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Philadelphia Expands Emergency Paid Sick Leave Benefits

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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).

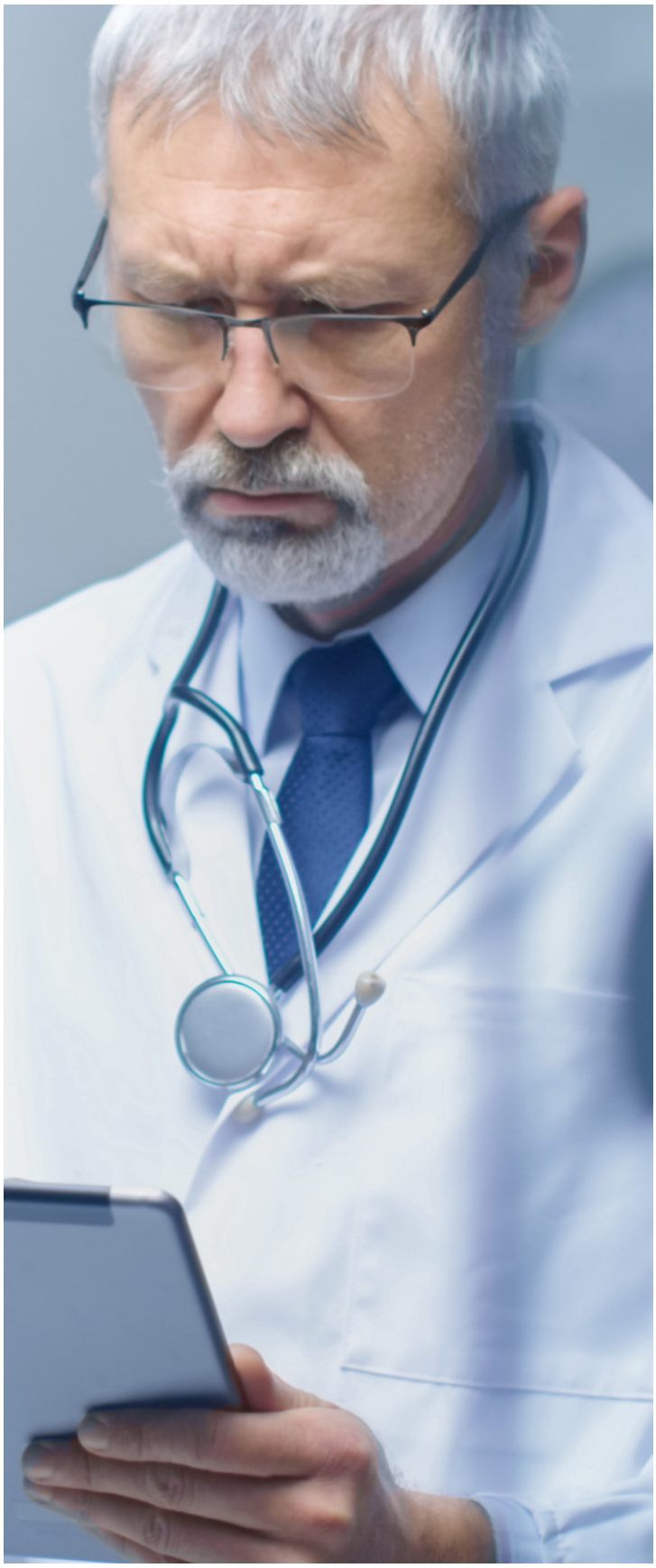
Other highlights from the guidance follow:

- 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.

2020 Compliance Bulletins
State Based

COLORADO

CONNECTICUT

MAINE

MICHIGAN

WASHINGTON

VIRGINIA

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-AxRjthHOF3d0RvGVwNeYJWU5XvyAe3l.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_qfHegI0qhvZ8c5DOaF39SBJToI889iwJ9l7nT3d4

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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