MY BENEFIT ADVISOR

2022: Third Quarter

Compliance Digest

Compliance Bulletins Released July to September

2022 Compliance Bulletins

July

August

September

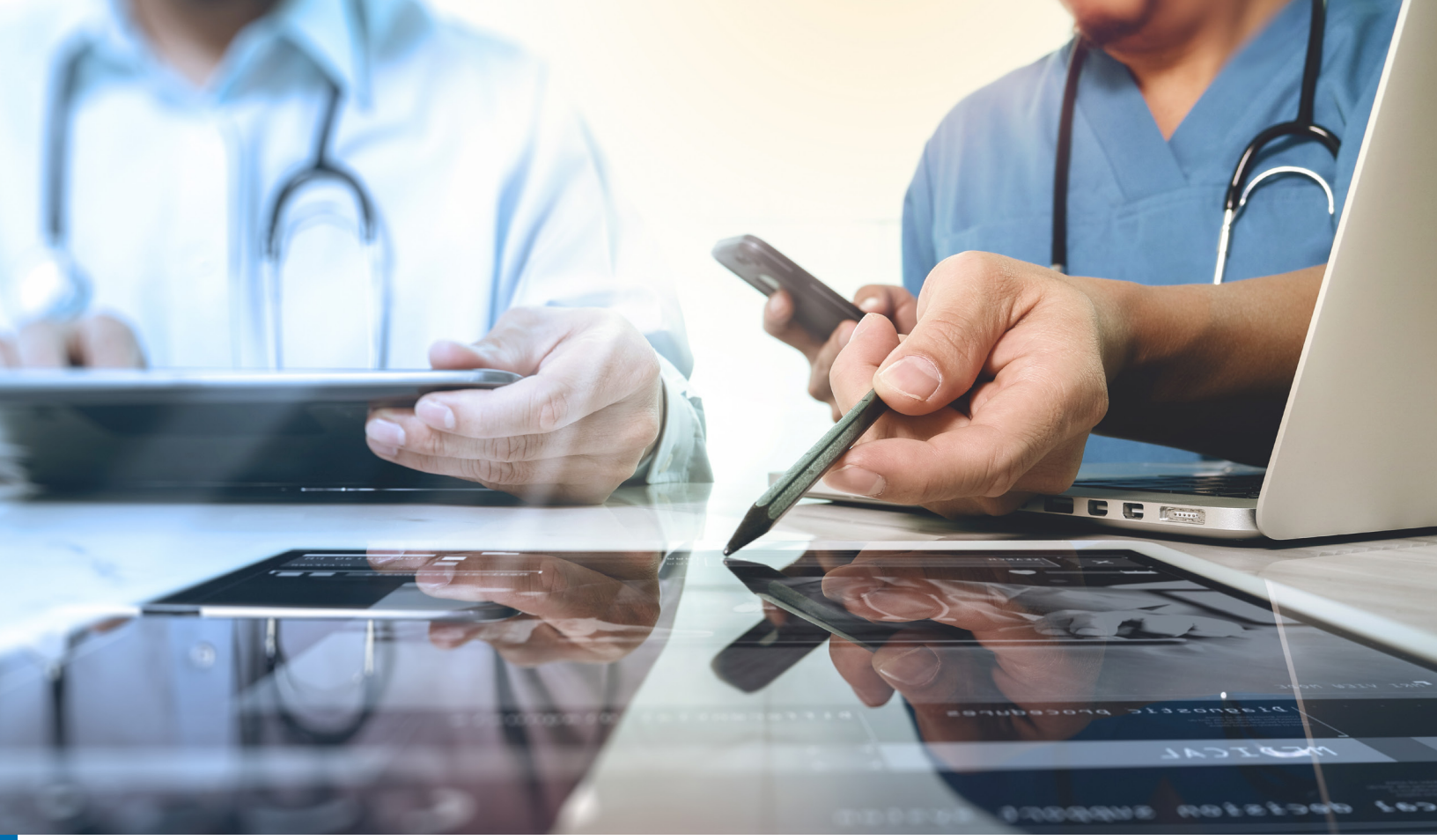
2022 State Bulletins

Colorado

Massachusetts

Washington

Oregon



New Mandatory Preventive Items And Services - 2022 Updates

Published: July 18, 2022

Most plans will be required to cover new preventive items and services beginning later this year or in 2023 (depending on the plan year), including ones related to condoms, double-electric breast pumps, suicide risk screening for adolescents, and diabetes screenings for certain populations.

Background

Non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services.

Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF") are considered to be "preventive." The USPSTF recommendations can change, and those changes generally apply for plan years that begin on or after the date that is one year after the date the new recommendation or guideline is considered to be issued. Additionally, the Health Resources and Services Administration ("HRSA") has updated preventive care and screening guidelines for women and for infants, children, and adolescents.

New Preventive Items and Services

The USPSTF newly covered items and services are as follows:

Topic	USPSTF Recommendation	Effective for Plan Years Beginning On or After
Gestational Diabetes: Screening asymptomatic pregnant persons at 24 weeks of gestation or after	Screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.	September 1, 2022
Prediabetes and Type 2 Diabetes: Screening asymptomatic adults aged 35 to 70 years who have overweight or obesity	Screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	September 1, 2022
Chlamydia and gonorrhea screening for sexually active women, including pregnant persons 24 years or younger	Screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection.	October 1, 2022
Aspirin use to prevent preeclampsia and related morbidity and mortality: preventive medication pregnant persons at high risk for preeclampsia	Use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia.	October 1, 2022
Prevention of dental caries (cavities) in children younger than 5 years: screening and interventions	Prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient influoride. Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	January 1, 2023

Effective for plan years beginning on or after January 1, 2023, the HRSA newly covered items and services specifically for women are as follows:

Topic	USPSTF Recommendation
Obesity Prevention in Midlife Women	Counseling midlife women aged 40 to 60 years with normal or overweight body mass index (“BMI”) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.
Breastfeeding Services and Supplies	Breastfeeding equipment and supplies must currently be covered. New guidance expands on the description to specifically include double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.
Contraception	Male condoms must be covered.

Screening for Human Immunodeficiency Virus Infection ("HIV")	HIV screening for all adolescent and adult women must currently be covered. New guidance specifies that adolescent and adult women ages 15 and older can receive a screening test for HIV at least once during their lifetime. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Risk assessment and prevention education for HIV infection begins at age 13 and continues as determined by risk.
Well-Woman Preventive Visits	Women must currently be offered at least one preventive care visit per year beginning in adolescence and continuing across the lifespan. New guidance indicates that preventive services may be completed at a single or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Well-women visits include pre-pregnancy, prenatal, postpartum and interpregnancy visits.

Effective for plan years beginning on or after January 1, 2023, the HRSA newly covered items and services specifically for children and adolescents are as follows:

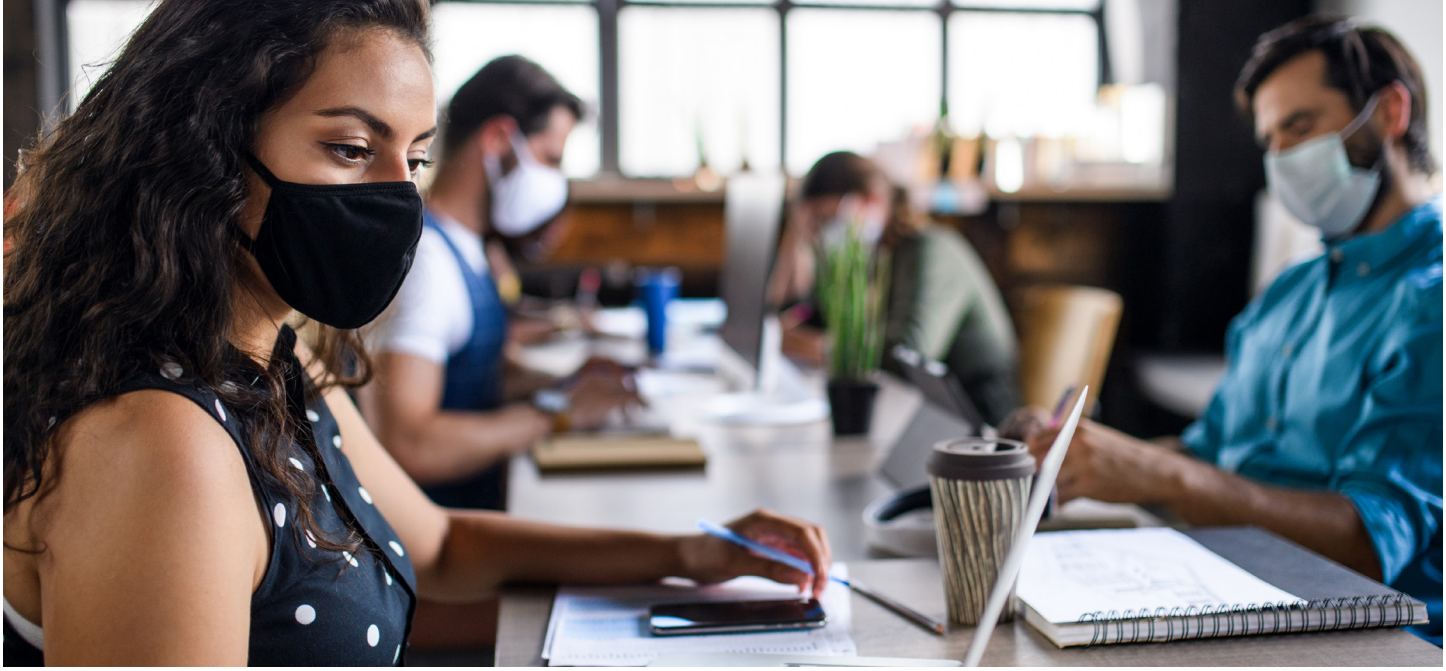
- An assessment for risks for cardiac arrest or death in ages 11-21 years was added.
- An assessment for hepatitis B virus infection in newborn to 21-year olds was added.
- Screening for suicide risk for ages 12-21 to the current Depression Screening category was added
- Psychosocial/behavioral assessment coverage was expanded to behavioral/social/emotional screening for newborn to 21-year olds.
- There is a clarifying reference to dental fluoride varnish and fluoride supplementation.

Employer Action

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

Fully insured health plans: Carriers are generally responsible for compliance and should include these benefits as applicable.

Self-funded health plans: Discuss with TPAs to ensure coverage is in effect for plan years that begin on or after the applicable effective dates.



HHS Extends Public Health Emergency Until October 13

Published: July 25, 2022

On July 15, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective July 15, 2022. This will once again extend the Public Health Emergency period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period	HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire October 13, 2022 (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, or 2) 60 days after the announced end of the COVID-19 National Emergency

The following summarizes benefit plan provisions that are directly impacted by the extension of the Emergency Period and highlights the relief with respect to the ongoing Outbreak Period. Other temporary benefit plan provisions and changes that are allowed due to the ongoing pandemic are not included.

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.

- **Over-The-Counter ("OTC") COVID-19 Testing:** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.

- **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.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes 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).

Note: There is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Employer Action

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

New Guidance On Prescription Drug Reporting Requirement

Published: August 01, 2022

As previously reported in December 2021, Section 204 of the Consolidated Appropriations Act, 2021 ("CAA") requires plan sponsors of group health plans to submit information annually about prescription drugs and health care spending to Centers for Medicare and Medicaid Services ("CMS") on behalf of the departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, the "Departments"). The first deadline is **December 27, 2022**. CMS recently updated guidance related to this reporting requirement that provides some helpful clarification.

What Must Be Reported?

- Plan name
- Plan number
- Plan year
- Employer size
- Plan sponsor's principal place of business
- Premiums (for self-funded plans, the premium equivalents)
- Average monthly premiums paid by the employer and the enrollees
- States in which the plan is offered
- Number of enrollees
- 50 most common brand prescription drugs dispensed
- 50 most costly drugs to total annual spending
- 50 drugs with the greatest year-over-year cost increase for the plan
- Total spending by the plan broken down by:
    - Types of cost (e.g., hospital, primary care, specialty care, medical benefit drugs, and other medical costs and services
    - Plan and enrollee spending on prescription drugs
- Impact on premiums and out-of-pocket cost associated with rebates, fees, or other payments by drug manufacturers to the plan (narrative response)
    - Includes prescription drug rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed for each therapeutic class of drugs, as well as 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

Who Must Report?

Employers with fully insured or self-funded (includes level funded) group health plans, including grandfathered plans, church plans subject to the Internal Revenue Code, and governmental plans.

The term "group health plan" does not include excepted benefits such as onsite clinics and accident-only policies. It also does not include account-based plans (e.g., HRAs or health FSAs).

Periods That Must Be Reported

Information is reported on a calendar year basis, regardless of plan year. This is referred to as a "reference year."

How is Reporting Done?

Data is reported through the RxDC module in the Health Insurance Oversight System ("HIOS"). An account must be created unless the employer:

- already has a HIOS account; or
- is not uploading anything because another vendor is handling the full filing; or
- where the employer is uploading partial data, not including any files.

NOTE: It can take up to two weeks to create an account so plan sponsors should plan accordingly.

The instructions to create a CMS Enterprise Portal and HIOS accounts are in the HIOS Portal User Manual. The instructions for using the RxDC module are in the RxDC HIOS User Manual. To log in to HIOS, go to the CMS Enterprise Portal at https://portal.cms.gov/portal/.

Can a Vendor Submit Information on an Employer's Behalf?

Yes.

Insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier.

Self-funded plans may enter into a written agreement with their third-party administrator ("TPA"), pharmacy benefit manager ("PBM"), or other vendor to fulfill reporting function on behalf of the plan; however, the plan sponsor remains liable for any failures.

An entity that submits some or all required information is called a "reporting entity." Reporting entities may charge additional fees for compiling and filing the data.

A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf. For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file and separately contract with a PBM to submit the Top 50 Most Costly Drugs file. Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.

Some of the above-listed data points may not be known by the issuer, TPAs, PBMs, or other vendors. Employers should be prepared to receive a request for information from the carrier, TPA, or PBM and either timely provide the information or prepare to do a partial filing.

Some carriers, TPAs, and PBMs have started to release information as it relates to this reporting. For example:

- UnitedHealthcare has indicated they will submit the full report for fully insured business. For self-funded business:
    - UnitedHealthcare will submit the full report where coverage is integrated with UnitedHealthcare (includes UMR and All Savers).

- If UHC is not the PBM (carve-out, including OptumRx Direct) or stop loss administrator, plan sponsors must ensure their vendors submit the appropriate files.

- CVS (a PBM) offers an option where it will submit certain data files (D3-D8) on behalf of the plan, but the employer remains responsible for submitting all Plan Files, Data Files D1-D2, and the narrative response (likely in coordination with the medical plan TPA).

If a plan, issuer, or carrier changes vendors during the reference year (such as changing a TPA or PBM), there are two reporting options:

1. The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or

2. The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data.

Either way, the plan sponsor must ensure that all their data is reported and that it is not double reported.

For mixed-funded plans, which generally self-fund some benefits and fully insure other benefits, the self-funded business is reported in the self-funded market segment and the fully insured business is reported in the fully insured market segment. For example, suppose a large employer self-funds the pharmacy benefit of a plan and purchases insurance for the medical benefits. In this case, the pharmacy benefits would be attributed to the market segment for self-funded large employer plans and the medical component of the same plan would be attributed to the fully insured large group market.

Currently, CMS does not have a mechanism to notify plans, issuers, or carriers when data has been submitted on their behalf. To confirm submission, plans should contact their reporting entities directly.

Fully-Insured to Self-Insured (or vice versa) during the Reference Year

The fully insured business is reported in the small group or large group market segments and the self-funded business is reported in the self-funded small employer or large employer market segments.

Deadline

The last day to submit data for the 2020 and 2021 reference years is December 27, 2022. The deadline for subsequent reference years is June 1st of the calendar year immediately following the reference year. So, June 1, 2023, is the second deadline, reporting calendar year 2022 information.

Penalty for Noncompliance

The penalty is $100 per affected individual. In addition, the DOL can enforce compliance.

Relief

For the 2020 and 2021 reference years only, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are not available and they are reported for the 2022 reference year and all future reference years.

Additional Information

For additional information on the requirements, please visit: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

IRS Announces 2023 ACA Affordability Indexed Amount

Published: August 08, 2022

The IRS recently announced in Revenue Procedure 2022-34 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be **9.12%** for plan years that begin in 2023. This is a notable decrease from the 2022 percentage amount (9.61%), and below the original 9.5% threshold.

Background

Rev. Proc. 2022-34 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 2023

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 2023 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

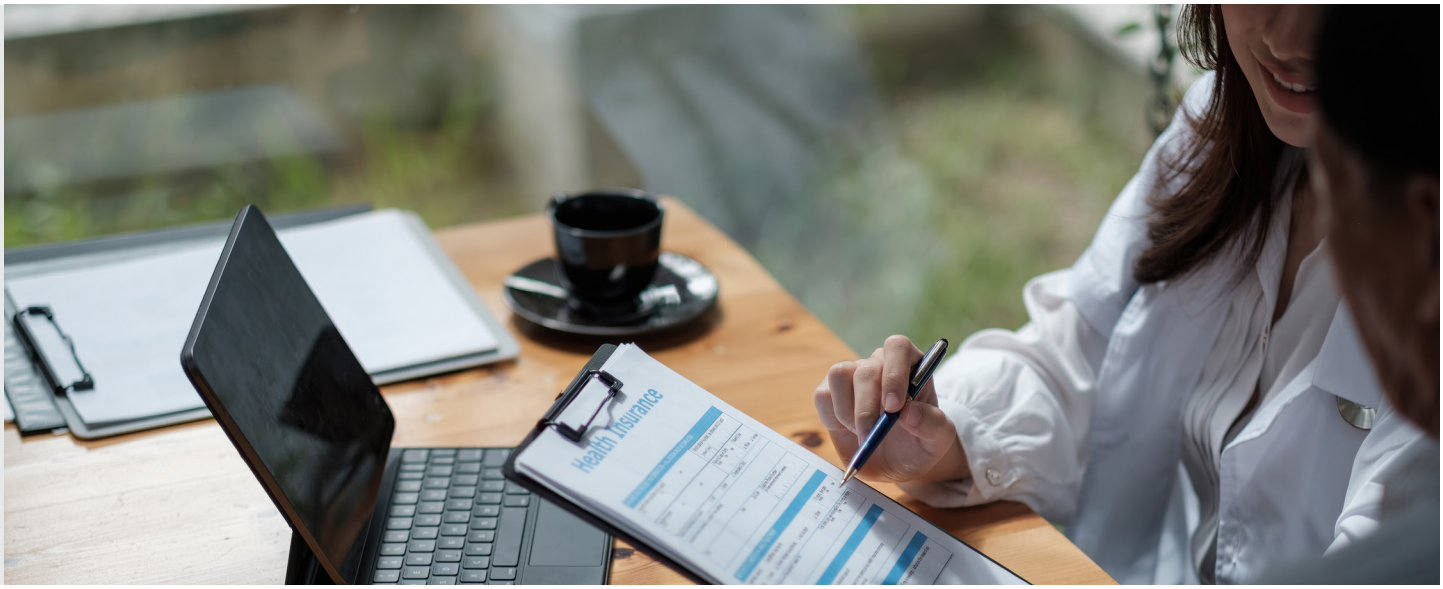
1. **The W-2 safe harbor.** The employee's monthly contribution amount for the self-only premium of the employer's
   lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.12% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined 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.

2. **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 9.12% 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.

3. **Federal Poverty Level ("FPL") safe harbor.** Coverage is affordable if it does not exceed 9.12% of the FPL. For a 2023 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 **$103.28** (48 contiguous states), $129.12 (Alaska), or $118.78 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2023 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.



Further Guidance Issued On Contraceptive Coverage

Published: August 12, 2022

On July 28, 2022, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 54 to clarify protections for contraceptive coverage under the Affordable Care Act (the "ACA"). In January 2022, the Departments had issued guidance on the ACA Preventive Care Mandate, including contraception.

Background

As background, non-grandfathered group health plans must cover certain in-network preventive care items and services without cost-sharing. This includes, with respect to women, contraceptive services.

On December 30, 2021, the Health Resources and Services Administration ("HRSA") expanded the 2019 recommendation to include contraceptives that are not female-controlled, such as male condoms (which must be covered by the plan when prescribed).

Changes in recommendations or guidelines are typically applicable on the first day of the plan year that begins on or after the date that is one year after the date on which the recommendation or guideline is issued. Therefore, plans and issuers must currently provide coverage consistent with the new 2021 guidelines beginning with plan years starting on and after December 30, 2022 (compliance for calendar year plans begins on January 1, 2023).

FAQ Part 54

The Departments issued FAQ Part 54:

- In response to reports that individuals continue to experience difficulty accessing contraceptive coverage without cost sharing;
- To clarify application of the contraceptive coverage requirements to fertility awareness-based methods and to emergency contraceptives; and
- To address federal preemption of state law.

The Departments specifically note their commitment to ensuring access to contraceptive benefits without cost-sharing as entitled under the law and will take enforcement action as warranted. Violations may be subject to an excise tax of $100 per day per affected individuals under Code Sec. 4980D.

Briefly, the FAQs provide the following clarifications:

- Plans must cover, without cost sharing, items and services that are integral to the furnishing of recommended preventive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before provision of certain forms of contraceptives, such as an intrauterine device (also known as an IUD), regardless of whether the items and services are billed separately.

- In addition to what's outlined in the HRSA guidelines, plans must cover without cost sharing any contraceptive services and FDA approved, cleared, or granted contraceptive products that an individual and their attending provider have determined to be medically appropriate, whether or not those services or products are specifically identified in the categories listed in the HRSA-guidelines, including contraceptive products more recently approved, cleared, or granted by the FDA.

- Consistent with previous guidance (and as supported by HRSA guidelines), plans must cover, without cost sharing, (1) FDA-approved emergency contraception (levonorgestrel), and (2) emergency contraception (ulipristal acetate), including OTC products, when the product is prescribed for an individual by their attending provider. This includes when they are prescribed for advanced provision. The Departments encourage (but do not require) plans to cover dispensing of a 12-month supply of contraception (such as oral contraceptives) at one time without cost-sharing.

- Confirms the 2021 HRSA guidelines include "screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). This includes instruction in fertility awareness-based methods, including lactation amenorrhea.

- The guidance reaffirms that a health savings account ("HSA"), a health reimbursement arrangement ("HRA") and a health flexible spending account ("FSA") can reimburse an individual for the cost (or portion of the cost) incurred for OTC contraception to the extent that cost is not paid or reimbursed by another plan or coverage. Plans that cover the costs of OTC contraceptives without a prescription should advise individuals not to seek reimbursement from these tax favored accounts (no double dipping).

The FAQ further highlights when medical management may (and may not) be used for contraceptives. Specifically, the Departments caution plans and issuers of implementing burdensome, unreasonable medical management techniques which included situations such as:

- Denying coverage for all or particular brand name contraceptives, even after the individual's attending provider determines and communicates to the plan or issuer that a particular service or FDA-approved, cleared, or granted contraceptive product is medically necessary with respect to that individual;

- Requiring individuals to fail first using numerous other services or FDA-approved, cleared, or granted contraceptive products within the same category of contraception before the plan or issuer will approve coverage for the service or FDA-approved, cleared, or granted contraceptive product that is medically necessary for the individual, as determined by the individual's attending health care provider.

- Requiring individuals to fail first using other services or FDA-approved, cleared, or granted contraceptive products in other contraceptive categories before the plan or issuer will approve coverage for a service or FDA-approved, cleared, or granted contraceptive product in a particular contraceptive category.

- Imposing an age limit on contraceptive coverage instead of providing these benefits to all individuals with reproductive capacity.

- Requiring a participant or beneficiary to go through the plan's or issuer's internal claims and appeals process to obtain an exception to an adverse benefit determination.

Finally, the Departments specified that federal law would preempt any state law to the extent that it prevents the application of the ACA's preventive care mandate and highlights the Departments enforcement authority over plans.

Employer Action

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

Fully insured health plans. Carriers are generally responsible for compliance and should include these benefits as applicable.

Self-funded health plans. Discuss with TPAs to ensure coverage is in effect for plan years that begin on or after the applicable effective dates.

New Philadelphia Employee Commuter Transit Benefit Programs

Published: August 15, 2022

On June 22, 2022, Mayor Jim Kenney signed the Employee Commuter Transit Benefit Ordinance into law (the "Ordinance"). The Ordinance adds new commuter transit benefit programs in Philadelphia that require certain employers to provide a mass transit and bicycle commuter benefit program, beginning on December 31, 2022.

Who Does this Apply to?

Covered Employers are employers that employ at least 50 Covered Employees. Covered Employees are those who work at least 30 hours per week within the geographic boundaries of Philadelphia for the same employer within the previous 12 months.

What Must be Provided?

Covered Employers are required to make at least one of the following employee commuter transit benefit programs availability to all of their Covered Employees:

- Election of a pre-tax, payroll deduction for Mass Transit Expenses;
- An employer-paid benefit where the Covered Employer provides a pass, token, fare card or similar item entitling a person to transportation on public transit; or
- Any combination of the above. For 2022, the IRS will allow employees to set aside a maximum of $280 per month for commuter benefits on a tax-free basis.

In addition, Covered Employers also must offer their Covered Employees who regularly use a bicycle for commuting to and from work, a tax-free reimbursement of Qualified Bicycle Expenses, up to $20 per month. Cyclists are not permitted to exclude qualified bicycle commuting reimbursements from their income for federal income tax purposes for years 2018 through 2025.

What is a Mass Transit Expense?

A Mass Transit Expense is an expense incurred for a Fare Instrument or transportation in a commute highway vehicle, if used for travel between an employees' residence and workplace.

What Qualifies as a Bicycle Expense?

A Qualified Bicycle Expense is a reasonable expense incurred by a Covered Employee who regularly uses a bicycle for commuting to and from work. This includes the purchase, maintenance, repair and storage expenses related to bicycle commuting.

What is the Effective Date of the Ordinance?

The effective date of these programs is December 31, 2022. Covered Employees may report their employer. If a

Covered Employer does not comply with the Ordinances within 30 days after a written warning by the agency designated by the Mayor, fines ranging from $140 to $300 per day may be imposed for each day the Covered Employer fails to comply (each a separate violation).

Employer Action

Covered Employers should:

- Review their current policies related to any commuter transit benefit program and ensure they comply with the Ordinance
- Begin taking steps to implement a commuter transit benefit program if they do not currently have one in place
- Notify employees of the new benefits once any new commuter benefit programs are implemented
- Keep an eye out for additional guidance and discuss next steps with their payroll providers and third-party vendors

New Cost-Sharing Disclosure In 2023-Reminder

Published: August 24, 2022

Another compliance deadline is quickly approaching. For plan years that begin on or after **January 1, 2023**, group health plans must provide for advance disclosure of cost-sharing information to enrollees seeking health services, upon request and to the extent practicable.

The format of the disclosure is through an Internet-based self-service tool, telephone, or paper format (upon request).

The tool allows the enrollee to compare the amount of cost-sharing that he or she would be responsible for with respect to a discrete covered item or service by billing code or descriptive term. The required information relates to geographic region and in-network and out-of-network providers and initially addresses 500 items and services. Full compliance (all items and services) is required for plan years beginning on or after January 1, 2024.

Specifically, the following cost-sharing information must be disclosed. The information should be accurate as of the time the request is made.

Content	Description
Estimated cost-sharing	An estimate of the covered enrollee's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan.
Accumulated amounts	Accumulated amounts of cost-sharing that the enrollee has already incurred under the plan at the time the request is made. This includes a current statement of how much the enrollee has already paid toward the deductible and out-of-pocket limit.
In-network negotiated rates	The plan would need to disclose the dollar amount they have agreed to pay in-network providers for a certain service or prescription drug.
Out-of-network allowed amounts	The plan must provide the maximum amount that could be paid by the plan for a particular service or drug that is out-of-network.
If applicable, bundled payment arrangements	Cost-sharing information for each item and each service within the bundle must be disclosed.
Pre-requisites	Any coverage prerequisites (e.g., prior authorization or step therapy) before an enrollee can receive a service or item.

Disclosure	Disclosure that includes definitions of key terms, disclaimers related to billed charges versus estimated charges, a reminder that balance billing is not included in cost estimates, and contact information for questions. A model notice is available.

Good faith relief is available. When a plan or carrier makes an error or omission when acting in good faith and with reasonable diligence a plan will not fail to comply because:

- An error or omission in the required disclosure is made, provided the information is corrected as soon as practicable.
- The internet website is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable.
- Information must be obtained from a third party to comply with this requirement, and is relied upon in good faith, unless it is known (or reasonably should have known) the information is incomplete or inaccurate.

Insurers are responsible for compliance with respect to insured plans. Employers with a fully insured plan can agree in writing to have the carrier provide the disclosure. If the carrier fails to comply, the carrier (and not the plan's sponsor) is liable.

While employers are responsible for compliance with respect to self-funded plans, third party administrators are expected to handle this task on their behalf. Employers should seek written assurances of their assistance with this requirement.

Additional guidance may be issued before the effective date. We will continue to monitor developments.

Inflation Reduction Act-Health Care Considerations

Published: August 25, 2022

On August 16, 2022, President Biden signed the "Inflation Reduction Act" into law. The legislation includes key health care,tax, and climate change components.

As it relates to health care, the bill:

- Temporarily extends through 2025 the expanded premium tax credits available in the Marketplace. Originally, under the American Rescue Plan Act ("ARPA"), the expanded subsidies were only available in 2021 and 2022.

- Creates a safe harbor that permits first dollar coverage for "selected insulin products" under a qualified high deductible health plan ("HDHP"), effective for plan years beginning on or after January 1, 2023.

    - "Selected insulin products" means any dosage form (such as vial, pump, or inhaler dosage forms) of any different type of insulin (such as rapid-acting, short-acting, intermediate-acting, long-acting, ultra-long-acting, and premixed).

    - Under earlier guidance, insulin and other glucose lowering agents may be treated as preventive care for individuals diagnosed with diabetes. Many HDHPs may already cover insulin as preventive care under this guidance.

- Includes several provisions under Medicare, particularly with respect to pharmaceutical coverage and Medicare Part D.

    - Permits the federal government to negotiate directly with pharmaceutical manufacturers on prices for certain Medicare prescription drugs beginning in 2026. In addition, beginning in 2023 the law requires drug companies to pay a rebate to the government if prices rise faster than inflation.

    - Sets a $35 cap on out-of-pocket costs for insulin for those with Medicare coverage.

    - Sets a $2,000 "hard" cap on Medicare Part D out-of-pocket cost sharing starting in 2025.

It should be noted that the pricing negotiated by the government, as well as the rebates, are not available to commercial plans (including employer-sponsored health plans). Because of this, and with the additions of the new cap on insulin and the upcoming hard cap on Medicare Part D out-of-pocket cost, there could be a cost-shifting by the pharmaceutical manufacturers and/or pharmacy benefit managers to the commercial marketplace.

Employer Action

If offering an HDHP with an HSA, the law codifies the ability of a plan to provide first dollar coverage for insulin without jeopardizing an individual's ability to make HSA contributions.

Employers should stay informed as to the impact on prescription drug costs in the commercial market as a result of the federal government new negotiation power. While this will not take effect until 2026, it will be important to watch the costs in this area.

New York Extension Of Paid Leave For COVID-19 Vaccinations

Published: August 26, 2022

Governor Cuomo signed legislation on March 12, 2021, requiring all New York public and private employers to provide employees up to four (4) hours of paid leave per required dose of the COVID-19 vaccine. Employees requiring two separate injections (e.g., the Pfizer and Moderna COVID-19 vaccines) will be entitled to up to eight (8) hours of paid leave. The provisions of this Act took effect immediately and are in effect through December 31, 2022.

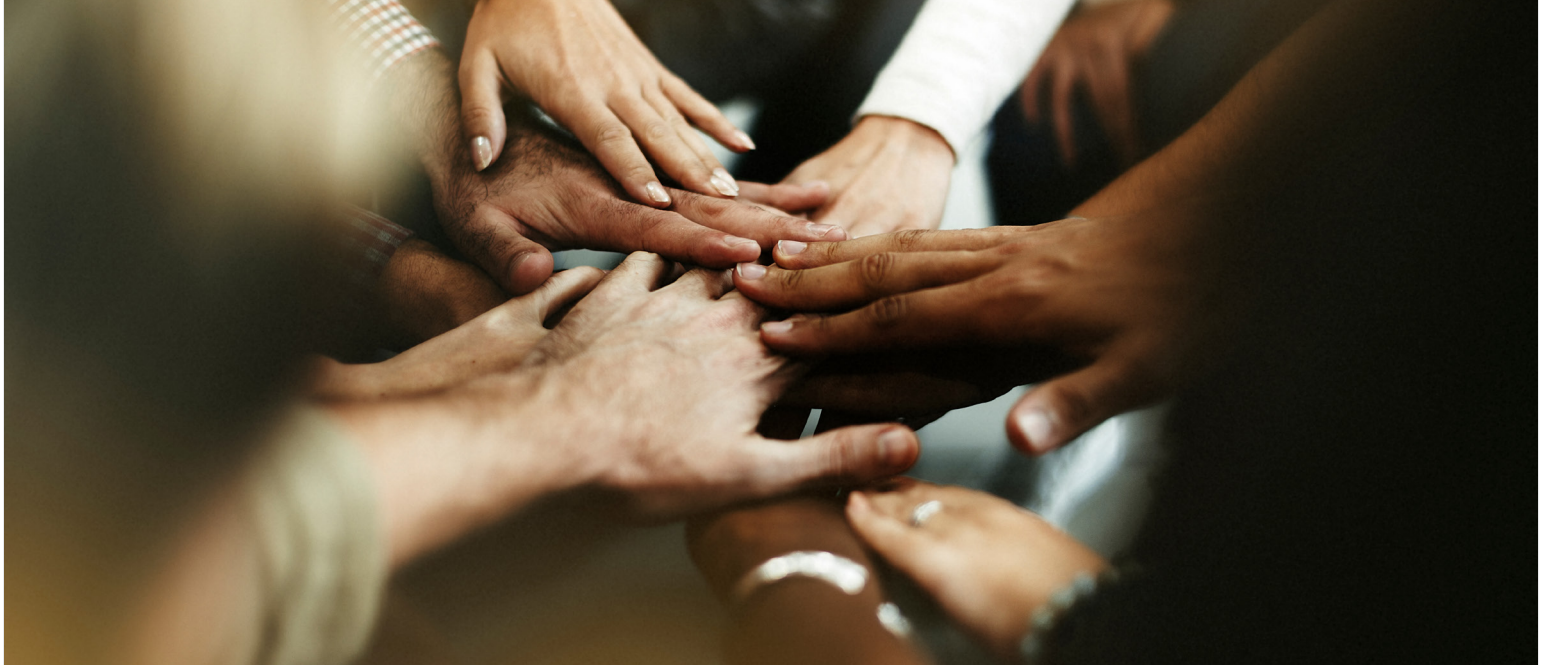
On June 28, 2022, New York Governor Kathy Hochul signed into law a bill extending the state's COVID-19 vaccine paid leave law for an additional year, through December 31, 2023. The law permits paid time off for boosters, as well.

As a reminder, the following are key points of interest for the COVID-19 vaccination leave:

- The leave must be paid at the employee's regular rate of pay.
- Time off to receive the vaccination may not be charged against any other leave to which the employee may be entitled such as accrued sick or vacation time.
- Employees covered under a collective bargaining agreement ("CBA") are entitled to at least eight (8) hours of vaccination leave unless additional time is specifically granted under the CBA.
- The provisions of the bill may only be waived by a CBA that explicitly references the new provision of the New York labor law provided under this Act.
- An employer may not retaliate against an employee for exercising his or her rights under this Act.

Employer Action

New York employers should communicate the required COVID-19 leave policy with their employees to help encourage vaccine scheduling.



HHS Proposes Expanded Section 1557 Nondiscrimination Rules

Published: September 09, 2022

On July 25, 2022, the Department of Health and Human Services ("HHS") issued a proposed rule that intends to broaden the interpretation and application of the nondiscrimination rules under Section 1557 of the Affordable Care Act ("ACA") to include:

- Reinstatement of protections on the basis of gender identity,
- Expanding who is subject to Section 1557, and
- Reinstating certain notice requirements.

While Section 1557 generally applies to covered entities, these changes may impact some employer sponsored group health plans.

Background

Section 1557, which has been in effect since the ACA was enacted in 2010, prohibits discrimination in certain health care programs and activities on the basis of race, color, national origin, sex, age, or disability. Initial regulations issued in May 2016 were partially repealed under current regulations issued in June 2020. There have also been numerous court challenges under Section 1557, including those on religious grounds.

This article only addresses details under the proposed rule that would likely apply to employers who sponsor group health plans. If finalized as is, the new rule's effective date would generally be 60 days after publication in the Federal Register. However, it appears provisions applicable to plans would be effective as of the next plan year.

Highlighted Changes to the Rule

The related HHS press release highlights changes under the rule, as follows (with additional commentary added):

» Reinstates the scope of Section 1557 to cover HHS' health programs and activities.

- This would broaden the situations where Section 1557 may apply, by mostly reverting back to the 2016 rule, and undoing the 2020 rule that narrowly applies to entities "principally engaged" in healthcare.
- For employer purposes, the proposed rule would generally apply to every health program or activity, any part of which receives federal financial assistance, directly or indirectly, from HHS.
- "Covered entities" are recipients of such assistance and could include state or local health agencies;

- hospitals; health clinics; health insurance issuers; physician's practices; pharmacies; community-based health care providers; nursing facilities; and residential or community-based treatment facilities.

- A "health program or activity" will mean any project, enterprise, venture or undertaking to provide or administer health-related services, health insurance coverage, or other health-related coverage; provide assistance to persons in obtaining health-related services, health insurance coverage, or other health-related coverage; provide clinical, pharmaceutical, or medical care; engage in health research; or provide health education for health care professionals or others.

» Clarifies the application of Section 1557 nondiscrimination requirements to health insurance issuers that receive federal financial assistance.

- This would undo the 2020 rule that narrows applicability specifically to health insurance products for which an issuer received federal financial assistance.

- Any health insurance issuer receiving any federal financial assistance, such as through offering of Marketplace coverage, would have to comply with nondiscrimination requirements for all its health insurance business, including when it serves as a TPA for self-insured group health plans.

    - The Office of Civil Rights (OCR) can hold TPAs responsible for discriminatory action the TPAs control with respect to plan design and administration.

- Most significantly, the proposed rule would not apply Section 1557 to an employer's employment practices, including its health benefits programs, even if offered by a covered entity such as a health care provider.

    - For a discriminatory self-insured plan design controlled by a plan sponsor, whether or not a covered entity, OCR can refer complaints to the EEOC or the DOJ, such as for possible violations of Title VII of the Civil Rights Act of 1964.

    - Though employers sponsoring employee health benefit plans may not be directly subject to the proposed rule, individuals covered by such plans may have certain rights and receive various communications from an issuer or TPA pertaining to Section 1557.

» Aligns regulatory requirements with Federal court opinions to prohibit discrimination on the basis of sex including sexual orientation and gender identity.

- This is consistent with the Supreme Court conclusion in Bostock v. Clayton County, GA, and HHS' previously announced interpretation and enforcement of Section 1557 pursuant to that case.

New FAQ Addresses NSA And TiC Rules

Published: September 13, 2022

The Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 55, providing guidance as it relates to certain aspects of the No Surprises Act ("NSA") and the Transparency in Coverage ("TiC") final regulations. FAQ 55 includes 23 questions and answers. The guidance is lengthy and very detailed. Below you will find some of the key highlights of the guidance.

No Surprises Act

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

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

The FAQ:

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

- Addresses how the NSA applies to plans without a network of providers, closed network plans and air ambulances services;

- Confirms the NSA applies to emergency services furnished in behavioral health crisis facilities;
- Clarifies the disclosure requirements and provides a revised model disclosure notice for group health plans; and
- Further explains calculating the qualifying payment amount ("QPA") and answers various questions related to the federal independent dispute resolution ("IDR") process.

No Network Plans

In a plan that does not have a network of providers (e.g., reference-based pricing plans):

- The surprise billing protections apply to OON emergency services and OON air ambulance services. However, the protections with respect to non-emergency services provided by OON providers at in-network facilities would never be triggered if a plan does not have a network of participating facilities.
- Cost-sharing for OON items and services subject to the NSA is based on the lesser of the billed charge or the QPA. When a plan does not have sufficient information to calculate a median contracted rate, for example because the plan does not have a network of participating providers for the items or services involved, the QPA should be calculated using an eligible data base in accordance with the regulations.
- Out-of-pocket spending incurred by a participant for emergency services should be counted against the maximum out-of-pocket ("MOOP") spending with respect to providers who do not accept the reference price. Under the NSA, this definition is expanded to include post-stabilization services that are emergency services.

Closed Network Plans

The NSA protections for emergency services, non-emergency services furnished by an OON provider at an in-network facility, and air ambulance services apply if those services are otherwise covered under the plan, even if the plan does not provide coverage OON.

This requirement may result in the plan providing benefits for OON items and services subject to the NSA even if the plan would not otherwise cover these items and service on an OON basis.

Disclosures for Protection Against Balance Billing

Under the NSA, a group health plan and carrier must make a disclosure of the protections under the NSA publicly available, posted on a public website of the plan or carrier and included on each explanation of benefits ("EOB") for NSA claims.

The FAQ:

- Clarifies that if a group health plan does not have a website, the plan may satisfy the public posting requirement by entering into a written agreement with a carrier or TPA to post the information on its public website where information is normally made available to participants. This would apply in instances where the plan sponsor (for example, an employer) may maintain a public website, but the group health plan sponsored by the employer does not.
- Confirms that plans are not required to provide information on all state balance billing laws in the required disclosure. Rather plans are only required to provide information on applicable state laws regarding OON balance billing. If a plan is a self-funded ERISA plan, generally state balance billing laws are not applicable; therefore, a plan does not need to include state balance billing information. However,if a self-funded plan has voluntarily "opted in" to a state balance billing law, the plan must disclose that information.

The model NSA disclosure has been updated for use by group health plans and carriers for plan years beginning on

or after January 1, 2023. Before this date, a plan may use either the original model notice or the updated version. For the revised instructions and notice, visit: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (starts on page 14).

Calculating the Qualifying Payment Amount

The FAQ provides additional clarification on calculating the QPA by provider specialty and permits self-funded health plans with multiple benefit options administered by different TPAs to calculate median contracted rates separate for those benefit packages administered by the TPA (instead of having to aggregate the rate across separate benefit package options administered by separate TPAs).

Federal IDR Process

The FAQ offers further clarification on the federal IDR process to ensure billing disputes are resolved in a timely manner. Among other requirements, the FAQs address timeframes and additional disclosures that must be satisfied when the plan makes an initial payment or send notice of a denial of payment to a provider or facility, and the process for initiating an open negotiation period that must precede any initiation of the federal IDR process.

Transparency in Coverage

The final TiC rule requires group health plans and carriers make public three machine-readable files ("MRFs") disclosing:

1. In-network rates,
2. OON allowed amounts and billed charges, and
3. Negotiated rates and historical net prices for covered prescription drugs.

With respect to (1) and (2), the requirement to post MRFs took effect July 1, 2022 (for plan years that began between January 1, 2022 and July 1, 2022) and, for plan years that begin after July 1, 2022, the file must be posted in the month the plan year begins. These files must be updated monthly. The MRF related to prescription drugs is not being enforced pending further guidance.

In addition, for plan years beginning on or after January 1, 2023, group health plans and carriers must disclose cost sharing information with respect to 500 identified items and services in advance of receiving care. Full compliance is required for plan years beginning on or after January 1, 2024.

TiC – Machine-Readable Files

There was some confusion with respect to the website posting requirement under the regulations. The FAQ confirms:

- If a group health plan does not have its own public website, nothing in the final rules requires the plan to create its own website for the purposes of providing a link to a location where the MRFs are publicly available.
- A plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the machine-readable files on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable.

TiC – Cost-Sharing Disclosure

The FAQ provides a link to the list of the 500 items and services that must be included in the first phase of implementation of the internet-based self-service tool: www.cms.gov/healthplan-price-transparency/resources/500-items-services.

The Departments will update the list quarterly to reflect changes (including the retirement of any codes) and provide a reasonable period of time for plan and carriers to update their tools to reflect current codes.

Plans and carriers should refer to this webpage for the most up-to-date list of codes to comply with the requirements regarding the self-service tool for plan years beginning on or after January 1, 2023.

Employer Action

The guidance provides helpful clarification. Many aspects of the NSA and TiC rules are functions of plan administration and claims payment; support from carriers and third-party administrators ("TPAs") is essential for compliance.

For fully insured plans, these requirements should be handled by the carrier.

For a self-funded plan (including level-funded), the plan is ultimately responsible for compliance and should work with third party administrators to ensure the plan is administered in accordance with the NSA and TiC rules.

Additional Guidance On New Prescription Reporting Requirement

Published: September 14, 2022

As previously reported in 2021, Section 204 of the Consolidated Appropriations Act, 2021 ("CAA") requires plan sponsors of group health plans to submit information annually about prescription drugs and health care spending to Centers for Medicare and Medicaid Services ("CMS") on behalf of the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, the "Departments"). The first deadline is December 27, 2022. CMS recently updated guidance related to this reporting requirement that provides some helpful clarification.

What is Reported?

- Plan name
- Plan number
- Plan year
- Employer size (self-funded plans must elect an reasonable method of determining determine number of employees)
- Plan sponsor's principal place of business (for self-funded MEWAs, employer's principal place of business)
- Premiums (premium equivalents for self-funded plans)
- Average monthly premiums paid by the employer and the enrollees
- States in which the plan is offered
- Number of enrollees
- 50 most common brand prescription drugs dispensed
- 50 drugs with the greatest year-over-year cost increase for the plan
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, medical benefit drugs, and other medical costs and services)
  - Plan and enrollee spending on prescription drugs
- Impact on premiums and out-of-pocket costs associated with rebates, fees, or other payments by drug manufacturers to the plan (narrative response)
  - Includes prescription drug rebates, fees, and any other renumeration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed for each therapeutic class of drugs, as well as 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

Who must Report?

Employers with fully insured or self-funded (includes level funded) group health plans, including grandfathered plans, church plans subject to the Internal Revenue Code, and governmental plans.

The term "group health plan" does not include excepted benefits such as onsite clinics and accident-only policies. It also does not include account-based plans (e.g., HRAs or health FSAs).

What Periods are Reported?

Information is reported on a calendar year basis, regardless of plan year. This is referred to as a "reference year."

How is Date Reported?

Data is reported through the RxDC module in the Health Insurance Oversight System ("HIOS"). An account must be created unless the employer:

- Already has a HIOS account; or
- Is not uploading anything because another vendor is handling the full filing; or
- Where the employer is uploading partial data, not including any files.

NOTE: It can take up to two weeks to create an account so plan sponsors should plan accordingly.

The instructions to create a CMS Enterprise Portal and HIOS accounts are in the HIOS Portal User Manual. The instructions for using the RxDC module are in the RxDC HIOS User Manual. To log in to HIOS, go to the CMS Enterprise Portal at https://portal.cms.gov/portal/.

Can a Vendor Submit Information on the Employer's Behalf?

Yes. Insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier.

Self-funded plans may enter into a written agreement with their third-party administrator ("TPA"), pharmacy benefit manager ("PBM"), or other vendor to fulfill reporting function on behalf of the plan; however, the plan sponsor remains liable for any failures.

An entity that submits some or all required information is called a "reporting entity." Reporting entities may charge additional fees for compiling and filing the data.

A plan, issuer, or carrier can allow multiple reporting entities to submit on its behalf. For example, a self-funded group health plan may contract with a TPA to submit the Spending by Category data file and separately contract with a PBM to submit the Top 50 Most Costly Drugs file. Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.

Some of the above-listed data points may not be known by the issuer, TPAs, PBMs, or other vendors. Employers should be prepared to receive a request for information from the carrier, TPA, or PBM and either timely provide the information or prepare to do a partial filing.

If a plan, issuer, or carrier changes vendors during the reference year (such as changing a TPA or PBM), there are two reporting options:

1. The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or
2. The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data.

Either way, the plan sponsor must ensure that all their data is reported and that it is not double reported.

For mixed-funded plans, which generally self-fund some benefits and fully insure other benefits, the self-funded business is reported in the self-funded market segment

and the fully insured business is reported in the fully insured market segment. For example, suppose a large employer self-funds the pharmacy benefit of a plan and purchases insurance for the medical benefits. In this case, the pharmacy benefits would be attributed to the market segment for self-funded large employer plans and the medical component of the same plan would be attributed to the fully insured large group market.

Currently, CMS does not have a mechanism to notify plans, issuers, or carriers when data has been submitted on their behalf. To confirm submission, plans should contact their reporting entities directly.

What if a Plan Changes from a Fully-Insured Product to Self-Funded Coverage in the Middle of the Reference Year or Vice Versa?

The fully insured business is reported in the small group or large group market segments and the self-funded business is reported in the self-funded small employer or large employer market segments.

When is the Deadline and What is the Penalty for Noncompliance?

The last day to submit data for the 2020 and 2021 reference years is **December 27, 2022.** The deadline for subsequent reference years is **June 1st** of the calendar year immediately following the reference year. So, June 1, 2023, is the second deadline, reporting calendar year 2022 information.

The penalty is $100 per affected individual. In addition, the DOL can enforce compliance.

Is there any Relief?

For the 2020 and 2021 reference years only, the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are not available and they are reported for the 2022 reference year and all future reference years.

There remain many unanswered questions with respect to this reporting. Hopefully, the Departments will issue further guidance before the due date.

Issuers, TPAs, PBMs, and other third-party vendors are expected to be reaching out to plan sponsors in the coming months.

Medicare Part D Notification Requirements

Published: September 16, 2022

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, 2022 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, generally imposes a lifetime penalty for late enrollment if an individual delays enrolling in Part D after initial eligibility (for example, after reaching age 65), unless the individual continues to be covered by an employer’s group medical plan because of active employment or COBRA, and coverage under the plan is “creditable” (meaning equal to or better than coverage provided under a Part D standard plan).

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 in connection with 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.

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, 2023 for a 2023 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.

2022 MLR Rebate Checks To Be Issued Soon To Fully Insured Plans

Published: September 20, 2022

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 are required to distribute MLR checks to employers by September 30, 2022.

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 [September ___] 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 to 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.

Final Rules Adopt Administrative Changes To The No Surprises Act

Published: September 22, 2022

On August 26, 2022, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") published final rules on the No Surprises Act, making changes to the administrative duties of insurance carriers, HMOs, third-party administrators, out-of-network healthcare providers, and certain other entities responsible for the Act's implementation.

The new rules, which take effect on October 25, 2022, are narrow in scope, and include the following changes:

- During processing of claims under the No Surprises Act, if "down-coding" occurs (i.e., the group medical plan alters or replaces the medical billing codes chosen by the out-of-network healthcare provider, resulting in a lower claim payment), then the final rules impose additional disclosure requirements on the plan.

- If a group medical plan and an out-of-network healthcare provider are unable to agree on the final claim payment under the No Surprises Act, and the dispute is referred to a certified independent dispute resolution entity ("IDR entity"), the final rules require the IDR entity to consider more evidence before making its decision, and to disregard any presumption in favor of the qualified payment amount ("QPA") (contrary to the position previously taken by the Departments).

Background

The No Surprises Act, which was enacted into law as part of the Consolidated Appropriations Act, 2021, generally limits out-of-network cost sharing, and prohibits balance billing, when participants in a group medical plan receive (1) emergency services from an out-of-network healthcare provider, (2) non-emergency services from an out-of-network healthcare provider at an in-network medical facility, or (3) air ambulance services.

The Departments then published interim final rules on the No Surprises Act in July 2021 and in October 2021. Certain aspects of the October 2021 interim final rules were subsequently set aside by a federal district court. Rather than appeal the court's decision, the Departments decided to alter the interim final rules, resulting in publication of the current rules.

Down-Coding

According to the final rules, "down-coding" occurs when the insurance carrier, HMO or third-party administrator for a group medical plan alters a medical billing code to another code, or alters, adds, or removes a modifier, if the changed code or modifier is associated with a lower claim payment compared to the code or modifier that was chosen by the out-of-network healthcare provider.

The final rules state that, whenever "down-coding" occurs under the No Surprises Act, the insurance carrier, HMO or third-party administrator for the group medical plan is required to furnish the following additional information to the out-of-network healthcare provider:

- A statement that the medical billing code or modifier chosen by the out-of-network healthcare provider was down-coded;
- An explanation of why the code or modifier was down-coded, including a description of which codes were altered (if any), and which modifiers were altered, added, or removed (if any); and
- The amount that would have been paid by the plan had the code or modifier not been down-coded.

Additionally, the final rules state that the Departments are responsible for monitoring the accuracy of claim payment calculations under the No Surprises Act and is committed to conducting audits for that purpose.

Determination of Claim Payments under Independent Dispute Resolution

Under the No Surprises Act, if the insurance carrier, HMO or third-party administrator for the group medical plan is unable to reach agreement with an out-of-network healthcare provider on the final claim payment (which is called the "out-of-network rate"), then either party may refer the dispute over the out-of-network rate to a certified independent dispute resolution entity. Then:

- Each party will make an offer regarding the out-of-network rate to the IDR entity, along with arguments in support of its offer.
- The IDR entity must select one of the two offers as the out-of-network rate for each item or service that is subject to the dispute.

Before the federal district court set aside portions of the interim final rules, the IDR entity began with the presumption that the QPA constituted a reasonable market-based payment for the relevant items and services. The IDR entity would then evaluate additional information from the parties (subject to certain restrictions set forth in the interim final rules) before making its decision.

The final rules remove the presumption in favor of the group medical plan, and also remove certain restrictions on information that may be furnished by the parties in support of their offers. The final rules now specify that the IDR entity must consider all credible information submitted by the parties and determine which offer best reflects the appropriate out-of-network rate.

Examples of information that may be submitted to the IDR entity include the following:

- If the out-of-network healthcare provider is a Level 1 trauma center, the provider could furnish (a) information showing that the scope of services available at the facility was critical to the delivery of emergency services to the patient, given the patient's health condition at the time, and (b) information showing that the offer made by the group medical plan is based on emergency services from lower level facilities (i.e., not Level 1 trauma centers).

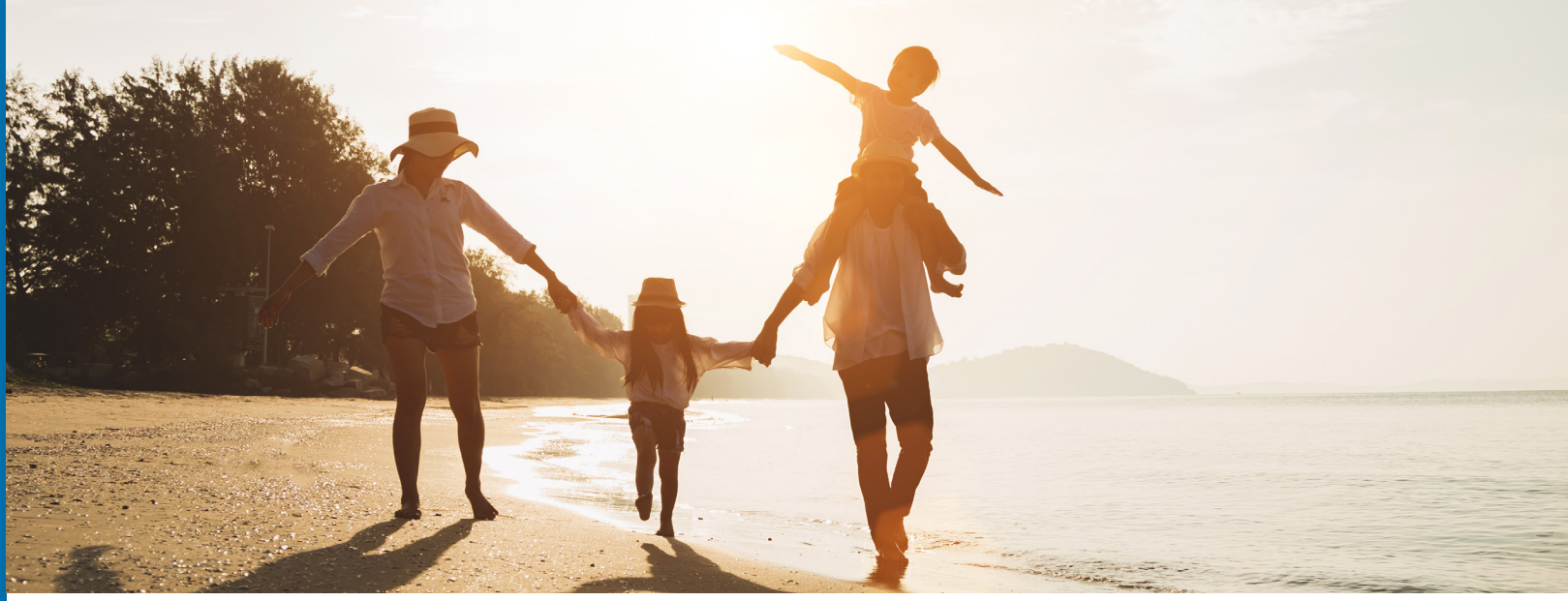
- If the out-of-network healthcare provider submits information showing that the patient's condition required the taking of a comprehensive history, a comprehensive examination, and a medical decision of high complexity, the group medical plan could respond with information showing that these factors are already included within the medical billing code chosen by the plan as the basis for its offer.

In addition, the final rules require the IDR entity to explain its payment determinations and underlying rationale in a written decision submitted to the parties and the Departments.

Employer Action

For fully insured group medical plans, the insurance carrier or HMO is responsible for complying with the final rules.

For self-funded group medical plans, the third-party administrator should be handling compliance with the final rules, although the employer or other plan sponsor is ultimately liable for any noncompliance. It will be important for the employer or other plan sponsor to monitor and confirm that the TPA is operating the plan in compliance with the final rules, especially in view of the Departments' promise to conduct audits of claim payment calculations under the No Surprises Act.



New York Paid Family Leave 2023 Contributions and Benefits

Published: September 23, 2022

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2023, will be reduced by **10%** and be set at **.455%** of weekly wages.

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 ("NYAWW"). For 2023:

- NYAWW in effect will be **$1,688.19**, an increase of 5.9% from the 2022 NYAWW of $1,594.57. The annualized NYAWW is **$87,785.88**.
- The maximum annual employee contribution will be $399.43 ($423.71 in 2022).

The PFL benefit is 67% of an employee's Average Weekly Wage (up to the NYAWW) payable for 12 weeks. For 2023:

- The maximum weekly PFL benefit will be **$1,131.08** ($1,068.36 in 2022).
- The maximum annual PFL benefit payable for 12 weeks will be **$13,572.96** ($12,820.32 in 2022).

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.
- If an employee begins continuous leave in 2022 and the leave extends into the 2023, the benefit is based on the rate in effect on the first day of leave (i.e., in 2022) and is not recalculated at the 2023 rate.
- If an employee begins intermittent leave in 2022 and the leave extends into the following year and there is at least a three-month lapse in days taken under NYPFL, the leave is considered a new claim under the law in 2023 and the benefit is calculated at the 2023 rate.

Employer Action

Employers should prepare for the 2023 New York PFL contribution and benefit changes that begin in January. PFL 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 New York Workers' Compensation Board.

Colorado Enacts New Paid Family and Medical Leave Requirement

On November 3, 2020, Colorado voters approved the Colorado Paid Family and Medical Leave Insurance Act ("the Act"), creating the Paid Family and Medical Leave Insurance program ("the FAMLI program"). Joining a handful of other states with similar laws, the FAMLI program will provide most Colorado employees with partial wage replacement for 12-16 weeks of leave, depending on the circumstances. The state recently published guidance regarding the FAMLI program.

Overview

- The FAMLI paid leave requirements are applicable to any employer that employs at least one individual in Colorado.
- Benefits will be funded by employer and employee contributions. In the program's first two years, the initial premium rate will be 0.9% of wages per employee. Beginning in 2025, the FAMLI program director can set the premium up to 1.2% of an employee's taxable wages.
- Employers with 10 or more employees must pay at least 50% of the premium. Employers with fewer than 10 employees do not have to contribute to the program, but do need to remit their employees' share of premium payments.
- Contributions are scheduled to begin January 1, 2023, while paid benefits under the FAMLI program will commence January 1, 2024.

Covered Employers

Most Colorado employers will be covered by the FAMLI program. Private employers with at least one employee in Colorado must provide paid family and medical leave to its eligible Colorado employees.

Local government employers, including charter schools, may choose to opt out of the FAMLI program by holding a vote in 2022. If a local government declines to participate in the program, notice must be provided to its employees within 30 days of the vote. This notice must inform its employees that they may still opt into the FAMLI program individually similar to self-employed individuals or independent contractors.

Local governments must also notify the FAMLI Division in writing of their decision to opt out of the program by January 1, 2023. Failure to do so will result in presumed participation in the FAMLI program.

Regardless of the decision to opt out or participate, local governments are required to register with FAMLI's online employer service system. This registration allows FAMLI to track the local government employer's participation decision, including the obligation to revisit an opt out vote after eight years. Also, the online registration facilitates the submission of wage reports and individually participating employees' premium deductions via payroll deductions from local governments that have opted out of fully participating.

Federal government employees and certain railroad employees are not covered by the FAMLI program.

Employee Eligibility

To be eligible, and receive benefits from the FAMLI program, employees must have earned at least $2,500 in wages in the State of Colorado during the 12-month period prior to requesting benefits. There is no distinction between full-time and part-time employees.

Employees that work a portion of their time within Colorado may also be eligible for paid leave. Specifically, the following employees are eligible for the paid leave:

- Employees who perform work both within and outside of Colorado but work outside of Colorado is incidental to employee's work within the state, or is temporary or transitory and consists of isolated transactions; or
- Employees whose work is not primarily localized in any state, but some work is performed in Colorado and:
  - The employer's base of operations is in Colorado, or, if the employer does not have a base of operations, the employee's work is directed or controlled from Colorado; or
  - The employer's base of operations nor place from where the work is directed is not from any state, but the employee's individual residence is in Colorado.

Self-employed individuals and independent contractors may also be eligible if they have opted into coverage for no less than three years and live and work in Colorado.

Reasons for Leave

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth, adoption or placement through foster care;
- To care for a family member with a serious health condition;
- To provide leave to the employee due to a serious health condition;
- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee; and
- The employee, or a family member of the employee, is a victim of domestic violence, stalking, or sexual assault.

Benefit Amount and Duration

Covered individuals will be eligible for paid leave equal to:

- 90% of their average weekly wage for the portion of their wages equal to or less than 50% of the state average weekly wage; and
- 50% of the portion of their wages that exceeds the state average weekly wage.

For covered leave beginning before January 1, 2025, benefit payments will be capped at $1,100 per week. Thereafter, the maximum weekly benefit will be 90% of the state average weekly wage.

Covered individuals are eligible to receive benefit payments for up to 12 weeks in an application year. An individual may receive an additional four weeks of paid leave if they have a serious health condition related to pregnancy or childbirth complications, for a total of 16 weeks.

Contribution Rates

Beginning January 1, 2023, employers and their employees will be responsible for funding the FAMLI program. The initial premium rate is 0.9% of wages per employee. In 2025, the premium may increase up to 1.2% of an employee's taxable wages. Employers with 10 or more employees are required to pay at least 50% of the premium, but may choose to contribute a larger percentage. Employers with fewer than 10 employees are not required to contribute, but must still remit their employees' share of premium payments equal to 50% of the 0.9% premium rate (i.e., 0.45% of wages per employee).

The "wages" subject to the FAMLI program's payroll tax include salary or hourly wages, commissions, payments on a project basis, bonuses, or other forms of compensation (e.g., lodging and board, payments in kind, etc.). However, premiums are capped at the Social Security Wage base, which for 2023 is projected to be $155,100. This would result in a total maximum annual premium of $1,395.90 (combined employer and employee contribution) for the 2023 calendar year.

Employers must submit to the Colorado Department of Labor and Employment ("CDLE") both their share, if required, and their employees' share of the FAMLI premiums through an online system at the end of each quarter. These quarterly filings should be similar to how most companies currently submit their unemployment insurance.

Employer Private Plan Substitution

A covered employer may satisfy their obligations under the program through their own, approved private paid medical and family leave plan. To be approved, the private plan must be as generous as the FAMLI program, offering at a minimum the same rights, protections and benefits. Employees can be required to contribute to the private plan, but not more than what the employee would otherwise be required to contribute under the FAMLI program.

Additional details regarding private plan substitutions are expected from the CDLE and an update will be provided once available.

An employer may choose to have the FAMLI program to run concurrently with FMLA and should update their leave documents accordingly if that is their intent.

Employee Notice Requirements

If the need for FAMLI leave is foreseeable, employees must provide their employer with at least 30 days' advance notice before taking leave. If the leave is unforeseeable, notice to the employer will be due as soon as practicable. Employees must also make reasonable efforts to schedule their FAMLI leave so that is does not unduly interrupt their employer's operations.

In many circumstances, FAMLI leave may also qualify as leave under the FMLA and may run concurrently with FMLA leave. Employers are permitted to require that payments made under the FAMLI program are coordinated with payments made to the employee under a disability policy or other leave policy offered solely for FAMLI purposes. However, employees can't be required to use or exhaust any accrued vacation, sick, or other paid time off prior to or while receiving FAMLI benefits. The employer and employee may mutually agree to such an arrangement, but the total weekly benefit received by the employee can't exceed their average weekly wage.

Employer Responsibilities

Employers must prominently post the FAMLI Division's poster, available here, in the workplace and provide this written notice to employees upon hire. In addition, upon learning that a covered individual has experienced or is experiencing a triggering event under the program, the employer must remind the employee about the FAMLI benefit and provide the written notice.

Employer Action

Employers should:

- Determine how FAMLI will apply to your business – Consider your FAMLI plan options. While markets for private plans are not yet available and details on self-insured options are still forthcoming, you should start having conversations now on your intended course of action.
- Estimate your premium liability – The CDLE has provided a FAMLI premium and benefits calculator, available HERE.
- Update employee communications – Incorporate language into benefit guides regarding FAMLI premium deductions beginning January 1, 2023. Provide written notice to all covered employees of their rights and duties under the FAMLI program, including the FAMLI Division's poster.
- Register with the FAMLI Division – Await published guidance from the FAMLI Division on how to establish your account and/or providing information on a private plan.
- Prepare to collect premiums – If you use a payroll company, or if you process payroll in-house, you will need a plan to have the FAMLI premiums deducted and submitted to the CDLE beginning January 1, 2023.

Massachusetts Releases 2023 MCC Amounts

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 02-22 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage (MCC) regulation, 956 CMR 5.00. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2023 and provides those respective dollar amounts, which are unchanged from 2022.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

The 2007 regulations mandated a $2,000/$4,000 deductible limit and a separate prescription deductible limit of up to $250/$500 for in-network covered services. In 2013, after recognizing that the deductible limits were out-of-step with some segments of the market and health care cost inflation, the Health Connector approved the indexing of deductibles according to a federal indexing statute. However, that statute was repealed before the indexing could ever take effect, which means that the deductible limits had not changed since 2007.

The Health Connector published updated MCC regulations on December 27, 2019, effective January 1, 2020. Part of the updated regulations indexed the deductible limits to the annual out-of-pocket maximum ("OOPM") adjustment percentage under federal law, rounded down to the next $50.

Administrative Bulletin 02-22 sets the 2023 maximum MCC deductibles as $2,850/$5,700. If the plan has a separate prescription drug deductible, the amounts cannot exceed $350/$700 and the total maximum deductible applies.

Out of Pocket Maximums

In 2017, the Health Connector published Administrative Bulletin 02-17, tying the indexed OOPMs under MCC to the federally indexed OOPMs that apply to non-grandfathered plans.

For 2023, the OOPM will be $9,100/$18,200.

What Else do you Need to Know?

Administrative Bulletin 02-22 takes effect immediately; although the indexed amounts are unchanged, the amounts in this Bulletin are applicable to employer-sponsored plans with plan years beginning on or after January 1, 2023.

2023 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2023 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 2023 calendar year (January 1 to December 31, 2023), the adjusted rates are:

- $518 per month for an employee with no spouse, domestic partner, or dependents;
- $881 per month for an employee with only dependents;
- $1,036 per month for an employee with only a spouse or domestic partner;
- $1,555 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.

It should be noted that in the latest legal developments, the 9th Circuit Court of Appeals ruled that the Ordinance was not preempted by ERISA. The ERISA Industry Committee (on behalf of its affected members) applied to the Supreme Court to hear the case. As of the date of publication, the Supreme Court has not decided whether to add the matter to the docket.

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 2023 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.

Paid Leave Oregon Update – Equivalent Plans

Oregon enacted a paid family and medical leave law that will be effective January 1, 2023, known as Paid Leave Oregon ("PLO"). Recently, the Oregon Employment Department ("OED") finalized rules related to equivalent plan application and approval. Employers intending to sponsor equivalent plans, whether fully insured or self-funded, may now submit equivalent plan applications or a declaration of intent if the actual plan design has not been finalized.

Background

On June 1, 2019, Governor Kate Brown signed HB 2005 into law, establishing the Paid Family and Medical Leave Insurance Fund ("PFMLIF") and making Oregon the eighth state to pass a paid family and medical leave law.

- The PFMLIF will be funded by employer contributions and employee payroll deductions
- The law will be phased in with contributions beginning in January of 2023 and benefits becoming available in September of 2023
- The total contribution amount will equal 1% of employee wages capped at $132,900 in 2023

All employers will participate in the state insurance fund unless the employer establishes an approved equivalent plan to provide these benefits. On August 22, 2022, additional rules were finalized related to equivalent plans.

Paid Leave Oregon Website

The PLO website has been updated to provide extensive information for employers including program information, employer resources, printable forms, and FAQs. Employers interested in sponsoring an equivalent plan, whether insured or self-funded, can now access the Equivalent Plans Guidebook that provides information on sponsoring an equivalent plan to comply with PLO requirements. Employers can also access the Equivalent Plans Checklist to assist them in preparing their equivalent plan application.

Equivalent Plan Application

Equivalent plan applications can now be submitted to OED via "Frances," the online reporting portal used by Oregon employers to submit required reporting and premiums for PLO. Frances is also used for reporting and payment of

unemployment insurance premiums. All Oregon employers will need to register with Frances if they have not already done so.

Employers will have until November 30, 2022 to apply for an equivalent plan that can be approved by the January 1, 2023 effective date for premium collection.

Equivalent plan applications will be processed within 30 days. Approved equivalent plans will be effective on the first day of the quarter following approval. Printable application forms are available on the PLO website along with information explaining the proof of solvency requirements that are needed for equivalent plan approval.

Declaration of Intent

Employers that are not prepared to complete an equivalent plan application but intend to sponsor an equivalent plan prior to the September 4, 2023 effective date for benefits may complete a Declaration of Intent that will allow the employer to delay premium collection and payment until September 4, 2023. The Declaration of Intent must be followed by an equivalent plan application no later than May 31, 2023, in order to have the equivalent plan approved on time.

Employers that file the Declaration of Intent but fail to obtain equivalent plan approval will be required to pay all owed employee and employer premiums due from January 1, 2023. In this situation, employers may not take deductions from employees to pay premiums that were not deducted when due.

Model Notice (Poster)

Updated resources also include the model notice that all employers are required to post and provide to all covered employees. The notice should be provided to all covered employees at the time of hire and anytime the policy or procedures change. The notice should be provided in the language that the employer typically uses to communicate with employees. The employer resources page provides the model notice in twelve (12) languages.

Employer Action

Employers intending to sponsor an equivalent plan should review the Equivalent Plan Guidebook and Equivalent Plan Checklist, both available on the PLO employer resources website in multiple languages.

Declarations of Intent and/or equivalent plan applications should be submitted as soon as possible.

Employers that want an equivalent plan effective January 1, 2023, will need to apply no later than November 30, 2022.

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