MY BENEFIT ADVISOR

2023: Third Quarter

Compliance Digest

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California Makes Changes to its SDI Program

Issued date: 07/05/23

California's State Disability Insurance (SDI) Program has several upcoming changes, including:

- Beginning January 1, 2024, the wage ceiling for employee SDI payroll contributions is eliminated.
- Beginning January 1, 2025, the wage replacement rate for short-term disability benefits and paid family leave benefits is increased to 70-90% (from 60-70%) depending on income, up to a maximum weekly benefit.

Background

California's State Disability Insurance (SDI) program provides both short-term Disability Insurance (DI) and Paid Family Leave (PFL), which are temporary wage replacement benefits paid from the state to eligible employees who need to be absent from work for specified reasons.

- Under DI, after a 7-day waiting period, California employees who are unable to work because of a non-work-related illness, injury, or pregnancy may be eligible for up to 52 weeks of disability insurance benefits of 60-70% of wages (depending on income), up to a maximum weekly benefit ($1,620/week in 2023).
- Under PFL, California employees who need time off from work to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying exigency related to covered active duty of the employee's family member, may be eligible for up to 8 weeks of paid family leave benefits of 60-70% of wages (depending on income), up to a maximum weekly benefit ($1,620/week in 2023).

This 60-70% wage replacement rate for DI/PFL benefits was scheduled to expire at the end of 2022 and revert back to 55% of wages (as it was in 2017).

Eligible employees pay for their participation in the DI and PFL programs by making payroll contributions to California's state disability insurance.

- In 2023, employees contribute 0.9% of pay up to a wage ceiling of $153,164; the maximum withholding from an employee is $1,378.48 in this year.

- In 2022, employees contributed 1.1% of pay up to a wage ceiling of $145,600; the maximum withholding from an employee was $1,601.60 in this year.

An employer that has applied to and received approval from California's Employment Development Department (EDD) may maintain a voluntary plan to provide short-term disability insurance and paid family leave to its employees, in lieu of its employees participating in the state program.

New Developments

In September 2022, Governor Newsom signed Senate Bill 951 into law, which made three important changes to California's SDI Program.

First, SB 951 extended the 60-70% wage replacement rate for DI/PFL benefits through the end of 2024.

Second, beginning January 1, 2025, the wage replacement rate for DI/PFL benefits will increase to 70-90% of weekly wages, depending on the employee's income. This change will primarily affect lower paid employees whose weekly benefit is less than the maximum weekly benefit.

Finally, in order to fund this increase in DI/PFL benefits, the wage ceiling on employee SDI payroll contributions is eliminated, beginning January 1, 2024 (i.e., one year before the increase in DI/PFL benefits). This means all California wages will be subject to withholding for SDI payroll contributions, without regard to any wage ceiling or cap. This change will only affect employees who earn more than the existing wage cap on SDI payroll contributions ($153,164 in 2023).

It is important to note that these changes also apply to an employer that maintains a voluntary plan to provide short-term disability insurance and paid family leave to its employees in lieu of the state program. For example, the voluntary plan's benefits must be amended to match the increases to the state-provided DI and PFL benefits.

IRS Addresses COVID-19 Testing and Treatment for HDHPs

Issued date: 07/07/23

As a result of the COVID-19 pandemic, high deductible health plans ("HDHPs") can provide coverage for COVID-19 testing and treatment before the minimum deductible is satisfied without jeopardizing an individual's ability to have tax-favored contributions made to their health savings account ("HSA"). This relief remains in effect pending future IRS guidance.

On June 24, 2023, the IRS issued Notice 2023-37, announcing that this relief will sunset with respect to plan years ending on or before December 31, 2024.

In addition, IRS Notice 2023-37 states that HDHPs may continue to provide first-dollar coverage for preventive care with an "A" or "B" rating by the United States Preventive Services Task Force ("USPSTF"), prior to satisfaction of the HDHP's minimum deductible, without jeopardizing the ability of a participant to contribute to an HSA.

Background

During the Public Health Emergency ("PHE"), all group health plans (including HDHPs) were required to cover COVID-19 testing without cost-sharing in-network and out-of-network (they were not required to cover COVID-19 treatment without cost-sharing and most plans opted to cover treatment as any other medical expense, subject to deductible and cost-sharing and not first dollar).

As a general rule, an HDHP may not provide first-dollar coverage for medical expenses before a minimum deductible is satisfied, with an exception for preventive care. The IRS issued Notice 2020-15 creating a special exception that permitted first-dollar coverage of COVID-19 testing and treatment without jeopardizing the ability of participants to have contributions made to their HSA.

While the PHE expired on May 11, 2023, this relief remains in effect following the end of the PHE until further guidance is issued. On June 24, 2023, the IRS issued guidance to end this relief.

HDHPs and COVID-19 Testing and Treatment

Notice 2023-37 states that HDHPs can continue providing first-dollar coverage of COVID-19 testing and treatment before satisfaction of the HDHP's deductible without jeopardizing HSA eligibility for HDHP plan years ending on or before December 31, 2024. For subsequent plan years, first dollar coverage for COVID-19 testing or treatment will disqualify a participant from HSA eligibility.

According to the guidance, testing for COVID-19 does not currently fit within the preventive care safe harbor set forth in IRS Notice 2004-23, which allows testing for certain illnesses to be covered by HDHPs as preventive care without cost sharing to the participant. As described below, it is also not currently part of the Affordable Care Act's ("ACA's") mandated preventive services.

Preventive Services

IRS Notice 2023-37 also states that items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010, are treated as preventive care under the rules governing HDHPs, regardless of whether these items or services must be covered without cost-sharing under the ACA. Therefore, an HDHP may provide first-dollar coverage of these items and services, prior to satisfaction of the deductible, without jeopardizing the ability of participants in the HDHP to have contributions made to their HSA.

This guidance is in response to the decision in Braidwood Management v. Becerra that eliminated the ACA's requirement that plans cover, without cost sharing, those items and services recommended by the USPSTF on or after March 23, 2010, under Public Health Service Act Section 2713.

IRS Notice 2023-37 also states that, if COVID-19 testing receives an "A" or B" rating in the future from the USPSTF, then HDHPs could provide first-dollar coverage of COVID-19 testing, prior to satisfaction of the deductible, for plan years ending after December 31, 2024, without jeopardizing the ability of participants in the HDHP to have contributions made to their HSA.

Employer Action

Employers sponsoring fully insured HDHPs should confirm with their carriers when the COVID-19 testing coverage requirements due to the PHE ended or will end so that appropriate communications can be provided to employees. While many carriers stopped providing first dollar coverage upon the expiration of the PHE, some continued coverage for testing through the end of the plan year. Further, a few states (e.g., California, New Mexico) require fully insured plans to continue to cover COVID-19 testing without cost-sharing.

Employers sponsoring self-funded HDHPs that have continued to provide first-dollar coverage of COVID-19 testing and/or treatment without cost-sharing should review the plan design with their third-party administrator to determine the appropriate timeframe to implement required cost-sharing to maintain HSA contribution eligibility for participants.

- Non-calendar year plans will need to comply with the new requirements prior to December 31, 2024. For example, an HDHP with a June 1 plan year should stop providing first-dollar coverage for COVID-19 testing and/or treatment effective with the plan year that begins June 1, 2024.

- Calendar year plans must comply with the plan year that begins on January 1, 2025.

Gag Clause Prohibition and Attestation Reminder

Issued date: 07/13/23

As previously reported, insurance carriers and plan sponsors of group health plans must submit information annually to the Centers of Medicare and Medicaid Services ("CMS") attesting that their plan(s) do not include prohibited gag clauses. The first attestation is due December 31, 2023.

Carriers and TPAs are beginning to notify clients how they intend to comply with the Gag Clause Prohibition Compliance Attestation ("GCPCA"). At this time it seems there is no uniformity as to how the various carriers/TPAs will address the attestation requirements.

Although the first attestation is not due until December 31, 2023, CMS is currently accepting attestations.

Background

A gag clause is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. These clauses may be found in agreements between a plan or carrier and any of the following parties:

- a health care provider;
- a network or association of providers;
- a third-party administrator ("TPA"); or
- another service provider offering access to a network of providers

Fully insured plans: If the group health plan is fully insured, the plan and the carrier both have the obligation to file an attestation however, if the carrier submits the attestation on behalf of the fully insured arrangement, no further action should be required by the plan. However, plan sponsors should not assume the carrier will submit the attestation on their behalf. The carrier may request information from the client to enable submission on the client's behalf or may decline to submit and place the obligation on the client to file the attestation.

Self-funded plans: A self-funded plan is responsible for the attestation however, the plan sponsor may enter into a written agreement with the provider (TPA, PBM) to submit the attestation on behalf of the plan. However, plan sponsors may be tasked with having to submit the attestation for their plans and may need to obtain written confirmation from the carrier/ TPA that the contractual arrangements do in fact satisfy the gag clause prohibition requirements.

Plan sponsors who will need to file an attestation will submit their attestation via the webform by selecting the link for "Gag Clause Prohibition Compliance Attestation" at https://hios.cms.gov/HIOS-GCPCA-UI

Employer Action

Employers who sponsor group health plans should carefully review any communication provided by the carrier or TPA to ascertain what approach they will undertake for this initial attestation, which is due by December 31, 2023.

It is important to note that employers do not have to wait until December 31 to submit; employer may submit attestations now.

IRS Regulations Expand Requirement to File Electronically

Issued date: 07/25/23

Final regulations issued by the Internal Revenue Service ("IRS") expand the requirement to electronically file certain returns and other documents with the IRS. This new requirement will impact employers who file Forms 1094-C, 1095-C, 1094-B and 1095-B. It will take effect for returns due to be filed on or after January 1, 2024.

As a practical effect, all applicable large employers ("ALEs," employers with at least 50 full-time employees, including equivalent employees) should prepare to file Forms 1094-C and 1095-C electronically with the IRS for calendar year ("CY") 2023 reporting due March 31, 2024.

In addition, small employers who offer self-funded plans and who are required to file Forms 1094-B and 1095-B in 2024 should prepare for electronic filing of those forms if filing 10 or more Forms.

Background

Prior to the adoption of these final regulations, the IRS rules regarding mandatory electronic filing of information returns or statements were applicable only to organizations issuing more than 250 forms of each type. Thus, for example, an organization that filed 200 Forms W-2 and 175 Forms 1095-C did not have to file the respective forms electronically. These old rules continue to apply through calendar year or fiscal year 2023, as applicable.

What's New?

Beginning on January 1, 2024 (or for returns related to taxable years ending on or after January 1, 2024), an organization filing 10 or more returns or statements in a calendar year will be required to file electronically.

This requirement extends to the Forms 1094-C, 1095-C, 1094-B and 1095-B, among others.

Importantly, unlike before, the final regulations require filers to aggregate together all forms required to be filed to determine whether a filer meets the 10-return threshold. If, in the aggregate, there are 10 or more forms, the filer would be required to file them electronically. Further, any corrections will need to be filed in the same manner as the original.

The final regulations also clarify that although there is a hardship exception, these exceptions will not be given freely and that there are few "small business" exceptions to the electronic filing rule.

Employer Action

With respect to these new requirements, employers should:

- Review the final rules and determine which forms will need to be filed electronically beginning in 2024. Briefly:
    - All ALEs will need to file Forms 1094-C and 1095-C electronically for CY 2023 filings, due March 31, 2024.
    - Small employers who are not ALEs, but offer a self-funded health plan, will need to file Forms 1094-B and 1095-B electronically with the IRS if filing 10 or more returns (determined in the aggregate). Filings for CY 2023 are due by March 31, 2024.
- Work with payroll vendors and/or third-party vendors to determine the best method of filing the applicable forms electronically to ensure compliance.

Proposed Rule Addresses Variety of Health Plans Arrangements

Issued date: 08/03/23

On July 7, 2023, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") released a notice of proposed rulemaking ("NPRM") that aims to:

- Revise the conditions for hospital fixed indemnity or other fixed indemnity insurance to be considered an excepted benefit;
- Clarify that payments from an employer-provided fixed indemnity plan are not excludable from gross income if the amounts are paid without regard to the actual amount of incurred expenses and impose a substantiation requirement;
- Modify the definition of short-term, limited-duration insurance ("STLDI"); and
- Solicit comments regarding specified disease excepted benefits coverage and level-funded plan arrangements.

The Departments issued this NPRM to support the goals of the Affordable Care Act ("ACA") by increasing access to affordable and comprehensive coverage, strengthening health insurance markets, and promoting consumer understanding of coverage options.

If finalized "as is," these rules would impact employers offering hospital indemnity and other fixed indemnity insurance. In addition, the guidance suggests additional rulemaking may be forthcoming as it relates to level-funded plans and specific disease-related coverage.

The Departments are accepting written comments through September 11, 2023.

Below are some of the highlights from the NPRM:

Fixed Indemnity Insurance – Excepted Benefit

Hospital and fixed indemnity excepted benefits coverage is exempt from the ACA market reforms, as these products generally provide income replacement as opposed to comprehensive medical coverage.

It is important to note that if a fixed indemnity policy does not meet the definition of an excepted benefit, it will likely be considered a group health plan. If it does not comply with the ACA market reforms penalties of $100/day per individual affected may apply.

Under the existing rules, to qualify as an excepted benefit, the hospital or other fixed indemnity coverage must meet the following requirements:

- The benefits are provided under a separate policy, certificate, or contract of insurance (self-funded arrangements will not meet this definition);
- There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor;
- The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor; and
- The insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred or the type of service.

The Departments are concerned about reports of troubling marketing and sales tactics and the creation of new benefit designs that mislead consumers to believe hospital indemnity or other fixed indemnity insurance constitutes comprehensive coverage.

In response, the NPRM reinforces that to qualify as an excepted benefit, the fixed indemnity coverage must pay benefits as a fixed dollar amount per day (or per other time period) of hospitalization or illness regardless of the amount of expenses incurred and affirm that benefits cannot be paid on any other basis (such as on a per-item or per-service basis).

Benefits paid under fixed indemnity excepted benefits coverage must be paid regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered member, or any other characteristics particular to a course of treatment.

A fixed indemnity policy that merely adds “per day” to its definition would not satisfy the excepted benefit definition.

The NPRM would require a new notice in at least 14-point type to be affixed to marketing, application, and enrollment materials (including on a website advertising or offering an opportunity to enroll in fixed indemnity excepted benefits coverage). The NPRM provides model language.

These proposed changes would take effect as follows:

- For coverage sold on and after the effective date of the final rule, the rules apply as of the effective date of the final rules.

- For coverage sold before the effective date of the final rule, the rules apply to plan years that begin on or after January 1, 2027.

- The notice requirement would take effect when final rules are issued.

Fixed Indemnity Insurance and Specified Disease or Illness Coverage – Tax Treatment

The Treasury and IRS have expressed concern around certain arrangements that claim to avoid income and employment taxes by characterizing cash benefits as amounts paid for reimbursement of medical care, even though those amounts are paid without regard to the actual amount of any incurred, and otherwise unreimbursed, medical expenses.

The NPRM clarifies the tax treatment of payments made to individuals under fixed indemnity excepted benefits or any plan that pays an amount regardless of medical care expenses actually incurred (e.g., some specified disease or illness coverage). Specifically, if the premiums for the coverage are paid on a pre-tax basis, the benefit received by the individual is considered income to the individual if the benefit is paid without regard to the amount of medical expenses incurred. For any amount to be excluded from income, the payment or reimbursement must be substantiated.

It is important to note that if an employee pays for the fixed indemnity or similar coverage on an after-tax basis, the reimbursement should remain tax-free.

These proposed changes would take effect as of the later of:

- The date the final rule is published; or

- January 1, 2024.

Short-Term, Limited-Duration Insurance

STLDI is a type of health insurance coverage primarily designed to fill temporary gaps in coverage and is not subject to the ACA requirements and protections. STLDI may be useful when, for example, an individual is transitioning from one plan or coverage to another. It is not usually an employer-sponsored plan.

The NPRM:

- Reduces the length of an initial STLDI contract period to no more than 3 months (from 12 months) and the maximum coverage period to no more than 4 months (from 36 months), including renewals or extensions.

- Prohibits an STLDI issuer from issuing multiple STLDI policies to the same policyholder within a 12-month period, although an individual could secure STLDI coverage from a different carrier within this time period.

- Requires a notice to be prominently displayed in the contract and in any application materials provided in connection with enrollment in STLDI, in at least 14-point font.

These proposed changes would take effect as follows:

- For coverage sold on and after the effective date of the final rule, the rules apply as of the effective date of the final rules.

- For coverage sold or issued before the effective date of the final rule, individuals may keep their coverage for the full duration allowed under current rules (up to 36 months, including renewals and extensions), to the extent permitted by applicable state law.

- The notice requirement would take effect when final rules are issued.

Comments Sought

Specified Disease Excepted Benefit Coverage: The Departments are not proposing any changes to specified disease coverage although they are seeking comments to better understand typical benefit designs and whether the proposed changes to the fixed indemnity rules would have unintended consequences for specified disease coverage.

Level Funded Plan Arrangements: With the increase in the number of level-funded plans, the Departments have heard concerns and received questions from interested parties related to level-funded arrangements' status as self-funded health plans.

The Departments are seeking comments to better understand the prevalence of level-funded plans, such plans' designs, and whether additional guidance or rulemaking is needed to clarify a plan sponsor's obligation with respect to coverage provided through a level-funded plan arrangement

Employer Action

The NPRM is in a proposed format and no immediate action is required.

However, if the rule is finalized "as is," employers offering fixed indemnity insurance may need to consider some changes. In the meantime, employers that are offering fixed indemnity insurance should review their policies to understand whether they will be viewed as excepted benefits and prepare for changes to the tax treatment of the benefits paid from fixed indemnity policies or certain specified disease or illness policies that are paid for on a pre-tax basis. The tax changes could be effective as early as January 1, 2024.

We anticipate further guidance from the Departments on level-funded plans and specific disease coverage.

Plans Encouraged to Extend Special Enrollment for Medicaid and CHIP

Issued date: 08/07/23

On July 20, 2023, the Centers for Medicare & Medicaid Services ("CMS") and the Departments of Labor ("DOL") and the Treasury (collectively, "the Departments") issued a letter to employers, plan sponsors and carriers encouraging that they allow additional time to enroll in employer-sponsored health plans for individuals who have lost Medicaid and Children's Health Insurance Program ("CHIP") coverage due to Medicaid resuming normal eligibility and enrollment procedures and operations.

Background

Typically, eligibility for Medicaid coverage must be renewed annually; however, during the COVID-19 Public Health Emergency, the eligibility rules for renewal were paused to minimize coverage loss for members. This termination pause expired on March 31, 2023, under the terms of the Consolidated Appropriations Act of 2023.

Medicaid agencies nationwide are now in the process of resuming normal eligibility and enrollment procedures and operations, which includes reviewing coverage eligibility for all individuals under Medicaid/CHIP. With this resumption of the "pre-COVID" process, many individuals are no longer eligible and will lose Medicaid or CHIP coverage. The Departments note that:

> Given the exceptional circumstances surrounding the resumption of Medicaid and CHIP renewals for the first time in three years, many individuals will need more than the typical 60-day window after loss of Medicaid or CHIP coverage to apply for and enroll in other coverage. For example, employees may not realize that they lost their Medicaid or CHIP coverage until they access care, since they may have missed notices from their state agency, and then missed their opportunity to enroll in other coverage.

To offset this loss of coverage, CMS has implemented a temporary special enrollment period for individuals who lose Medicaid or CHIP coverage between March 31, 2023 and July 31, 2024 to enroll in individual coverage on Healthcare.gov. This special enrollment period only applies to enrollments on Healthcare.gov and does not apply to group health plans.

DOL Advisement to Employer Sponsored Plans

Normally, under the HIPAA Special Enrollment rules, participants have 60 days to notify their employer-sponsored group health plan of a loss of eligibility for Medicaid/CHIP.

However, as a result of this upcoming change, while not requiring it, the Departments are encouraging employer plan sponsors to also extend the additional time to participants and beneficiaries that have lost eligibility for Medicaid/CHIP to allow them to enroll in employer-sponsored health plans. Specifically, the Departments suggest that individuals who lose Medicaid and CHIP eligibility be able to enroll anytime during this annual redetermination process (March 31, 2023 – July 31, 2024) and highlight that there is no legal or regulatory barrier that would prevent a group health plan from allowing a special enrollment period beyond the minimum 60 days required by statute.

The Departments are also encouraging employers and other plan sponsors to:

- Inform employees about Medicaid and CHIP renewal and remind employees to update their information with their state agency. The letter includes links to additional information, including a Fact Sheet, https://www.medicaid.gov/resources-for-states/downloads/employee-coverage-loss-factsheet.pdf.
- Ensure HR and other staff members involved in health plan administration are prepared to assist employees.
- Remind employees that they may be eligible for health insurance through the Marketplace if they are not otherwise eligible for the employer-sponsored group health plan.

Employer Action

While encouraged by the Departments to do so, employers are not required to extend additional enrollment time for participants and beneficiaries who lose coverage under Medicaid and CHIP.

Employers considering adopting this extension should:

- Evaluate the potential cost impact on the plan.
- Work with their carriers to ensure that this additional time will be honored by the carriers (including stop loss) and the underlying plan. As this is not a requirement, carrier approval must be sought.
- Amend their plan documents to reflect this extension under HIPAA's special enrollment period rules, and communicate the change accordingly.

Employers that do not adopt this extension may consider providing additional information on the availability of health insurance coverage in the Marketplace if employees are not eligible for employer-sponsored coverage.

New Proposed MHPAEA Guidance Released

Issued date: 08/11/23

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") recently published mental health parity enforcement guidance, including new proposed rules for compliance with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Departments seek to improve mental health and substance use disorder ("MH/SUD") benefits in group health plans through enforcement and rulemaking, with a major focus on expanding access to in-network MH/SUD providers.

In addition, the Departments published their annual report to Congress detailing significant MHPAEA enforcement activities and efforts to work with employer plan sponsors, carriers, and third-party administrators ("TPAs") to correct potential failures. Notably, the report highlights that significant compliance gaps with MHPAEA exist and that the enforcement of health plan requirements around MH/SUD benefits remains a top priority of the Departments.

Background

MHPAEA applies to:

1. Employers with at least 51 employees offering a group health plan that provides coverage for any MH/SUD benefits, and

2. Fully insured group health plans in the small market that are required to provide all essential health benefits, including MH/SUD benefits.

Briefly, MHPAEA:

- Provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

- Prohibits separate treatment limitations that apply only to MH/SUD benefits.

- Provides that non-quantitative treatment limitations ("NQTLs") may not be imposed on MH/SUD benefits in any classification unless, the processes, strategies, evidentiary standards, and other factors are comparable and applied no more stringently for MH/SUD benefits than for medical/surgical benefits under the terms of the plan (or health insurance coverage) as written and in operation.

    - With respect to NQTLs, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity.

- Imposes certain disclosure requirements, including a requirement that group health plans and health insurers conduct a comparative analysis of all NQTLs imposed on MH/SUD benefits and make that analysis available to the Departments and participants and beneficiaries (including their authorized representatives) upon request.

Report to Congress

In July 2023, the 2023 MHPAEA Comparative Analysis Report to Congress was released indicating that between February 2021 and July 2022, the DOL issued 182 letters requesting comparative analyses for over 450 NQTLs. During its second reporting period during that time, November 2021 to July 2022, the DOL sent 25 letters requesting comparative analyses for nearly 70 NQTLs and continued to receive insufficient responses.

The Report to Congress highlights the DOL's ongoing enforcement priorities, including two new priorities added this year:

- Prior authorization requirements for in-network and out-of-network inpatient services;

- Concurrent care review for in-network and out-of-network inpatient and outpatient services;

- Standards for provider admission to participate in a network including reimbursement rates;

- Out of network reimbursement rates for determining usual, customary and reasonable changes;

- NEW: Network adequacy standards for MH/SUD providers; and

- NEW: Impermissible exclusions of key MH/SUD treatments, including applied behavioral analysis therapy ("ABA therapy") for autism spectrum disorder, medication assisted treatment, and nutritional counseling for eating disorders

The DOL indicated that they have placed increased priority on NQTLs related to network adequacy, including the composition of MH/SUD provider networks and the provider reimbursement rates.

Based on their latest investigations, the DOL concluded that, once again, none of NQTL analyses were sufficient to demonstrate compliance with MHPAEA. The DOL cited the same deficiencies identified in their 2022 report to Congress and also included the following additional examples of failures:

- A lack of explanation as to how factors were applied to determine what benefits would be subject to an NQTL;
- How these factors were comparably applied to MH/SUD benefits versus medical/surgical benefits;
- An explanation as to how an NQTL was applied in operation; and
- No demonstration that, in operation, the NQTL was comparably applied to MH/SUD benefits and medical/surgical benefits.

The report specifically mentions that the Departments' investigations have revealed more exclusions of key treatments for MH/SUD conditions than expected, such as ABA therapy to treat autism spectrum disorder, medication-assisted treatment ("MAT"), medications for opioid use disorder ("MOUD"), and nutritional counseling for eating disorders.

Overall, it appears the Departments are working with plans and issuers to achieve voluntary corrective action, including removing exclusions, ending gatekeeper programs, and removing prior authorization when no preauthorization is required for comparable medical/surgical services.

Enforcement Activity

In addition to the Report to Congress, the Departments published a 2022 MHPAEA Enforcement fact sheet. The fact sheet details enforcement beyond the NQTL comparative analysis reviews.

Specifically, as it relates to employer-sponsored group health plans investigations:

- There were 145 health plan investigations in 2022 - 86 of these involved plans subject to MHPAEA.
- 18 of the 86 plans involved MHPAEA violations leading to 11 investigations (one fully insured plan, 10 self-insured plans). The violations included:
    - 3 annual/lifetime limits
    - 2 financial requirements
    - 2 Quantitative Treatment Limits ("QTLs")
    - 10 NQTLs and
- 1 final determination of noncompliance with the NQTL comparative analysis.

Generally, plans worked with EBSA, their state, if applicable, and their carriers to reprocess, eliminate, or reimburse a claim or increase access, to ameliorate the violations.

It should be noted that, as described in the Report to Congress, if a plan receives a final determination of noncompliance with respect to the NQTL comparative analysis (after a 45-day window to cure the violations) the plan is identified on a list reported to Congress and the failure must be disclosed to members covered by the plan.

Due to this increase in guidance, EBSA expects more complete comparative analyses from the start of the investigation process. If comparative analyses are insufficient, EBSA will expect them to be cured more quickly and may not provide the same opportunities to further supplement a submission before issuing a final determination of non-compliance.

Proposed Rules

On July 25, 2023, the Departments published a Notice of Proposed Rulemaking ("NPRM") seeking to amend the regulations implementing MHPAEA. If finalized, these rules would impose new requirements for health plans and issuers to collect and evaluate data around the impact of an NQTL on access to MH/SUD benefits. Of particular concern to the Departments are NQTLs affecting network composition and access to MH/SUD providers. In addition, future guidance would specify the type, form, and manner of collection and evaluation of the data.

These proposed rules would be effective for the 2025 plan year. Key proposals include:

- Requiring plans to collect and evaluate certain relevant data to assess an NQTL's impact on access to MH/SUD and medical/surgical benefits.
- Requiring plans use medical/surgical claims data to determine whether an NQTL on MH/SUD benefits is more restrictive.
- Allowing plans the ability to impose NQTLs consistent with recognized independent professional or clinical standards or standards related to fraud, waste and abuse, and in some cases reduce information required in the comparative analysis for the particular NQTL.
- Expanding content requirements in the NQTL comparative analysis to include evaluation of the outcomes from the NQTL, and for plans subject to ERISA, fiduciary certification.
- Requesting that all data be collected and evaluated by a third-party administrator or other service provider in the aggregate for all plans which utilize the same network or reimbursement rates.
- New and revised examples applying the proposed rules to a variety of NQTLs and providing an illustrative, non-exhaustive list of NQTLs.
- Delineating a process that Departments will follow to review a plan's NQTL comparative analysis.
- Eliminating the MHPAEA opt-out for nonfederal government plans.

Specifically, for NQTLs related to network composition, the proposed rules would require health plans and issuers to collect the following data:

- Out-of-network utilization rates;
- The percentage of in-network providers actively submitting claims;

- Network adequacy metrics (including time and distance data and data on providers accepting new patients); and
- Provider reimbursement rates (including as compared to billed charges)

The NPRM also proposed the creation of a safe harbor for health plans and issuers that implement NQTLs related to network composition. Under this potential safe harbor, if the data demonstrates that the plan meets or exceeds the data standards for NQTLs related to network composition, the plan or issuer would be exempt from enforcement actions with respect to NQTLs related to network composition for a period of two years from when the comparative analysis was requested.

In addition, the NPRM makes clear that for purposes of MHPAEA autism spectrum disorder and eating disorders are considered mental health conditions. Therefore, under the proposed amended definitions, if a plan provides benefits for autism or eating disorders such coverage may not be defined by the plan or issuer as a medical/surgical condition.

Employer Action

Employers should continue compliance with MHPAEA rules as they currently exist, as compliance is an enforcement priority of the Departments. These proposed rules, if finalized "as is," would take effect for plan years beginning on or after January 1, 2025.

Employers should continue to carefully evaluate their health plans for compliance with MHPAEA and be prepared to respond to requests by the Departments for this information. Coordination with carriers, TPAs and other service providers will be essential.

Plan sponsors should review their plan's current limits on MH/SUD and the plan's written comparative analysis to determine whether changes are required in light of recent enforcement efforts. If a plan includes exclusions or other limitations around autism spectrum disorder or eating disorder benefits, employers should consider removing these limitations.

Employers may wish to make plan design changes starting in 2025 if the rules are finalized as proposed, including an analysis of network adequacy.

We will continue to monitor this issue and will keep employers updated as applicable.

IRS Announces 2024 ACA Affordability Indexed Amount

Issued date: 08/28/23

The IRS recently announced in Revenue Procedure 2023-29 that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 8.39% for plan years that begin in 2024. This is a significant decrease from the 2023 percentage amount (9.12%), and again below the original 9.5% threshold. It will be important to evaluate contribution tiers for 2024 plan years for affordability because of this decrease in the required contribution percentage.

Background

Rev. Proc. 2023-29 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 2024

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 2024 meets 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 **8.39% 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.

1. **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 **8.39% 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. For example, an hourly employee has a $10/hour rate of pay. For a 2024 plan year, coverage is "affordable" for the employee if the employee's cost for self-only coverage does not exceed $109.07/month (($10 x 130 hours) x .0839). This is measured based on the cost for self-only coverage in the lowest cost plan option that provides a minimum value offered to the employee.

2. **Federal Poverty Level ("FPL") safe harbor.** Coverage is affordable if it does not exceed **8.39% of the FPL**.
   For a 2024 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 **$101.93** (48 contiguous states), $127.31 (Alaska), or $117.25 (Hawaii). Note, this amount may increase (or decrease) when the 2024 FPL guidelines are issued (for a calendar year, generally in January of the applicable year).

Employer Action

Employers budgeting and preparing for the 2024 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.

Medicare Part D Notification Requirements

Issued date: 09/13/23

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.

This information 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:

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 (**February 29, 2024** for a 2024 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/employers-plan-sponsors/creditable-coverage/disclosure-form.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.

2023 MLR Rebate Checks To Be Issued Soon To Fully Insured Plans

Issued date: 09/14/23

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, 2023.

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 To Do with this MLR Rebate Check?

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 employer?

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.

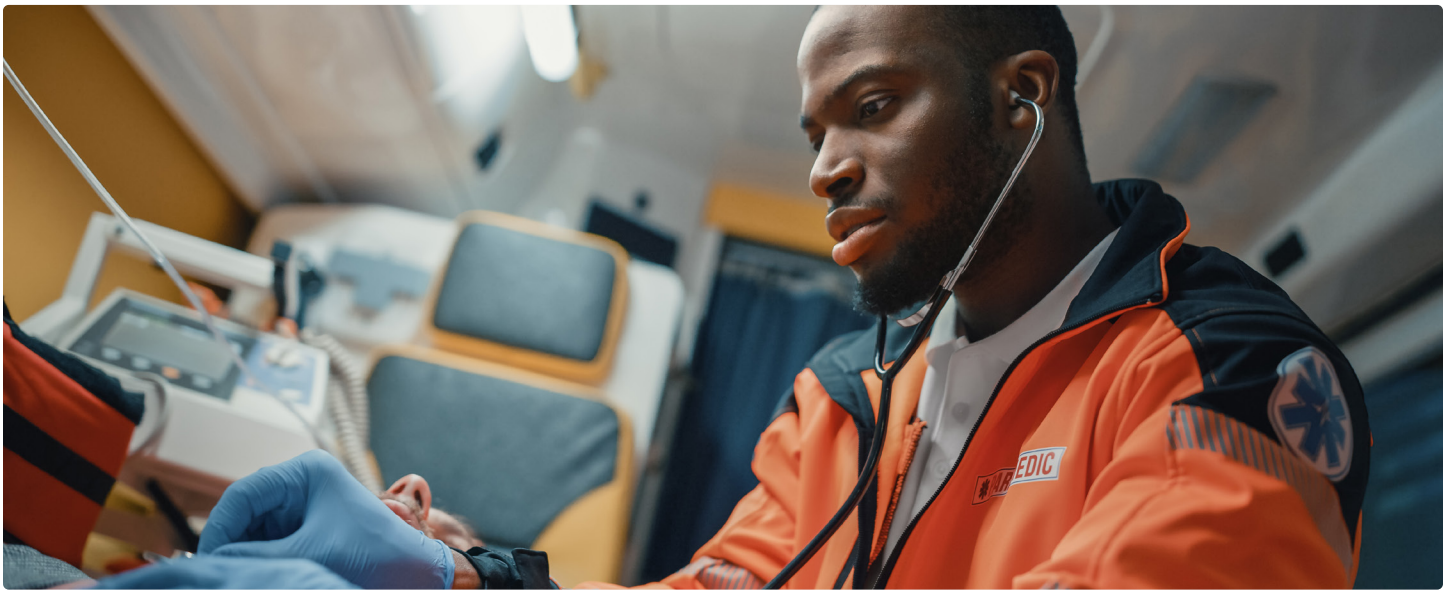
If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

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.



Another Successful Challenge to No Surprises Act IDR Process

Issued date: 09/18/23

In a recent decision, Texas Medical Association v. U.S. Department of Health and Human Services ("HHS"), a U.S. district court in Texas vacated portions of the regulations implementing the federal independent dispute resolution ("IDR") process under the No Surprises Act ("NSA"). Specifically, the now vacated rules deal with:

- The fees charged to engage in the IDR process; and
- Batching claims for IDR payment determinations.

Background

Under the NSA, the federal IDR process is used by group health plans, carriers and providers when determining the out-of-network ("OON") rates for claims subject to the NSA:

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

Briefly, IDR may be used when the provider receives an initial payment (or denial notice) from the group health plan for NSA-eligible items or services and the plan and provider do not agree on a payment amount through an open negotiation process. The federal IDR process applies unless there is a specified state law or All-Payer Model agreement.

Most self-funded group health plans are subject to the federal IDR process except where a self-funded health plan has opted into a specified state law or the All-Payer Model applies.

There is an administrative fee that must be paid by each party to begin IDR. This fee is generally set annually and based on an estimate of the cost to operate the IDR process. For 2022, this fee was $50. However, through subsequent guidance, the fee was increased to $350 for 2023.

In addition, the Departments of Labor ("DOL"), HHS, and the Treasury (collectively, "the Departments") issued an interim final rule outlining the criteria for batching items and services for payment determinations. Briefly, subject to certain requirements, batching allows multiple qualified items and services for IDR disputes to be considered jointly as a single determination by
the IDR entity.

A trade association of health care providers sued the Departments over these regulations arguing that the fee guidance and the rules on batched claims violated the notice-and-comment rulemaking requirements under the Administrative Procedure Act ("APA").

Court Decision

The court agreed with the association, finding both the batching rules and the fee guidance were subject to the notice and comment rulemaking, and, therefore, the Departments' actions in implementing these rules without a notice and comment period violated the APA. The court has vacated the fee guidance and the batching regulations.

As a result, HHS announced that effective August 8, 2023, the IDR process has been temporarily suspended, except for:

- Single and bundled disputes initiated in 2022;
- Single and bundled disputes initiated in 2023 where the administrative fee was paid (or the deadline to collect the fee expired) before August 3, 2023; and
- Batched disputes where the IDR entity determined that the batched dispute was eligible, and the administrative fee was paid (or the deadline to collect the fee expired) before August 3, 2023.

On August 11, 2023, the Departments issued an FAQ to explain how the administrative fee will be handled in accordance with the court's decision.

- For any disputes initiated on or after August 3, 2023, the administrative fee is $50 per party per dispute.
- For disputes initiated between January 1, 2023 and before August 3, 2023 where the $350 administrative fee was paid, the fee remains $350. No refund of the administrative fee is provided.

Notably, the FAQ does not announce the reopening of the IDR portal for new disputes. The process remains suspended. The Departments intend to reopen the portal for the submission of new disputes soon and will provide notification at that time.

Employer Action

Group health plans and their administrators should anticipate that the suspension of the IDR process will impact claims payments, as many claims will not be reviewed until the process is resumed. This will create an additional lag in getting claims pending federal IDR to be paid. Employers with self-funded plans should discuss this issue with their TPA and stop loss providers to ensure sufficient coverage (including stop loss) for claims that are delayed and later processed when the IDR process resumes.

Another Successful Challenge to No Surprises Act IDR Process

Issued date: 09/19/23

On August 8, 2023, the Department of Labor ("DOL") released its long-awaited final rule updating guidance related to the Davis Bacon and Related Acts ("DBRA"). The final rule expands and finalizes requirements across a variety of areas relevant to contracts subject to the DBRA. This update focuses on the impacts to fringe benefit administration.

The final rule will be effective 60 days after its publication in the *Federal Register*.

Background

The DBRA applies to contracts in excess of $2,000, issued by the federal government or District of Columbia for construction, alteration, or repair of public buildings or public works. It also applies to projects receiving federal assistance (including contracts issued by states but receiving federal assistance). Amongst the various requirements, a contract subject to the DBRA will include a wage determination which specifies the locally prevailing wage and fringe benefits that a contractor must pay to its covered employees.

Covered contractors may meet their obligation to pay fringe benefits by:

- Making irrevocable contributions to a trustee or third party pursuant to a bona fide fringe benefit fund, plan, or program (e.g., health, dental, vision and life insurance); or

- Paying the designated fringe rate as wages.

Contractors subject to the DBRA must comply with strict recordkeeping requirements, including submitting certified payroll records, maintaining employee biographical information, wage determination classifications, and rates of pay. In addition, to meet their fringe benefit obligations, contractors must also track their covered employees' hours worked and all fringe benefit payments made to these employees.

The Final Rule

The final rule implements requirements across a broad range of issues applicable to contracts subject to the DBRA.

Regarding fringe benefit administration under the DBRA, the final rule:

- Codifies the requirement that fringe benefit payments must be annualized,
- Clarifies and formalizes the requirement that unfunded benefit plans must be approved by the DOL to be credited as a bona fide fringe benefit, and
- Finalizes the DOL's existing approach that certain administrative expenses may not be credited against fringe benefit requirements.

The final rule stresses that these new requirements do not expand obligations under the DBRA, rather they formalize approaches to enforcement that have long been utilized by the DOL.

Annualization of Fringe Benefit Payments

Annualization is the method of calculating the hourly equivalent amount of a contractor's contributions to fringe benefit plans that may be credited against the contractor's fringe benefits obligations. Under annualization, an employee's total amount of hours worked (on both covered and uncovered projects) are divided by the total amount of payments made for fringe benefits. Since fringe benefit rates are stated as an hourly rate in a contract, annualization converts annual (or monthly) fringe benefit payments to an hourly amount to determine whether the contractor has met their obligations under the contract.

While the DOL has long been enforcing an annualization requirement through previously released guidance, the final rule formally codifies this requirement.

Additionally, contractors may request an exception from the annualization requirement where:

- The benefit provided is not continuous in nature;
- The benefit does not provide compensation for both public and private work; and
- The plan provides for immediate participation and essentially immediate vesting.

Unfunded Benefit Plans

The final rule formally codifies the requirement that an unfunded benefit plan must be approved by the DOL to be considered a bona fide fringe benefit and creditable against a contractor's fringe benefit requirements.

It should be noted that if an employer subject to the DBRA wants to use an unfunded, self-insured health plan to meet the fringe benefit obligations, that plan must be approved by the DOL.

Contractors wishing to utilize an unfunded benefit plan to meet their fringe benefit requirements must submit a written request to the DOL to consider whether the benefit plan meets the requirements to be considered "bona fide." These requests may be submitted by email to the DOL's Wage and Hour Division at unfunded@dol.gov.

Noncreditable Administrative Expenses

It is common practice for contractors to engage third party administrators to provide certain administrative services on behalf of the contractor regarding their covered employee population. These services can include employee hours tracking, fringe benefit payment accounting and reconciliation, benefit administration support, recordkeeping, and employee communications.

The final rule makes clear that where administrative expenses are incurred primarily for the benefit or convenience of the contractor or subcontractor, they cannot be credited against the contractor's fringe benefit obligations. In other words, an expense incurred for performing services that would ordinarily be the responsibility of the contractor cannot be "pushed onto" their covered employees and credited toward the fringe obligation.

Examples of expenses that are noncreditable include:

- Recordkeeping costs incurred to ensure compliance with fringe benefit requirements (e.g., tracking of covered employees' hours worked and fringe benefit contributions paid),
- The cost of completing claim forms,
- Transmitting enrollment information to insurance carriers or service providers, and
- Updating or maintaining the contractor's personnel records.

The final rule states that not all administrative expenses incurred by a contractor are noncreditable. A contractor may credit costs incurred that are directly related to the administration and delivery of bona fide fringe benefits.

Applicability to Service Contracts Act ("SCA") Contracts

The SCA applies to service contracts in excess of $2,500 issued by the federal government or District of Columbia and includes similar prevailing wage and fringe benefit requirements as the DBRA.

While the final rule is targeted at contracts covered by the DBRA, it appears likely that the DOL intends to enforce the requirements against SCA contractors as well. The final rule frequently references the similarities between the fringe benefit requirements under the DBRA and the SCA. Specifically, the rule reinforces that it is not an expansion of the requirements under either the DBRA or SCA, but rather a codification of longstanding enforcement practice by the DOL with regards to the requirements under *both* statutes. Further guidance would be welcome.

Employer Action

Employers subject to the DBRA and the SCA should review their current fringe benefit administration to ensure that all fringe benefit payments have been properly annualized.

Any unfunded benefit plans that covered employers are crediting against their fringe benefit obligations should be submitted to the DOL for approval.

Contractors utilizing third party administrators to assist in their fringe benefit administration should determine whether these expenses can be credited against their fringe benefit obligations.

San Francisco HCSO Expenditures and Reporting Update for 2024

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2024 have been released, and the HCSO Annual Reporting Form for calendar year 2023 is due on April 30, 2024.

2024 Minimum Expenditure Rates

Under the HCSO, covered employers must make minimum health care expenditures at the following rates for each hour worked by covered employees in San Francisco:

Employer Size	Number of Employees	2023 Health Care Expenditure Rate	2024 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.40 per hour payable	$3.51 per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.27 per hour payable	$2.34 per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2024 the maximum required health care expenditure for a covered employee of a large employer is $603.72 per month ($3.51/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $402.48 per month ($2.34/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2023, the earnings threshold for these employees to be exempt from the HCSO is $114,141 per year (or $54.88 per hour). As of January 1, 2024, the new threshold will be $121,372 per year (or $58.35 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement ("OLSE") HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2023 is expected to become available on the HCSO website by April 1, 2024, and is due by April 30, 2024.

Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2024 at the new rates for employees in San Francisco and maintain records showing compliance with the HCSO requirements.

The 2024 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2023. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2024 version of the poster by January 1, 2024.

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2023 no later than April 30, 2024.

Update to Colorado HFWA Paid Leaves

Recently, Colorado modified its existing paid family leaves under the Health Families and Workplaces Act ("HFWA").

This new amendment, which became effective August 7, 2023, expands the list of reasons why an employee can use paid sick leave to include:

- Attendance at a funeral or memorial service, or attend to financial or legal matters related to a family member's death;
- Care for a family member when their school or place of care is closed due to inclement weather; loss of power, heat, or water; or any other unexpected event that results in the school or place of care's closure; or
- The employee's required evacuation of their own place of residence because of inclement weather; loss of power, heat, or water; or any

Employer Action

These changes in the law will require employers to update their existing policies and provide updated information to their employees. The mandatory workplace HFWA poster has been modified to include these new leave requirements and is available at the Colorado Department of Labor and Employment's website.

In addition, it may be a good idea for employers to remind themselves and employees about material differences between HFWA and FAMLI requirements, especially where some of the types of leaves may overlap. The Colorado Department of Labor and Employment provides a very good brief overview of key considerations for employers when implementing their paid leaves.

Trio of Laws Affecting Health Insurance Coverage in Florida

Over the past few weeks, the Florida legislature and Governor Ron DeSantis have passed and signed three new laws that may affect how Florida residents receive their health insurance coverage.

- The first law, Florida SB 1550, the Prescription Drug Reform Act (the "PDRA"), concerns how pharmacy benefit managers ("PBMs") engage in business in Florida, setting forth a regulatory framework for PBMs.

- The second law, Florida SB 1580, Protections of Medical Conscience, allows payors and providers, including doctors, nurses, pharmacies, hospitals, mental health providers and group health plans to deny care to patients based on moral, ethical or religious beliefs.

- The third law, Florida SB 254, prohibits minors (under 18) from receiving any gender-affirming care, such as puberty blockers and hormone therapy. On June 6, 2023, a federal judge did partially block the state from enforcing this ban on three families while the case is being heard challenging the legality of the law.

PBM Legislation

The PDRA has several provisions that govern how PBMs will be able to conduct business in the state. As background, PBMs act as intermediaries between pharmacies and prescription drug plans (both self-funded and insured). When a participant goes to fill a prescription, the pharmacy checks with the PBM to determine that person's coverage and copayment information. After the participant leaves with his or her prescription, the PBM reimburses the pharmacy for the prescription, less the amount of the participant's copayment.

The main provisions of the PDRA are as follows:

1. PBMs will be required to disclose price increases of prescription drugs which will be published on the state of Florida's website.

2. PBMs are required to obtain (and maintain) a certificate of authority from the state on or before January 1, 2024, and will be subject to enhanced requirements under Florida's Insurance Code.

3. The Florida Office of Insurance Regulation ("OIR") is authorized with the ability to audit PBMs and requires PBMs to submit an annual financial statement and an attestation to the PBM's compliance with the network requirements under Florida law.

4. As it relates to group health plans and PBMs, the PDRA regulates contractual agreements between PBMs and pharmacy benefit plans and pharmacies. Such contracts must:

    a. use a pass-through pricing model,

    b. exclude provisions that allow for spread pricing, whether direct or indirect, unless the PBM passes the entire amount of any difference to the plan; and

    c. require the PBM to pass 100% of all manufacturer rebates to the plan or program, assuming that the PBM is delegated the authority to negotiate rebates to the PBM.

5. Finally, the law further limits PBM contracts by prohibiting financial clawbacks related to performance measures, erroneous claims, fraud, waste or abuse, claims adjudicated in error, adjustments made as part of an audit and also requires PBMs to provide a reasonable appeal procedure.

What about ERISA Preemption?

It is unclear whether a preemption challenge to the Florida law would be successful. The Supreme Court reviewed the Arkansas statute in Rutledge v. Pharmaceutical Care Management Association and found that the Employee Retirement Income Security Act of 1974 ("ERISA") did not preempt that law which regulated mostly rate-setting by PBMs. However, a challenge to an Oklahoma PBM law that appears to go beyond mere rate-setting activities to include requirements that may directly affect plan design and administration is currently before the 10th Court of Appeals. The outcome of that case may shed some light on the reach state regulation of PBMs may have under ERISA.

For now, Florida is expected to develop new rules to implement the PDRA.

Employer Action

- Fully insured plans should coordinate with their carriers to ascertain what impacts these regulations will have on any upcoming renewals.

- Self-funded plans should work with their TPAs and PBMs to determine the impact that the regulations will have on plan costs and to plan and budget accordingly. In addition, plan sponsors should monitor the developments out of the 10th Circuit as it relates to ERISA

Protections of Medical Conscience Law

Florida's Protections of Medical Conscience Law provides health care providers and payors the ability to refuse services based on their moral, ethical, or religious beliefs. The legislation defines "conscience-based objection" ("CBO") as based on a "sincerely held religious, moral or ethical belief." Health care payors include "any employer, as well as any health insurer, health plan, HMO or any other entity that pays for, or arranges for payment of, any health care service."

The law protects the health care providers from being subject to discipline or retaliation or the threat of discrimination for refusing to provide medical care based upon the provider's moral, ethical or religious objection. Under the law, the types of health care services that can be denied include, but are not limited to, medical research, medical procedures, testing, diagnosis, referral, dispensing medications, therapy, recordkeeping and any other care or service. The law also prohibits individuals and entities from discriminating against a health care provider or payor based on a CBO. Finally, the law provides civil immunity to health care providers and payors for exercising their right of conscience and provides whistleblower protections.

Employer Action

Florida employers that want to take advantage of this law should consult with their legal counsel and work with their carriers and/or TPAs to allow/restrict certain types of medical procedures from being covered by the plan. While the law prohibits the payors and providers from discrimination, presumably this protection applies to state law actions and not necessarily federal claims (for example claims of discrimination under Title VII of the Civil Rights Act).

Additionally, employers should be aware of this law as plan participants may be denied certain coverage for a variety of services, including, but not limited to, gender dysphoria and reproductive rights. Participants may come to the employer seeking solutions for these potential issues.

Florida SB 254

Florida Senate Bill 254 (SB 254) prohibits:

- The provision of sex-reassignment prescriptions or procedures to minors under the age of 18;
- The ability to prescribe sex-reassignment medications to adults via telemedicine; and
- State funds from paying for sex-reassignment prescriptions or procedures.

The law does not prohibit the provision of other types of care, such as behavioral health services.

With respect to restrictions on care for minors, parental consent is not considered under this law. There is a narrow exception for a patient that started receiving sex-reassignment prescriptions or procedures before the bill was signed into law. The law allows the state to take emergency jurisdiction of a child if necessary to prevent the minor from either being at risk of, or currently undergoing any sex-reassignment prescriptions or procedures.

The law and Florida's recent categorical ban on the treatment of gender dysphoria in minors were challenged in Doe et al. v. Ladapo et al. Recently, a federal court in Florida enjoined Florida from enforcing this statute against the named defendants in Ladapo. While using strong language suggesting that the statute would not survive legal review, the court refused to enjoin Florida from enforcement of the statute and the ban on the treatment of gender dysphoria in minors while Ladapo is working through the courts.

Employer Action

Employers should discuss with carriers and TPAs compliance with this new law, at least with respect to Florida participants should the law be enforced. It will be important to monitor the ongoing litigation and status of this law as it proceeds through the court system to determine whether Florida can ultimately enforce these provisions.

Illinois Amends the Day and Temporary Labor Services Act

On August 4, 2023, Governor Pritzker signed into law House Bill 2862 (PA 103-437) which amended the Day and Temporary Labor Services Act (820 ILCS 175) (the "Act") to require certain day and temporary labor service agencies to provide, among other requirements, certain minimum compensation and benefits for day or temporary laborers.

Note that this update highlights the employee benefit implications of the law. However, the Act imposes, among other things, certain disclosures, registration, training obligations, and limitations on conversion or placement fees an agency may charge which is beyond the scope of this article. Affected employers should carefully review all changes affecting their business operations.

The law took effect immediately, but on August 7th, the Illinois Department of Labor issued emergency rules clarifying the law and proposed certain permanent rules to take effect at a later date.

The Act requires any day or temporary labor service agency that places a laborer with a third-party client for longer than 90 calendar days within any 12-month period (whether consecutively or intermittently) to pay the laborer at the same or greater rate of pay and extend the equivalent benefits as a directly hired employee of the third-party client. The rate of pay and equivalent benefits must be at least as much as the lowest paid direct hire of the third-party employer with the same level of seniority that performs the same or substantially similar work. If there isn't a comparable directly hired employee of the third party client, the laborer cannot be paid less than the rate of pay and equivalent benefits of the lowest paid direct hire employee of the third party client with the closest level of seniority.

The obligation to offer equivalent benefits as a similar direct hire employee of the third-party client may prove particularly challenging for agencies that place laborers with numerous third parties and have to offer benefit plans to match every third party's plan designs. In lieu of offering equivalent benefits, the agency may pay the hourly cash equivalent of the actual cost of the benefits. The statute and rules do not clarify any method for calculating the cash equivalent, nor do they indicate how to value voluntary plans; additional guidance in this area would be welcomed.

In addition to the obligations imposed upon day labor agencies, the Act also extends certain responsibilities to third party clients that utilize day and temporary labor agencies. Namely, upon request by the labor service agency, a client that has an assigned laborer for more than 90 days must provide the temporary labor service agency with all necessary information related to job duties, pay, and benefits of directly hired employees necessary for the labor service agency to comply with the requirements of the law.

Plan sponsors may be curious as to the applicability of such a law to their insurance programs. Generally, ERISA preempts state laws regulating employee benefit programs, but states are able to pass laws regulating insurance policies, which is why insured plans are typically subject to state mandates and self-funded plans are not. With that said, given that the Act permits the labor service agency to pay laborers the cash equivalent of the benefits as wages, it appears this law may be considered an employment law and may survive challenges regarding ERISA preemption.

Employer Action

These requirements apply to certain day and temporary labor services agencies and their third-party clients that are located in, operating in, or transacting business in Illinois. While awaiting future developments, covered staffing or temporary agencies should review these requirements with counsel and be prepared to comply with applicable changes.

Louisiana Employees Entitled to Leave for Certain Medical Reasons

On June 8, 2023, Governor Edwards signed into law Act No. 210 which requires employers to provide each employee in Louisiana one day off from work to obtain a genetic test or preventive cancer screening when medically necessary.

How Does this Work?

An employee who wishes to request such leave must provide at least 15 days' notice to the employer in advance of the leave and make a reasonable effort to schedule the leave so as not to unduly disrupt the operations of the employer. The employee is required to provide documentation confirming the performance of such genetic test or cancer screening when requested by the employer. An employee cannot be required to disclose the results of the genetic test or a preventive cancer screening.

The leave is not paid. However, an employee is permitted to substitute any accrued vacation time or other appropriate paid leave for this leave.

This new law is effective August 1, 2023.

Poster

Employers are required to post in a conspicuous location on their premises a notice, to be prepared by the Louisiana Workforce Commission, setting forth the requirements described above.

GINA Considerations

Under federal law (the Genetic Information Nondiscrimination Act or "GINA"), employers are prohibited from requesting or requiring genetic information about an employee (unless one of several limited exceptions applies). If an employer has genetic information about an employee, the information must be maintained in a separate file and must be treated as a confidential medical record within the meaning of the Americans with Disabilities Act.

Employer Action

Employers with Louisiana employees should be ready to comply with this new law on August 1, 2023 and check the Louisiana Workforce Commission website for the poster.

Maine Establishes Paid Family and Medical Leave Benefits Program

On June 11, 2023, Maine Governor Janet Mills signed into law the state's budget bill which provides for a paid family and medical leave benefit program (the "Program"). The Program provides wage replacement benefits for employees taking family or medical leave. Contribution withholdings under the state program begin January 1, 2025, and claims processing begins May 1, 2026. Employers can opt out of the state program and offer a private plan if certain conditions are met.

Employer Coverage

All private and public employers who employ one or more employees in Maine are required to provide paid family and medical leave. A "covered individual" is defined as an employee who earned at least six times the state average weekly wage during their "base period."

The Program does not apply to the federal government. Self-employed individuals and tribal governments can opt-in to the Program.

Types of Leave

The Program will provide both paid family leave and paid medical leave to covered individuals.

Paid Family Leave

A covered individual is entitled to 12 weeks of paid family leave per benefit year. Paid family leave is available:

- to bond with the covered individual's child during the first 12 months after the child's birth or the first 12 months after the placement of the child for adoption or foster care with the covered individual;
- to care for a family member with a serious health condition;
- to attend to a qualifying exigency (same as per federal FMLA);
- to care for a family member of the covered individual who is a covered service member;
- to take safe leave; or
- any other reason allowed under the state's existing unpaid family leave laws.

Paid Medical Leave

A covered individual is entitled to 12 weeks of paid medical leave per benefit year. A covered individual with a serious health condition that makes the covered individual unable to work is eligible for medical leave. Medical leave benefits are not payable during the first 7 calendar days of the leave, except that an employee may use accrued sick or vacation pay, or other paid leave provided under a collective bargaining agreement or employer policy during the first 7 calendar days of the leave.

A covered individual may not take more than 12 weeks, in the aggregate, of family leave and medical leave in the same benefit year. However, this does not prevent a covered individual from taking medical leave that is immediately followed by family leave when the medical leave is taken during pregnancy or recovery from childbirth and is supported by documentation from a health care provider.

The Program allows for intermittent leave or a reduced leave schedule for all reasons covered under the Program. The intermittent leave cannot be less than 8 hours or on a reduced leave schedule otherwise agreed to by the employee and the employer.

Funding the Benefit

The law establishes the Paid Family and Medical Leave Insurance Fund (the "Fund") to collect premiums and pay claims. The Fund will be administered by the Treasurer of State. Contributions are funded through a mandatory payroll tax, starting at a combined contribution rate (employee and employer) of not more than 1.0% of wages. Beginning January 1, 2025, an employer must remit employer contribution reports and premiums for each employee on a quarterly basis.

The following contribution provisions apply to Maine employers as follows:

- An employer with 15 or more employees may only deduct up to 50% of the required premium from an employee's wages and must remit 100% of the combined premium contribution to the Fund (i.e., the required premium may be equally shared between the employee and employer).

- An employer with fewer than 15 employees may only deduct up to 50% of the required premium from an employee's wages and must remit 50% of the premium to the Fund as businesses with fewer than 15 employees are exempt from paying into the state plan.

The Program caps the amount of an employee's earnings subject to contributions at the same amount of earnings subject to Social Security taxes.

Amount of Benefit

The weekly benefit amount paid to employees and self-employed individuals on family or medical leave is calculated as follows:

- The portion of the covered individual's average weekly wage that is equal to or less than 50% of the state average weekly wage must be replaced at a rate of 90%; and

- The portion of the covered individual's average weekly wage that is more than 50% of the state average weekly wage must be replaced at a rate of 66% up to the maximum weekly benefit.

The maximum weekly benefit amount calculated is the state average weekly wage. By January 1st, 2026, and annually thereafter, the Maine Department of Labor (the "Department") must take into consideration the recommendation to adjust the maximum weekly benefit amount as necessary, with the adjusted maximum weekly benefit amount taking effect on the January 1st of the year following the adjustment.

If a covered individual takes family or medical leave on an intermittent or reduced leave schedule, the weekly benefit amount must be prorated as determined by the Department.

The weekly benefit amount must be reduced by any wages or wage replacement that a covered individual receives for that period under any of the following while on family or medical leave:

- A government program or law, including, but not limited to, unemployment insurance, workers' compensation, other than for permanent partial disability incurred prior to the family or medical leave claim, or under other state or federal temporary or permanent disability benefits law; or

- A permanent disability policy or program of an employer.

Approved Private Plan

An employer may apply to the Department for approval to meet its obligations through a private plan. To be approved, a private plan must confer rights, protections and benefits substantially equivalent to those provided to employees in the state program. A private plan may be provided through an insurance policy or through self-insurance. If an employer's plan provides for insurance, the forms of the policy must be issued by an insurer authorized to do business in the state. If an employer's plan is in the form of self-insurance, the employer must furnish a bond to the state with a surety company authorized to transact business in the state as a surety.

Employee Notice to Employer

Absent an emergency, illness, or other sudden necessity for taking leave, an employee must give reasonable notice to the employee's supervisor of the employee's intent to use leave. Leave must be scheduled to prevent undue hardship on the employer as reasonably determined by the employer.

Employee

An employer must post in a conspicuous place on each of its premises a workplace notice provided or approved by the Department. An employer must issue to each employee not more than 30 days from the beginning date of the employee's employment the following written information provided or approved by the Department in the employee's primary language:

- An explanation of the availability of family leave benefits and medical leave benefits, including rights to reinstatement of employment and continuation of health insurance;

- The employee's contribution amount and obligations;

- The name and mailing address of the employer;

- The identification number assigned to the employer by the department administering the program (the "Administrator") or an authorized 3rd party conducting any functions necessary to implement and operate the program.

- Instructions on how to file a claim for family leave benefits or medical leave benefits;
- The mailing address, e-mail address and telephone number of the Administrator; and
- Any other information deemed necessary by the Administrator.

An employer that fails to comply with the notification requirements is subject to a civil penalty of $50 per employee for the first violation and $150 per employee for each subsequent violation. The employer has the burden of demonstrating compliance with notification requirements.

Applications and Claims for Benefits

An individual may file an application for family and medical leave benefits no more than 60 days before the anticipated start date of family and medical leave and no more than 90 days after the start date of family and medical leave. The Administrator will notify the relevant employer within 5 business days of a claim being filed.

Accrual of Benefits During Leave

The taking of family or medical leave may not affect an employee's right to accrue vacation time, sick time, bonuses, advancement, seniority, length of service credit or other employment benefits. During the duration of an employee's family or medical leave, the employer must continue to provide and contribute to the employee's employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if the employee had continued working continuously for the duration of leave.

Employee Restoration After Leave

Except for an employee who has not been employed for at least 120 days, an employee who exercises the right to family or medical leave is entitled to be restored to the position held by the employee when the leave began or to be restored to an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment.

An employer may not discharge, fire, suspend, expel, or discipline, through the application of attendance policies or otherwise, or threaten or in any manner discriminate against an employee for the exercise of any right to which the employee is entitled or with the purpose of interfering with the exercise of any right to which the employee is entitled under the program.

Interaction with Other Policies and Leave Laws

The law will not prevent an employer's obligations to comply with any company policy, law or collective bargaining agreement that provides for greater or additional leave rights. Leave taken under the Program runs concurrently with leave taken under the federal Family and Medical Leave Act.

Employer Action

Employers should work with employment and labor counsel as well as payroll processors to review their leave policies and procedures to ensure they are compliant with the law by January 1, 2025. In addition, employers should monitor the state's website for additional guidance and regulations. USI will continue to monitor this issue as well and will keep employers updated as applicable.

Massachusetts Releases 2024 MCC Amounts

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 03-23 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage ("MCC") regulation. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2024 and provides those respective dollar amounts.

Administrative Bulletin 03-23 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2024.

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, and updated the regulations again effective October 1, 2021. 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 03-23 sets the 2024 maximum MCC deductibles as $2,950/$5,900. If the plan has a separate prescription drug deductible, the amounts cannot exceed $360/$720 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 2024, the OOPM will be $9,450/$18,900. Note that 2024 HSA/QHDHP OOPMs cannot exceed

$8,050/$16,100. These OOPMs are lower than what is required under the Affordable Care Act.

New York Paid Family Leave 2024 Contributions and Benefits

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, 2024, will be set at **0.373%** 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 2024:

- NYAWW in effect will be **$1,718.15**, an increase of 1.8% from the 2023 NYAWW of $1,688.19. The *annualized* NYAWW is **$89,343.80**.
- The maximum annual employee contribution will be $333.25 ($399.43 in 2023).

The PFL benefit is **67%** of an employee's Average Weekly Wage (up to the NYAWW) payable for **12 weeks**. For 2024:

- The maximum weekly PFL benefit will be $1,151.16 ($1,131.08 in 2023).
- The maximum annual PFL benefit payable for 12 weeks will be $13,813.92 ($13,572.96 in 2023).

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 2023 and the leave extends into the 2024, the benefit is based on the rate in effect on the first day of leave (i.e., in 2023) and is not recalculated at the 2024 rate.
- If an employee begins intermittent leave in 2023 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2024 and the benefit is calculated at the 2024 rate.

Employer Action

Employers should prepare for the 2024 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.

Ohio Extends Dental and Vision Insurance to Age 26

Recently, Ohio Governor Mike DeWine signed into law House Bill 33, an operating budget for fiscal years 2024-2025 which included a provision relating to dental and vision insurance. The law requires dental and vision insurance policies to continue coverage for an unmarried child, stepchild, adopted child, or other dependent child until the child turns age 26. The law is effective for dental and vision health benefit plans issued, renewed, or amended on or after January 1, 2024.

Background

Currently, Ohio insurance law follows the Affordable Care Act ("ACA"), in which vision and dental coverage for children is considered an essential health benefit through age 19. To ease the administration of benefits, Ohio insurers will often quote vision and dental benefits to align with the ACA's requirement of medical coverage to age 26, but until now, this was not mandated by the state.

What's Changed?

The bill amends Ohio insurance law to provide dental and vision coverage to certain dependent children up to age 26 if they are:

- Unmarried,
- A resident of Ohio or a full-time student at an accredited public or private institution of higher education,
- Not employed by an employer that offers any health benefit plan under which the child is eligible for coverage, and
- Not eligible for Medicaid or Medicare program.

The law allows dental and vision policies to terminate coverage for young adults before age 26 if they obtain coverage through their employer.

The amendments have not yet been updated in the Ohio Laws & Administrative Rules of the Legislative Service Commission. As such, there will likely be additional information or updates once the statutes are amended. As written

in the bill, the law extends to ERISA covered plans as well, but the laws being amended do not apply to ERISA plans, other than government and church plans, so it remains to be seen how the actual amendments are written, whether they will apply to self-funded ERISA plans, and whether there will be any ERISA preemption issues.

Employer Action

Employers should work with their broker partners and fully insured carriers to ensure compliance when the new law becomes effective on January 1, 2024, including:

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

Paid Leave Oregon Benefit and Contribution Amount Adjustments

As previously reported, leave and benefits under Paid Leave Oregon ("PLO") will become available on September 3, 2023. Recently, the Oregon Employment Department ("ED") announced the adjusted weekly wage replacement benefit amounts based on the State Average Weekly Wage. Additionally, the Oregon Legislature modified PLO to align the wage cap for employee contributions with the social security wage limit.

Background

PLO took effect January 1, 2023 and will begin providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits.

Wage Replacement

On June 1, 2023, ED announced the weekly benefit amounts for PLO effective July 1, 2023, through June 30, 2024. The minimum and maximum weekly benefit amounts are adjusted annually based on the Oregon State Average Weekly Wage set by ED. The State Average Weekly Wage ("SAWW") increased to **$1,269.69** from $1,224.82. The minimum weekly benefit under PLO is 5% of the SAWW and the maximum is 120% of the SAWW.

	Minimum weekly benefit amount	Maximum weekly benefit amount
July 1, 2023 – June 30, 2024	$63.48	$1,523.63

Contribution Limit

Employers that do not sponsor approved equivalent plans are required to deduct PLO premiums from employee paychecks and remit those premiums to the Paid Family and Medical Leave Insurance Fund. ED annually sets the maximum wage limit from which employers deduct premiums. Initially, the wage limit was set at $132,900. Recently Oregon enacted SB 913 which aligned the PLO wage cap with the Social Security wage cap beginning January 1, 2024. While the Social Security cap has not yet been announced, estimates project that it will be set at $167,700. ED is required to announce the actual contribution limit by November 2023 for the 2024 calendar year.

Paid Leave Oregon Website

The PLO website provides extensive information for employers including program information, employer resources, printable forms, employee contribution calculators, and FAQs. Employers can also access program guidebooks, checklists, and guidance and tools related to administering equivalent plans.

Employer Action

Employers should plan to update their 2024 employee payroll deductions to the adjusted amount starting for payroll dates on or after January 1, 2024.

New Texas Mandated Benefits

The Texas legislature wrapped up its 88th legislative session in June having passed approximately 60 bills related to health insurance. Below are the bills signed into law that relate to employer-sponsored plans. They apply to insured medical plans written out of Texas only and are effective for health plans delivered or renewed on or after January 1, 2024, unless otherwise noted below.

House Bill 109 – If a hearing aid charge exceeds the maximum benefit allowed under the plan, the claim will not be denied. Instead, the maximum benefit allowed will be paid and the patient will pay the difference.

House Bill 1649 – Coverage for fertility preservation services is required for patients who receive cancer treatments that may impair fertility. This mandate does not include storage related to fertility preservation.

House Bill 2002 – Under a PPO plan, an insurer must credit toward an insured's deductible and annual maximum out-of-pocket an amount the insured paid directly to any provider for a medically necessary item or service if:

- a claim was not submitted to the insurer; and
- the amount paid was less than the average discounted rate for the item or service paid to an equivalently licensed or authorized network provider under the insured's plan.

House Bill 3359 –There are measurable network adequacy standard requirements for insurers of PPO plans.

House Bill 4500 – Effective January 1, 2024, insurers must make a website available to providers that:

- confirms whether the patient has coverage; and
- lists the cost-sharing for which the patient is responsible.

Senate Bill 989 – Biomarker testing is required to be covered for the purpose of diagnosis or treatment if the test is scientifically valid and predominantly addresses the acute issue for which the test is being ordered.

Senate Bill 2476 – Applicable to emergency services provided on and after January 1, 2024, "surprise billing" protections are in place for out-of-network ground ambulance services provided by a political subdivision such as a county or city. Insurers pay rates filed with the Texas Department of Insurance, if submitted by the provider. Otherwise, insurers pay the lesser of the provider's billed charge or 325% of the current Medicare rate.

House Bill 290 – Certain self-employed individuals may participate in an association plan. This change is to go into effect September 1, 2023. However, the federal regulations to which this state law is intended to align were set aside in 2019.

House Bill 711 – Anti-steering, anti-tiering, gag clauses, and most favored nation clauses are prohibited in provider network contracts. The effective date is the earlier of:

- the effective date of a provider network contract amendment that eliminates the anti-steering or anti-tiering provisions; or

- December 31, 2023.

Note that all group health plans, including self-funded plans, and insurers are subject to a federal law prohibiting gag clauses, effective December 27, 2020.

Senate Bill 833 – Insurers cannot use environmental, social, and governance (ESG) factors when setting rates.

Senate Bill 1040 – Insurers cannot cover a human organ transplant or post-transplant care if the transplant was performed in China or another country known to have participated in forced organ harvesting.

Employer Action

No employer action is required; however, employers with insured medical plans written out of Texas should be aware of the above changes.

2024 Seattle Hotel Employees Ordinance Expenditure Rates

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2024 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.

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.

The amounts of the healthcare expenditure are adjusted each calendar year.

For the 2024 calendar year (January 1 to December 31, 2024), the adjusted rates are:

- $530 per month for an employee with no spouse, domestic partner, or dependents;
- $902 per month for an employee with only dependents;
- $1,062 per month for an employee with only a spouse or domestic partner;
- $1,592 per month for an employee with a spouse or domestic partner and one or more dependents.

It should be noted that the U.S. Supreme Court declined to review the earlier decision from the 9th Circuit Court of Appeals that held the Ordinance is not preempted by ERISA. This means the Ordinance continues to stand and employers should comply with its requirements.

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 2024 plan year, the adjusted rates should be used to determine appropriate expenditures. Employer should include the adjusted rates of the expenditure as part of the annual notification required to covered employees.

Employer should continue to monitor OLS FAQs and website for further information.

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