MY BENEFIT ADVISOR

2021: Third Quarter

Compliance Digest

Compliance Bulletins Released July-September

2021 Compliance Bulletins

July

Request for Information on Pharmacy Transparency
07/28/2021 3

August

ARPA Subsidy:
New Notice Required for Small New Jersey Employers
08/02/2021 5

First Guidance on Surprise Medical Billing Issued
08/05/2021 7

COBRA Subsidy Termination Notice Reminder
08/09/2021 12

Additional Guidance Issued on the 2021 COBRA Subsidy
08/10/2021 13

HHS Extends Public Health Emergency until October 18, 2021
08/11/2021 16

More Employers May Be Required to Electronically File Some IRS Forms
08/26/2021 18

Guidance on Preventive Care Services and PrEP Coverage
08/30/2021 20

September

Some Transparency in Coverage and CAA Deadlines Delayed
09/02/2021 22

New York Paid Family Leave 2022 Contributions and Benefits
09/07/2021 26

IRS Announces 2022 ACA Affordability Indexed Amount
09/10/2021 28

President Biden Announces Plan to Increase Number of Vaccinated Americans
09/16/2021 30

Medicare Part D Notification Requirements
09/20/2021 33

2021 MLR Rebate Checks Recently Issued to Fully Insured Plans
09/21/2021 37

Proposed Requirements Address Air Ambulance Reporting Requirement
09/27/2021 42

2021 State Bulletins

Connecticut

Connecticut Extends Dental and Vision Insurance to Age 26 . . . 44

Illinois

Illinois Passes Consumer Coverage Disclosure Act 45

New Hampshire

New Hampshire Establishes Paid Family and Medical Leave Program 46

Oregon

Oregon Delays Paid Family and Medical Leave 48

Texas

Texas Heartbeat Act and the Possible Impact on Health Plans 49

Virginia

Home Health Workers to Receive Paid Sick Leave in Virginia 51

Washington

2022 Seattle Hotel Employees Ordinance Expenditure Rates 53

Washington State's PAL Assessment Update 54

Guidance Issued on the 2021 COBRA Subsidy

Published: July 28, 2021

The Consolidated Appropriations Act, 2021 ("CAA") imposes new reporting requirements related to pharmacy benefits and prescription drug costs that apply to group health plans and health insurance issuers. On June 21, 2021, the Departments of Labor, the Treasury and Health and Human Services (collectively, "the Departments") issued a request for information ("RFI") regarding this new requirement. The RFI will help the Departments formulate rulemaking to implement this new requirement.

While there are no action items for employers related to the RFI, it does lay out some initial questions related to this new requirement and provides some insight as to the Departments' thinking.

Background

As previously reported, by December 27, 2021, and not later than June 1 of each year thereafter, the CAA requires group health plans and health insurance carriers offering group or individual health insurance coverage to submit a report to the Departments with respect to certain health plan and prescription drug information based on the previous plan year.

Specifically, the report will include:

- beginning and end dates of the plan year;
- the number of participants, beneficiaries, or enrollees, as applicable;
- each state in which the plan or coverage is offered;
- the 50 most frequently dispensed brand prescription drug and the total number of paid claims for each such drug;
- the 50 most costly prescription drugs by total annual spending and the annual amount spent by the plan or coverage for each such drug;

- the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year;
- total spending by the plan or coverage broken down by the type of health care services;
- spending on prescription drugs by the plan or coverage as well as by participants, beneficiaries, and enrollees, as applicable;
- the average monthly premiums paid (broken out by employer and employee contributions);
- rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year; and
- any reduction in premiums and out-of-pocket costs associated with these rebates, fees, or other remuneration.

Eighteen months after the date this information is submitted and biannually thereafter, the Departments will issue a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, aggregated so that no drug or plan specific information is made public.

Request For Comments

The RFI asks 41 questions related to this new reporting requirements (with some containing multiple sub-questions). Responses will be used to help formulate future guidance.

Some of the questions are summarized as follows:

- General implementation concerns. This includes:
  - What challenges do plans and issuers anticipate facing in meeting the statutory reporting obligations? For example, do plans or issuers currently have access to all the information they are required to report?
  - How much time will plans and issuers need to prepare their data and submit it to the Departments? What data sources are readily available and which data may take longer to compile?
  - Among group health plans, are there different considerations for reporting by fully insured versus self-funded plans, or for insured plans with small group versus large group coverage?
- Entities that must report. Will self-insured plans contract with third-party administrators to submit this information on behalf of the plan? What role will Pharmacy Benefits Managers (“PBMs”) play in furnishing necessary information to plans and will PBMs conduct some or all of the reporting?
- Information required to be reported. This includes:
  - How will the plan determine the 50 prescription drugs that are most frequently dispensed and the 50 drugs with the greatest increase in expenditures?
  - How will the plan determine the 25 drugs with the highest amount of rebates from drug manufacturers during the plan year?
- Compliance costs. What costs or other impacts do plans anticipate from implementing this new reporting requirement?

Employer Action

As this is just an RFI, there are no action items at this time. However, this information is helpful to understand the complexities of this upcoming reporting requirement. It is likely the Departments will issue regulations at a later date.

ARPA Subsidy

New Notice Required for Small New Jersey Employers

Published: August 2, 2021

The New Jersey Department of Banking and Insurance recently issued Bulletin No. 21-08, which establishes a new notice requirement for small employers of fully insured group health plans subject to New Jersey State Continuation. The Bulletin provides that employees that were otherwise furloughed or work reduced hours can now have access to coverage under the American Rescue Plan Act ("ARPA") of 2021.

Background

ARPA was signed into law in March 2021 and provides temporary premium assistance for COBRA continuation coverage. In order to qualify for this premium assistance, an individual has to be an Assistance Eligible Individual ("AEI"). In order to be an AEI, the individual must:

- Be eligible for COBRA or NJ state continuation due to a reduction in hours or due to involuntary termination for a reason other than gross misconduct;
- Elect COBRA or NJ state continuation; and
- Not be eligible for other group health coverage or Medicare.

Bulletin No. 20-12 relaxed the full-time requirement so that employees whose hours were reduced did not have to elect COBRA or NJ continuation; rather, furloughed employees or temporarily laid off employees could remain covered under the employer's group health plan.

Bulletin 21-08

Small employers that continued to cover employees under small employer plans using the relaxed full time requirement or while the employee were furloughed or temporarily laid off are required to comply with new notice requirements in order for those employees to receive premium assistance as AEIs under ARPA.

Employer Action

Small employers currently covering employees whose hours were reduced below 25 hours per week or who are on furlough or layoff status should provide notice that coverage ended as of April 1, 2021 and that continuation coverage under COBRA or New Jersey continuation is available. The qualifying event was April 1, 2021. For New Jersey continuation, employers should use the Alternative Notice of ARP Continuation Coverage Election Notice that has been modified for use with New Jersey continuation. This notice may be found at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/cobra/premium-subsidy/model-alternative-election-notice.pdf.

For COBRA continuation use the model notice provided at www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

Action to Provide an Extended Election Period

Small employers whose employees had the opportunity to elect continuation due to reduced hours, furlough or layoff, but who did not elect continuation or who elected continuation but later terminated it, must be given the opportunity for an extended election period. The Department gave very little notice to comply with the original dates set forth in the Bulletin: employers must provide notice of the extended election period no later than May 31, 2021 with respect to COBRA continuation and no later than 5 business days following July 21, 2021 for State continuation. Employers should provide this notice as soon as possible, if they haven't already.

We will continue to keep you updated.

First Guidance on Surprise Medical Billing Issued

Published: August 5, 2021

On July 13, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") jointly published an interim final rule implementing provisions of the No Surprises Act ("NSA"). This is the first set of regulations to address the NSA ("Part I Regulations"); additional rules are forthcoming, including guidance on the Independent Dispute Resolution ("IDR") process.

Briefly, as it relates to group health plans, the regulations:

- Include protections to limit out-of-network ("OON") cost-sharing and "balance billing" as they relate to emergency services, OON providers of air ambulance services, and non-emergency services performed by OON providers at in-network facilities (with limited exceptions).
- Prescribe a formula to determine a participant's cost-sharing for these services and how much the plan will pay to the provider for these services. Generally, this will be the lesser of a Qualified Payment Amount ("QPA") or the provider's billed charge, unless a state law or the All-Payer Model Agreement applies.
- Describe new notification obligations, including posting information about the surprise medical bill protections on the plan's website as well as including such information in the Explanations of Benefits ("EOBs") issued with respect to these services.

These rules take effect for plan years beginning on or after January 1, 2022, and apply to all group health plans (including grandfathered plans), except:

- Excepted benefits (e.g., dental and vision plans);
- Short-term limited duration insurance;
- HRAs and other account-based plans; and
- Retiree plans (plans with fewer than 2 participants who are current employees).

For fully insured group health plans, the carrier will be responsible for compliance.

For self-funded group health plans, the plan sponsor is responsible and will need to work closely with third-party administrators ("TPAs") to comply with these rules. TPAs will likely need to update plan documents to reflect the changes required under the NSA and could pass additional administrative costs on to plan sponsors.

The following highlights some of the additional details from these rules. It will be important to discuss implementation and compliance with TPAs. The Departments request comments on numerous aspects of the rule by September 7, 2021.

Background

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

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

"Balance billing" refers to the practice of an OON provider billing a patient the difference between (1) the provider's billed charges and (2) the amount collected from the plan (or carrier) plus any amounts previously collected from the patient (e.g., copays, coinsurance, or amounts paid toward the deductible).

The law also establishes a pathway for resolving payer-provider payment disputes using negotiation and arbitration. If entities are unable to come to an agreement, the IDR process requires each party to submit a final payment offer and the arbiter will select one of these offers as the final payment amount. The arbitrator's decision is final and generally may not be appealed.

Generally, the requirements of the NSA apply to the items and services described above unless the state has an "All-Payer Model Agreement" ("APMA") (used by Maryland, Pennsylvania and Vermont) or state balance billing law (including Delaware, Massachusetts and Pennsylvania that applies.

In general, self-funded ERISA group health plans will be subject to the requirements of the NSA (versus state law or APMA). However, where state law allows, a plan sponsor may voluntarily "opt-in" to a state's balance billing protections that provide a method for determining the cost-sharing amount or total amount payable under such a plan (versus the NSA). Currently four states – Nevada, New Jersey, Virginia and Washington – provide such an option. A plan that opts in to such a state law must do so for all items and services to which the state law applies.

Self-funded plans that opt-in to the state law must prominently display in their plan materials describing the coverage of OON items and services a statement that the plan has opted into a specified state law, identify the state (or states), and include a general description of the items and services provided by OON facilities and providers that are covered by the specified state law.

Interim Final Rules

General Requirements

With respect to OON emergency services, non-emergency services furnished by an OON provider in an in-network facility and OON air ambulance services, the NSA requires the services be provided:

- without cost-sharing requirements that are greater than those that would apply if the services were provided in-network;
- by calculating cost-sharing requirements as if the total amount that would have been charged for the services were equal to the "recognized amount" for such services; and
- by counting any cost-sharing payments toward any in-network deductible or out-of-pocket maximum ("OOPM") (including the annual limit on cost-sharing).

Emergency Services

If a group health plan provides coverage for emergency services in a hospital's emergency department (or an independent free-standing emergency department), the coverage must be provided:

- without any prior authorization;
- regardless of whether the provider furnishing the emergency services is an in-network provider (or facility);
- without limiting what constitutes an emergency medical condition solely based on diagnosis codes; and
- without regard to any other term or condition of coverage, other than:
  - an exclusion or coordination of benefit;
  - a waiting period; or
  - applicable cost-sharing.

The Departments are concerned that some plans (and carriers) currently deny coverage of certain services provided in the hospital's emergency department by determining whether the care involves an emergency medical condition based solely on the final diagnosis code. The interim final rules clarify that all pertinent documentation must be considered and should focus on the presenting symptoms and not final diagnosis when evaluating claims for emergency services.

The regulations further clarify that:

- Post-stabilization services are considered emergency services subject to the NSA unless certain conditions are satisfied.
- A plan that covers emergency services is prohibited from denying benefits to a participant with an emergency medical condition that receives emergency services based on a general plan exclusion.

Notice & Consent Exception for Non-Ancillary Services

In the case of non-emergency, non-ancillary services performed by an OON provider at certain in-network facilities, an exception to the prohibition on surprise medical billing may be permissible when the provider gives the patient advance oral and written notification and receives the patient's signed consent. The rules provide the specific content, method and timing of the notice and consent communications and provides substantial detail on each of these components.

This exception does not apply to ancillary services. For this purpose, ancillary services include items and services:

- related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services;
- that are diagnostic, including radiology and laboratory services; and
- provided by an OON provider, only if there is no in-network provider who can furnish such item or service at such facility.

In addition, the exception does not apply for items or services furnished because of unforeseen, urgent medical needs that arise at the time a service is furnished for which an OON provider otherwise satisfied the notice and consent requirements.

Cost-Sharing Calculations

Cost-sharing is what the participant or beneficiary must pay for a covered item or service under the terms of the group health plan (e.g., copayments, coinsurance, and amounts paid towards deductibles). Generally, cost-sharing does not include premium payments, balance billing by OON providers, or the cost of items or services that are not covered under the plan.

The participant's cost-sharing for OON emergency services and for non-emergency services furnished by an OON provider in an in-network facility is calculated based on the "recognized amount" for such services. Unless the APMA or a state law applies, the recognized amount is the lesser of the "Qualified Payment Amount" ("QPA"), or the amount billed by the provider or facility. If the APMA or state law applies, the recognized amount is determined by the APMA or specified state law.

With respect to OON air ambulance providers, APMA and state laws generally do not apply. Cost-sharing is determined based on the lesser of the QPA or the billed amount.

Qualified Payment Amount

The QPA is the median of the contracted rates for a particular item or service plus an inflation adjustment. The rules around calculating the QPA are complicated and described in much detail in the regulations, including various special rules that apply (e.g., related to anesthesiology, new plans, and limited data). Briefly, the QPA is determined by:

1. Calculating a median contracted rate by arranging in order from least to greatest the contracted rates of all group health plans of the plan sponsor in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished and selecting the middle number.
2. Adding an inflation adjustment (to be announced by the Departments annually).

Notably, for self-funded plans, the regulations define the "insurance market" as all self-insured group health plans of the plan sponsor or, at the option of the plan sponsor, all self-insured group health plans administered by the same entity that is responsible for calculating the QPA on behalf of the plan (in most cases, the TPA).

Plan/Provider Payment Process

The plan will determine whether the services are covered by the plan. Within 30 days of receipt of a "clean claim,"[1] the plan must send the provider an initial payment or notice of denial of the payment. The total amount paid by a plan for items and services is referred to as the "OON Rate." Assuming APMA and state laws do not apply, the plan must make a total payment equal to one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee:

- if the plan and the provider or facility have agreed on a payment amount, the agreed-on amount; or

- if the parties (plan and provider) enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

If the APMA or state law applies, then the OON rates is determined by the APMA or specified state law.

If the payment is disputed, an IDR process will begin after a 30-day window for open negotiation. The regulations addressing the IDR process and IDR entities will be issued in later rulemaking.

Group Health Plan Disclosures

Group health plans (and health insurance carriers) must make publicly available, post on a public website of the plan or issuer and include on each EOB for an item or service with respect to which the NSA applies a notice of the protections under the NSA. If a state balance billing law applies, this must be included in the notice. A model notice may be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

Employer Action

Employers should review these requirements with their carriers and TPAs for compliance effective with the first plan year that begins on or after January 1, 2022. As most of these requirements are functions of claim payment and adjudication, it will be important that vendors can support the changes required by the NSA. Self-funded health plans will want to ensure TPAs can meet these new requirements.

We expect additional guidance on the NSA, including the IDR process.

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

COBRA Subsidy Termination Notice Reminder

Published: August 9, 2021

The American Rescue Plan Act of 2021 included COBRA premium assistance (a 100% COBRA subsidy) for certain assistance eligible individuals ("AEIs") who lose group health plan coverage as the result of an involuntary termination of employment or a reduction of hours. The COBRA subsidy is available to AEIs for the period between April 1, 2021 and September 30, 2021. Among other requirements, employers (and their COBRA vendors) must issue notice prior to the expiration of the subsidy.

Specifically, with respect to the September 30, 2021 expiration date, AEIs must be provided with a notice of expiration of the COBRA subsidy between August 16 and September 15, 2021. The notice must explain the date that the premium assistance will expire and that the individual may be eligible for coverage without any premium assistance through COBRA, a group health plan, the Marketplace, or Medicare/Medicaid.

The Departments have issued a Model Notice of Expiration of Period of Premium Assistance. While employers are not required to use the Model Notice, doing so is considered a best practice. The model notice may be found under Model Notices at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy-for-employers-and-advisers.

Employer Action

With respect to the September 30, 2021 subsidy expiration date, employers should work with their COBRA vendors to provide AEIs with this notice between August 16 and September 15, 2021. Employers will need to confirm each AEI's date for the end of the maximum COBRA period and the premium to continue COBRA coverage when the subsidy expires.

Additional Guidance Issued on the 2021 COBRA Subsidy

Published: August 10, 2021

On July 26, 2021, the IRS released Notice 2021-46 providing additional guidance on the 2021 COBRA premium assistance (or "COBRA subsidy"). The 2021 COBRA subsidy was included as part of the American Rescue Plan Act ("ARP"). This IRS guidance is coming relatively late, with only two months remaining in the COBRA subsidy period.

Background

Assistance eligible individuals ("AEIs") who are COBRA qualified beneficiaries ("QBs") because of an involuntary termination of employment or a reduction in hours receive a 100% COBRA subsidy for the period of April 1, 2021 through September 30, 2021.

The subsidy expires the earlier of:

- The first date that the AEI is eligible for other group health plan coverage or Medicare;
- The end of the maximum COBRA period; or
- September 30, 2021.

Employers are eligible to recoup the cost of the subsidy as a payroll tax credit.

Employers and their COBRA administrators must issue notices with respect to the subsidy.

This latest guidance from the IRS includes a series of FAQs that provides additional information to employers, health insurers, and plan administrators on the COBRA subsidy. While the guidance does not answer all outstanding questions related to the COBRA subsidy, it does provide helpful clarification on the availability of the COBRA subsidy for extended coverage periods, loss of the COBRA subsidy for dental and vision coverage, and which entity may claim the COBRA subsidy tax credit.

Eligibility for COBRA Premium Assistance – Extended Coverage Options

Q: Is the COBRA subsidy available for an AEI eligible for an extended period of COBRA continuation coverage due to a disability determination, second qualifying event, or state mini-COBRA?

Yes. The IRS confirmed that for those AEIs who are eligible to continue COBRA coverage beyond 18 months due to a disability determination, second qualifying event, or an extension under state mini-COBRA, such individuals will also be considered AEIs (absent eligibility for other group coverage or Medicare) to the extent the additional coverage period falls between April 1, 2021 and September 30, 2021.

End of the COBRA Subsidy – Dental and Vision Coverage

Q: If an AEI elects COBRA continuation coverage for only dental and/or vision coverage and receives a COBRA subsidy, does the AEI cease to be eligible for the COBRA subsidy if they subsequently become eligible for other group health plan coverage or Medicare that does not provide dental or vision benefits?

Yes. The AEI's COBRA subsidy for all plans ends when the individual becomes eligible for coverage under any other disqualifying group health plan or Medicare. As a result, an AEI that becomes eligible for Medicare will lose eligibility for the COBRA subsidies for medal, vision, and dental coverage despite most Medicare plans' limited coverage of dental or vision benefits. The same holds true for an AEI that becomes eligible for other group medical coverage where the AEI's new plan sponsor does not offer vision or dental benefits, or if the benefits provide less coverage than the COBRA plans in which the AEI is currently enrolled.

It is important to note that the subsidy requirements terminate once an AEI becomes eligible for a form of disqualifying coverage. The AEI does not need to enroll in the coverage to lose the subsidy.

Claiming the COBRA Subsidy Payroll Tax Credit

As described in ARP and subsequent guidance, the funding to offset the additional expense of subsidized COBRA coverage for AEIs comes in the form of a payroll tax credit. With respect to federal COBRA, the common law employer sponsoring the plan will generally receive the payroll tax credit. Carriers claim the credit with respect to fully insured plans that are not subject to federal COBRA but are subject to a state mini-COBRA law.

In Notice 2021-46, the IRS provides additional clarification on the entity that may claim these credits and specifies certain situations where the right to claim the COBRA subsidy payroll tax credit falls to any entity other than the common law employer of the AEI.

Q: Who is the common law employer maintaining the plan?

The common law employer maintaining the plan is the current common law employer for an AEI whose hours have been reduced or the former common law employer for those AEIs who have been involuntarily terminated from employment.

Q: Who may claim the COBRA payroll tax credit when the group health plan is subject to both federal COBRA and the state mini-COBRA coverage?

The common law employer maintaining the plan is entitled to claim the payroll tax credit when the state mini-COBRA coverage is comparable to federal COBRA and the group health plan is subject to both laws. Therefore, even if the state mini-COBRA coverage would otherwise require the AEI to pay the premiums directly to the insurer during the period of state-mandated coverage after federal COBRA coverage ends, the insurer is not entitled to claim the COBRA subsidy payroll tax credit.

Q: Which entity is entitled to claim the COBRA subsidy payroll tax credit when a group health plan subject to federal COBRA covers employees of different common law employers who are members of the same controlled group?

When a plan subject to federal COBRA covers employees of two or more members of a controlled group, each common law employer that is a member of the controlled group is entitled to claim the payroll tax credit with respect to its employees or former employees who are AEIs. While all members of a controlled group are treated as a single employer for employee benefit purposes, each member is a separate common law employer for employment tax purposes.

Q: In the event of business reorganizations, which entity is entitled to claim the COBRA payroll tax credit for AEIs who are merger and acquisition qualified beneficiaries ("M&A QBs") if the selling group remains obligated to provide COBRA constitution coverage?

When the selling group remains obligated to provide COBRA continuation coverage to M&A QBs after a business reorganization, the entity in the selling group that maintains the group health plan is entitled to claim the COBRA subsidy payroll tax credit.

The FAQs above highlight some of the information contained in Notice 2021-46. The guidance also provides clarification as it relates to who claims the payroll tax credit in a Multiple Employer Welfare Plan ("MEWA") and Professional Employer Organizations ("PEOs"), certain government plans and small market group plans purchased through the Small Business Health Options Program ("SHOP"). Review the guidance for further details.

Employer Action

Employers should continue to work with their COBRA administrators to ensure compliance with the ARP COBRA subsidy. Employers may need to engage payroll or tax professionals for assistance in claiming the tax credits.

HHS Extends Public Health Emergency until October 18, 2021

Published: August 11, 2021

On July 19, 2021, the Secretary of Health and Human Services ("HHS"), announced that the administration will renew the COVID-19 pandemic Public Health Emergency, scheduled to expire on July 20, 2021. 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.

As previously noted, in a letter sent to state governors, HHS indicated that the agency expects that the Public Health Emergency will likely remain in place for all of 2021. While not formal agency action, it appears that HHS intends to continue to renew the Public Health Emergency through, at least, the end of 2021.

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire October 18, 2021 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief and 2) 60 days after the announced end of the National Emergency. The Departments are expected to announce the end date; at this time, no end date has been announced.

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

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

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

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

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

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

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

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

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

On an individual basis, group health plans, disability, and other employee welfare benefit plans will disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

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

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

- **ERISA Claims Deadlines.** 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.

More Employers May Be Required to Electronically File Some IRS Forms

Published: August 26, 2021

On July 23, 2021, the IRS issued proposed rules that would significantly expand the number of employers required to electronically file information returns with the IRS. Among others things, this change would impact filing of Forms 1094-C/1095-C. If finalized "as is," this change would take effect for filings due in 2022 (e.g., calendar year 2021 Forms 1094-C/1095-C due to be filed with the IRS by March 31, 2022). It should be noted that this article is limited to the impact the proposed rule may have on Forms 1094-C and Forms 1095-C; however, Forms 1094/1095-B are also affected (e.g., employers with fewer than 50 full-time employees who have a self-funded health plan may use these forms to comply with health coverage reporting). In addition, other forms are affected by this proposed rule but are not addressed in this article, including Forms W-2, 1099 and 5330. Review the proposed regulations for more information.

Under the current rules, employers are required to file Forms 1094-C and 1095-C electronically when filing 250 or more returns. When determining whether the 250 threshold is satisfied, each type of return is considered separately. In addition, corrected returns are generally counted separately from the original information filing and each corrected return is counted separately to determine whether electronic filing is required.

These proposed rules would change those parameters as follows:

- Lower the filing threshold. For filings due in 2022, the proposed regulations require electronic filing when 100 or more returns are filed (as opposed to 250). For filings due in 2023 and beyond, the threshold is further reduced to 10. It is important to note that employers with 50 or more full-time employees are generally required to file Forms 1094/1095-C to comply with the employer shared responsibility mandate. If finalized "as is" the 10-filing threshold will effectively require electronic filing for all Forms 1094/1095-C by 2023.

- Require aggregation. To determine whether an employer must file forms electronically, the proposed rules require all returns to be counted together. For example, under these proposed rules, an employer who files 300 Forms W-2 and 75 Forms 1095-C in 2022 would be required to file Form 1094-C and all Forms 1095-C electronically because, when aggregated, the employer files at least 100 returns (300 W-2s + 75 Forms 1095-C).

- Corrected returns. A corrected information return would be required to be filed in the same manner as the original form.

Employer Action

Although these are only proposed rules, given the potential 2022 effective date, employers should monitor this situation as electronic filing could be required as early as January 2022 for employers who were previously exempt.

Guidance on Preventive Care Services and PrEP Coverage

Published: August 30, 2021

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") have jointly released a new FAQ regarding preventive care services and coverage for pre-exposure prophylaxis ("PrEP").

As background, non-grandfathered group health plans must cover certain preventive care items and services without cost-sharing. On June 11, 2019, the USPSTF released a recommendation with an "A" rating that clinicians offer PrEP with "effective antiretroviral therapy to persons who are at high risk of human immunodeficiency virus ("HIV") acquisition." Non-grandfathered group health plans must cover PrEP consistent with the USPSTF recommendations and without cost-sharing effective for plan years beginning on or after June 30, 2020.

This FAQ 47 clarifies:

- Plans must cover, without cost-sharing, items and services that USPSTF recommends should be received prior to being prescribed PrEP as part of the determination of whether such medication is appropriate for the individual and for ongoing follow-up and monitoring. The Q/A-1 provides additional detail of baseline and monitoring services.

- Plans are also required to cover, without cost-sharing, office visits associated with each recommended preventive service for the individual when:
  - the service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and
  - the primary purpose of the office visit is the delivery of the recommended preventive service.

- Plans may not use reasonable medical management techniques to restrict the frequency of benefits for services specified in the USPSTF recommendation for PrEP, such as HIV and STI screening.
  - When PrEP is medically appropriate for an individual specified in the USPSTF recommendation, as determined by the individual's health care provider, it would not be reasonable to restrict the number of times the individual may start PrEP.

- Reasonable medical management techniques with respect to coverage of PrEP may be used to encourage individuals prescribed PrEP to use specific items and services, to the extent the frequency, method, treatment, or setting is not specified in the USPSTF recommendation.
    - For example, since the branded version of PrEP is not specified in the USPSTF recommendation, plans may cover a generic version of PrEP without cost-sharing and impose cost-sharing on an equivalent branded version (subject to an accommodation when the generic is not medically appropriate for a particular individual).
- As described in earlier guidance, plans utilizing reasonable medical management techniques must have an easily accessible, transparent, and sufficiently expedient exceptions process.
    - For example, one that allows prescribing and accessing PrEP medications on the same day that an individual receives a negative HIV test or decides to start taking PrEP. Such process cannot be unduly burdensome on the individual or provider.

As plans may not have understood that the regulatory coverage requirements apply to all support services of the USPSTF's recommendation for PrEP, the Departments will not take enforcement action against a plan for failing to provide coverage of such services until September 17, 2021 (the period ending 60 days after publication of these FAQs), and encourage states to take a similar enforcement approach.

Some Transparency in Coverage and CAA Deadlines Delayed

Published: September 2, 2021

On August 20, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively called "the Departments") jointly issued an FAQ which implements parts of the Consolidated Appropriations Act ("CAA") that was passed at the end of 2020 and the Transparency in Coverage ("TiC") final regulations that were issued in November of 2020. The requirements under the CAA apply to all group health plans, including grandfathered plans.

The FAQ defers enforcement of certain provisions of the CAA and TiC regulations, including:

- TiC – Machine Readable Files:
  - For files associated with in-network rates and out-of-network allowed amounts and billed charges, delayed until July 1, 2022.
  - For prescription drug files, delayed pending future guidance.

- CAA Price Comparison Tools: Delayed until the first plan year that begins on or after January 1, 2023 (to align with TiC requirements).

- Good Faith Estimate ("GFE") and Advance Explanation of Benefits ("EOBs"):
  - Delayed pending future rulemaking.

- Reporting on Pharmacy Benefits and Drug Costs:
  - Delayed pending future rulemaking – compliance expected by December 27, 2022.

Other provisions of the CAA will continue to take effect as described under the statute, but with good faith relief available pending future guidance or rulemaking. The following describes each requirement and any available relief.

Transparency in Coverage – Machine Readable Files

Requirement: Group health plans and health insurance carriers must make public three machine-readable files disclosing:

1. in-network rates,
2. out-of-network ("OON") allowed amounts and billed charges, and
3. negotiated rates and historical net prices for covered prescription drugs.

Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief: FAQ 49 provides the following relief with respect to publishing machine readable files:

- The requirement to make public in-network rates and OON allowed amounts and billed charges (1 and 2 above) is delayed until July 1, 2022.
  - For plan years that begin between January 1, 2022 and July 1, 2022, the files must be posted by July 1, 2022.
  - For plan years that begin after July 1, 2022, the files must be posted in the month in which the plan year begins.
- The requirement to make public negotiated rates and historical net prices for covered prescription drug (3 above) has been delayed pending further rulemaking.

Transparency in Coverage – Price Comparison Tools (Including CAA Requirements)

Requirement: Under the TiC requirements, group health plans and carriers must provide for the disclosure of cost sharing information in advance of receiving care. Such disclosure is required to be made through an internet-based self-service tool and in paper form. This requirement takes effect for plan years beginning on or after January 1, 2023, with respect to 500 identified items and services. Full compliance is required for plan years beginning on or after January 1, 2024.

The CAA includes price transparency and cost information requirements that are similar to (if not duplicative of) what is required by the TiC. Under the statute, the CAA requirements take effect for plan years beginning on or after January 1, 2022.

Enforcement Relief: The Departments will delay enforcement of the CAA's price comparison requirement to align with the TiC effective date (plan years beginning on or after January 1, 2023). In addition, the Departments will undertake rulemaking to determine whether the requirements from the TiC final rules also satisfy the requirements of the CAA. Notably, future guidance will require that cost sharing information be available via telephone (as well as through the internet and in paper form). Plans with existing tools should continue to make them available.

While the TiC requirements do not apply to grandfathered plans, to the extent they are duplicative of requirements under the CAA, grandfathered plans will likely need to comply.

Insurance ID Cards

Requirement: The CAA requires plans and carriers to include on any physical or electronic ID cards information about deductibles, out-of-pocket maximums, and a telephone number and website address for individuals to seek consumer assistance. Group health plans must comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: While regulations are expected to implement the ID card requirements, they will not be issued until after January 1, 2022. Plans should continue to implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

Good Faith Estimate and Advance Explanation of Benefits

Requirement: The GFE and Advance EOB requirements under the CAA go hand in hand. Upon the scheduling of items or services (or upon patient request) providers are required to:

- inquire whether the individual has health insurance coverage, and
- provide a GFE of the expected charges for furnishing those items and services to the group health plan.

Upon receiving a GFE, the group health plan must send the participant or beneficiary an Advance EOB that includes certain prescribed information. Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief

The Departments are delaying enforcement until future guidance is issued. Any future guidance will include a prospective applicability date to provide additional time for compliance.

Prohibition on Gag Clauses on Price and Quality Data

Requirement: Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from:

- furnishing provider-specific cost or quality of care information or data;
- electronically accessing de-identified claims and encounter data for each participant or beneficiary; and
- sharing such information, consistent with applicable privacy regulations.

Plans and carriers must submit an attestation of compliance.

This requirement was effective December 27, 2020.

Good Faith Relief: Plans should implement this requirement using a good faith, reasonable interpretation of the statute. Future guidance is expected as to how plans will complete and submit the required attestation. This attestation process is expected to begin in 2022.

Provider Directories

Requirement: Group health plans must update and verify the accuracy of provider directory information (every 90 days) and establish a protocol for responding to requests by telephone and email from a member about a provider's network participation status.

If a participant or beneficiary is furnished an item or service by a non-participating provider (or facility) and the individual was provided inaccurate directory information that stated the provider was "in-network", the plan must generally treat the item or service as provided in-network.

Group health plans should comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

The Departments have stated that plans will not be out of compliance if they do not impose more than in-network cost-sharing and count any cost-sharing toward the in-network deductible and out-of-pocket maximum in situations where the participant is provided information stating that a provider is in-network.

Balance Billing Disclosure

Requirement: The CAA requires plans and carriers to make certain disclosures regarding balance billing protections to participants and beneficiaries. This notice requirement is effective for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Plans will not be out of compliance when using the model notice (as appropriately modified).

Requirement: For plan years beginning on or after January 1, 2022, a patient in a course of treatment with an in-network provider/facility that becomes OON must be notified and given an opportunity to receive coverage on the same terms for up to 90 days.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Any future rulemaking will apply prospectively allowing plans and carriers a reasonable time to comply.

Reporting on Pharmacy Benefits and Drug Costs

Requirement: Group health plans and carriers must submit a report to the Departments with respect to certain health plan and prescription drug information based on the previous plan year. Notably, the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs.

Enforcement Relief: Recognizing the significant operational challenges with this requirement, the Departments will defer enforcement for both the first and second deadlines (December 27, 2021 and July 1, 2022, respectively) pending the issuance of regulations or further guidance.

Plans should work to ensure they are able to comply with 2020 and 2021 information reporting by December 27, 2022.

Employer Action

As many of these provisions are a function of plan administration, it will be important to consult carriers and TPAs (and PBMs with respect to pharmacy reporting) to understand their capabilities to assist in compliance with these new requirements. While the delayed timeframes are helpful, it will be important to understand the provisions and timeframe for when the requirements apply to your group health plan.

New York Paid Family Leave 2022 Contributions and Benefits

Published: September 7, 2021

The New York State Department of Financial Services has announced the contribution rate and benefit schedule under the New York Paid Family Leave ("PFL") law effective January 1, 2022 as follows:

- The contribution rate remains at 0.511% of weekly wages, up to a maximum annual contribution of $423.71.
- The maximum weekly benefit increases to 67% of average weekly wages payable for 12 weeks and will be capped at $1,068.36.

Additional details are provided below.

Contributions

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the annualized New York State Average Weekly Wage ("AWW"). For 2022, the contribution percentage has been set at 0.511% (includes a 0.005% risk adjustment for COVID-19 quarantine claims) and the New York State AWW in effect will be $1,594.57. A comparison to the 2021 contribution amounts is as follows:

	2021	2022	Percentage change
Contribution Percentage	0.511%	0.511%	0%
NYS Average Weekly Wage	$1,450.17	$1,594.57	10%
Annualized NYS Average Weekly Wage	$75,408,84	$82,917.64	10%
Maximum Annual Contribution	$385.34	$423.71	10%

Benefits

Beginning January 1, 2022, the PFL benefit had increased to the final phased-in maximum 67% of an employee's Average Weekly Wage (up to the New York State AWW) payable for 12 weeks. The maximum weekly benefit for 2022 will be $1,068.36 (the maximum annual benefit in 2022 increases to $12,820.32). A comparison to the 2021 benefit levels is as follows:

	2021	2022	Percentage change
Benefit Percentage	67%	67%	0%
Weeks Payable	12	12	0.0%
Maximum Weekly Benefit	$971.61	$1,068.36	10%
Maximum Annual Benefit	$11,659.32	$12,820.32	10%

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a 52-consecutive week period is limited to 26 weeks.

- The Superintendent of the NYS Department of Financial Services has the discretion to delay the scheduled PFL benefit increase if it is determined the increase may negatively impact employees, employers, insurers and the overall economic climate. For 2021, the Superintendent has determined the 2021 PFL benefit increase is appropriate and therefore, will be implemented as scheduled and noted above.

Employer Action

Employers should prepare for the 2022 New York PFL contribution and benefit increases that begin in January. Paid Family Leave coverage will typically be added as a rider on an employer's existing disability insurance policy although benefits can be provided through a self-funded plan approved by the state Workers' Compensation Board.

IRS Announces 2022 ACA Affordability Indexed Amount

Published: September 10, 2021

The IRS recently announced in Revenue Procedure 2021-36 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.61% for plan years that begin in 2022. This is a decrease from the 2021 percentage amount (9.83%).

Background

Rev. Proc. 2021-36 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2022

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2022 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

The W-2 safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.61% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

Rate of pay safe harbor.

The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.61% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

Federal Poverty Level (FPL) safe harbor.

Coverage is affordable if it does not exceed 9.61% of the FPL.

For a 2022 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $103.14 (48 contiguous states), $128.85 (Alaska), or $118.68 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2022 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

President Biden Announces Plan to Increase Number of Vaccinated Americans

Published: September 10, 2021

On September 9, 2021, President Biden announced a "Path out of the Pandemic," indicating that he will use regulatory powers and other actions to increase the number of vaccinated Americans. In short, his plan provides the following:

- Employers with at least 100 employees must require their employees to be vaccinated or require unvaccinated employees to produce a negative test at least weekly before coming to work
- Federal workers and federal contractors must be vaccinated
- Booster shots should be available soon at no cost
- Health care workers at Medicare and Medicaid participating hospitals and other health care settings must be vaccinated
- Employers with more than 100 employees must provide paid time off to their employees to get vaccinated
- Large entertainment venues are requested to require proof of vaccination or testing for entry
- There are increased school safety measures
- Additional economic recovery is available

The plan includes a multi-pronged, comprehensive national strategy, discussed below. While the action plan lays out the administration's next steps, it also raises several questions that will hopefully be addressed in the rulemaking process.

Vaccination or Weekly Testing

The Department of Labor's Occupational Safety and Health Administration (OSHA) is developing a rule that will require all employers with 100 or more employees to ensure their workforce is fully vaccinated or require any unvaccinated workers to produce a negative test result on at least a weekly basis before coming to work. OSHA will issue an Emergency Temporary Standard

(ETS) to implement this requirement. While penalties for non-compliance are not outlined in the President's plan, the maximum penalty amount under existing OSHA enforcement protocols is $13,653 per violation. There will likely be challenges to this requirement based on overreach of OSHA's authority.

We are hopeful that future guidance will answer the numerous unanswered questions we are left with including:

- Whether the employer will need to be involved in facilitating the weekly testing option for unvaccinated workers and what (if any) of the expense the employer must cover.
- Under current guidance, group health plans are not required to cover COVID-19 testing as it relates to an employment requirement. Will the Departments revisit this guidance in light of this new directive by the President?
- How does the mandate apply to a remote workforce who do not "come into work"?
- While the mandate applies to employers with 100 or more employees, are there any steps employers with fewer than 100 employees should consider?
- Will the availability of a booster shot affect what it means to be "vaccinated" for this purpose (i.e., do you need the two-shot series or two shots plus the booster to be considered vaccinated)?
- How will the new availability of free tests at pharmacies affect this mandate?

Subsequent to the President's announcement, the IRS issued a reminder that the cost of home testing for COVID-19 is an eligible medical expense that can be paid or reimbursed under health flexible spending arrangements (health FSAs), health savings accounts (HSAs), or health reimbursement arrangements (HRAs). Additionally, costs of personal protective equipment (PPE) such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of COVID-19 are eligible medical expenses that can be paid or reimbursed through these accounts.

Vaccinations for all Federal Workers and Federal Contractors

All federal executive branch workers must be vaccinated. The President also signed an Executive Order requiring employees of contractors that do business with the federal government to be vaccinated.

Vaccinations for Providers who Accept Medicare or Medicaid

The Centers for Medicare & Medicaid Services (CMS) is taking action to require COVID-19 vaccinations for workers in most health care settings that receive Medicare or Medicaid reimbursement, including but not limited to hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies. This action builds on the vaccination requirement for nursing facilities recently announced by CMS, and will apply to nursing home staff as well as staff in hospitals and other CMS-regulated settings, including clinical staff, individuals providing services under arrangements, volunteers, and staff who are not involved in direct patient, resident, or client care.

Paid Time Off

OSHA is developing a rule that will require employers with more than 100 employees to provide paid time off for the time it takes for workers to get vaccinated or to recover if they are under the weather post-vaccination. This requirement will be implemented through the ETS.

Easy Access to Booster Shots

The Biden Administration is preparing for boosters to start as early as the week of September 20, subject to authorization or approval by the FDA and a recommendation from the Advisory Committee on Immunization Practices. Booster shots will be free and widely available across 80,000 locations – from pharmacies to doctors' offices to health centers.

Individuals will be able to find a vaccination site at Vaccines.gov, including what vaccines are available at each site and, for many sites, what appointments are open. A toll-free number, 1-800-232-0233, will also be available in over 150

languages. Americans who have already utilized the text code 438829 or WhatsApp to get vaccine information will automatically receive a text with information on boosters, if and when recommended.

Large Entertainment Venues-Proof

The President's plan calls on entertainment venues like sports arenas, large concert halls, and other venues where large groups of people gather to require that their patrons be vaccinated or show a negative test for entry.

School Safety

School safety measures include:

- Requiring staff in head start programs, Department of Defense schools, and Bureau of Indian Education-operated schools to be vaccinated
- Calling on all states to adopt vaccine requirements for all school employees
- Providing additional funding to school districts for safe school reopening
- Using the Department of Education's legal authority to protect students' access to in-person instruction
- Getting students and school staff tested regularly
- Providing every resource to the FDA to support timely review of vaccines for individuals under the age of 12

Increasing Safety and Care

Increased prevention and treatment efforts include:

- Mobilizing industry to expand easy-to-use testing production
- Making at-home tests more affordable
- Sending free rapid, at-home tests to food banks and community health centers
- Expanding free pharmacy testing
- Continuing to require masking for interstate travel and double fines
- Continue to require masking on federal property
- Increasing support for COVID-burdened hospitals
- Getting monoclonal antibody treatment to those who need it and training health care professionals to provide this treatment

Additional Economic Recovery

Other reforms include:

- New loan support for small businesses impacted by COVID-19
- A streamlined Paycheck Protection Program (PPP) loan forgiveness process
- Launching a Community Navigator Program to connect small businesses to the help they need

Employer Action

Further rulemaking is expected to implement the President's vaccination mandate in the workplace. Employers should review this new information and prepare for compliance. In the meantime, employers may want to consult with legal counsel and think about crafting a vaccine policy that considers exemptions for employees with qualified disabilities as defined under the Americans with Disabilities Act, as well as employees with sincerely held religious beliefs, as defined under Title VII of the Civil Rights Act.

We will continue to monitor these issues and keep you updated as guidance develops.

Medicare Part D Notification Requirements

Published: September 20, 2021

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

Employers should send these notices no later than October 15, 2021 if they haven't done so already.

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

What are the Notification Requirements About?

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

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

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

Participant Notice

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

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

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

To Whom Should the Participant Notice Be Sent?

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

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

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

If the disclosure notice is provided to all plan participants annually, CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

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

How Should the Participant Notice Be Sent?

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

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

Mail

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

Electronic Delivery

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

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

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

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

Open Enrollment Materials

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

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

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

Personalized Notices

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

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

CMS Notification

When and How Should Notification be Given to CMS?

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

- Within 60 days after the beginning date of the plan year (March 1, 2022 for a 2022 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

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

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

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

How is Creditable Coverage Determined?

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

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

Actuarial Determination

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

Simplified Determination

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

A prescription drug plan is deemed to be creditable if:

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

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

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

2021 MLR Rebate Checks Recently Issued to Fully Insured Plans

Published: September 21, 2021

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, 2021.

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.

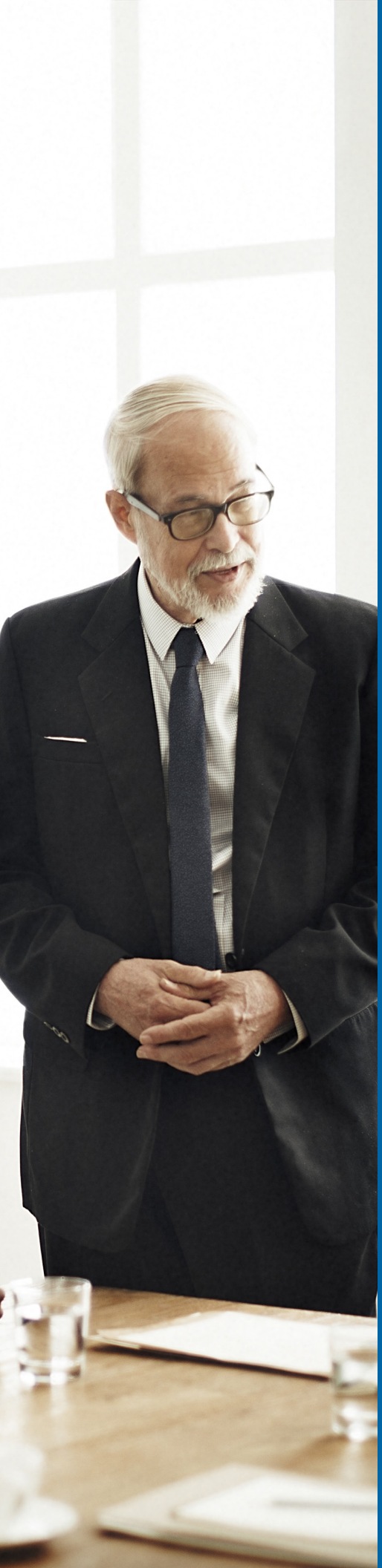
If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

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.



Proposed Requirements Address Air Ambulance Reporting Requirement

Published: September 27, 2021

On September 13, 2021, proposed regulations were issued that would implement certain provisions of the No Surprises Act, requiring group health plans to submit information related to air ambulance claims to the Department of Health and Human Services ("HHS") for 2022 and 2023.

Plans Subject to the Requirement

Major medical health plans (insured and self-insured, grandfathered and non-grandfathered) are subject to this requirement.

Data

The report must include the following data elements with respect to air ambulance services provided under a group health plan:

1. Identifying information for any group health plan, plan sponsor, or issuer, and any entity reporting on behalf of the plan or issuer, as applicable.

2. Market type for the plan or coverage (large group, small group, self- insured plans offered by small employers, and self-insured plans offered by large employers).

3. Date of service.

4. Billing NPI information.

5. Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code information.

6. Transport information (including aircraft type, loaded miles, pick-up (origin zip code) and drop-off (destination zip code) locations, whether the transport was emergent or non-emergent, whether the transport was an inter-facility transport, and, to the extent this information is available to the plan or issuer, the service delivery model of the provider (such as government-sponsored (federal, state, county, city/township, other municipal), public-private partnership, tribally-operated program in

Alaska, hospital-owned or sponsored program, hospital independent partnership (hybrid) program, independent).

7. Whether the provider had a contract with the group health plan or issuer of group or individual health insurance coverage, as applicable, to furnish air ambulance services under the plan or coverage, respectively.

8. Claim adjudication information, including whether the claim was paid, denied, appealed; denial reason; and appeal outcome.

9. Claim payment information, including submitted charges, amounts paid by each payor, and cost sharing amount, if applicable.

Confidentiality

As the requested information is claims-level data as opposed to aggregate data, HHS proposes to collect only that claims-level data that would be sufficient for producing the comprehensive report required by the No Surprises Act. HHS also intends to collect and maintain the information using information technology systems that are designed to meet all of the security standards protocols established under federal law or by HHS.

Timing

Plans must submit data regarding air ambulance services on a calendar year ("CY") basis for 2022 and 2023 within 90 days of the end of the calendar year.

- For CY 2022, by March 31, 2023, regardless of plan year.

- For CY 2023, by March 31, 2024 regardless of plan year.

Written Agreement

Insured plans

An employer with an insured plan satisfies the reporting requirements if it requires the health insurance issuer offering the coverage to report the required information pursuant to a written agreement. In this case, the issuer and not the plan is liable for any failure to file.

Self-funded plans

An employer with a self-funded plan may satisfy the reporting requirements by entering into a written agreement with the third-party administrator ("TPA"). The plan generally remains liable. However, nothing prevents a self-insured group health plan from including a clause in the written agreement for the TPA indemnifying the plan in the event the TPA fails to submit a complete or timely report.

Employer Action

Employers will not have the required data necessary to report. Therefore, employers should begin reaching out to carriers and TPAs handling their health programs during the calendar year 2022 and enter into written agreements with them, requiring issuers and TPAs to handle reporting. Employers with self-funded plans should consider adding indemnification provisions to their agreements in the event the TPA is not compliant.

Connecticut Extends Dental and Vision Insurance to Age 26

Connecticut Governor Ned Lamont signed into law SB 1004, requiring fully insured health, dental and vision insurance policies to continue coverage for a child, stepchild, or other dependent child until the policy anniversary date on or after the date the child turns age 26, even if they are offered plans through their employer. The law is effective January 1, 2022.

Background

Currently, Connecticut insurance law follows the Affordable Care Act ("ACA") in which vision and dental coverage for children is considered an essential health benefit through age 19. The law allows dental and vision policies to terminate coverage for young adults before age 26 if they obtain coverage through their employer. To ease administration of benefits, Connecticut insurers will often quote vision and dental benefits to align with the ACA's requirement of medical coverage to age 26, but until now, this was not mandated by the state. Additionally, current health law does not recognize stepchildren and other dependent children.

Employer Action

Employers should work with their broker partners and fully insured carriers to ensure compliance when the new law becomes effective on January 1, 2022, including:

- Communicating the change in the law;
- Updating eligibility rules in all required documents; and
- Facilitating enrollment/reenrollment in plans.

Illinois Passes Consumer Coverage Disclosure Act

On August 27, 2021 Governor Pritzker signed into law the Consumer Coverage Disclosure Act ("the Act") requiring all businesses that sponsor a group health plan and employ individuals in Illinois to provide a new disclosure to all Illinois employees eligible for the coverage. This disclosure requirement applies to employers of any size that sponsor a self-funded or fully insured group health plan offering coverage to employees in Illinois (regardless of where the plan is situsted).

The law requires employers to provide a written list of the covered benefits included in the group coverage in a manner that easily compares the benefits under the group plan to the essential health benefits required in the individual marketplace in Illinois. While no additional details are available at this time, the Illinois Department of Labor ("IL DOL") will provide a template in the coming weeks that employers may use to meet the requirements.

Employers must distribute the list to those eligible for the group health plan upon request, at hire, and annually thereafter. The statute is silent as to timing beyond those general periods, so it is unclear how long employers will have to respond to a request or the timeframe they are allowed after an employee's hire for the initial distribution. Additional guidance is welcomed. Employers may meet the distribution requirements by providing the information via email to employees or providing the information on a website that an employee is able to regularly access. Employers must be able to demonstrate that each employee received the information and retain such records for a period of one year.

The IL DOL may penalize employers that do not comply with the requirements of the Act. The civil penalties vary depending upon whether the employer has fewer than 4 employees or 4 or more employees. It is unclear at this time whether all employees are counted or only those employed within the state of Illinois.

Fewer than 4 employees:

- 1st offense = not to exceed $500
- 2nd offense = not to exceed $1,000
- 3 or more offenses = not to exceed $3,000

4 or more employees:

- 1st offense = not to exceed $1,000
- 2nd offense = not to exceed $3,000
- 3 or more offenses = not to exceed $5,000

The amount of the penalty will also consider good faith efforts made by the employer to comply and the gravity of the violation.

Employer Action

Employers with employees located in Illinois should reach out to their insurer or TPA and ask whether they intend to assist employers with compliance with this requirement. We will monitor and provide an update when the Illinois Department of Insurance issues additional guidance, including a disclosure template.

New Hampshire Establishes Paid Family and Medical Leave Program

New Hampshire recently established the Granite State Paid Family Leave Plan as part of its state budget bill, a unique take on family and medical leave insurance ("FMLI") wage replacement benefits. Briefly, the state will provide up to six weeks of FMLI benefits for the roughly 10,000 New Hampshire state employees. Non-state employers and non-state employees can voluntarily opt-in to the program. The law was effective July 1, 2021, and FMLI coverage will become available for purchase by January 1, 2023.

Participation

State employees will automatically be covered under the program with the state paying the full cost to provide the benefit. The state will select an insurance carrier or carriers to provide the FMLI benefits through a process established by the state's Department of Administrative Services ("DAS"). The state employees will serve as the risk pool for the program.

All non-state public and private employers with more than 50 employees can opt-in to the program. These employers have the option of paying the entire premium or share the cost with employees.

Employees of these large employers who do not opt-in or do not offer an FMLI benefit that is at least equivalent to this coverage, or employees of employers with less than 50 employees may individually opt-in to the program. Coverage through the pool for these groups will include a 7-month waiting period, a one-week elimination period, and a 60-day annual open enrollment period as established by DAS.

Amount of Benefit

Eligible employees will receive 60 percent of their average weekly wage for up to six weeks of work per year. Wages used to determine the 60 percent FMLI coverage will be capped at the amount of the Social Security taxable wage maximum.

Qualifying Reasons for Leave

Employees can generally take FMLI for the same types of leave permitted under the federal Family Medical Leave Act ("FMLA") except certain restrictions apply pertaining to leave for an employee's own serious health condition:

- The birth, placement for adoption or foster care of an employee's child within one year of birth or placement;
- Serious health condition of a family member;
- Any qualifying exigency arising from foreign deployment with the armed forces, or to care for a service member with a serious injury or illness as permitted under the federal FMLA; or
- An employee's serious health condition that is not related to employment and their employer does not offer Short Term Disability insurance.

Cost of Benefit and Who Pays?

The benefit is free to state employees and will cost up to $5 per week for all other participants.

Employers with 50 or more employees (1) opting-in to the program, or (2) do not opt-in but their individual employees elect to participate in the FMLI program, will be required to withhold and remit premiums to the program through payroll deductions.

Employees of employers with fewer than 50 employees who opt-in to the program will be required to make premium payments directly to DAS. The law does not require employers with fewer than 50 employees to offer family medical leave or process payroll deductions on behalf employees choosing to participate in the program as individuals.

Business Tax Incentive

Employers that pay for FMLI benefits can deduct 50 percent of the amount they pay in premiums from their business taxes for the taxable period in which the premiums are paid.

Employee Protections

Employers with 50 or more employees that opt-in to the program must allow their employees to be restored to the position she or he held prior to such leave or to an equivalent position by her or his employer consistent with the job restoration provisions of the federal FMLA. These employers must continue to provide health insurance to employees during the leave. However, employees must remain responsible for any employee-shared costs associated with the health insurance benefits. These employers must not discriminate or retaliate against any employee for accessing FMLI benefits. Employers of employees participating in the program may require that paid leave taken under the program be taken concurrently or otherwise coordinated with leave allowed under the terms of a collective bargaining agreement or other established employer policy or the FMLA, as applicable.

Future Regulations

While the law contains few details regarding administration of the program, it does provide direction for state regulators. Information forthcoming includes:

- The base period by which the average weekly wage will be determined.
- The tenure requirement, expressed in terms of months of work, before an employee is eligible to be covered provided, however, that no tenure requirement will apply to an employee who has already met the requirement and then changes jobs.
- A waiting period or elimination period provided, however, that a waiting or elimination period will not be a required element of the benefit structure, and DAS will have authority to implement a plan with no such requirement.
- The minimum participation requirement.
- The parameters for open enrollment periods.
- Procedures for contributory plans, partially contributory plans, and non-contributory plans.
- Procedures for payroll deduction and premium remittance for employers with more than 50 employees.

Employer Action

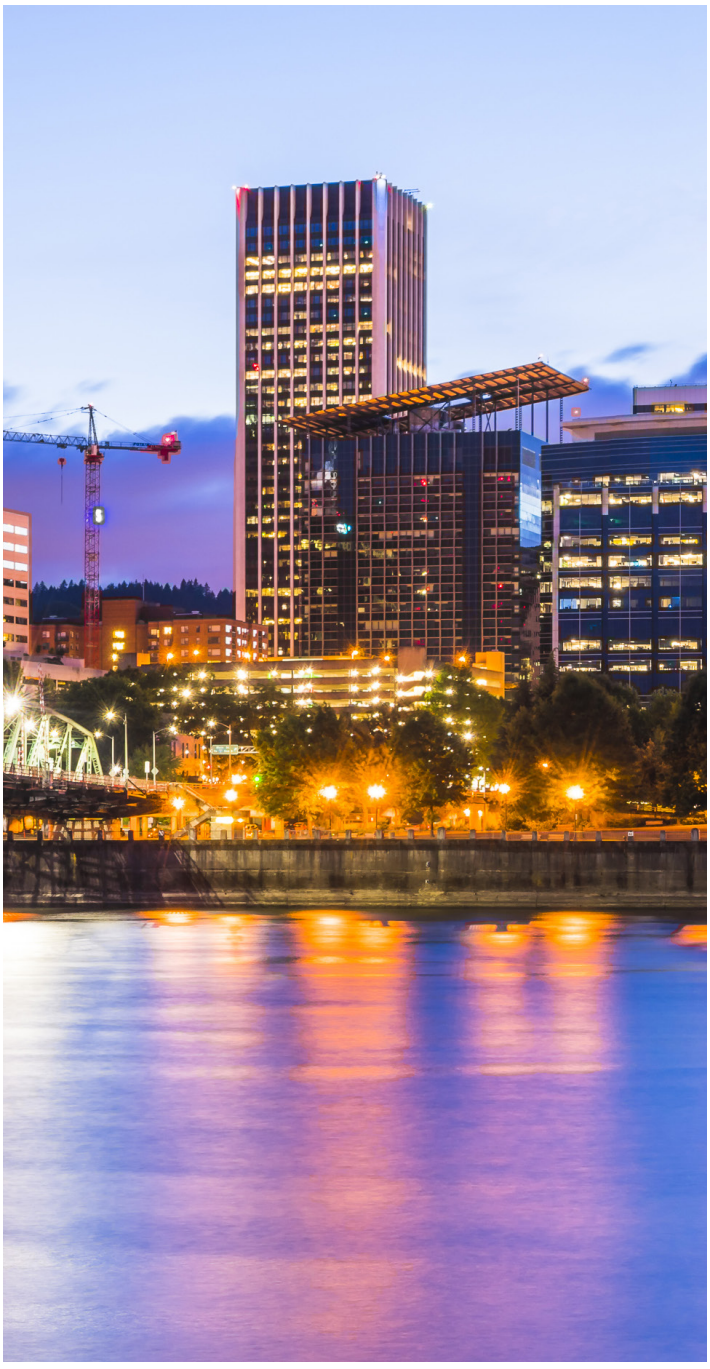
The implementation timeline of FMLI benefits is relatively aggressive. The law was effective July 1, 2021. The request for proposals for FMLI coverage by a carrier or carriers will be issued no later than March 31, 2022. The FMLI coverage will be in place for state government employees and available for purchase by other public and private employers with more than 50 employees and individuals by January 1, 2023. Employers should review their current leave programs and begin discussing with their employment and labor counsels, leave management vendors, payroll departments and payroll vendors how this law will impact their current programs so that they can make informed decisions regardless of whether they choose to opt-in to the program.

Oregon Delays Paid Family and Medical Leave

On July 27, 2021, Oregon Governor Kate Brown signed HB 3398, delaying the effective date of the Oregon Paid Family and Medical Leave law. HB 3398 will delay:

- premium payments funded by both employers and employees via payroll deductions from January 1, 2022 until January 1, 2023.
- the availability of benefits under the program from January 1, 2023 until September 1, 2023.

Additionally, the bill delays rulemaking, notice requirements, and general funding from the state.



Texas Heartbeat Act and the Possible Impact on Health Plans

Effective September 1, 2021, the Texas Heartbeat Act (the "Act," also known as Senate Bill 8) bans abortions after about six weeks of gestation except in the case of medical emergency. Additionally, the law includes a unique enforcement method, allowing private citizens to bring civil lawsuits against those who perform or are involved in the facilitation of a banned abortion.

Background

On May 19, 2021, Governor Greg Abbott signed the Act into law. The law was challenged from abortion providers and others that sought to block its enforcement before it went into effect. The Supreme Court declined to block the law preemptively by a vote of 5-4.

"Aiding and Abetting"

The law authorizes a private citizen to initiate a civil action against anyone who "knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise, if the abortion is performed or induced in violation of [the law]."

A court can award:

- injunctive relief sufficient to prevent the defendant from getting or aiding and abetting an abortion;
- statutory damages in an amount of not less than $10,000; and
- attorney 's fees.

In defining who can possibly be a defendant in a civil action under the Act, the list seems to be near limitless. Importantly, in the context of employee benefits, an employer whose plan covers abortion in violation of this law could be held liable. It could also potentially include employees at clinics; anyone who provides transportation for a patient to an abortion provider; those who donate funds for an abortion; and friends or family members who provide information to a patient about where to get an abortion.

Enforcement Challenges

Even though the Supreme Court declined to step in to stop the law from becoming effective, it is possible that the law will be found unenforceable under one or more of the following bases:

- **ERISA Preemption.** Under Section 514(a), ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." However, determining the meaning of "relate to" is often at issue in ERISA litigation.

- **General Federal Law Preemption.** The Act has been challenged by the Department of Justice on constitutional grounds as well as the supremacy clause.

- **Lack of Standing.** It is unclear whether a private citizen with no nexus to a pregnant woman can enforce the law.

- **Unauthorized Government Subcontracting.** The government is generally prohibited from being able to delegate its duties to private citizens to enforce criminal laws.

At the time of this article, BCBSTX, Cigna, and Aetna are in discussions of what changes, if any, they will make to their insured plans and communications to employers with self-funded plans but have not yet made any decisions. UHC has no plans to make any changes.

Employer Action

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

- Employers should watch for further developments, as this law is already facing challenges.

Home Health Workers to Receive Paid Sick Leave in Virginia

Beginning July 1, 2021, all employers who employ home health workers in the Commonwealth of Virginia will be required to offer these employees paid sick leave.

Leave Accrual

As signed into law, the regulations require employees to accrue a minimum of one hour of paid sick leave for every thirty hours worked, up to a maximum of forty hours of paid sick leave in a year. The leave will begin to accrue upon commencement of employment.

Eligibility for Leave

Under the regulations, an employee is defined as a home health worker who works on average at least 20 hours per week or 90 hours per month.

The definition does not include an individual who:

- Is licensed, registered, or certified by a health regulatory board within the Virginia Department of Health Professions;
- Is employed by a hospital licensed by the Virginia Department of Health; and
- Works, on average, no more than 30 hours per month.

Reasons for Leave

Covered employees must be allowed to use accrued sick leave for any of the following reasons:

- An employee's mental or physical illness, injury, or health condition; an employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or an employee's need for preventive medical care; or
- For the care of a family member for the same reasons as stated for the employee.

Substitution of Other Leave

An employer that provides covered employees with other forms of leave, such as PTO, that meets the requirements of the law will not be required to provide additional paid sick leave.

Administration of Leave

- A covered employer is required to provide paid sick leave upon request by the employee. This request can be oral, written, electronic, or any other means acceptable to the employer.
- Although not expressly required, any such request by an employee should include an expected duration of the absence.
- Where the leave is foreseeable, the employee is required to make a good faith effort to provide the employer with notice of the need for leave in advance of the leave, as well as make reasonable efforts to schedule the leave in a manner that does not unduly disrupt the employer's operations.

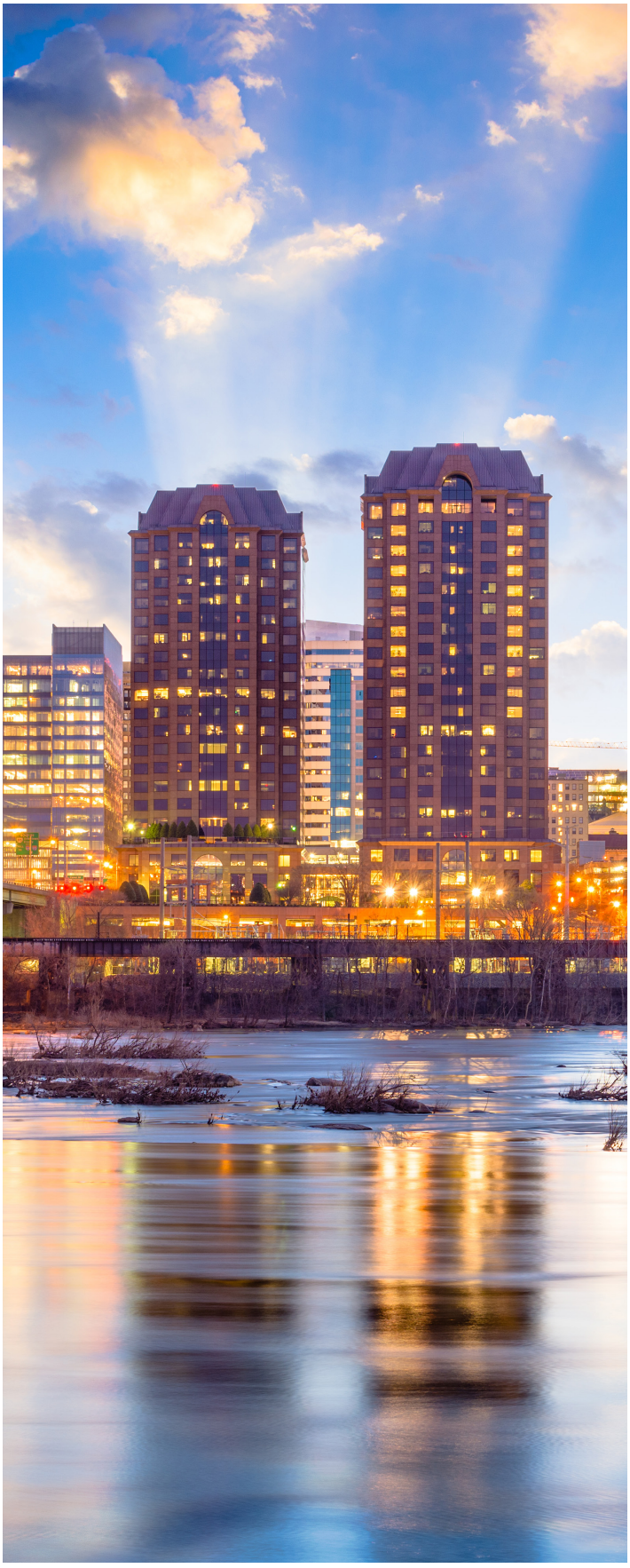
- If an employer requires notice from employees of the need to use leave, they must provide a written policy to employees which contains all applicable procedures. Failure to do so will prevent an employer from denying leave based on lack of notice received from an employee.

- An employer is permitted to require reasonable documentation that the leave was used in a permitted fashion for any paid sick leave of three or more consecutive workdays.

- Retaliation of any kind towards the exercise of these leave benefits by an employee is expressly prohibited.

Employer Action

Employers that employ home health workers should consult their existing leave policies to determine if they comply with the requirements of the statute. If not, they should work with independent employment counsel to formulate a compliant leave policy.



2022 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2022 health care expenditures required by the Improving Access to Medical Care Hotel Employees Ordinance, Seattle Municipal Code (SMC) 14.28.

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

For the 2022 calendar year (January 1 to December 31, 2022), the adjusted rates are:

- $459 per month for an employee with no spouse, domestic partner, or dependents;
- $779 per month for an employee with only dependents;
- $916 per month for an employee with only a spouse or domestic partner;
- $1,375 per month for an employee with a spouse or domestic partner and one or more dependents.

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

Employer Action

- Covered employers subject to the Ordinance should comply (or prepare to comply) with the law.
- If compliance is required with a plan year that begins in 2022 plan year, the adjusted rates should be used to determine appropriate expenditures.
- Include the adjusted rates of the expenditure as part of the annual notification required to covered employees.
- Monitor OLS FAQs and website for further information.

Washington State's PAL Assessment Update

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021. Washington's Health Care Authority ("HCA") is responsible for enforcement of this provision. The HCA contracted with KidsVax to administer the reporting and payment of the assessment. KidsVax has established a website at www.wapalfund.org to administer the reporting of covered lives and provide information to stakeholders and payers including self-funded plan sponsors.

The PAL assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provide health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

HCA updated its FAQs with the following additional information:

- Third-party vendor for administration of the WAPAL Fund assessment. HCA has contracted with KidsVax, who will act as the third-party administrator to calculate and administer the assessments. KidsVax will begin reaching out to assessed entities in summer 2021 with more information.
- Assessment applies to out-of-state employers. Out-of-state employers who insure Washington residents are subject to the assessment.
- Baseline reporting. Entities will be asked to complete a baseline-setting covered lives report to be submitted sometime in late August or early September. This baseline report will lead to a null, $0 assessment and is necessary for program implementation. It is not clear how assessed entities will be notified to submit the baseline reporting.
- First regular reporting and payment. The first regular covered lives report will be for the period of July 1 to September 30, 2021 and must be submitted within 45 calendar days after the end of the quarter (or by November 14, 2021). Invoices will be issued upon filing the covered lives report and are due upon receipt. However, entities will have a 30-day grace period to deliver payment
- Exception for self-funded tribal member-only plans. Self-funded tribal member-only plans are not subject to the PAL assessment. However, tribal governments may be subject to the assessment if they are not funded by contract health services or purchased/referred care (CHS/PRC) funds.

KidsVax has established a website, www.wapalfund.org, to provide important additional information to payers to facilitate paying the assessment, including:

- Overview of the program with FAQs
- Training webinar for payer registration and how to report covered lives
- PDF instructions for online account registration and covered lives report completion

- Page for submitting questions to KidsVax
- Registration page for email alerts

Employer Action

Employers sponsoring self-funded health plans covering Washington residents should be aware of this assessment. It appears that payers will need to register on the website and complete their first covered lives reports for the period of July 1, 2021 – September 30, 2021 as required. Payers will register by entering their federal Employer Identification Number, email address, and a password of their choice. The first covered lives report will generate a $0 (zero) assessment required for program implementation. Subsequent covered lives reports will generate assessments that can be paid by check via U.S. Mail or by ACH at the choice of the payer. It will be important to coordinate with TPAs to determine any assistance they may provide in handling the PAL assessment.

For fully insured health plans, the carrier is responsible for compliance with the PAL assessment.

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