiana Benefits Legislative Update

The 2019 regular session of the Louisiana legislature concluded on June 6, 2019 and Governor Edwards signed 45 bills into law, including a handful of health-related bills addressing pharmacy benefit managers ("PBMs") and drug cost transparency, claims reporting, and health insurance-related mandates. While these laws are not directly employer-related, employers should be aware of the changes which are summarized below.

PBM Restrictions and Drug Transparency

SB 41 (Act No. 124) provides for the following increased regulation of PBMs doing business in the state of Louisiana:

- Increased licensing requirements;

- Additions to Louisiana's unfair trade practices including, but not limited to, the following:
  - spread pricing (i.e., charging a health insurer for payment of the same prescription or pharmacy services differently than the amount paid to the pharmacy);
  - steering patients to pharmacies in which the PBM has ownership;
  - reimbursing a local pharmacy less than the amount it reimburses chain, mail-order, or specialty pharmacies for the same drug or device; and
  - requiring a patient to follow step therapy protocols before dispensing a prescription drug in the manner prescribed by the ordering physician.

SB 41 takes effect July 1, 2020.

Prescription Drug Disclosure

HB 119 (Act No. 206) requires a health insurer to provide a prescriber with a list of alternative, disease-specific formulary medications in writing upon denial of prescription drug based on step therapy, fail first protocols, or nonformulary status.

HB 119 will be enforced against a health insurer for acts taking place on or after January 1, 2020 if the health insurer sends an electronic notice. For notices provided in any other manner, the law will be enforceable July 1, 2020.

Increased Reporting and Earlier Renewal Notice

HB 408 (Act No. 112) requires health insurers to provide claims information, plan utilization, and premium information on a monthly basis to large employer clients (more than 50 employees).

Additionally, health insurance carriers are required to provide the employer with more than 50 employees (rather than 100 employees currently) with the premium rates required to renew the group policy within 90 days prior to the date the policy is set to renew.

HB 408 became effective on August 1, 2019. An employer will need to make a request with its insurance carrier to initiate the monthly report.

Contingent ACA-Related Mandated Benefits

SB 173 (Act No. 412), also known as the "Healthcare Coverage for Louisiana Families Protection Act," mandates that health insurers cover essential health benefits and provide certain patient protections currently required under the Affordable Care Act ("ACA") such as:

- The prohibition of preexisting condition exclusions;
- The prohibition of annual and lifetime limits; and
- Required eligibility of dependent children to age 26.

This law will take effect immediately upon a final court ruling that the ACA is unconstitutional.

New Mandated Benefit – Cancer Screening

HB 345 (Act No. 118) requires health insurance plans within Louisiana to provide coverage for breast and ovarian cancer susceptibility screening. Health insurance carriers must cover the cost of the genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and ovarian cancer when recommended by a health care provider in accordance with United States Preventive Services Task Force recommendations. Coverage provided may be subject to the deductible, coinsurance, and copayment provisions consistent with other benefits provided under the plan. The law applies to fully insured plans. It also purports to apply to self-funded plans, although that application appears to be preempted by ERISA.

HB 345 takes effect for health plans delivered, issued, or renewed on or after January 1, 2020.

Louisiana Temporarily Expands Access to Telemedicine

On March 23, 2020, Louisiana Insurance Commissioner issued Emergency Rule 37 (the "Rule") expanding access to telehealth services during the COVID-19 pandemic. The Rule is effective March 23, 2020 through April 9, 2020.

The Rule applies to all state regulated health insurance plans, pharmacy benefit managers, and third-party administrators (TPAs) acting on behalf of health insurers and policyholders.

This Rule expands access to telemedicine services so that Louisiana residents are able to continue to receive necessary medical care without an in-person visit to a hospital or clinic in light of the shortage and lack of availability of in-network provider visits. It requires that insurers waive existing telehealth coverage limitations so that a participant can receive covered services through telehealth in the same manner that coverage would have been provided through an in-person visit. The Rule also allows coverage for mental health services provided through telemedicine to the same extent such coverage would be provided through an in-person visit. Under the rule, participants may access telehealth services through their telephone or personal electronic device.

In addition to waiving existing telehealth coverage limitations, the Rule requires that insurers broaden access to telehealth providers by waiving restrictions requiring participants to only conduct telemedicine visits with providers within the insurer's existing telemedicine network. The Rule also waives the requirement that participants have a prior relationship with the provider in order to receive services.

Insurers are required to evaluate their out-of-network costs as they relate to telehealth visits to ensure that participants are not unreasonably charged extra cost-sharing amounts under their health plan if in-network access becomes limited.

Employer Action

Employers with insured health plans written in Louisiana should anticipate coverage and network access changes related to telemedicine services provided through the group health plan.

The Rule is likely a welcome relief for Louisiana residents experiencing difficulties with scheduling in-person visits with their provider in light of the lack of resources and availability of network providers.

Nevada Health Insurance and Paid Leave Response to COVID-19

In response to the COVID-19 pandemic, Nevada has announced the following developments with respect to health insurance and leaves of absence in Nevada:

Special Enrollment Period for Nevada Health Link

The Silver State Health Insurance Exchange has announced that eligible uninsured residents of Nevada have a Special Enrollment Period to obtain an individual health insurance policy from Nevada Health Link, which is Nevada's online Marketplace. The Special Enrollment Period runs through April 15, 2020 and is open to Nevada residents who are not and have not been previously enrolled in Marketplace coverage during 2020. Coverage will begin on April 1, 2020 if applied for on or before April 1. Coverage will begin on May 1, 2020 if applied for between April 2 and April 15, 2020. Employers have the option, but are not required, to inform employees residing in Nevada about the Special Enrollment Period at Nevada Health Link.

Leaves of Absence

The Nevada Labor Commissioner announced on March 11, 2020 that if an employee is subject to a mandatory government quarantine by a federal, state or local agency, and the employee is unable to report to work, the employer should not treat the mandatory government quarantine time as leave that is counted against the employee or taken from the balance of his/her leave, unless the employee elects to use leave (including paid leave), or other leave is required to be used (such as FMLA leave). This guidance is intended primarily for employers with 50 or more employees in Nevada that are providing paid leave accruals to employees under Nevada law for each hour of work performed; employees are eligible to use their paid leave beginning on their 90th day of employment. The announcement recommends that employers with fewer than 50 employees also follow this guidance as needed.

Additionally, the announcement states:

- Depending on the employer's internal policy, employees may not be accruing any type of leave or pay while under a mandatory government quarantine.
- Employers are encouraged to pay employees during the time they are absent on a mandatory government quarantine, and to offer alternative working arrangements (such as teleworking or additional paid time off), but the employer is not required to do so.
- An employee can choose to request to use paid leave or other applicable leave (if available) while absent on mandatory government quarantine, at the employee's option. FMLA leave may also apply to the employee's situation, condition, and length of absence.

Finally, the announcement states that the above guidance does not replace current collective bargaining agreements or other contracts.

COVID-19 Testing and Immunization: Waiver of Cost Sharing

On March 5, 2020, the Nevada Division of Insurance published emergency regulations which state that health insurers:

- Must not impose an out-of-pocket cost for visiting a provider office, urgent care center, or emergency room, when the purpose of the visit is to be tested for COVID-19;
- Must not impose an out-of-pocket cost for COVID-19 testing;
- Must cover the costs of COVID-19 immunization as one becomes available.

The emergency regulations do not apply to self-insured plans or short-term limited duration plans.

The Nevada Division of Insurance later released a Consumer Alert and separate FAQs on the emergency regulations which contain additional information about the cost-sharing waiver. The FAQs re-affirm that health insurers are required to cover – with no out-of-pocket cost – testing for COVID-19 and the office, urgent care center, or emergency room visit (including the patient exam) when the purpose of the visit is to be tested for COVID-19. No "out-of-pocket cost" means that covered individuals cannot be charged a copay or be required to meet a deductible for the test or visit.

The Consumer Alert and FAQs contain contradictory information, however, about the procedure that covered individuals should follow to obtain COVID-19 testing. The Consumer Alert implies that covered individuals can decide for themselves whether to get tested for COVID-19:

If you think you may have COVID-19, your health insurance must pay for the cost of visiting your doctor and the test as a preventive measure. Anyone who may have been exposed to, or is experiencing symptoms of COVID-19, should take immediate precautions to prevent spreading of the virus. A precaution may include consulting with your medical provider to determine whether you need to be tested for the virus.

On the other hand, the FAQs state that covered individuals must contact their health care provider for information about getting tested. On the question of whether the healthcare provider is required to test for COVID-19 if a covered individual has no symptoms but wants to be tested, the answer according to the FAQs is that testing protocols are up to providers, and testing or treatment required to address a patient's situation is between the patient and the patient's provider.

The FAQs also ask what happens if an in-network provider cannot see the covered individual, who then visits an out-of-network provider for COVID-19 testing. The answer is that testing performed by an out-of-network provider must be covered by the health insurer at no out-of-pocket cost, in situations where there is an issue with accessing care through an in-network provider that would prolong testing for COVID-19.

Finally, if a covered individual has COVID-19, the FAQs state that coverage for COVID-19 treatment will depend on the terms and conditions of the insurance policy. Health insurance plans typically cover medically necessary services, according to the FAQs; if the insurance policy has copays and deductibles, they will apply to treatment for COVID-19. Covered individuals are directed to contact their employer and health insurer for more details.

Off-Formulary Prescription Drugs

The Nevada Division of Insurance's emergency regulations state that, to ensure adequate access to prescription drugs due to shortages caused by supply-chain disruptions, health insurers must provide coverage for off-formulary prescription drugs if a formulary drug is not available to treat a covered individual. In addition, the cost to the covered person of the off-formulary prescription drugs in this situation must be the same as the cost for his/her usual medication, according to the Consumer Alert from the Nevada Division of Insurance. The FAQs phrase this requirement in a similar fashion: "If prescription drugs are not available due to supply disruptions, health insurers must cover off-formulary prescriptions at no additional cost to you."

As stated above, the emergency regulations from the Nevada Division of Insurance do not apply to self-insured plans or short-term limited duration plans.

Guidance from Health Insurance Carriers

According to the emergency regulations from the Nevada Division of Insurance, health insurers must issue guidance to covered individuals and network providers to inform them about available benefits, options for medical advice and treatment through telehealth, and preventive measures related to COVID-19.

Employer Action

Employers should consider sending a communication to employees residing in Nevada who are not enrolled in the employer's group medical plan (i.e. they are not eligible for coverage or they waived coverage), informing them about the special enrollment period through April 15, 2020 to obtain individual health insurance from Nevada Health Link. Employers should also review their paid leave policies and procedures for Nevada employees, and ensure that in the event employees are unable to work due to a mandatory government quarantine, they are not required to use their accrued paid leave during the time away (although they may choose to do so). Finally, Nevada employers with insured plans should keep an eye out for carrier information about insurance coverage and COVID-19, and coordinate with carriers if necessary, to distribute the information to covered individuals.

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

Ohio Expands Health Insurance Eligibility for COVID-19 Testing

On March 20, 2020, as a result of the coronavirus disease 2019 ("COVID-19") pandemic, the State of Ohio's Department of Insurance released two new Bulletins pertaining to health insurance in Ohio in response to Governor Mike DeWine's March 9, 2020 Executive Order 2020-01D. Briefly, these Bulletins require:

- fully insured health plans (and stop loss carriers) based in Ohio must continue health benefits eligibility for employees that have reduced hours. This order also gives a grace period of 60 days for the "insured" to defer premium payments.

- health insurance carriers providing fully insured health plans in Ohio must provide certain coverages related to COVID-19 testing.

Health Insurance Coverage Flexibility for Ohio Employees

Bulletin 2020-03 provides that insurers in Ohio must (1) allow employers to continue coverage for employees under the group plan, even if the employee is otherwise ineligible for coverage because of a drop in hours, and (2) allow employers to continue coverage for employees under the group plan regardless of eligibility requirements, like an "actively at work" requirement. Insurers are not permitted to increase premium rates because of COVID-19 related enrollment/participation decreases.

All insurers must give "insureds" an optional grace period, in which the insured may defer premium payments, without interest, for up to sixty (60) days from the premium payment's due date. It is unclear whether this grace period applies to participants or the employer to remit premiums. The order states only that "all insurers are to give their 'insureds' the option of deferring premium payments coming due, interest free, for up to 60 calendars days, interest free, for up to 60 calendar days from each original premium due date." A definition of "insured" is not in the order. It is also unclear if this applies to employees that are terminated – likely it does not. This appears only to apply to those that have had their hours reduced but remain employed. A more likely interpretation is that those that are terminated would be subject to COBRA or state continuation of coverage. Carrier reactions will likely be forthcoming and further guidance would be appreciated.

This order only applies to fully insured health insurance plan written in Ohio. In most cases it does not appear it would apply to a self-insured health plan, as self-insured health plans are not subject to state laws. However, it appears that a stop-loss carrier contract written in Ohio could not deny coverage for an employee that is not a work, but still employed, due to a temporary reduction in hours that would have otherwise made them ineligible under the plan. Additionally, all MEWAs in Ohio are subject to Ohio insurance laws and would need to follow this.

The order was effective immediately on Marc 20, 2020 and is effective until the State of Ohio is no longer under a State of Emergency.

COVID-19 Testing and Treatment: Out-of-Network Coverage

Bulletin 2020-05 provides that, effective March 20, 2020, fully insured health insurance plans in Ohio must:

- Include testing and treatment related to the COVID-19 virus in the definition of emergency medical conditions.

- Cover these emergency services with an out-of-network provider without preauthorization and cover the same cost sharing level as if the provider was in-network.

- Provide benefits with respect to an emergency service (including the testing and treatment of COVID-19) in an amount at least equal to the greatest of the amount negotiated with in-network providers, the amount calculated using the same method the plan generally uses to determine payments for out-of-network services, or the amount that would be paid under Medicare.

Further, fully insured health plans written in Ohio must ensure coverage for out-of-network emergency services (including the testing and treatment of COVID-19) without balance billing.

This order applies to fully insured health insurance plans written in Ohio. Health insurance carriers (not employers) will be responsible for compliance with this mandate. The order does not apply to self-insured plans due to ERISA preemption, but does apply to MEWAs in Ohio.

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

Oregon Health Insurance Response to COVID-19

On March 5, 2020, Governor Kate Brown announced that Oregon had reached an agreement with health insurance companies to waive cost-sharing for their insureds for coronavirus disease 2019 (COVID-19) testing. No expiration date was included as part of the announcement.

The Oregon Agreement

In Oregon, consumers with fully insured individual and group health plans will not be charged co-payments, co-insurance, or deductibles related to COVID-19 for the following:

- COVID-19 testing at an in-network provider, in-network urgent-care center, or emergency room
- COVID-19 immunizations when they become available

The Oregon agreement has been reached with the following insurers as of the announcement:

- BridgeSpan Health Company
- Health Net Health Plan of Oregon, Inc.
- Kaiser Permanente
- Moda Health Plan, Inc.
- PacificSource Health Plans
- Providence Health Plans
- Regence Blue Cross Blue Shield
- Samaritan Health Plans, Inc.

Oregon is also seeking clarification from the federal government about exceptions to cost sharing for Medicare Advantage plans and health savings account eligible high deductible health plans. The IRS announced on March 11, 2020 that reimbursements prior to satisfaction of the minimum deductible for costs related to testing and treatment of coronavirus will not cause participants in a qualified HDHP to lose eligibility to make HSA contributions.

As with the other directives of this nature, their applicability does not extend to self-funded plans subject to ERISA. Oregon is working on the same agreement with self-funded health plans but no information has been provided on this issue. However, nothing prevents a self-funded plan sponsor from providing the same or similar benefits.

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

Fifth Circuit Affirms ACA's Individual Mandate is Unconstitutional

This article is intended to provide you with an update on current legal challenges to invalidate the ACA. There is no immediate impact to employer-sponsored health plans or other requirements under the ACA.

On December 18, 2019, the U.S. Court of Appeals for the Fifth Circuit affirmed the U.S. District Court for the Northern District of Texas' finding that the Affordable Care Act's ("ACA's") individual mandate is unconstitutional. However, the Fifth Circuit disagreed that the entire ACA must be invalidated and remanded the case back to the Texas U.S. District Court for further review.

Background

One of the ACA's major provisions is that Americans must have health insurance or pay a penalty. That provision was challenged and, on June 28, 2012, the Supreme Court ruled that the Individual Mandate is not a valid exercise of Congress' power under the Commerce Clause (i.e., the federal government cannot force individuals to buy insurance), but nevertheless upheld it due to Congress' power under the Taxing Clause (i.e., the federal government has broad authority to monetarily penalize individuals).

In December 2017, Congress, through the Tax Cuts and Jobs Act, changed the Individual Mandate Penalty to $0, beginning January 1, 2019.

In a renewed effort to strike down the ACA, Texas Attorney General Ken Paxton and 19 other Republican state attorneys general filed a lawsuit which charged that Congress' changes to the law in last year's tax bill rendered the entire ACA unconstitutional. In Texas vs. U.S., Judge O'Connor of the U.S. District Court for the Northern District of Texas agreed with the Republican state attorneys general and invalidated the entire ACA.

The case was appealed to the Fifth Circuit.

Fifth Circuit Court of Appeals Ruling

In its decision on appeal, the Fifth Circuit agreed with the District Court that the ACA's Individual Mandate is only constitutional to the extent that it is paired with an individual mandate penalty tax. Accordingly, the reduction of the individual mandate penalty tax to "$0" as part of the Tax Cuts and Jobs Act renders the ACA's individual mandate unconstitutional.

However, the Fifth Circuit disagreed with the lower court's conclusion that the entire ACA must be struck down if the individual mandate is unconstitutional. The Fifth Circuit remanded the case back to the lower court for a detailed analysis of the ACA provisions, if any, that could be severed from the individual mandate and thereby survive. The Fifth Circuit also directed the lower court to determine whether the decision affects only the three states within the Fifth Circuit (Louisiana, Mississippi and Texas) and whether relief should be limited to those ACA provisions that injured the parties that filed the lawsuit.

It is important to note that because the case has not reached its final resolution, there is no immediate impact on employers or plan sponsors. For now, the ACA remains the law of the land and employers should continue to comply with the various aspects of the law.

Petition to Supreme Court for Expedited Review

Following the Fifth Circuit's ruling, Democrats defending the ACA filed a petition to the Supreme Court for an expedited review of the Fifth Circuit's ruling in an attempt to bypass a lengthy legal battle and have the Court rule on the matter before the 2020 presidential election. However, on January 21, 2020, the Supreme Court rejected this effort by Democrats to fast-track their appeal of the Fifth Circuit's ruling and has instead chosen to adhere to a normal briefing schedule.

Employer Action

There is no immediate impact to employer-sponsored health plans or other requirements under the ACA.

Amendments to Seattle Paid Sick and Safe Time Ordinance

The Seattle Office of Labor Standards amended the Paid Sick and Safe Time (PSST) Ordinance in response to challenges faced by workers caused by the COVID-19 pandemic. Effective March 18, 2020, all employees may use PSST when a family member's school or place of care has been closed. Additionally, employees of businesses with 250 or more full time equivalent employees can use PSST when their place of business has reduced operations or been closed for any health or safety reason.

Background

City of Seattle PSST is employer-paid time off that employees can use for an absence from work due to a personal or family member's physical or mental health condition, illness, or critical safety issues. Prior to the new amendments, employees could use PSST when their child's place of care or school was closed due to the order of a public health official for a health-related reason.

Updated FAQs

The Office of Labor Standards has provided updated FAQs to clarify the changes.

Updated: What is paid sick and safe time (PSST)?

Paid sick and safe time is employer-paid time off that employees can use:

- To care for themselves or a family member for an illness, injury, or health condition
- To go to the doctor to get medical and preventative care for themselves or a family member
- When employees are recommended by public health officials to self-quarantine
- When their family member's school or place of care closes
- When their place of business has been closed by order of public official for health-related reasons
- For a business of 250 or more full-time equivalent employees worldwide: when their place of business closes for any health or safety reason

Updated: Can an employee use PSST if their place of work is closed because of a possible health concern like COVID-19?

Yes, under the following circumstances:

- All employers must allow employees to take PSST if their place of work is closed by order of a public official for a health-related reason.
- Employers of 250 or more full-time equivalent employees worldwide must allow employees to take PSST if their place of work reduces operations or closes for any health or safety related reason. The closure does not have to be ordered or recommended by a public official.

Updated: Can an employee use PSST if their family member's school or place of care is closed?

Yes. An employee may use PSST if their family member's school or place of care has been closed. Prior to the March 2020 amendments, employees could use PSST when their

child's place of care or school was closed due to the order of a public health official for a health-related reason. Now an employee may use PSST if any family member's place of care or school is closed. Also, the law no longer requires that the closure be for a health-related reason or that a public official order the closure.

The definition of qualifying family member has been updated to include a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Employees are not required to share the reason for using PSST, but employers may ask for verification that the use of PSST was for an authorized reason after more than three consecutive workdays of PSST although employers may not inquire about the nature of the use. This means that an employer may ask for documentation that continued use of PSST is necessary but not that the employee explain the nature of the use of PSST.

Additionally, the Office of Labor Standards clearly states that documentation is not required for the use of PSST.

Employer Action

Employers within the City of Seattle and subject to the PSST should consider amending their leave policies to align their policies with the new requirements.

Mandated Long-Term Care Insurance Coming to Washington

Washington State enacted H.B. 1087 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 demonstrate that they have long-term care insurance will be exempt 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.

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.

Employer Action

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 may demonstrate coverage by a long-term care policy to avoid the payroll tax.

Washington State Health Insurance Response to COVID-19

On March 5, 2020, Washington State Insurance Commissioner Mike Kreidler issued an emergency order requiring health insurance carriers to waive copays and deductibles for any consumer requiring testing for coronavirus disease 2019 (COVID-19).

This mandate is effective March 5, 2020 through May 4, 2020 and applies to all state regulated health insurance plans and short-term limited duration medical plans. It does not directly apply to self-funded group health plans subject to ERISA.

Briefly, carriers are required to:

- Cover, prior to application of any deductible and with no cost-sharing, the health care provider visit and FDA-authorized COVID-19 testing for enrollees who meet the CDC criteria for testing, as determined by the enrollee's health care provider.
- Allow enrollees to obtain a one-time refill of their covered prescription medications prior to the expiration of the waiting period between refills so that enrollees can maintain an adequate supply of necessary medication.
- Suspend any prior authorization requirements that apply to covered diagnostic testing and treatment of COVID-19.

If a carrier has an insufficient number or type of providers in their network to provide testing and treatment of COVID-19, the carrier must ensure that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost than if the provider were in-network.

Employer Action

- Employers with insured group health plans written in Washington should anticipate first dollar coverage for office visits and testing associated with COVID-19. Carriers are likely to make additional information available in the coming days.
- Employers with self-funded group health plans subject to ERISA are not subject to this requirement. However, you can discuss enhanced benefits around office visits and testing for COVID-19 and consider whether to adopt any plan changes. Be aware some carriers and TPAs will require employers sponsoring self-funded group health plans to opt-in to or opt-out of expanded coverage related to COVID-19.

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

2020 Compliance Bulletins
State Based - Quarter Two

NORTH CAROLINA

SEATTLE

WASHINGTON

North Carolina DOI Activates Premiums Deferral Mandate

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

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

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

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

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

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

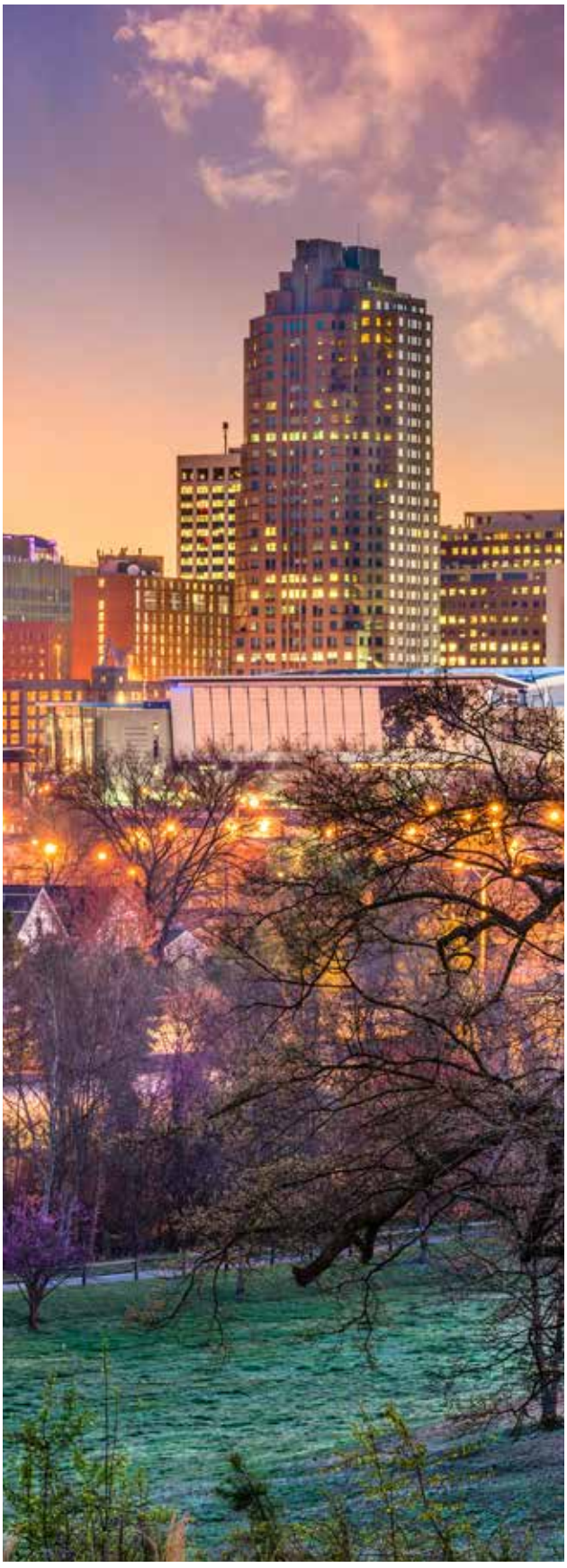
- Claims submissions
- Appeals filing
- Authorization requests of medical services
- Additions of newborn and adopted children to a policy

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

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

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

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



Seattle Hotel Employee Protections Ordinances Proposed Rules

The City of Seattle Office of Labor Standards ("OLS") proposed administrative rules to implement the four Hotel Employee Protections Ordinances passed in 2019. One of the laws, the Improving Access to Medical Care for Hotel Employees Ordinance (SMC 14.28) ("MC Ordinance"), requires employers to provide hourly, non-supervisory employees working in large hotels and certain ancillary hotel businesses with increased access to medical care by mandating a monthly healthcare expenditure.

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

The proposed rulemaking adds definitions for the following terms:

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

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

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

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

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

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

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

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

Covered Employees

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

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

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

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

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

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

Waivers Due to Other Coverage

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

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

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

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

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

Expenditure Rate

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

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

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

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

Self-Funded Plans

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

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

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

Employer Action

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

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

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

Covered employers should:

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

Washington Expands Workplace Protections for High-Risk Employees

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

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

High-Risk Individuals

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

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

Required Protections

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

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

If the above are not feasible, employers must:

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

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

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

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

Employer Action

With respect to group health plan coverage benefits:

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

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

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

2020 Compliance Bulletins
State Based - Quarter Three

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;

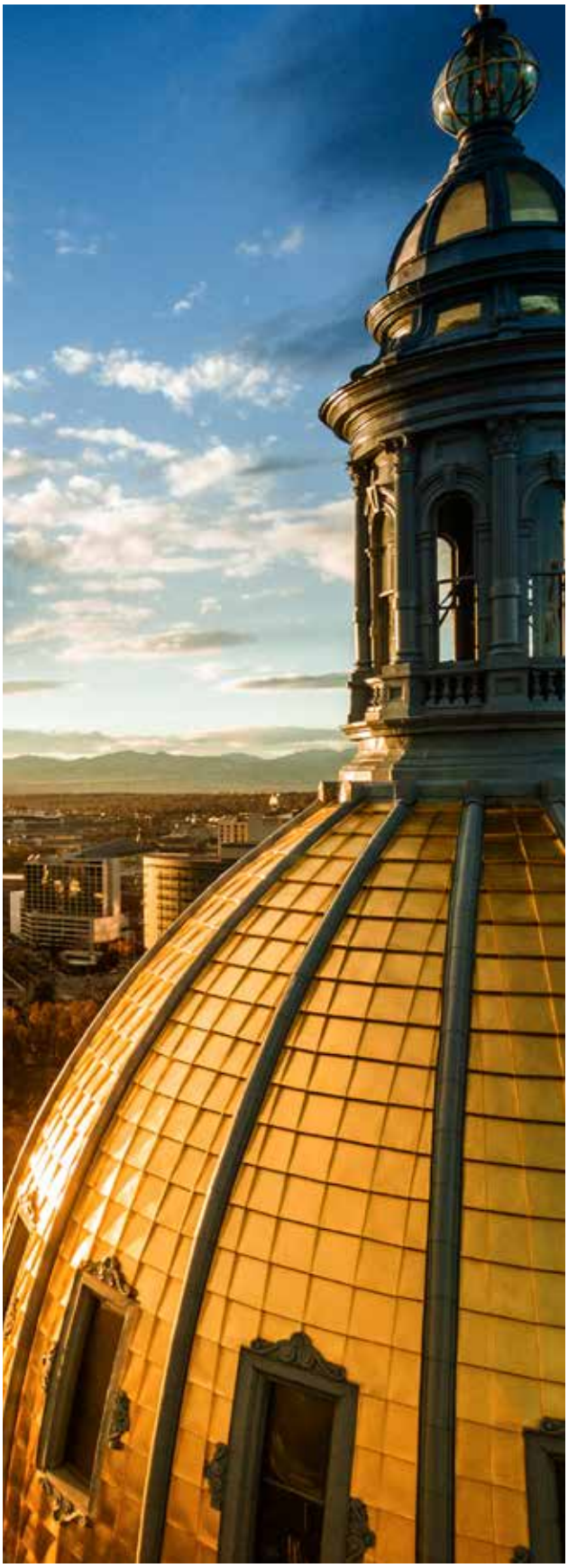
3. Seek or obtain medical diagnosis, care, or treatment if experiencing symptoms of a communicable disease causing a public health emergency;

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

2020 Compliance Bulletins
State Based - Quarter Four

New Annual Assessment for Colorado Health Insurance

Colorado Governor Jared Polis signed Senate Bill 20-215 into law on July 6, 2020. The new state law imposes a tax on the health benefit plans issued in the state effective January 1, 2021. The fee amount for non-profit carriers will equal 1.15% of premiums collected and 2.1% of premiums collected by for-profit carriers.

Background

Beginning in 2014, section 9010 of the Affordable Care Act imposed an annual health insurance tax ("HIT") on insurers that offered fully insured health coverage in the individual, small group and large group markets, as well as on public programs.

Congress imposed one-year moratoriums on the HIT for 2017 and 2019, and repealed the HIT entirely beginning in 2021.

The Colorado Health Insurance Affordability Fee

Senate Bill 20-215 is intended to replace the HIT in Colorado upon its expiration in January 2021. The new legislation creates the Health Insurance Affordability Enterprise (the "HIA Enterprise") within the Colorado Division of Insurance. The HIA Enterprise is responsible for assessing and collecting a new health insurance affordability fee from carriers that offer health benefit plans in the state by July 15 each year. Non-profit carriers will be required to pay a fee equal to 1.15% of premiums collected during the preceding calendar year, while for-profit carriers will be required to pay a fee equal to 2.1% of premiums collected during the preceding calendar year.

The health insurance affordability fee collected by the HIA Enterprise will be used to extend Colorado's reinsurance program and provide stability in the insurance market. The fee is also intended to expand access to high-quality, affordable health care for low-income and uninsured Coloradans through the state's marketplace.

Employer Impact

Fully insured contracts in Colorado will see an increase in renewal rates for 2021 and future years due to the health insurance affordability fee.

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, the HFWA requires all employers with 16 or more employees 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. Effective January 1, 2022, all employers (regardless of size) will be subject to the law.

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.

Additional information follows.

COVID-19 Related Leave

Employers with 500 or more employees (and public employers of any size) 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.

PHE 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.

Connecticut Paid Leave Employer Process Clarified

The Connecticut Paid Leave Authority ("CTPLA") has clarified the registration process for Connecticut Paid Leave ("CTPL") that must be completed by December 31, 2020. In addition, the CTPLA has finally detailed the exemption process for a private plan.

This Update will highlight these processes and provide links to the detailed CTPLA videos and resources.

Background

Connecticut established CTPL to provide wage replacement benefits to certain employees taking leave for reasons allowed under Connecticut's Paid Family and Medical Leave Act. Contribution withholdings under the state program begin January 1, 2021, and CTPL generally provides 12 weeks of benefits beginning January 1, 2022. Employers can opt-out of the state program and into a private plan, as long as certain conditions are met.

All employers (including out-of-state employers) with one or more employees working in Connecticut must participate in the CTPL program. Unionized employees of the State of Connecticut and employees of the federal government, a municipality, a local or regional board of education, or a non-public elementary or secondary school, generally are not covered under CTPL, but coverage may be collectively bargained.

Register Your Business

While no formal regulations have been issued since passage of CTPL, the CTPLA provided information and tools to assist employers with the registration process for either the state program or a private plan. The registration must be completed by December 31, 2020. Employers must register for either the state program or a private program by this date.

The CTPLA has created an eight-minute tutorial video that details step-by-step (and line-by-line) how to register your business for CTPL. The video can be found at https://youtu.be/WngZaiCZFOw. The CTPLA has also created a step-by-step PDF for how to register for a private plan exemption. The guide may be found at: https://ctpaidleave.my.salesforce.com/sfc/p/#t00000004XRe/a/t00000017Xnn/6OwV6rimr1ew1KGRWiHMAIAb4ynke8QUiawMA.HEEbc

Registration and the various registration tools are available at ctpaidleave.org.

Private Plan Alternative

As an alternative to the state program, employers may apply to the CTPLA for approval to offer a private plan. To obtain approval, an employer must provide its employees with at least the same level of benefits, under the same conditions and employee costs, as the state program.

There are a number of steps involved before an employer may offer a private plan option (in lieu of the state program) that should be carefully reviewed.

Insured or self-insured plan

A private plan may be provided through an insurance policy or a self-insured plan.

- If an employer's plan is insured, the forms of the policy must be approved by the Connecticut Insurance Department and be issued by an approved insurer.

- If an employer's plan is self-insured, the employer must furnish a bond running to the state, with a surety company authorized to transact business in the state.

Voting requirement

One feature unique to the CTPL program is a voting requirement. Before an employer may offer a private plan option (insured or self-funded), the employer is required to seek approval by a "majority vote" of the employer's Connecticut employees.

Other considerations

In evaluating a private plan versus the state program, employers should consider cost, access to benefits, customer service, and benefits offered to their employees.

- The CTPLA held a webinar detailing private plans and the registration process for applying for a private plan. If the private plan option is the preferred solution, it will be very important to review the webinar and other information produced by CTPLA to correctly apply and be approved for such a plan. For the Private Plan webinar, please visit: https://zoom.us/rec/share/p1U3IRGVxrvyYGoDlHJWBs30iJyRCgxJ-AxRjthHOF3d0RvGVwNeYJWU5XvyAe3I.YTaMxxcOvasUDwUX (Passcode: .eHs0*eV)

A final note to consider when evaluating the private plan option: unlike other states that have a private plan option, all carriers offering a Connecticut private plan require you to have your life and disability plans with that carrier.

Employer Action

- All employers with one or more employees working in Connecticut must register with the state by December 31, 2020.

- Employers will need to decide whether to participate in the state program or offer a private plan (insured or self-funded).
  - If offering a private plan, there are numerous steps and approvals that must be secured before the program is approved. It will be important to work with a carrier or TPA to understand the steps and begin the process.

- Employers subject to CTPL should also consult their payroll departments, payroll vendors and TPAs to ensure that employee contributions will be ready to be withheld beginning January 1, 2021 and remitted to the state quarterly or to the carrier as per their guidelines.

RESOURCES

- For the CTPLA website, please visit: ctpaidleave.org

- For the registration tutorial, please visit: https://youtu.be/WngZaiCZFOw

- For the Policy and Procedures for an Employer to Apply to Use a Private Plan to Meet Its Obligations Under the Connecticut Paid Leave Program, please visit: https://ctpaidleave.my.salesforce.com/sfc/p/#t00000004XRe/a/t000000188zt/uW_qfHegI0qhvZ8c5DOaF39SBJToI889iwJ9I7nT3d4

Maine DOL Adopts Final Rules for Earned Paid Leave Law

The Maine Department of Labor ("MDOL") published final Rules governing the Earned Paid Leave ("EPL") law. The Rules provide clarity to employers, employees, and others on how the MDOL intends to implement the law.

Highlights of the Rules follow.

Employer Coverage

Beginning January 1, 2021, the law requires an employer that employs more than 10 employees for more than 120 calendar days in any calendar year, to permit each employee to earn paid leave.

Specifically excluded from the paid leave mandate are:

- employees in a seasonal industry,
- municipalities or other political subdivisions, and
- an employee covered by a collective bargaining agreement ("CBA") during the period between January 1, 2021 and the expiration of the CBA. New CBAs after that date must include this benefit at a minimum.

Accrual

Beginning on the date of hire, an employee must earn one (1) hour of paid leave from a single employer for every 40 hours worked, up to 40 hours. An employer may impose up to a 120-calendar day waiting period before allowing an employee to use the accrued leave. Employees taking earned leave must be paid at least the same base rate of pay they received the week immediately prior to the leave taken.

Covered Employees with accrued and unused hours of earned paid leave from the previous year of employment will have those hours available for use by the employee in the current year of employment, up to a maximum of 40 hours. Hours are only required to continue to accrue up to 40 hours in the current year of employment.

An employee who returns to work within a one-year period of the last date of previous employment with the same employer is entitled to any unused balance of earned paid leave that was not paid out at the time of separation of employment.

Notice and Use of Leave

Absent an emergency, illness or other sudden necessity for taking earned paid leave, the employer may have a written policy requiring up to 4 weeks' notice to the employer of the employee's intent to use earned leave. Notice required for an emergency, illness or other sudden necessity must be reasonable under the circumstances, recognizing that advance notice may not be feasible. In such circumstances, a covered employee must make a good faith effort to provide as much notice as is feasible under the circumstances to the employer of the employee's intent to use earned paid leave.

The employer may place reasonable limits on the scheduling of earned paid leave for reasons other than emergency, illness or other sudden necessity, to prevent undue hardship on the employer as reasonably determined by the employer. Employees may use earned paid leave in increments of at least one hour, unless the employer chooses to allow smaller increments.

Regulation of Employment Poster

All employers are required to post Maine's Regulation of Employment poster in all workplaces. This poster was recently updated to include information on Maine's Earned Paid Leave law, and is available here: https://www.maine.gov/labor/docs/2020/posters/regulationofemployment.pdf

Employer Action

Employers should work with employment and labor counsel to review their leave policies and procedures to make sure they are compliant with the law by January 1, 2021. In addition, employers should monitor the MDOL Earned Paid Leave website for additional guidance.

Michigan's New No-Fault Auto Law:
Self-Funded Health Plan Changes

As of July 2020, Michigan residents will have new options for collision-related medical expense coverage as part of their auto insurance policy. Employers with self-funded group health plans should re-examine how their benefits coordinate with Michigan's new no-fault auto insurance laws if they have any participants in the State of Michigan.

Michigan auto insurance policies are no-fault. This means that each individual's coverage pays for their own claims related to the accident; it does not matter which driver was "at fault" or caused the accident. Before July 1, 2020, Michigan auto policies provided unlimited Personal Injury Protection ("PIP") coverage as part of their automotive insurance. PIP is the portion of Michigan auto insurance policies that provides coverage for medical and injury expenses related to automobile accidents. This means that the auto insurance will provide coverage for any medical and injury claims related to automobile accident. This coverage was not optional. This has now changed.

What Has Changed?

For auto insurance policies that renew on or after July 1, 2020, Michigan motorists will have options as to how much coverage they would like for PIP. Motorists will select one of the following options for PIP coverage when purchasing or renewing their individual auto insurance policy on or after July 1, 2020:

- Unlimited PIP coverage;
- PIP coverage of up to $500,000;
- PIP coverage of up to $250,000;
- PIP coverage of up to $50,000 (only available if the individual has another source of coverage, such as Medicaid that will provide coverage in the event of an accident); or
- Opt-out of PIP coverage entirely, if the individual has separate health insurance (i.e., an employer health plan) that covers collision-related injuries.

How does this Impact Self-Funded Health Plans?

All health plans have "coordination of benefits" rules within their plan document. These rules govern how and when the health plan will pay when there is another source of payment available (i.e., auto insurance) for the same injury or medical claim.

Plan sponsors of self-funded plans should review how their plans currently coordinate with auto insurance coverage when a participant has sustained injuries or medical claims related to an auto accident. This will enable the health insurance plan to make funding decisions on whether the employer-sponsored plan will be the primary or secondary source of coverage for medical expenses related to an accident. Many self-funded plans may have already chosen to pay secondary for coordination of benefits or exclude auto insurance coverage altogether for Michigan residents. This information can be obtained from the insurance plan document or from the plan's administrator or TPA.

What About Fully Insured Health Plans?

What About Fully Insured Health Plans?

If a Michigan resident is also enrolled in a fully insured employer health plan, that plan is required to pay first for any medical claims related to an auto injury.

Employers should confirm their coordination of benefits rules with their health insurance carriers.

Employer Action

1. Plan sponsors of self-funded medical plans should work with their TPAs and stop-loss carriers to determine how their employer-sponsored health plan will coordinate with participants that have Michigan No-Fault Auto Insurance.
   Most TPAs will have specific rules on how the plan can coordinate with auto insurance. Some TPAs will limit the available options based on their ability to administer the plan. Most TPAs may provide the following options for coordinating benefits with individual auto insurance policies:
   - **Choose for the self-funded health plan to pay primary.** This means that if an individual gets into an auto accident, the employer's health plan would pay for auto-accident related medical expenses first. The auto-insurer would then pay secondary. In this instance, the self-funded plan would likely incur the majority of medical expenses for auto accidents of their employees and dependents.
   - **Choose for the self-funded health plan to pay secondary** (auto insurance would pay primary). This means that if an individual gets into an auto accident, their PIP coverage under their auto insurance policy would pay for medical expenses first. After the PIP coverage limit (i.e., if the auto insurance only covers $250k or $500k in PIP expenses), the employer medical plan would provide coverage next.
   - **Choose for the self-funded health plan to pay secondary, but only after a certain dollar threshold.** The plan can choose to pay for auto accidents only after a certain dollar threshold, e.g., the plan can choose to pay after i.e., $250k or $500k paid by auto insurer. However, if the employee doesn't have PIP, then the employee would be personally liable for that first $250k or $500k – they would be without coverage. Employees would need to choose either $250k or $500k of PIP coverage on their auto insurance to receive any coverage under their employer's health plan.
     - **Important Note:** Plans that take this approach should consult with their legal counsel and administrator before implementing. It is possible that this could run afoul out-of-pocket maximum limits under the Affordable Care Act because the employee would not get coverage from the employer's plan until they (or their auto insurer) have paid either $250k or $500k, which functions much like a deductible in practice. If the regulators were to take this view, $250k or $500k could be viewed in excess of the allowed out-of-pocket limits under the ACA.
   - **Exclude Auto Accident Coverage.** This would mean that the plan would need to remind participants that they will need to obtain PIP coverage when they enroll in their auto insurance policies. Otherwise, the participant would risk being uncovered for medical expenses related to an auto accident. Plan sponsors should always discuss any exclusions with legal counsel before implementing.
2. Employers with self-funded plans should discuss with their TPAs how their current subrogation rules will coordinate with the Michigan Auto Insurance Plans.
3. Employers should communicate how their plans coordinate with auto insurance to employees and participants in Michigan. Employers should remind employees how their plan will interact with individual auto insurance policies. This will allow employees to ensure they are making the appropriate coverage selection when they renew their auto insurance policies. Employers may need to work with their health insurance carrier or TPA to obtain letters to provide information to participants on how their health plan coordinates with Michigan Auto Insurance. Many Michigan auto insurers require this letter when individuals are purchasing auto insurance coverage.
4. Employers should review their plan coordination decisions and subrogation rules with legal counsel.

City of Seattle Commuter Benefits Updated Q&A

The City of Seattle issued an updated Q&A providing more guidance to assist covered employer compliance with the Commuter Benefits Ordinance ("the Ordinance").

Background

The Ordinance took effect January 1, 2020 and requires businesses with 20 or more employees to offer their covered employees the opportunity to make monthly pre-tax payroll deductions for transit and vanpool expenses up to the IRS limit for transit benefits ($270 per month in 2020) or provide a fully or partially subsidized transit pass. Employers can administer a program themselves with King County Metro or use a TPA. Enforcement begins January 1, 2021.

Updated Q&A

A dedicated website is available for information on the Ordinance (link below). Recently, the Q&A was updated to provide additional guidance. Some highlights include:

- Employers that satisfy the requirement by providing a partially subsidized transit pass instead of a pre-tax deduction must subsidize at least 30% of a retail monthly transit pass covering fares for King County Metro and Sound Transit Link Light Rail Service
  - For 2020, that amount is $35.10 per month (30% of $117)
  - An ORCA card through the Business Passport Program satisfies the requirements of a partially subsidized transit pass
- Employees that are not eligible because they do not average at least 10 hours of work per week in Seattle but later become eligible must be offered the benefit when they become eligible and the benefit must be effective within 30 calendar days of the employee's election
- The employer may offer the benefit in the enrollment format that they choose but it must be something presented specifically to the employee for acceptance or rejection
- Employees are not required to make a pre-tax deduction or accept a transit pass
- Employees may choose to make a pre-tax deduction or accept a transit pass at any time after becoming eligible and the benefit must be effective within 30 days of the employee's election
- Direct employer reimbursement of commuting expenses DOES NOT satisfy the requirements of the Ordinance. Employers must offer the pre-tax deduction or the fully or partially subsidized transit pass

Employers can engage a TPA or work with King County Metro to facilitate using employee deductions to contribute to the employee's ORCA e-purse account. Employers can also contact Commute Seattle for information on the options available for establishing a pre-tax deduction program.

Virginia Law Tackles Surprise Medical Billing

Virginia has passed new legislation attempting to address surprise medical bills, more commonly known as balance billing. Effective January 1, 2021, out-of-network providers will be prohibited from balance billing for emergency services and for certain non-emergency services provided at an in-network facility if the non-emergency services involve surgical or ancillary services (including, for example, anesthesiology, radiology, surgery, pathology, hospitalist services, and laboratory services) provided by an out-of-network provider.

Who Does the New Law Affect?

The new law will apply to all employer-sponsored managed care health plans regulated by the commonwealth, individual health plans purchased on healthcare.gov, and state employee benefit plans.

- Only plans situsedin Virginia will be subject to the law – plans written outside of Virginia, even those that cover employees residing in the state, will not be covered by the new regulations.

- Self-funded ERISA plans or other arrangements where an employer provides benefits that are administered by a third party are also not covered by the law but may opt-in if they so choose. Groups can opt-in by completing and submitting an online application with the Virginia State Corporation Commission's Bureau of Insurance.

What is Surprise Medical Billing?

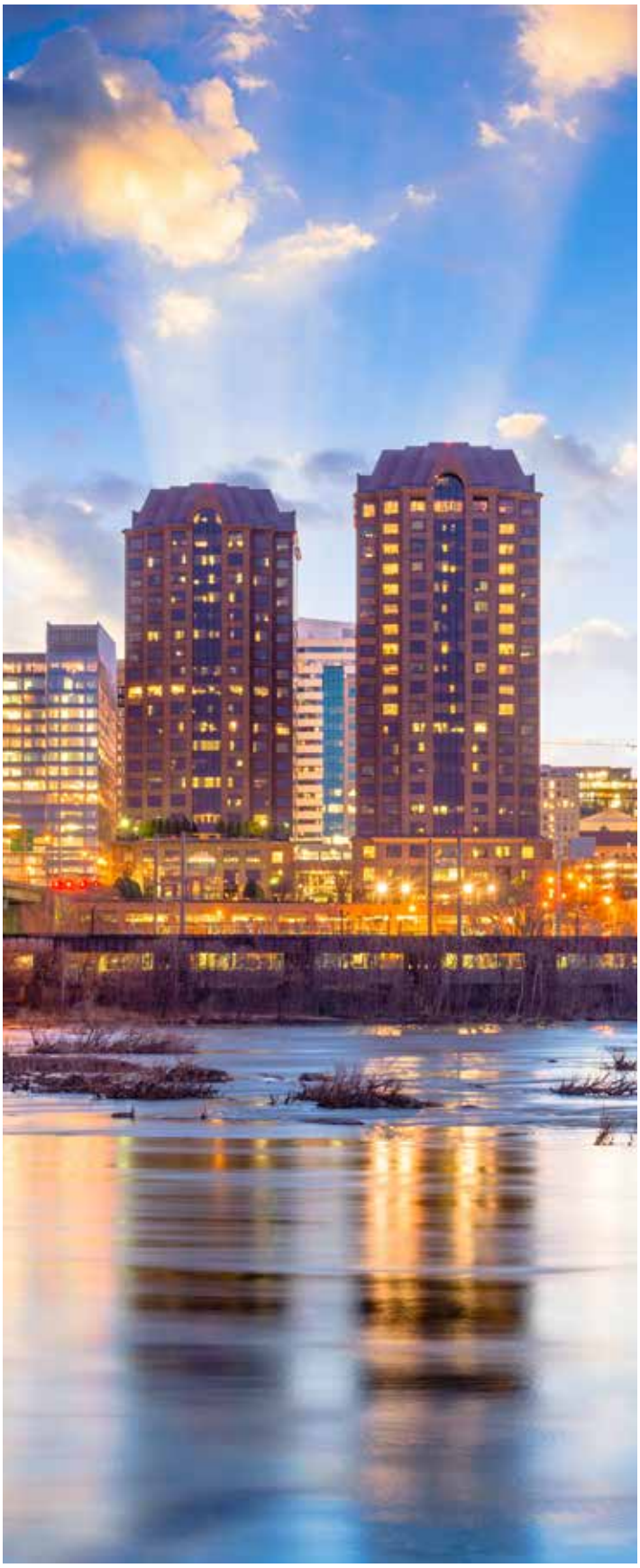
Surprise billing, or balance billing, occurs when patients enrolled in managed care health insurance plans receive bills for more than their plan's cost-sharing amounts directly from medical service providers who do not participate in a managed care plan's network of providers – often referred to as "out-of-network" providers.

Virginia's law stipulates that a member enrolled in medical insurance satisfies their obligation to pay for the out-of-network services if they pay the in-network cost-sharing requirement specified in the insurance contract. The health insurance carrier will provide to both the member and the out-of-network provider an Explanation of Benefits (EOB) which details the cost-sharing requirement. The health insurance carrier and the provider must ensure that the member does not pay any costs greater than the in-network cost-sharing requirement. Additionally, the law requires health insurance carriers to apply any cost-sharing paid by the member under this law toward the member's in-network deductible and maximum out-of-pocket limit.

What Happens When Balance Billing Occurs?

If a member were to pay an out-of-network provider an amount exceeding the in-network cost-share amount, the provider has 30 business days from receipt of the payment to refund the excess amount. If the provider does not issue the refund within the 30-day time limit, they must repay the excess amount, plus interest compounded daily from when the 30-day limit elapsed.

In determining the in-network cost-share amount, the law requires health insurance carriers to use a commercially reasonable amount, based upon payments for the same or similar services provided in a similar geographic area. The carrier will have 30 days from receipt of a claim to pay the out-of-network provider the commercially reasonable amount. If the provider disputes this amount, the carrier and the provider will have an additional 30-day window to negotiate and reach an agreement. If no agreement is reached, the dispute will be settled through arbitration.



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