2023 YEAR IN REVIEW

Compliance Digest

COMPLIANCE BULLETINS
RELEASED JANUARY - DECEMBER

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2023 Compliance Bulletins

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January

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State Health Coverage Reporting Requirements for Calendar Year 2022

Issued date: 01/09/23

The Internal Revenue Service ("IRS") has permanently extended the deadline to **March 2nd** each year for furnishing Affordable Care Act ("ACA") Forms 1095-C (or 1095-B) to full-time employees and other individuals to demonstrate proof of health insurance coverage for each month of the calendar year ("CY"). Form 1094-C and all Forms 1095-C for the prior CY must be furnished to the IRS by **March 31st** each year (unless eligible for paper filing, then by February 28).

For ACA compliance, the IRS permits insurance carriers to post information on their website how plan members may access and receive a copy of the Form 1095-B in lieu of automatically mailing (or electronically issuing) statements to plan members. Insurance carriers must still prepare Forms 1095-B and file these forms with the IRS no later than **March 31, 2023**, for the calendar year 2022 reporting requirements.

Currently five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia have enacted individual health insurance mandates with their own requirements for:

- furnishing information regarding health insurance coverage to residents of the state, and
- filing that information with certain state agencies.

These requirements and deadlines may (or may not) align with the federal requirements. The following chart summarizes important deadlines related to 2022 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2023. However, no penalty is imposed for failing to furnish by this deadline.	March 31, 2023. No penalties will be assessed if filed by May 31, 2023.
District of Columbia	March 2, 2023	April 30, 2023 (30 days after federal deadline)
Massachusetts	January 31, 2023	January 31, 2023
New Jersey	March 2, 2023	March 31, 2023
Rhode Island	March 2, 2023	March 31, 2023
Vermont	N/A	N/A

Important issues to consider regarding furnishing and issuing state-level MEC information are as follows:

- **State residents**: Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.
- **Employers with fully insured plans**: Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency. The District of Columbia also has reporting obligations for certain employers sponsoring fully insured plans. It should be noted that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.
- **Employers with fully insured plans issued out-of-state**: Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.
- **Employers with self-funded plans**: Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state individual mandate reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.

HHS Extends Public Health Emergency until April 11, 2023

Issued date: 01/13/23

On January 11, 2023, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency. This will once again extend the Public Health Emergency Period (the "Emergency Period") for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period	HHS issued a Public Health Emergency beginning January 27, 2020. The Emergency Period is now set to expire **April 11, 2023** (unless further extended or shortened by HHS). HHS has indicated it will provide at least 60 days advance notice if the Emergency Period will not be extended again. We should know by February 10, 2023, if this is the last extension.
Outbreak Period	The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, or 2) 60 days after the announced end of the COVID-19 National Emergency. As of now, the National Emergency is set to expire after February 28, 2023, unless the President announces another continuation.

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

It should be noted that some carriers and TPAs are beginning to take steps to address how a plan will treat COVID-19 benefit requirements once the Emergency Period ends. Options for plan sponsors include maintaining the status quo or removing or limiting coverage that is required while the Emergency Period is in effect.

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

- **COVID-19 Testing.** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.
- **Over-the-Counter ("OTC") COVID-19 Testing.** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.
- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network. Note, COVID-19 vaccines are considered mandatory preventive care under the ACA and will need to be covered in-network at 100% even after the Emergency Period expires.
- **Excepted Benefits and COVID-19 Testing.** An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.
- **Expanded Telehealth and Remote Care Services.** Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.
- **Summary of Benefits and Coverage ("SBC") Changes.** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.
- **Grandfathered plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

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

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

- **COBRA.** Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.
- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth, adoption, or placement for adoption.
- **ERISA Claims Deadlines.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.
    - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.
- **Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans.** A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

It should be noted that there is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Employer Action

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

2023 Federal Poverty Guidelines Announced

Issued date: 01/24/23

The Department of Health & Human Services ("HHS") recently announced the 2023 Federal Poverty Level ("FPL") guidelines which, among other things, establish the FPL affordability safe harbor for purposes of the Affordable Care Act ("ACA") employer mandate.

For plan years beginning February 1, 2023 or later, the 2023 FPL safe harbor is $110.80/month in the lower 48 states and DC, $138.39/month for Alaska, and $127.45/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of using an affordability safe harbor. Because the 2023 FPL guidelines were announced after the start of the calendar year, plans with plan years beginning on January 1, 2023 use $103.28/month for the lower 48 states and DC ($129.12/month for Alaska and $118.78/month for Hawaii), which is 9.12% of the applicable 2022 FPL. The increased threshold of $110.80/month for the lower 48 states and DC based on the 2023 FPL applies to plan years beginning on or after February 1, 2023.

Background and FPL Safe Harbor

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

A large employer's offer of coverage will be considered "affordable" under the FPL safe harbor if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2023 FPL Affordability Safe Harbor

For FPL affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The 2023 FPL is $14,580 for a single individual in every state (and Washington D.C.) except Alaska or Hawaii. Thus, if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value is $110.80 (9.12% of $14,580/12, rounded down) or less, the employer's offer of coverage meets the FPL affordability safe harbor for a plan year beginning February 1, 2023 or later in the lower 48 states and DC.

FPL Guidelines

The following are the 2023 HHS poverty guidelines:

2023 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/household	Poverty Guideline
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

2023 Poverty Guidelines for Alaska	
Persons in family/household	Poverty Guideline
1	$18,210
2	$24,640
3	$31,070
4	$37,500
5	$43,930
6	$50,360
7	$56,790
8	$63,220
For families/households with more than 8 persons, add $6,430 for each additional person.	

2023 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty Guideline
1	$16,770
2	$22,680
3	$28,590
4	$34,500
5	$40,410
6	$46,320
7	$52,230
8	$58,140
For families/households with more than 8 persons, add $5,910 for each additional person.	

For the new poverty guidelines, visit: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

DOL Penalties Increase for 2023

Issued date: 01/25/23

The Department of Labor ("DOL") has published the annual adjustments for 2023 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2023

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

Description	2022 Penalty (Old)	2023 Penalty (NEW)
Failure to file Form 5500	Up to $2,400 per day	Up to $2,586 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,746 per day	Up to $1,881 per day
Failure to provide CHIP Notice	Up to $127 per day per employee	Up to $137 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$127 per day per violation (per participant/beneficiary)	$137 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,264 per failure	Up to $1,362 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL on request	$171 per day $1,713 cap per request	$184 per day $1,846 cap per request
Genetic information failures	$127 per day (per participant/beneficiary)	$137 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,192 minimum	$3,439 minimum
Failure to meet genetic information requirements – not de minimis failures	$19,157 minimum	$20,641 minimum
Cap on unintentional failures to meet genetic information requirements	$638,556 maximum	$688,012 maximum

It should be noted that, with respect to certain notice and disclosure deadlines, a plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

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

Emergency Periods Related to COVID-19 to End May 11, 2023

Issued date: 02/03/23

On January 30, 2023, the Biden Administration announced its intent to end the Public Health Emergency and the National Emergency related to the COVID-19 pandemic on May 11, 2023. They are currently set to expire after February 28, 2023 and on April 11, 2023, respectively.

This announcement came in response to two bills in the House of Representatives proposing to end the national emergencies at an earlier date.

As previously reported, various employee benefit plan requirements are directly impacted by the Public Health Emergency and the National Emergency. Employers sponsoring health and welfare programs will need to make some decisions with respect to their programs.

End of the Public Health Emergency

When the Public Health Emergency ("PHE") ends on May 11, 2023 various requirements as they relate to group health plan coverage, along with some helpful relief, will come to end.

- **COVID-19 Testing.** During the PHE, all group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered. This includes coverage for over-the counter (OTC) tests. When the PHE ends, this requirement no longer applies.

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers. When the PHE ends, non-grandfathered plans must continue to provide the vaccine under the ACA preventive care mandate in-network; however, cost-sharing may apply out-of-network.
- **Expanded Telehealth Relief for Large Employers.** Large employers (51 or more employees) with plan years that begin before the end of the PHE may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer. This relief expires for plan years that begin on or after May 11, 2023 (e.g., a June 1, 2023 plan year).
- **Summary of Benefits and Coverage (SBC).** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the PHE ends, provided the plan members are timely made aware
  of any increase and/or decrease in plan benefits summarized on the SBC.
- **Grandfathered Plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the PHE (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the PHE ends.

Employers should review these changes and decide how to manage the expiration in May of these requirements. Carriers and third-party administrators ("TPAs") may also issue information for you to review and provide directions on next steps. In some cases (and to the extent allowed) carriers or TPAs may make changes with the next plan year.

End of the National Emergency

The Outbreak Period started March 1, 2020. It applies on an individual basis to group health plans, disability, and other employee welfare programs. Government plans (e.g., a health plan of a city or county) are not required to comply.

During this time, a plan must disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** The timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.
- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth, adoption, or placement for adoption.
- **ERISA Claims Deadlines.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.
  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

With the announced end of the National Emergency on May 11, 2023, the Outbreak Period will end **July 10, 2023**. This means original deadlines will begin to run after July 10, 2023.

It should be noted that there is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Hopefully, additional guidance as it relates to the end of the Outbreak Period and measuring deadlines is forthcoming. There are many unanswered questions as it relates to this relief.

In addition, there is fiduciary relief available during the Outbreak Period as it relates to certain notice and disclosure deadlines. Notably, many employers took advantage of good faith relief that allowed furnishing of certain notices and disclosure through electronic means, such as email or text, without having to satisfy more burdensome electronic delivery requirements. This relief will also expire after July 10, 2023.

Other Relief

There is other relief for qualified high deductible health plans ("HDHPs") with a health savings account ("HSA") that came about as a result of the COVID-19 pandemic but is not tied to the PHE or National Emergency. As such, these provisions should not be affected when these timeframes end.

- **IRS Notice 2020-15.** Allows a qualified HDHP to provide coverage for COVID-19 testing or treatment before the IRS deductible is satisfied without jeopardizing HSA eligibility. This relief applies until further guidance is issued. It does not appear that the end of the PHE will affect this relief, unless the IRS issues guidance stating otherwise.
- **Telehealth Relief.** For plan years that begin after December 31, 2022 and before January 1, 2025, an HDHP/HSA plan may offer telehealth or other remote care services before the minimum IRS deductible is satisfied without jeopardizing HSA eligibility.

Special Enrollment Opportunity

As a result of the end of the PHE, it is expected that many individuals will lose eligibility for Medicaid and the Children's Health Insurance Program ("CHIP"). The loss of Medicaid or CHIP coverage is a special enrollment opportunity onto a group health plan sponsored by an employer. Employers should be prepared to address requests for special enrollment from otherwise eligible employees who lose Medicaid or CHIP coverage.

Employer Action

With respect to the end of the PHE, employers should discuss benefit plan design changes with carriers and TPAs. Employers should be prepared to address requests for special enrollment as a result of a loss of eligibility for Medicaid or CHIP.

Employers should also monitor developments as the government funding to purchase COVID-19 vaccines is expected to end. Most group health plans will need to cover the cost of the vaccine as required preventive care (along with the administration) in-network and without cost-sharing. Reports from Pfizer and Moderna indicate the commercial cost could range between $110-130 per dose.

With respect to the end of the Outbreak Period, employers should:

- Await additional guidance from the regulators; and
- Consider providing notice to employees that the extended deadlines will come to an end on July 10, 2023 and discuss COBRA implications with COBRA vendors.

Notification Reminder for Forms 1095-C and 1095-B

Issued date: 02/07/23

Under the Affordable Care Act ("ACA"), the deadline for applicable large employers ("ALEs") to furnish Form 1095-C and 1095-B to certain individuals (such as full-time employees in the case of Form 1095-C) is January 31 with respect to the preceding calendar year. The Internal Revenue Service ("IRS") released final regulations on December 12, 2022 with respect to ACA reporting requirements. These final regulations provided an automatic extension of 30 days to furnish these statements to individuals.

This means that Wednesday, March 2, 2023 is the deadline to furnish individuals with 2022 Forms 1095-C and 1095-B. This extension is automatic; employers or other reporting entities are not required to file a request with the IRS, or to demonstrate reasonable cause to justify the extension.

It should be noted that the final rule did not extend the deadline to file completed Forms 1095-C and 1095-B with the IRS. This due date remains March 31, 2023 (or February 28, 2023 for paper filing if filing fewer than 250 forms).

While the IRS has provided the automatic extension of time to furnish these statements, it should be noted that if an ALE is operating in a state with an individual mandate, the timing to furnish proof of coverage to covered residents may be different.

Alternative Method for Furnishing ACA Statements

Under the ACA, IRS Forms 1095-C and 1095-B must be sent by first class mail to the last known permanent address of the individual. If no permanent address is known, the statement must be sent by first class mail to the individual's temporary address. The statement may also be furnished electronically if certain requirements are met.

The final regulations make permanent an alternative method for furnishing IRS Form 1095-B to individuals, for as long as penalties under the ACA's individual shared responsibility rules remain zero. The alternative method is available to the following reporting entities:

- Health insurance carriers and plan sponsors (other than ALEs) that are using IRS Form 1095-B to provide proof of MEC
- ALEs with a self-funded group medical plan that are using IRS Form 1095-B to provide proof of MEC to individuals who are not considered "full-time" under the ACA for any month of the calendar year (i.e., non-full-time employees and non-employees covered under the plan during the calendar year)
- Small employers (not ALEs) with a self-funded health plan that are using IRS Form 1095-B to provide proof of MEC

It should be noted that the alternative method is not available to ALEs that are furnishing IRS Form 1095-C to employees considered "full-time" under the ACA for one or more months of the calendar year. Further, the alternative method may not be available if operating in a state with an individual mandate where Forms 1095-C or 1095-B must be furnished to covered residents. Keep in mind, if the alternative method is used, the reporting entity must still file the Form 1095-B with the IRS.

The following steps must be followed by a reporting entity that elects to use the alternative method:

- A clear and conspicuous notice that meets certain technical requirements must appear on the reporting entity's website
- The notice must state that covered individuals may receive a copy of IRS Form 1095-B upon request, and informs them how the request may be made
- The notice must appear in the same website location through October 15 (or the next business day if October 15 falls on a Saturday, Sunday, or legal holiday) following the end of the calendar year to which the form relates
- IRS Form 1095-B must be furnished to the requesting individual within 30 days after the request is received; the ACA statement may be furnished electronically if certain requirements are met.

Employer Action

With respect to furnishing Forms 1095-C and 1095-B for CY 2022, employers must furnish these statements to individuals no later than March 2, 2023. Final Forms and Instructions are now available.

Employers should know whether carriers will take advantage of the alternative furnishing method with respect to Forms 1095-B they issue.

Employers in a state with an individual mandate (California, District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont), and required to furnish covered residents with proof of coverage during the calendar year, should continue to comply with state rules.

Air Ambulance Reporting Update

Issued date: 02/13/23

As previously reported, group health plans will be required to submit information related to air ambulance claims to the Department of Health and Human Services ("HHS").

In a September 2021 proposed rule, the regulators expected that rulemaking would be finalized during 2021, and that plans and carriers would be required to submit the data for calendar year 2022 by March 31, 2023, and the data for calendar year 2023 by March 31, 2024.

However, under the statute, the reporting is not due until regulations are final, and the proposed rule has not been finalized. As a result, absent further guidance, there should be no reporting requirement in 2023. HHS has unofficially stated there would be no data collection in 2023.

Once regulations are finalized, the reporting requirements will become effective. We anticipate that the final rule will include due dates for reporting. We will continue to monitor the guidance and provide updated information when available.

Employer Action

Group health plans will not need to submit the air ambulance report in 2023.

Keep an eye out for additional guidance, including issuance of a final rule.

Once guidance is finalized, coordinate with carriers and third-party administrators to ensure reporting is prepared and timely submitted.

Medicare Part D – CMS Notification Reminder

Issued date: 02/24/23

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

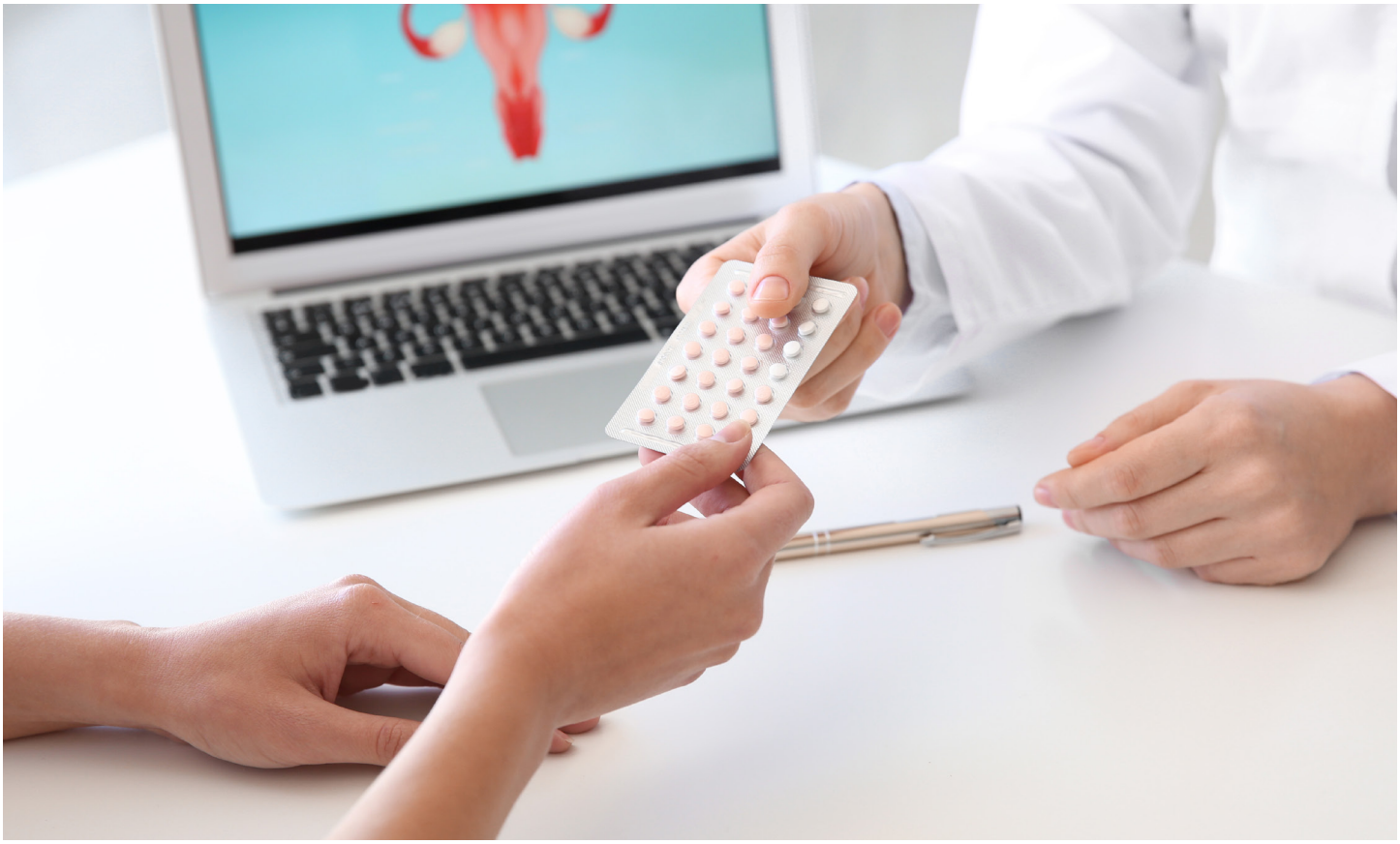
As a reminder, notice must be provided by the following deadlines:

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

For example, an employer with a calendar year plan (January 1 – December 31, 2023) must complete this reporting **no later than Wednesday, March 1, 2023**.

Additional resources on completing the form is available at:

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



Proposed Update to Contraceptive Services Mandate

Issued date: 02/24/23

On January 30, 2023, the Departments of Labor, Treasury, and Health and Human Services (collectively, "the Departments") issued a new proposed regulation related to the provision of contraceptive services in a group health plan. This rule would strengthen access to birth control coverage under the Affordable Care Act ("ACA") so that all women who need or want birth control are able to obtain it. Briefly, the rule:

- Creates a new, optional pathway for individuals to obtain contraceptive services when a group health plan does not provide such services due to religious objection; and
- Removes the existing exemption for moral objection.

Background

Under the ACA's preventive care mandate, all non-grandfathered group health plans must cover all FDA-approved contraceptive services without participant cost-sharing.

Under a final rule issued in 2018, non-governmental employers sponsoring a group health plan and objecting to providing some (or all) of the mandated contraceptive services based on seriously held religious beliefs or moral objection are exempt from the requirement. An optional accommodations process is available to allow participants to obtain contraceptives for no cost from a carrier and/or TPA without involvement of the objecting employer sponsor.

What's New?

The new proposed rule creates individual contraceptive arrangements for participants to obtain contraceptives without the involvement of their objecting plan sponsor that invoked the religious exemption and does not use the optional accommodation process.

Under the proposed rule, a willing provider may provide contraceptive services directly to eligible individuals at no cost. The provider will then seek reimbursement from a health insurance carrier participating in the federal or state-run Exchange and that carrier will, in turn, receive a reduction in Exchange user fees. Objecting group health plan sponsors are not required to provide notice to participants of the availability of this process, although they are still subject to the disclosure rules that normally apply to group health plans such as SPD and SBC distribution.

Additionally, the proposed rule would rescind the moral objection exemption from the contraceptive mandate. Group health plans that previously relied on this exemption would be required to cover contraceptive services. The proposed rule does not make any changes to the exemption or accommodation process for religious objection.

Employer Action

Group health plans excluding coverage of contraceptives under a religious exemption may continue to do so without further action. Plans that exclude coverage of contraceptives under non-religious moral grounds may need to consider changes to contraceptive coverage if the rule is finalized "as is." The Departments are seeking comment on the type and magnitude this design change would have on plans who historically have relied on the moral objection exemption, as well as alternatives to
a full rescission.

It should be noted that this rule is in proposed form and is not final. Any final rule may change from the proposed rule and should include an effective date. It is possible, when finalized, that the new rule could face legal challenges.

California Requires COVID-19 Coverage After Emergency Ends

California has enacted a state insurance law that generally requires group health insurance policies and health maintenance organizations ("HMOs") in California to continue covering the cost of COVID-19 testing, vaccinations, and therapeutics after the end of the federal Public Health Emergency ("PHE") related to the COVID-19 pandemic. The Biden administration has announced its intention to end the federal PHE on May 11, 2023.

COVID-19 Testing and Vaccination Coverage

After the end of the federal PHE, this California insurance law will apply as follows:

Group health insurance policies and HMOs in California are generally required to continue to cover the cost of COVID-19 diagnostic and screening testing and the cost of COVID-19 vaccinations, without cost-sharing and without prior authorization or other utilization management requirements, whether delivered by an in-network provider or an out-of-network provider. These requirements are the same as those in place during the federal PHE.

However, beginning six months after the federal PHE ends (November 11, 2023, if the federal PHE ends as expected on May 11, 2023), group health insurance policies and HMOs in California may impose cost-sharing when the COVID-19 testing or vaccinations are delivered by an out-of-network provider (unless otherwise required by law).

COVID-19 Therapeutics Coverage

California insurance law also requires group health insurance policies and HMOs to cover the cost of COVID-19 therapeutics (treatments intended to be administered as soon as possible after an individual's positive COVID-19 test result), without cost-sharing and without prior authorization or other utilization management requirements, whether delivered by an in-network provider or an out-of-network provider.

These requirements generally apply to group health insurance policies and HMO contracts that are issued, amended, or renewed after September 25, 2022, and continue to apply after the end of the federal PHE.

However, beginning six months after the federal PHE ends (November 11, 2023, if the federal PHE ends as expected on May 11, 2023), group health insurance policies and HMOs may impose cost-sharing when COVID therapeutics are delivered by an out-of-network provider (unless otherwise required by law).

Application of California Insurance Law to Group Health Plans

The California insurance law requirements set forth above generally apply to:

- Group health insurance policies issued or delivered (i.e., situsued) in California
- HMOs in California
- Group health insurance policies issued or delivered (i.e., situsued) outside of California, to the extent that the policy covers California residents; but not if (a) the employer's principal place of business is located outside of California, and (b) a majority of employees are located outside of California

The California law does not apply to specialized health insurance policies that provide only dental or vision-care benefits, and to certain other insurance policies. In addition, the California law does not apply to any self-funded group health plan.

Employer Action

Employers that maintain a fully insured group health plan situsued in California should be aware of the requirements of this California insurance law.

Employers that maintain a fully insured group health plan situsued outside of California that covers California residents should keep records relating to the location of its principal place of business and the location of its employees, for purposes of determining the extraterritorial application of California insurance law to its plan.

FAQs Address Gag Clause Prohibition and Attestation

Issued date: 03/08/23

The Departments of Labor, Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") issued FAQ 57, providing the first guidance as it relates to the prohibition on gag clauses in provider agreements and the annual attestation as required under the Consolidated Appropriation Act of 2021 ("CAA-21").

Among other things, the guidance requires group health plans and health insurance carriers to submit an annual attestation with the first attestation due no later than December 31, 2023.

Below you will find additional clarification provided by the FAQs:

What is a "gag clause?"

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.

Under the CAA-21, group health plans and carriers offering group health insurance are prohibited from entering into agreements with providers, TPAs or other service providers that include language that would constitute a "gag clause" and restrict:

1. Disclosure of provider specific cost or quality of care information to referring providers, the plan sponsor, participants, beneficiaries and or any other plan members;
2. Electronic access to de-identified claims and encounter information or data for each participant, beneficiary or enrollee in the plan upon request and consistent with relevant privacy rules; and
3. Sharing information or data described above or directing that such information or data be shared with a business associate.

Plans and carriers must annually submit to the Departments an attestation that the plan or carrier complies with these requirements ("Attestation").

The Attestation

The first Attestation is due no later than December 31, 2023, covering the period from December 27, 2020 through the date of the Attestation. Subsequent Attestations will be due by December 31 of each year and cover the period since the last Attestation was submitted.

The Attestation must be submitted to the Centers of Medicare and Medicaid Services ("CMS") through a webform. An authentication code to access to the web form is required and generated upon request. CMS issued a detailed instructions document with relevant submission information, which can be found at https://www.cms.gov/files/document/gag-clause-prohibition-compliance-attestation-instructions.pdf.

A reporting entity, generally the group health plan or group health insurance carrier, is responsible for ensuring either that it annually attests or has another party (e.g., carrier, TPA) attest on its behalf that the reporting entity is in compliance with the prohibition on gag clauses.

Fully insured plans

If a group health plan is fully insured, both the carrier and the plan are subject to the Attestation. However, the Departments will consider both the carrier and the plan to have met the attestation requirement if the carrier submits Attestations on behalf of the plan. Employers with fully insured plans should confirm the carrier will handle this obligation.

Self-funded (including level funded plans)

A self-funded plan is responsible for compliance and may satisfy the requirement by entering into a written agreement under which the plan's service provider (e.g., TPA) attests on its behalf. But like other CAA provisions, the legal responsibility will remain with the plan. Employers should seek written assurances from TPAs and other services providers that they will submit the attestation on their behalf.

The following plans are not subject to the requirement, and therefore do not need to attest:

- Account based plans such as a health FSA, HRA and ICHRA
- Excepted benefits, such as hospital indemnity insurance, dental and vision
- Short-term limited duration insurance

Employer Action

Employers should ensure that their group health plans do not include language or other restrictions that are considered "gag clauses" and coordinate with relevant carriers, TPAs and other service providers to timely submit the Attestation. The first due date is December 31, 2023. It should be noted that, although the first Attestation is not due until December 31, 2023, some employers have already received letters from HHS indicating that CMS is now collecting Attestations.

Employers with fully insured plans should confirm carriers will submit the Attestation on behalf of the insured group health plan. No further action is required if the carrier handles this step.

Employers with self-funded plans should enter into an agreement to have their TPA, PBM or other third party submit the Attestations on its behalf.

2022 RxDC Reporting Instructions Released

Issued date: 03/31/23

The Centers for Medicare and Medicaid Services ("CMS") recently released updated RxDC reporting instructions, the HIOS Manual User Guide, and the HIOS Quick Guide related to reporting 2022 data. While substantially rearranged, the substance of the instructions largely remains the same. Nevertheless, there are some notable changes.

Background

As previously reported, plan sponsors of group health plans must submit information annually about prescription drugs and health care spending ("RxDC reporting") to CMS. The first deadline was December 27, 2022 (extended to January 31, 2023) for reporting on calendar years 2020 and 2021. The next deadline is June 1, 2023, for reporting on calendar year 2022.

It should be noted that carriers, pharmacy benefit managers ("PBMs"), and third-party administrators ("TPAs") assisting with the reporting may have earlier deadlines for employers to respond to them with certain data points (e.g., plan name, average monthly premiums).

New Instructions

The following are the most relevant changes from the prior year:

- The enforcement relief available for failure to report average monthly premium paid by employers and members for 2020/2021 reporting is not available for 2022 reporting. Additionally, no other good faith relief has been extended with respect to 2022 reporting at this time.

- Changes providing clarification about what should be reported in D1 and D2 files:
    - Prescription drug rebates should be subtracted from premium equivalents in D1 regardless of whether the rebate received in the reference year is retrospective or prospective.Stop-loss reimbursements should be subtracted from premium equivalents in D1.
    - Stop-loss reimbursements should not be subtracted from total spending in D2.
    - Prescription drug rebates expected, but not yet received, should be subtracted from total spending in D2.
- Changes to incorporate lessons learned from the first submission date, particularly around making the submission more efficient and more precise.
    - There is an additional option for multiple vendors to submit the same data file on behalf of the same plan, issuer, or carrier.
        - Plans and carriers and their reporting entities are encouraged to work together to submit only one data file of each data file type for the same plan, issuer, or carrier. For example, if one reporting entity is responsible for only some of the fields in a data file, it might fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.
        - However, if entities are unwilling or unable to work together, more than one reporting entity may submit the same type of data file on behalf of the same plan, issuer, or carrier. For example, if a plan has two issuers, one for behavioral health benefits and another for other medical benefits, then both issuers can submit D2 on behalf of the plan. The first issuer's D2 would include the plan's data related to behavioral health benefits. The second issuer's D2 would include the plan's data related to other medical benefits.
        - Similarly, if a plan or carrier changes vendors during the reference year (such as changing a TPA or PBM), it's acceptable for the previous vendor to report the data from the period prior to the change, and the new vendor to report the data from the period beginning on the date the change was effective. Alternatively, the previous vendor may provide the data to the new vendor and the new vendor would report the entire year of data.
- There is an additional option for a reporting entity to create multiple submissions in HIOS for the same reference year.
    - A reporting entity may make multiple submissions in HIOS if the content of the submissions is mutually exclusive. That is, if a reporting entity creates multiple submissions, each plan in the plan lists and data files must be included in only one of the submissions. If multiple submissions with overlapping content are accidentally created, the RxDC HIOS Manual User Guide contains instructions on editing and deleting submissions. CMS discourages reporting entities from making multiple submissions in HIOS.
- Changes related to when reporting is and is not required:
    - RxDC reporting requirements do not apply to retiree-only plans.
    - Reporting must be done for all 50 states, the District of Columbia, and the U.S. territories.
    - Plans and carriers should make their own determination on whether to include information about prescriptions filled in other countries.

- Examples of when wellness services are billed on a claim and thus reportable:
    - A member sees a provider for the placement of a nicotine patch to help with smoking cessation, and the provider submits a claim for providing this service (for example, using codes CPT 1036f and S4990). This is a billed claim.
    - A member receives a gift card for completing a smoking cessation program. This is not a billed claim.

HIOS Guidance

The HIOS Manual User Guide and HIOS Quick Guide have been substantially changed, increasing from 8 pages to 34 pages. The first 3 pages include specific information that registrants should omit.

At this time, it does not appear the email reporting option available for 2020/2021 reporting will be available for employers responsible for filing P2 and D1 themselves for 2022. Therefore, if an employer needs to submit one (or more) of the "D" files (e.g., D1) on behalf of the group health plan because a TPA or PBM is not handling the full filing, the employer should sign up for a HIOS account.

Employer Action

With respect to these new instructions, employers should:

- Identify which of the above changes will impact their filing this year.
- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2022 data.

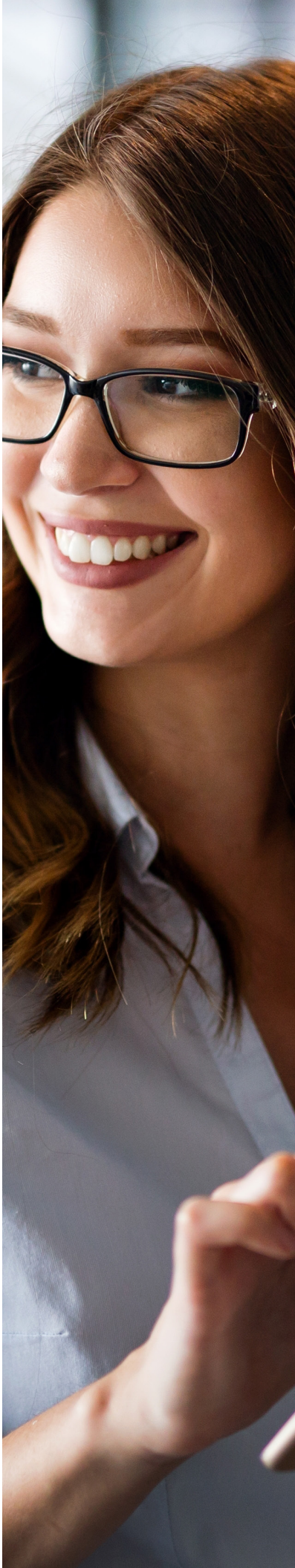
The instructions themselves are helpful and answer questions about the filing requirement and provide relevant examples when appropriate.

Additional guidance and/or relief could be issued before the June 1, 2023 filing deadline. We will continue to monitor and inform you of any applicable changes.

2023 State-Based Compliance: Quarter One

California

Washington



San Francisco Supplemental Pay for Military Leave

San Francisco now requires certain employers to provide up to 30 days of supplemental pay to employees who are on leave for military duty.

Background

On January 20, 2023, the mayor of San Francisco approved an Ordinance passed by the Board of Supervisors called the "Private Sector Military Leave Pay Protection Act." This Ordinance is intended to minimize the financial hardship of an employee who is absent from work due to military duty by mandating the employer provide partial pay to the employee for up to 30 days.

This Ordinance is administered and enforced by the San Francisco Office of Labor Standards Enforcement ("OLSE"). On February 16, 2023, the OLSE published implementation guidance on this Ordinance in the form of Frequently Asked Questions.

The requirements of the Ordinance became effective on February 19, 2023.

Covered Employers

The Ordinance applies to every employer with at least 100 employees worldwide, regardless of company location or headquarters. However, the Ordinance does not apply to any governmental employer (including the City and County of San Francisco) or to private businesses located in the Presidio, Fort Mason, the Golden Gate National Recreation Area, or other federal enclave.

All employees performing work for the employer worldwide are counted toward the threshold. If the number of employees fluctuates above and below 100 over the course of a year, the employer's size is calculated based on the average number of employees per pay period during the prior calendar year.

Covered Employees

The Ordinance applies to any employee (including any part-time or temporary employee) who both:

- performs work within the geographic boundaries of San Francisco for a covered employer, and
- is a member of the reserve corps of the US Armed Forces, National Guard, or other US uniformed service organization.

Covered Military Duty

The Ordinance applies to a covered employee's leave for military duty, for up to 30 days in a calendar year. "Military duty" is defined as:

- active military service in response to the September 11, 2001 terrorist attacks, international terrorism, the conflict in Iraq, or related extraordinary circumstances, or military service to provide medical or logistical support to federal, state, or local government responses to the COVID-19 pandemic, natural disasters, or engagement in military duty ordered for the purposes of military training, drills, encampment, naval cruises, special exercises, Emergency State Active Duty, or like activity.

Examples of military duty are when the covered employee is deployed to respond to a natural disaster or military conflict, or attends required annual military training.

Supplemental Pay Calculation

For the period during which covered employees are on leave for military duty, the covered employer must pay them (for up to 30 days in a calendar year) the difference between their gross military pay and the amount of gross pay they would have received from the employer had they worked their regular work schedule (for the hours that would have been worked in San Francisco) instead of being absent for military leave.

Gross military pay is the basic pay rate the employee receives for military service, excluding military pay allowances such as those for combat, clothing, housing, or aviation. The employer can estimate the amount of gross military pay by asking employees to provide a copy of their military orders (which disclose their military rank), and then looking up the federal Armed Forces basic pay rate for their military rank at www.dfas.mil (if the military orders do not already state their gross military pay). Also, after the leave ends, the employer can ask the employees to provide a wage statement verifying the military gross pay they actually received during the relevant period of military leave, and adjust for any discrepancies on the next paycheck.

Gross pay from the employer is easily calculated if covered employees have a regular work schedule (e.g., 40 hours per week every week), or have a work schedule predetermined for the time when they are required to take military leave. Otherwise, their "regular work schedule" can be determined by looking at the three monthly pay periods, six bi-weekly or semi-monthly pay periods, or twelve weekly pay periods immediately preceding the relevant period of military leave. Gross pay includes overtime pay if the employee's regular work schedule includes overtime. The calculation of gross pay should not include any pay periods during which the employee was on unpaid or partially paid leave prior to the relevant period of military leave.

The employer is required to make a good faith effort to provide the supplemental pay no later than the payday for the payroll period when the employee's military leave begins. Covered employees receiving supplemental pay while on leave for military duty should not receive more total compensation than they would have received by working their regular work schedule.

For those employees who receive supplemental pay under the Ordinance but who fail to return to their position with the employer within 60 days after being released from military duty (despite being fit for employment), the employer is permitted to treat the supplemental pay as a loan at a specified interest rate that must be paid back to the employer in equal monthly installments over a period not to exceed five years.

Employer Action

- Covered employers may require covered employees to comply with reasonable notice procedures, such as providing the employer with advance notice of the employee's use of supplemental pay for military leave, but only when the need for military leave is foreseeable (such as for scheduled trainings).
- Within a reasonable time after covered employees tell their covered employer they received written military orders and will require time off work, the employer should provide them with a notice of their right to supplemental pay under the Ordinance.
- If a covered employer publishes an employee handbook that describes other kinds of leave available to its employees, the employer must include a description of the right to supplemental pay under the Ordinance in the next edition of the handbook that is published.
- A covered employer should stay up-to-date on displaying the current labor law posters required at each San Francisco workplace or jobsite. The OLSE has indicated it will include a notification of the employee right to supplemental pay under the Ordinance in the labor law posters it updates annually and provides for employers.
- Covered employers must retain records for at least four years relating to employee schedules and hours worked, and military leave taken by covered employees, for purposes of documenting their compliance with the supplemental pay requirements of the Ordinance.

Reminder: San Francisco HCSO Reporting Due May 1

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") need to submit the 2022 Employer Annual Reporting Form by **Monday, May 1, 2023**. The form is completed and submitted online at https://sf.gov/submit-employer-annual-reporting-form-olse-0.

This annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"). Details related to the FCO are not addressed in this summary; visit the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE") for more information.

Employer Annual Reporting Form

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

Covered employers must also submit an online Employer Annual Reporting Form each year that summarizes how they complied with the HCSO.

The Form is normally due on April 30th of the following year, but since that date falls on a Sunday this year, the deadline to submit the 2022 Form has been shifted to Monday, May 1, 2023. The penalty for failing to timely submit the Employer Annual Reporting Form is up to $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2022 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2022 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

The OLSE has made a pdf of the 2022 Form available for employers who wish to preview the Form before completing it online (https://sf.gov/sites/default/files/2023-02/2022%20ARF%20PDF%20Preview_website.pdf). It has also published instructions for completing the 2022 Form (https://sf.gov/reports/february-2023/2022-arf-instructions).

HCSO Notice to Employees

If they haven't already, covered employers should make sure to post the official 2023 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at https://sf.gov/sites/default/files/2022-12/2023%20HCSO%20poster.pdf.

Washington LTC Voluntary Exemptions Categories Added

As previously reported, Washington's Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund") was delayed to allow the legislature to make changes to the program including adding individual exemption categories.

Beginning January 1, 2023, eligible individuals may apply for new exemptions based on newly added criteria described below.

Also, as a reminder, premium withholding for the program begins July 1, 2023.

Background

Beginning July 1, 2023, a 0.58% premium assessment applies on wages of all Washington employees to fund the WA Cares Fund. The program will provide long-term care benefits to eligible Washington residents (up to $36,500). All wages are subject to the premium assessment; there is no cap.

During the 2022 legislative session, ESHB 1733 was passed establishing four new categories of employees who may be eligible for a voluntary exemption from the payment of premiums to (and benefits from) the WA Cares Fund.

Briefly, the new exemptions are for people who are:

- **Disabled veterans**. An employee who is a veteran of the United States military who has been rated by the United States Department of Veterans Affairs as having a service-connected disability of at least 70 percent. This is the only permanent exemption created by ESHB 1733.
- **Spouse or registered domestic partners of an active duty service member**. An employee who is the spouse or registered domestic partner of an active duty service member of the United States Armed Forces. This exemption is temporary and must be discontinued within 90 days of either the employee's spouse or registered domestic partner being discharged or separated from military service, or the dissolution of the employee's marriage or registered domestic partnership.
- **Temporary employees with a nonimmigrant visa**. An employee who holds a nonimmigrant visa for temporary workers who is employed by an employer in Washington may apply for an exemption. This exemption is temporary and must be discontinued within 90 days of an employee's nonimmigrant visa for temporary workers status being terminated and the employee becoming a permanent resident or citizen employed in Washington
- **Living outside of Washington**. An employee who is employed in Washington but maintains a permanent residence outside of Washington as the employee's primary location of residence may apply for an exemption. The exemption is temporary and must be terminated within 90 days of the employee establishing a permanent address within Washington as the employee's primary location of residence.

Exemption Process

Washington's Employer Security Department ("ESD") recently opened the application process for eligible individuals who would like to apply for one of these exemptions.

The new exemptions are available on an ongoing basis. Individuals need to create a SecureAccessWashingon (SAW) account to apply. Information about establishing SAW accounts is available online at: https://wacaresfund.wa.gov/apply-for-an-exemption/

Individual exemptions are effective the quarter after the exemption is approved. Individuals with approved exemptions will receive an exemption approval letter from ESD which will need to be presented to current and future employers to avoid premium deductions. Failure to present the exemption approval letter to an employer could result in premium deductions that will not be returned to the employee.

It should be noted that employers cannot apply for exemptions on behalf of employees. The employee must apply for their own exemption.

What about exemptions for a private long-term care policy?

Individuals with private long-term care insurance before Nov. 1, 2021, were able to apply for a permanent exemption from the WA Cares Fund from Oct. 1, 2021, until Dec. 31, 2022. Individuals needed to secure the exemption within this timeframe. It is no longer available.

Employer Action

Employees who qualify for and would like to claim an exemption must apply on the WA Cares Fund website. Employees have the responsibility to notify and provide employers with a copy of any approved exemption letter for ESD. Once provided with that letter (and the effective date has passed), employers should not withhold premiums for WA Cares Fund. Any incorrectly withheld premiums should be returned to the employee.

Employers should coordinate with payroll to prepare for premium collection beginning July 1, 2023.

2023 Compliance Bulletins: Quarter Two

April

May

June

Guidance Issued On Emergency Period Expiration

Issued date: 04/14/23

This Compliance Bulletin contains guidance released in FAQ 58; however, President Joe Biden subsequently signed a House Bill on April 10, 2023 immediately ending the National Emergency, which may change certain dates referenced below. It is possible that FAQ 58 will be updated to reflect new dates. The signed Bill did not change the end of the Public Health Emergency, which remains May 11, 2023.

On March 29, 2023, the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") released FAQ 58, answering certain frequently asked questions regarding the announced end of the National Emergency and the Public Health Emergency ("PHE") on May 11, 2023.

Diagnostic Tests

During the PHE, plans and issuers are required to cover COVID-19 diagnostic tests without any cost sharing, whether in-network or out-of-network. The Departments indicated that, although the plan or issuer may exclude or may require cost sharing of COVID-19 diagnostic tests following the end of the PHE, including over-the-counter ("OTC") testing, they encourage plans to continue to cover COVID-19 testing.

Advance Notice

Plans or issuers that make material modifications to any of the plan or coverage terms that affect the most recently issued Summary of Benefits and Coverage ("SBC") outside of a renewal must provide 60 days advanced notice. However, to the extent the changes are only with respect to cost-sharing and coverage for diagnosis and treatment of COVID-19, or for telehealth or other remote care services in connection with the end of the PHE, the Departments will consider the plan or issuer's notice requirements satisfied if it:

- Previously notified the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing (such as, that the increased coverage applies only during the PHE); or

- Notifies the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing within a reasonable timeframe in advance of the reversal of the changes.

However, notices that were issued regarding coverage during previous plan years will not meet the notice relief described above.

It should be noted that for plans that utilize the standard SBC template, changes to COVID-19 coverage will not materially affect the disclosure and would not require the advanced notice. It is unclear whether these changes would be considered "material."

Although the FAQs did not address this issue, under ERISA, for health plans, a summary of material reduction should be distributed automatically to participants within 60 days of adoption of the material reduction in services or benefits or at regular intervals of not more than 90 days. Although somewhat of a gray area, this should mean that employees hear about the change at least 60 days in advance. It's unclear whether these changes would be considered "material." Regardless, it is recommended to provide advance notice.

A sample employee notice could be:

> Please be advised that in connection with the federal government's announced end of the Public Health Emergency, the **[HEALTH PLAN NAME]** will **[no longer cover or cover subject to regular cost-sharing]** COVID-19 testing (both over-the-counter and in-person). This change will take effect May 12, 2023. All claims incurred before then will be covered in accordance with the requirements of the Public Health Emergency and any relevant federal guidance. Should you have any questions, please contact **[NAME OF CONTACT]** at **[CONTACT INFORMATION]**.

HDHP Coverage Before Minimum Deductible

Normally, for individuals to make or receive health savings account ("HSA") contributions, with limited exceptions, high deductible health plans ("HDHPs") cannot offer any coverage to participants before they satisfy a minimum statutory deductible. While the IRS previously provided guidance that plans will not fail to be considered HDHPs because they cover COVID-19 testing and treatment before the deductible, that guidance was due to the PHE. The FAQs state that the same relief will remain in effect following the PHE until the IRS and Treasury release additional guidance, which will not require HDHPs to make any mid-plan year changes.

Outbreak Period

Certain time periods and deadlines for HIPAA special enrollments, COBRA continuation, and plan claims and appeals must be extended until the earlier of: 1) a period of one year or 2) the end of the Outbreak Period. The FAQs provide some examples illustrating the application of the end of the Outbreak Period (assuming a July 10, 2023 date), as summarized below. It should be noted that, as a result of President Biden's signed Bill, the Outbreak Period may end earlier than July 10, 2023.

Example 1: Electing COBRA

Facts: Individual A works for Employer X and participates in Employer X's group health plan. Individual A experiences a qualifying event for COBRA purposes and loses coverage on April 1, 2023. Individual A is eligible to elect COBRA

coverage under Employer X's plan and is provided a COBRA election notice on May 1, 2023. What is the deadline for Individual A to elect COBRA?

Conclusion: The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

Example 2: Paying COBRA Premiums

Facts: Individual B participates in Employer Y's group health plan. Individual B has a qualifying event and receives a COBRA election notice on October 1, 2022. Individual B elects COBRA continuation coverage on October 15, 2022, retroactive to October 1, 2022. When must Individual B make the initial COBRA premium payment and subsequent monthly COBRA premium payments?

Conclusion: Individual B has until 45 days after July 10, 2023 (the end of the Outbreak Period), which is August 24, 2023, to make the initial COBRA premium payment. The initial COBRA premium payment would include the monthly premium payments for October 2022 through July 2023. The premium payment for August 2023 must be paid by August 30, 2023 (the last day of the 30-day grace period for the August 2023 premium payment). Subsequent monthly COBRA premium payments would be due the first of each month, subject to a 30-day grace period.

Example 3: Special Enrollment Period

Facts: Individual C works for Employer Z. Individual C is eligible for Employer Z's group health plan, but previously declined participation. On April 1, 2023, Individual C gave birth and would like to enroll herself and the child in Employer Z's plan. However, open enrollment does not begin until November 15, 2023. When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as early as the date of the child's birth, April 1, 2023. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 10, 2023 (the end of the Outbreak Period), which is August 9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Employer Action

Employers should:

- Discuss benefit plan design changes with carriers and TPAs as they relate to the coverage for COVID-19 testing and treatment.
- Consider providing advance notice of the change to plan participants.
- Reach out to COBRA TPAs regarding sending out the notices.
- Await further guidance on the end date of the Outbreak Period.
- Be prepared for deadlines to begin to run earlier than expected.

ACA Preventive Care Court Ruling And FAQ

Issued date: 04/26/23

On April 13, 2023, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 59, providing guidance as it relates to the recent decision in Braidwood Management Inc. v. Becerra. In this case, a district federal court in Texas ruled that many of the ACA's preventive care mandates cannot be enforced nationwide.

Background

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC");
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Summary of the Case

Plaintiffs are six individuals and two businesses who challenge the legality of the preventive care mandates as violative of the Constitution's Appointments Clause and the Religious Freedom Restoration Act ("RFRA"), specifically as it relates to coverage for PrEP drugs (medication for HIV prevention), contraception, the HPV vaccine, and the screenings and behavioral counseling for STDs and drug use.

Among other things, the court in Braidwood ruled against the Departments and held that all agency action taken to implement or enforce the preventive care coverage requirements by the USPSTF (the "A" and "B" recommendations) on or after March 23, 2010, is unlawful and unenforceable nationwide. With respect to the RFRA claims, the court ruled in favor of the plaintiffs enjoining the Department from enforcing coverage as it relates to PrEP with respect to these plaintiffs. The court declined to strike down ACA mandates that provide coverage for contraception, HPV vaccine, and screenings related to STDs and drug use.

While the Department of Justice has filed an appeal and requested a stay of enforcement, the FAQs released provide initial guidance on the impact of the decision.

Effect on Plans

The decision merely enjoins the Departments from enforcing the preventive services requirements that were given an "A" or "B" rating by the USPTF on or after March 23, 2010. Importantly, the requirements to cover contraceptive services, preventive care and screenings, breastfeeding services and supplies, cervical cancer screening, and pediatric preventive care recommended by HRSA, in addition to immunizations recommended by ACIP, were not impacted by the decision. As such, non-grandfathered plans must continue to cover those services without member cost sharing.

While plans are not required to cover more recent "A" or "B" rated recommendations from the USPTF, the Departments strongly encourage plans to continue to do so without cost-sharing. In addition, the court's decision does not affect the application of state laws that may require fully insured plans to continue to cover such services.

However, if a plan chooses to eliminate the coverage or apply cost-sharing, it may require certain notices to participants. Any mid-year change to benefits that affects the content of the Summary of Benefits and Coverage ("SBC") requires a 60-day advanced notice. If the plan is subject to ERISA, it may also require a Summary of Material Reduction ("SMR") in benefits within 60 days following the reduction in coverage (the SMR requirements are met with the delivery of an updated SBC). If plans choose to do nothing, no participant notice is required.

Coverage of Coronavirus Vaccine

Since the ruling had no impact on immunizations recommended by ACIP, the order does not impact the requirement for plans to continue to cover the COVID-19 vaccine and any approved COVID-19 boosters without member cost-sharing.

Impact on High Deductible Health Plans

For a plan to be considered a high deductible health plan ("HDHP") (used in connection with a health savings account ("HSA")), it cannot provide any benefits before the applicable minimum deductible for that year has been satisfied. There is a safe harbor that allows an HDHP to cover certain preventive care before the deductible. While many of the preventive care services that the IRS includes in the safe harbor are also services that are covered by the USPTF recommendations, a plan will be able to continue the status quo until further guidance is issued. In other words, providing coverage for "A" and "B" recommended preventive care items and services before the deductible is met will not disqualify the HDHP or jeopardize an individual's HSA eligibility.

Employer Action

With the DOL appealing the court's decision, the litigation on these issues is not over. It could be the Supreme Court that ultimately decides whether the "A" and "B" recommendations of the USPTF can continue to be enforced. Moreover, further legal challenges may continue with respect to other aspects of the preventive care mandate, including coverage for contraceptives and ACIP recommendations on vaccines.

At this point, it is too early to tell whether carriers and plans will make broad changes to covered preventive care items and services as a result of the court's decision. If employers elect to make changes to their plans to eliminate coverage or apply cost-sharing with respect to the affected "A" and "B" items and services, they should abide by the respective notice requirements and do so in accordance with state law (fully insured plans). All employers should watch for further guidance clarifying uncertainties that exist as a result of this ruling.

IRS Explains High Standards For Substantiating FSA Claims

Issued date: 05/16/23

The IRS recently released a Chief Counsel Advice ("CCA") which addressed numerous situations regarding the substantiation of claims under a health flexible spending account ("FSA") and a dependent care FSA. A CCA is issued by the IRS's Office of Chief Counsel generally to an IRS field office in response to a request for assistance related to a taxpayer. While a CCA cannot be used or cited as precedent, it provides useful information on the Office's position on tax issues. Specifically, the IRS concluded in the CCA that when any expense of an employee is reimbursed by an FSA without being properly substantiated, the amount of the reimbursement is included in the gross income of such employee, including situations of:

- Expenses only self-certified by the employee;
- Substantiation only by random sampling;
- De minimis reimbursements without substantiation;
- No substantiation of charges from favored providers; and
- Advance substantiation for dependent care FSA expenses.

While the CCA does not reveal any new information, it serves as a reminder of the importance of proper substantiation of claims when using a health FSA and/or a dependent care FSA and the consequences for failing to have proper procedures in place.

Background

Internal Revenue Code sections 105(b), 125, and 129, and related regulations, set forth general rules allowing employers to set up FSAs for health care and dependent care expenses for employees, essentially through a cafeteria plan of an employer. If proper rules are followed:

- Employees can fund FSAs through salary reduction elections, which reduce their gross income for purposes of federal income taxes, state income taxes (most states), and FICA; and

- Employee expenses can be reimbursed for health care and dependent care expenses, including through the use of a debit card, and such reimbursements are not included in the employee's gross income.

A core component of the tax-favored treatment of these programs is that employees adequately substantiate all claims. Thus, the failure to meet the substantiation requirement can result in the loss of the employees' tax benefits from the FSA. Further, it can result in the cafeteria plan losing its tax-favored status – resulting in the loss of tax-favored treatment of employees' salary reduction elections for any benefits elected through the cafeteria plan.

The CCA

The CCA addressed two broad issues:

1. Must medical expenses reimbursed to an employee under a health FSA, where such expenses are not substantiated pursuant to guidance, be included in an employee's gross income?

2. Are expenses properly substantiated when certain short-cuts are allowed, or when dependent care expenses are substantiated only before they are incurred?

The CCA addressed six separate situations, one of which clarified what may be considered as compliant with substantiation requirements, and the other five illustrating situations that would fall short of meeting such requirements:

Example of meeting the substantiation requirements

A cafeteria plan with a health FSA and several features, all of which resulted in the IRS concluding the arrangement met substantiation requirements:

- Expenses are substantiated by information from an independent third party, which could include an explanation of benefits ("EOB") from an insurance company.

- The information describes:

  - The service or product;

  - The date of service or sale; and

  - The amount of the expense, including the employee's share through an EOB.

- The plan requires employees to certify that any expense paid by the plan has not been reimbursed by insurance or otherwise and that the employee will not seek reimbursement from any other plan covering health benefits.

- Debit cards can be used for reimbursements when meeting the requirements of proposed cafeteria plan regulations.

Examples of not meeting the substantiation requirements

- **Self-certification.** A health FSA that includes a feature where only the employee provides information regarding a claim for reimbursement of medical expenses, without a statement from an independent third party verifying the expenses, does not meet substantiation requirements. Notably, the CCA references the proposed regulation that prohibits self-substantiation of medical claims.

- **Sampling.** A health FSA with a debit card feature where the plan only requires substantiation of a random sample of charges. The CCA clarified that this too falls short of meeting substantiation requirements and included citation to guidance holding that sampling does not meet substantiation requirements.

- **De minimis.** A health FSA with a debit card feature does not require substantiation for charges below a specified dollar amount. Again, the CCA clarified that this fails to meet substantiation requirements and included a citation to a proposed regulation requiring substantiation for all claims, regardless of the amount.

- **Favored providers.** A health FSA with a debit card feature requires no substantiation for charges from certain dentists, doctors, hospitals, or other health care providers. The CCA emphasized that all claims must be substantiated.

- **Advance substantiation for dependent care FSA.** A dependent care FSA automatically reimburses employees for dependent care expenses when the employee has previously indicated such expenses would be incurred and the employee has not affirmatively notified the plan sponsor that such expenses were, in fact, incurred. The CCA makes clear that claims made in advance, without additional verification, do not meet substantiation requirements. It also notes the proposed regulations prohibit reimbursement of dependent care expenses before they have been incurred (i.e., merely formally being billed, or prepaying, is not sufficient) and without substantiating that they have been incurred.

Employer Action

While the substantiation requirements are not new, this is a good opportunity for employers to discuss and review substantiation procedures with FSA administrators, to ensure they are requiring full and proper substantiation of all claims for reimbursement, in keeping with existing guidance.

2024 Inflation Adjusted Amounts For HSAs

Issued date: 05/31//23

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying high deductible health plans ("HDHPs") effective for calendar year 2024, and the maximum amount that may be made available for excepted benefit health reimbursement arrangements ("HRAs"). All limits increased from the 2023 amounts.

Annual Contribution Limitation

For calendar year 2024, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$4,150**; the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$8,300**.

High Deductible Health Plan

For calendar year 2024, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,600 for self-only coverage** or **$3,200 for family coverage**, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $8,050 for self-only coverage** or **$16,100 for family coverage**.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Excepted Benefit HRA Adjustment

For plan years beginning in 2024, the maximum amount for an excepted benefit HRA that may be made newly available for the plan year is **$2,100**.

Fixed Indemnity Policy Proceeds Are Taxable To Employees

Issued date: 06/16//23

On June 9, 2023, the IRS issued guidance on the taxation of fixed-indemnity health insurance policies that provide payments to participating employees when they complete a health-related activity that is available at no cost or is covered by other insurance. These programs are often marketed as “no-cost wellness programs” that promote “tax free” reimbursements with the potential to provide significant payroll tax savings to employees and the employer. This guidance reinforces the IRS’ earlier concern about the tax treatment of these arrangements.

The guidance concludes that the employer must treat payments to employees under the fixed-indemnity policy as taxable wages.

Details About the Fixed-Indemnity Policy

According to the guidance, the employer, through this arrangement, maintains:

- a group health insurance policy that offers comprehensive health benefits, including preventive care (such as flu vaccinations) without cost-sharing, and
- a fixed-indemnity health insurance policy.

Employees may enroll in one or both options, or neither option. The fixed-indemnity policy has the following terms and conditions:

1. Each participating employee makes a monthly pre-tax contribution of $1,200 through the employer’s section 125 cafeteria plan to pay for the employee’s coverage under the fixed-indemnity policy.

1. The employer forwards the entire $1,200 contribution to the insurance carrier to pay the premium for the fixed-indemnity policy on the employee's behalf. The employer is not liable for any additional premium payments under the policy.

2. In return for the premium payment, the insurance carrier provides the following benefits to the employee under the fixed-indemnity policy:

    a. A benefit for each day that the employee is hospitalized.

    b. Wellness counseling, nutrition counseling, and telehealth benefits at no additional cost.

    c. Payment of $1,000 (limited to one payment per month) if the employee participates in certain health or wellness activities. The employee's use of preventive care (such as vaccinations), which are available without cost-sharing under the employer's comprehensive group health insurance policy, would qualify the employee for the payment, as would the free wellness counseling, nutrition counseling, and telehealth benefits that are available under the fixed-indemnity policy. The employee would be responsible for paying the cost of any other health or wellness activity that is intended to qualify the employee for the $1,000 payment.

4. When an employee qualifies for the $1,000 payment under the fixed-indemnity policy, the insurance carrier pays the money to the employer, which then pays the money to the employee via its payroll system.

Taxation of Payments Under the Fixed-Indemnity Policy

The IRS concludes in its guidance that the employer must treat the $1,000 payments to participating employees under the fixed-indemnity policy **as taxable wages**, because the payments are remuneration for employment under benefit plans funded by the employer through its section 125 cafeteria plan and exceed the amount of the actual expenses for medical care. Therefore, under Code sections 104 and 105, and accompanying regulations, the employer is required to report the payments as taxable income to the employees on IRS Form W-2, and to withhold income taxes and FICA taxes on the payments. The employer is also required to pay its share of FICA taxes, as well as FUTA taxes, on the payments.

Employer Action

Employers that may have implemented a fixed-indemnity program that provides "tax free" wellness benefits should carefully review the program in light of the recent IRS guidance and should work with their tax professionals to comply with the employer's tax reporting and collection responsibilities under this new guidance.

2023 PCOR Fee Filing Reminder For Self-Insured Plans

Issued date: 06/20/23

The Patient-Centered Outcomes Research ("PCOR") fee filing deadline is **July 31, 2023**, for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2022. Carriers are responsible for paying the fee for insured policies. The IRS issued Notice 2022-59 on November 14, 2022, announcing the adjusted fee amount for this year.

The plan years and associated PCOR fee amounts due July 31, 2023, are as follows:

Plan Year END Date	PCOR Fee Amount
January 31, 2022	$2.79/covered life/year
February 28, 2022	$2.79/covered life/year
March 31, 2022	$2.79/covered life/year
April 30, 2022	$2.79/covered life/year
May 31, 2022	$2.79/covered life/year
June 30, 2022	$2.79/covered life/year
July 31, 2022	$2.79/covered life/year
August 31, 2022	$2.79/covered life/year
September 30, 2022	$2.79/covered life/year
October 31, 2022	**$3.00/covered life/year**
November 30, 2022	**$3.00/covered life/year**
December 31, 2022	**$3.00/covered life/year**

Employers with self-funded health plans ending in 2022 should use the 2nd quarter Form 720 to file and pay the PCOR fee by July 31, 2023. The information is reported in Part II.

IRS Form 720 is a quarterly form that is used to report and pay many different taxes, including fuel and other transportation excise taxes. The IRS has adapted the Form 720 to be used for this annual reporting requirement. Each year, the PCOR section is updated with the fee rates in June for the July 31st due date (the 2nd quarter form).

Please note, Form 720 is a tax form (not an informational return form such as Form 5500), and as such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

Resources

For a copy of Notice 2022-59, visit https://www.irs.gov/pub/irs-drop/n-22-59.pdf

For a copy of the regulations, visit: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

For additional information, please visit the following IRS sites:

- Form 720, Quarterly Federal Excise Tax Return, instructions and forms: https://www.irs.gov/forms-pubs/about-form-720
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates

MHPAEA Exemption Ends for Self-Funded Governmental Health Plans

Issued date: 06/29//23

The Centers for Medicare and Medicaid Services ("CMS") released guidance to states, counties, school districts, municipalities, and other non-federal governmental entities that sponsor a self-funded group health plan, concerning the end of the optional exemption from the Mental Health Parity and Addiction Equity Act ("MHPAEA").

According to the CMS guidance, sponsors of a self-funded non-federal governmental group health plan that had previously opted out of MHPAEA are generally required to comply with the MHPAEA requirements beginning with the first plan year commencing on or after June 27, 2023. However, a special rule applies to collectively bargained plans which can result in a delay to the sunset date for a limited time if certain requirements are met.

Background

The sponsor of a self-funded non-federal governmental group health plan is generally permitted under the Health Insurance Portability and Accountability Act ("HIPAA") and the Affordable Care Act to make an election to opt-out of the following four requirements of the Public Health Services Act:

- Standards relating to benefits for newborns and mothers
- Required coverage for reconstructive surgery following a mastectomy
- Coverage for dependent students on a medically necessary leave of absence
- MHPAEA requirements

The Consolidated Appropriations Act of 2023, which was enacted into law on December 29, 2022, included a sunset provision that eliminates the ability of self-funded non-federal governmental group health plans to opt out of compliance with MHPAEA. As a result, sponsors of a self-funded non-federal governmental group health plan may only continue to opt out of the first three requirements of the Public Health Services Act set forth above. (Opt-out elections are not available for fully insured group health plans sponsored by a non-federal government entity.) MHPAEA generally requires that a group health plan provide mental health and substance use disorder benefits in parity with medical and surgical benefits in the same classification.

Sunset Date for the Opt-Out Election

According to the CMS guidance, no election to opt out of compliance with MHPAEA may be made by the sponsor of a self-funded non-federal governmental group health plan on or after December 29, 2022.

In addition, the CMS guidance states that no election to opt out of MHPAEA that expires on or after June 27, 2023 may be renewed, except as permitted under the special rule for collectively bargained plans.

Special Rule for Collectively Bargained Plans

The CMS guidance contains a special rule that applies to self-funded non-federal governmental group health plans that meet both of the following requirements:

- The plan is subject to multiple collective bargaining agreements of varying lengths; and
- The plan made an opt-out election for MHPAEA that was in effect on December 29, 2022, and that expires on or after June 27, 2023.

Under the special rule, collectively bargained plans that meet the above requirements may extend their election to opt out of MHPAEA until the date on which the term of the last collective bargaining agreement expires. To take advantage of this special rule, the sponsor must follow these steps:

1. The sponsor must send an email to CMS at HipaaOptOut@cms.hhs.gov, along with copies of the collective bargaining agreements and the self-funded group health plan document; the email must identify the effective date and termination date for each collective bargaining agreement, and the provisions which indicate that the collective bargaining agreements encompass the self-funded plan.

2. CMS will review the email and documents and notify the sponsor of its decision regarding application of the special rule to the sponsor's self-funded plan.

3. The sponsor must then submit a renewal opt-out (for MHPAEA) to CMS via HIOS by a specified date to extend the plan's existing opt-out. The renewal must be filed with CMS via HIOS before the first day of the plan year governed by the collective bargaining agreement, or by the 45th day after the latest applicable date of the term of the collective bargaining agreement (if the 45th day falls on or after the first day of the plan year).

4. The sponsor must also continue to comply with all other opt-out requirements, including the requirement to provide proper notice to enrollees.

Employer Action

The sponsor of a self-funded non-federal governmental group health plan that previously made an election to opt out of compliance with MHPAEA should take steps to make sure that the plan complies with MHPAEA's requirements by the sunset date for the opt-out election.

If the self-funded plan is subject to multiple collective bargaining agreements, the sponsor should work with its attorney or legal consultant to determine whether the special rule for a temporary extension of the opt-out election can apply to the plan. If the special rule can apply, the sponsor should follow the procedures outlined above to extend the opt-out election.

2023 State-Based Compliance: Quarter Two

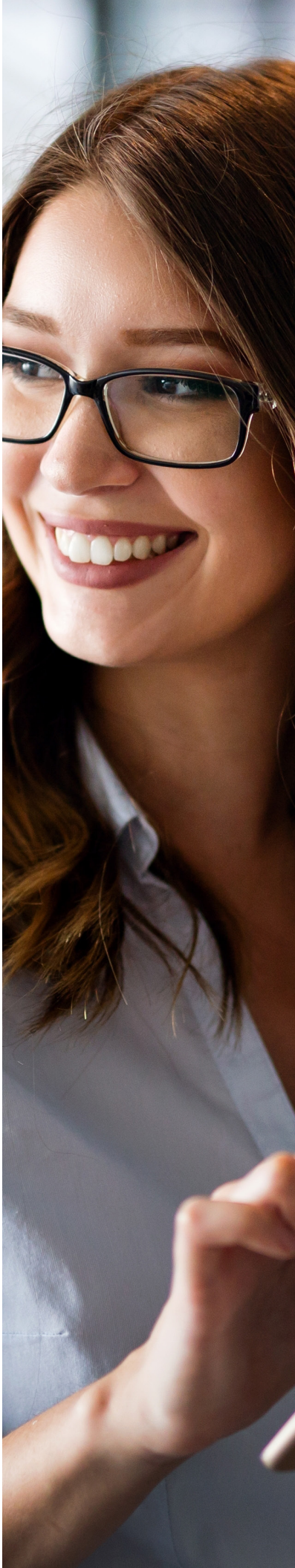
Minnesota

New Mexico

Oklahoma

Texas

Washington



Minnesota Passes Paid Family and Medical Leave Law

On May 25, 2023, Minnesota became the 12th state to provide paid family and medical leave ("PFML"). Starting January 1, 2026, eligible employees will be able to apply for up to 20 weeks of paid leave with the Minnesota Department of Employment and Economic Development ("DEED").

Covered Employers

Any employer with at least one employee working within Minnesota must provide PFML. This includes most private and public employers such as school districts and city/county public entities. Self-employed individuals and independent contractors may opt into the program. Seasonal hospitality employees (i.e., those that work less than 150 hours per year) are not eligible for PFML benefits.

Eligible Employees

Eligible employees have work and wage requirements. Eligible employees are those persons that either:

- Work at least 50% of their time within Minnesota;
- Do some of their work in Minnesota and reside within Minnesota for at least 50% of the calendar year; or
- Neither work or reside in Minnesota but the place where their work is directed from is located in Minnesota.

In addition, Minnesota employees must earn at least $3,500 in wages (from a single employer or multiple employers) within a period of 12 consecutive months prior to applying for paid leave.

Types of Leaves

The law classifies eligible leave into two categories (i) family leave, and (ii) other leave, with each providing up to 12 weeks of leave in a benefit period, although an employee may take up to 20 weeks of combined leave in a 12-month benefit period. The qualifying leave events are:

Family leave:

- Serious health condition for the employee.
- Pregnancy and parental leave, including bonding with a new biological, adopted or foster child.
- Care of family member's or military member's serious health condition.

Other leave:

- To care for self or family member's domestic assault, sexual assault, and/or stalking (includes legal assistance and household relocation).
- Qualifying exigencies, such as imminent departure of family member to active military duty.

To be eligible, the qualifying event must have an expected duration of at least seven days (except for bonding with a new child) and will be considered to be taken consecutively unless the event is identified as intermittent on the PFML application.

PFML defines "family member" as the employee's:

- spouse, domestic partner, child (including in loco parentis, legal guardian, and "de facto" parent), parent/legal guardian, sibling, grandparent (including spouse's grandparent), grandchild, son/daughter-in-law; and
- an individual who has a relationship with the applicant that creates an expectation and reliance that the applicant cares for the individual, whether or not the applicant and the individual reside together.

Additional guidance will be necessary on how to properly test or confirm the existence of such a relationship. Presumably, this broad definition incorporates leave for such persons as domestic partners, which is something that FMLA does not cover.

Contributions and Benefits

Starting January 1, 2026, employers will contribute 0.7% of employee wages, although employers can opt to pay the entire amount or elect to have employees pay up to 50% of the required premiums.

The PFML benefit is based upon a percentage of the employee's wages and the state's average weekly wage. Workers can expect to receive:

- 90% of their weekly wages that are less than or equal to 50% of the stage's average weekly wage);
- 66% of their weekly wages that is greater than 50% of the state's average weekly wage but less than 100% of the state average weekly wage; or
- 55% of their weekly wages that is more than 100% of the state average weekly wages.

An employer cannot require that the employee use their accrued PTO, sick and/or vacation time at the same time as PFML or instead of PFML Employees can however choose to use their accrued paid time off ("PTO"), sick and/or vacation time instead of the PFML and the PFML protections will still be in effect for the individual. An employer can choose to provide supplemental benefit payments to compensate employees to their normal compensation amounts.

Starting July 1, 2025, employers will be able to substitute state-approved private plans instead of participating in the state program. Additional guidance on the process will be forthcoming but private plans are expected to include a surety bond.

Notice Requirements and Retaliation Prohibition

Employers are required to post a notice in the workplace about the PFML in both English and the primary language of 5 or more employees. Employers are also required to provide newly hired employees with written notice on their expected PFML benefit amount and instructions on how to apply for the benefits. DEED is expected to produce a template for employers.

Employees are required to provide notice to the employer at least 30 days in advance of their intent to apply for a foreseeable leave or as soon as practicable for an unforeseeable leave. The employer can still require the employee to follow their normal call-in/reporting procedures if they do not unnecessarily interfere with the employee's ability to apply for the leave.

Employers are prohibited from retaliating against employees for utilizing their paid leave. Employees that were hired at least 90 days prior to using their leave have the right to be reinstated with their employer into either their same job or an equivalent job. Similar to FMLA, employees retain access to their health insurance while on paid leave.

Employer Action

Employers should begin to determine if they have employees that will be eligible for this future leave benefit. Creating a process to track eligibility would be prudent and to develop a process to provide the required written notice to new hires.

Employers may want to review their existing leave policies and handbooks to see if there is any potential overlap with the new requirements. This may be especially important for multi-state employers that have attempted to create uniform leave policies to satisfy the different leave laws in these jurisdictions.

DEED is currently drafting frequently asked questions and additional guidance for employers and employees. Employers may want to sign up for their newsletters to keep up with the most recent updates.

New Mexico to Continue COVID-19 Coverage After Emergency Ends

With the federal Public Health Emergency ending May 11, 2023, many plans will be adding patient cost sharing for COVID-19 testing. However, some states require insurance policies issued in their state to continue to cover COVID-19 testing with no patient cost share. New Mexico is one of those states.

COVID-19 and Flu-Related Coverage

The change began with an emergency order from the Office of Superintendent of Insurance (of New Mexico). New Mexico since enacted a state insurance law that prohibits any cost sharing requirement for the provision of testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency. For purposes of this rule, a public health emergency exists when declared by the state of New Mexico or the federal government. Even though the federal Public Emergency is ending May 11, 2023, and the New Mexico state Emergency Period is ending March 31, 2023, this rule applies permanently, unless amended.

Application to Group Health Plans

The New Mexico insurance law requirement set forth above applies to group health insurance policies (includes HMOs) issued or delivered (i.e., situsued) in New Mexico. The New Mexico law does not apply to fully insured plans written outside New Mexico or to self-funded medical plans.

Employer Action

Employers that maintain a fully insured group health plan situsued in New Mexico should be aware of the requirements of this New Mexico insurance law.

Status of Oklahoma's Patient's Right to Pharmacy Choice Act

In 2019, Oklahoma passed the Patient's Right to Pharmacy Choice Act (the "Act") which restricts what pharmacy benefit managers ("PBMs") can do. This article summarizes the Act and describes where it is today given an update, a legal challenge, and an enforcement action.

The Act

In part, under the Act, PBMs must comply with certain retail pharmacy network access standards and cannot:

- use mail-order pharmacies to meet access network access standards;
- restrict an individual's choice of an in-network provider for prescription drugs;
- incentivize patients to fill prescriptions through mail order rather than their pharmacy of choice;
- require patients to use pharmacies that are directly or indirectly owned by the PBM;
- deny a pharmacy the opportunity to participate in any pharmacy network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies; or
- restrict any pharmacy from informing an individual of any differential between the individual's out-of-pocket cost outside insurance.

It was effective September 1, 2020.

In April 2022, SB 737 updated the Act to prohibit spread pricing in Oklahoma, effective immediately. Oklahoma statutes define spread pricing as a prescription drug pricing model in which the PBM charges a health benefit plan a contracted price for prescription drugs that differs from the amount the PBM directly or indirectly pays the pharmacy or pharmacist.

Preemption

The Act was challenged by the Pharmaceutical Care Management Association ("PCMA"), the trade lobby for PBMs, as being preempted by ERISA. In April 2022, the federal district court concluded that there is no "connection with" an ERISA plan. Previously, the U.S. Supreme Court unanimously upheld a similar Arkansas law regulating PBMs against an ERISA preemption challenge in Rutledge v. PCMA, 141 S. Ct. 474 (2020). PCMA has appealed to the U.S. Tenth Circuit Court of Appeals. Oral arguments occurred on May 16, 2023 and a decision is expected in the near future.

Jurisdiction

Although the court did not specifically address the precise application, the view of the Oklahoma Insurance Department ("OID") is that the law is intended to protect all Oklahoma residents, regardless of whether the plan involved is:

- an Oklahoma based plan; or
- an out-of-state plan providing coverage to Oklahoma residents.

This includes self-funded plans.

Enforcement Action

The OID is taking enforcement action against PBMs operating in violation of the Act, even while it is being challenged in the courts. On January 20, 2022, the OID announced that it entered into a Settlement Agreement with CVS Caremark regarding its collection of transaction fees from pharmacies for Medicare Part D and ERISA plan claims. Under the terms of the agreement, CVS Caremark paid the state of Oklahoma $4.8 million. In addition, letters were supposed to be sent out by CVS Caremark to consumers explaining their options for prescriptions. Instead, in March 2023, CVS Caremark claimed that the law does not allow for the filling of 90-day supply prescriptions and turned off mail service access for all Oklahoma-based members. CVS then revisited this position and now allows 90-day fills at any willing pharmacies. To their understanding of OID requirements, this benefit design is opened up to allow any willing pharmacy to dispense a 90-day supply of drugs – including CVS's own mail order pharmacy.

Employer Action

No action is required, but employers may want to keep their eye on this law and similar laws affecting their benefit program offerings.

Texas' Implementation of the Federal No Surprises Act

The federal No Surprises Act ("NSA") prohibits balance billing in certain circumstances where there are out-of-network ("OON") charges and applies to all medical plans. Texas has a similar law that currently applies only to insured medical plans in Texas. Note that this does not include level-funded health plans, but does include non-federal governmental plans that are not subject to Texas' balance billing laws which may include plans for employees of state universities, and school districts that have opted out of participation in the Teacher Retirement System health plan

Texas HB 1592 was signed into law on June 14, 2023, and allows ERISA-covered self-funded medical plans to utilize Texas' balance billing and out-of-network dispute resolution requirements, effective September 1, 2023. A self-funded health plan would need to submit an annual election opting into the state's balance billing protections to the Texas Insurance Commissioner ("Commissioner"). The form and manner are not yet determined, but, not later than December 1, 2023, the Commissioner must adopt rules necessary to implement the change in law.

The following is a chart summarizing how each system works:

	Federal	Texas	Comments
Covered services	• Emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved. • Non-emergency services performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers). • Air ambulance services provided by OON providers. There is a limited exception as it relates to certain non-emergency and non-ancillary services where informed consent is obtained.	• Emergency care provided in a hospital emergency facility, free-standing emergency medical care facility, or comparable emergency facility. • Services provided by out-of-network providers at in-network facilities. • Out-of-network pathology/ laboratory services when the provider has not disclosed the price to the patient. • Radiology imaging that includes CTs, PET Scans, MRIs, or any combination of those technologies when the provider has not disclosed the price to the patient.	The types of covered services are very similar except that Texas does not handle air ambulance charges and in Texas, patients cannot waive their rights against balance billing.

		The Federal IDR process applies to air ambulance services furnished by OON providers.	
Initial payment	The initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan.	The initial payment is the usual and customary rate.	
Time to initiate independent dispute resolution (IDR)	If initial payment is not accepted, 30 days is given to begin a 30-day open negotiation period. If no agreement is reached, there are 4 days to declare initiation of IDR.	After 20 days from the date payment is received, either party can submit a case into the Texas IDR process.	
Arbitrator selection	The provider and plan jointly select an arbitrator within 3 business days after initiation of IDR. Otherwise, the Departments of the Treasury, Labor, and Health and Human Services select an arbitrator.	There are 30 days to select arbitrator by mutual agreement. Otherwise, the Texas Department of Insurance selects an arbitrator.	
Factors considered	1. The level of training, experience, and quality and outcomes measurements of the provider that furnished the item or service. Credible information should demonstrate the experience or level of training of a provider was necessary for providing the qualified IDR item or service to the patient, or that their experience or training made an impact on the care that was provided.	1. Whether there is a gross disparity between the fee billed by the out-of-network provider and: a. fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and	

	2. The market share held by the non-participating provider or the plan in the geographic region in which the item or service was provided. Credible information should demonstrate how the market share affects the appropriate out-of-network rate. 3. The acuity of the individual receiving the item or service or the complexity of furnishing the item or service to the individual; the teaching status, case mix, and scope of services of the nonparticipating facility that furnished the item or service. Credible information should demonstrate how patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee affects the appropriate out-of-network rate for the qualified IDR item or service. 4. Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or the plan to enter into network agreements and, if applicable, contracted rates during the previous four plan years. For example, a certified IDR entity should consider what the contracted rate might have been had the good faith negotiations resulted in the out-of-network provider or facility	b. fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region; 2. The level of training, education, and experience of the out-of-network provider; 3. The out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider; 4. The circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply; 5. Individual enrollee characteristics; 6. The 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database; 7. The 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area;	

	being in-network, if a party is able to provide related credible information of good faith efforts or the lack thereof.	8. The history of network contracting between the parties; 9. Historical data for the percentiles described by (6) and (7) above; and 10. An offer made during the required informal settlement teleconference.	
Style of negotiation	Baseball style arbitration	Baseball style arbitration	Baseball style arbitration means that either the provider's requested amount or the TPA's/carrier's requested amount is chosen by the arbitrator; an amount between the two or any other amount is not an option.

Employer Action

No employer action is required. Employers with self-funded medical plans considering opting into the Texas system should await additional guidance.

Coverage for Hearing Instruments Under New Washington Law

Under a new Washington insurance law, non-grandfathered large group health plans issued or renewed on or after January 1, 2024, will be required to provide coverage for hearing instruments, except over-the-counter ("OTC") instruments, including bone-conduction hearing devices. This requirement also applies to health plans offered to public employees and their dependents issued or renewed on or after January 1, 2024.

This coverage requirement does not apply to:

- Small group insurance; and
- ERISA self-funded group health plans.

Briefly:

- Coverage must include the hearing instrument, the initial assessment, fitting, adjustment, auditory training, and ear molds, as necessary, to maintain optimal fit.
- Coverage must be provided at no less than $3,000 per ear with hearing loss every 36 months.
- The benefit is not subject to the deductible. There is an exception for qualified high deductible health plans ("HDHP") used with a health savings account ("HSA"). In this case, the carrier may apply a deductible to the coverage, but only at the minimum level necessary to preserve HSA eligibility.
- Coverage for minors under age 18 is only available after the child has received medical clearance within the preceding 6 months from:
  - An otolaryngologist for an initial evaluation of hearing loss; or
  - A licensed physician, which indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

Employer Action

Large employers with fully insured group health plans in Washington should anticipate this new coverage requirement with their first renewal on or after January 1, 2024.

Health plans offered to public employees should review existing coverage and update for applicable changes with the first renewal on or after January 1, 2024.

It's unlikely this coverage change will materially impact rates.

Expect to see additional communications from your carriers as renewal approaches.

WA Cares Fund Payroll Tax Begins July 1, 2023

As previously reported, beginning July 1, 2023, a 0.58% premium assessment applies on the wages of all Washington employees to fund Washington's Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund"). All wages are subject to the premium assessment; there is no cap. The WA Cares premium is paid by employees via a payroll tax, there is no required employer contribution.

After an initial delay by the state legislature, employees will begin paying the premium assessment on July 1, 2023. Recent efforts to repeal the program failed in the last legislative session.

Unless an employee has an approved exemption, employers should deduct premiums from each paycheck an employee receives on or after July 1, 2023, regardless of when the hours were earned.

Quarterly, employers must report employees' wages and hours and remit collected premiums to the Employment Security Department ("ESD"). The first report and premium payment for the WA Cares Fund is due by October 31, 2023 (for July, August, and September 2023 payroll). WA Cares premiums are collected in the same manner as premiums for Washington's Paid Family and Medical Leave program. ESD is updating the Paid Leave reporting system so employers can report for both programs at the same time.

ESD has developed materials that will be helpful to employers in understanding and communicating information about the WA Cares Fund. Much of this information can be found under the Employer link on the WA Cares Fund website https://wacaresfund.wa.gov/employers/, including an employer toolkit and helpful FAQs.

Employer Action

Employers should coordinate with payroll for processing and reporting for the WA Cares Fund.

Washington State Increases 2024 PAL Assessment

The Washington Health Care Authority ("HCA") will increase the PAL assessment amount for fiscal year 2024 to $0.07 per covered life per month (increased from $0.06) effective for payments due on November 15, 2023.

Background

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021. Washington's HCA is responsible for the enforcement of this provision.

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

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

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services.

The assessment applies monthly and is paid quarterly following the end of the calendar quarter. Each year, HCA holds a rate-setting meeting to recommend the monthly assessment for the next fiscal year. The 2024 assessment of $0.07 applies with respect to payments due November 15, 2023, February 15, 2024, May 15, 2024, and August 15, 2024.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at:

- the current 2023 rate of $0.06 for the payment due August 15, 2023, and
- the higher 2024 rate of $0.07 for the payment due on November 15, 2023

A third-party administrator ("TPA") may be assisting with this process.

Carriers are responsible for the payment for fully insured group health plans. No employer action is necessary.

2023 Compliance Bulletins: Quarter Three

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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).
  fixed-indemnity policy on the employee's behalf. The employer is not liable for any additional premium payments under the policy.

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.

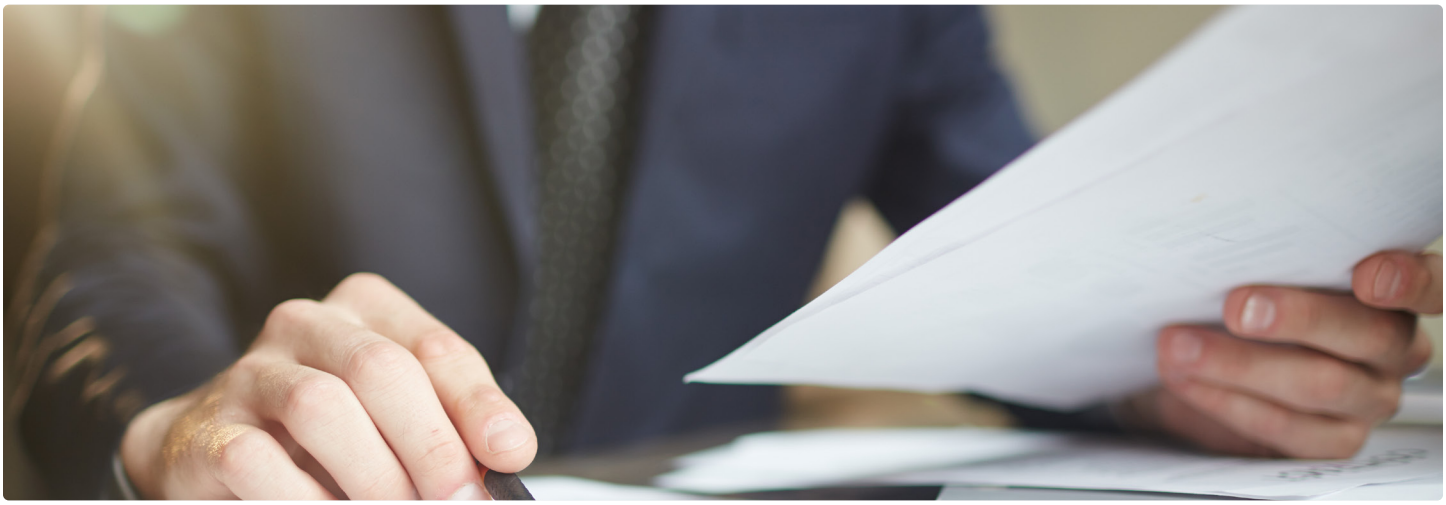
Employer Action

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.

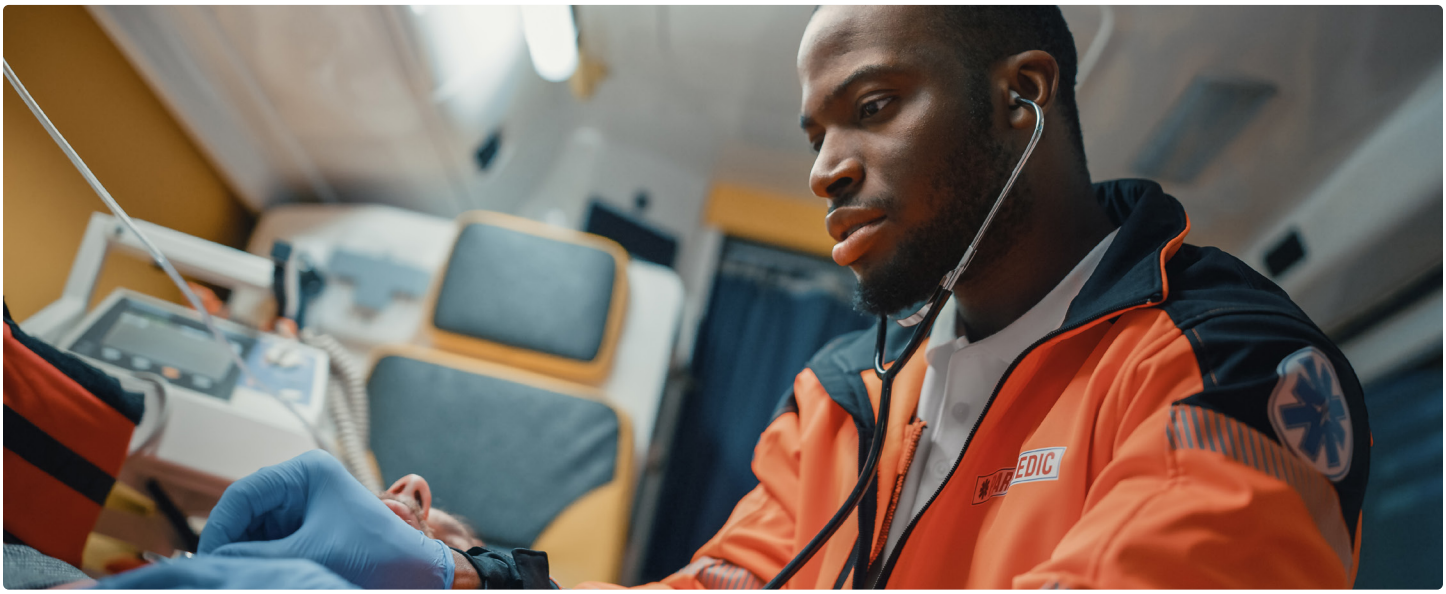
If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

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.

DOL Releases Final Rule To Update The Davis Bacon And Related Acts

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.

New York Paid Family Leave 2024 Contributions and Benefits

Issued date: 09/27/23

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.

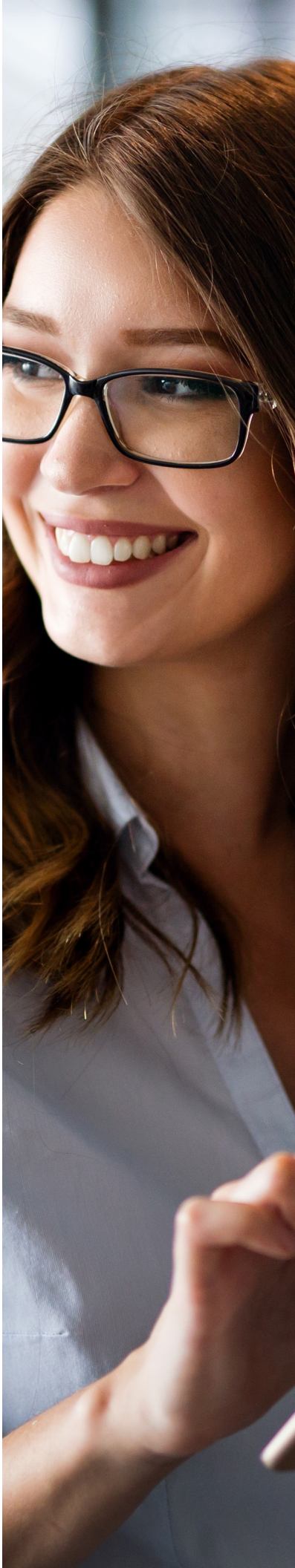
- If an employee begins intermittent leave in 2023 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2024 and the benefit is calculated at the 2024 rate.

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.

2023 State-Based Compliance: Quarter Three

2023 State Bulletins



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.

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.

2023 Compliance Bulletins: Quarter Four

October

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Massachusetts Paid Family Leave 2024 Contributions and Benefits

Issued date: 10/10/23

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2024. The DFML has also published the FY2023 Annual Report for the PFML program.

Contributions

The 2024 contribution rate on eligible wages will be 0.88% (adjusted up from the 2023 rate of 0.63%). Individual contributions are capped by the Social Security income limit. The 2024 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2023 limit which is currently set at $160,200.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2024:

- Medical Leave Contribution: 0.70% of eligible wages allocated as follows:
  - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
  - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).

- Family Leave Contributions: 0.18% of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2024 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- The portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- The portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2024:

- The MAAWW will be $1,796.72, an increase of 1.8% from the 2023 MAAWW of $1,765.34.
- The maximum weekly PFML benefit will be $1,144.90, an increase of 1.3% from the maximum weekly benefit of $1,129.82 in 2023.

Fiscal Year 2023 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2023.

Employer Action

Employers should prepare for the 2024 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2024. Updated workplace posters and notifications for the 2024 contribution rates and benefit amounts will be available to employers on the PFML website soon.

Illinois Enacts the Transportation Benefits Program Act

Issued date: 10/11/23

Illinois signed into law the Transportation Benefits Program Act [Public Act 103-0291] (the "Act") on July 28, 2023. Set to take effect January 1, 2024, the Act requires certain covered employers in Illinois to allow covered employees the option to exclude from taxable wages the employee's commuting costs for the purchase of a transit pass to use public transit or for the purchase of qualified parking, up to the maximum amount permitted under federal law.

Covered Employers

A covered employer under the Act is one that meets all the following requirements:

- Employs 50 or more full-time employees (works at least thirty-five hours per week and receives compensation on a full-time basis;
- The 50 or more full-time employees are employed at an address that is within one of the specified geographic areas; and,
- That location is within 1 mile of a fixed-route transit service run by the Regional Transportation Authority (RTA).

The physical address must be within 1 mile of a fixed-route transit service in one of the following areas:

- Addison Township
- Algonquin Township
- Aurora Township
- Avon Township
- Batavia Township
- Benton Township
- Bloomingdale Township
- Cook County
- Deerfield Township
- Downers Grove Township
- Dundee Township
- DuPage Township
- Elgin Township
- Frankfort Township in Will County
- Geneva Township
- Grant Township in Lake County
- Homer Township
- Joliet Township
- Libertyville Township
- Lisle Township
- Lockport Township
- McHenry Township
- Milton Township
- Naperville Township
- New Lenox Township
- Nunda Township
- Plainfield Township
- Shields Township
- St. Charles Township
- Troy Township
- Vernon Township
- Warren Township in Lake County
- Waukegan Township
- West Deerfield Township
- Wheatland Township in Will County
- Winfield Township
- York Township
- Zion Township

Covered Employees

A full-time employee working at a location meeting the above-referenced criteria is covered by the Act and must be allowed to payroll deduct contributions towards a transit pass. While an employer may choose to extend such a program to employees at all locations, the Act only applies to those locations that employ 50 or more covered employees. The employee must be eligible to participate in the transit program beginning the employee's first full pay period following 120 days of employment.

Employer Action

It is unclear whether the 120-day employment period before a covered employee must be able to participate in a qualified transit program will begin accruing after the law takes effect January 1st, 2024, or if employment leading up to the effective date will also be counted for this purpose. As such, conservative covered employers may wish to ensure a program is in effect for January 1st, 2024. Compliant programs are offered by the CTA and the RTA, as well as many third-party vendors.

Reminder: Massachusetts HIRD Reporting Due December 15, 2023

Issued date: 10/17/23

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure (HIRD) form through the MassTaxConnect (MTC) web portal. The HIRD reporting will be available to be filed starting November 15th and **must be completed by December 15th.**

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer **with six or more employees in Massachusetts** to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form.

- An individual is your employee if you, as the employer, included such individual in your quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- If you are an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is your employee if they are hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: https://www.mass.gov/info-details/masshealth-premium-assistance-pa.

Court Vacates Drug Manufacturer Coupon Cost-Sharing Rule

Issued date: 10/19/23

On September 29, 2023, the District Court for the District of Columbia vacated a Department of Health and Human Services ("HHS") rule that permitted (but did not require) group health plans and health insurance carriers to count manufacturer coupons toward the plan's cost-sharing.

As a result, HHS has been directed to reconsider the rules based on the Court's decision.

Background

Some drug manufacturers offer financial support (e.g., a coupon) to patients to help pay for certain prescription drugs.

Prior to the issuance of guidance, there were questions as to whether these coupons (and other reimbursements) apply to the participant's cost-sharing under the terms of the plan. For example, suppose the standard cost for a particular drug is $1,000, but the manufacturer provides a coupon for $600. The unsettled question has been whether the participant should receive credit towards the plan's out-of-pocket maximum ("OOPM") for the $400 that the participant actually paid for the drug, or the drug's actual cost of $1,000.

In 2019, HHS issued a final rule that clarified plans do not have to count the value of drug manufacturer coupons towards a participant's out-of-pocket calculations if a medically appropriate generic drug is available. Though not specifically stated, the language in the rule suggested that if a medically appropriate generic drug is not available, plans would need to count these coupons when calculating a participant's cost-sharing. This interpretation raised a conflict for qualified high deductible health plans ("HDHPs") that are compatible with health savings accounts ("HSAs"), because crediting the

coupon towards the deductible may be considered non-HDHP coverage that disqualifies a participant from being eligible to make or receive HSA contributions.

Subsequently, the Departments of Labor ("DOL"), the Treasury, and HHS (collectively, "the Departments") issued FAQ Part 40. The Departments recognized the HDHP/HSA conflict and announced they would not initiate enforcement action if a group health plan excludes the value of drug manufacturers' coupons from the OOPM calculation, even where there is no medically appropriate generic equivalent available. This non-enforcement position remained in effect until further guidance was issued.

In May 2020, HHS published the Notice of Benefit and Payment Parameters 2021 ("NBPP 2021"), a final rule that included a clarification on how drug manufacturer support, including coupons, may accrue towards the OOPM. Under the clarified policy, health insurance carriers and group health plans were permitted, but not required, to count any form of financial support offered by drug manufacturers to enrollees for specific prescription drugs toward the deductible and annual out-of-pocket maximums, to the extent consistent with state law.

It should be noted that with this permissive language, HDHP participants could retain HSA eligibility if drug manufacturer coupons were not credited toward the HDHP minimum statutory deductible.

Court Decision

Three advocacy groups, along with three individuals, challenged the NBPP 2021 drug manufacturer support rule in a lawsuit. The plaintiffs argued that:

- the rule conflicts with both the Affordable Care Act's ("ACA") statutory definition of "cost-sharing" and the pre-existing regulatory definition of that term, and

- the rule is arbitrary and capricious for a variety of reasons, including that the same statutory and regulatory language is defined in two conflicting ways.

The Court agreed with the plaintiffs, setting aside the NBPP 2021 drug manufacturer support rule based on both its contradictory reading of the same statutory and regulatory language, and the fact that the agencies have yet to offer a definitive interpretation of the term "cost-sharing" as applied to manufacturer assistance.

The Court directed HHS to reconsider the NBPP 2021 rule in a manner consistent with the Court's decision.

New PCOR Fee Announced

Issued date: 10/20/23

On October 18, 2023, the IRS released Notice 2023-70, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2023, and before October 1, 2024, is $3.22.

The PCOR filing deadline is July 31, 2024, for all self-funded medical plans (including level-funded) and some HRAs for plan years (including short plan years) ending in 2023. Carriers are responsible for paying the fee for insured policies.

PCOR Fee due by July 31, 2024:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2023	$3.00/covered life/year
February 28, 2023	$3.00/covered life/year
March 31, 2023	$3.00/covered life/year
April 30, 2023	$3.00/covered life/year
May 31, 2023	$3.00/covered life/year
June 30, 2023	$3.00/covered life/year
July 31, 2023	$3.00/covered life/year
August 31, 2023	$3.00/covered life/year
September 30, 2023	$3.00/covered life/year
October 31, 2023	**$3.22/covered life/year**

November 30, 2023	**$3.22/covered life/year**
December 31, 2023	**$3.22/covered life/year**

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in mid-2024 of the fee and additional information for filing and paying the PCOR fee with the IRS.

It should be noted that we have seen increased enforcement activity from the IRS around missing PCOR fees. Specifically, the IRS is issuing CP161 notices to employers who appear to have missed a prior year PCOR fee filing, requesting payment (including interest and penalties).

HHS Penalties Increase for 2023

Issued date: 10/23/23

The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "Inflation Adjustment Act") directs federal agencies to adjust the civil monetary penalties for inflation. On October 6, 2023, the Department of Health and Human Services ("HHS") issued final rules adjusting civil monetary penalties for inflation.

The adjusted penalties are applicable to penalties assessed on or after October 6, 2023 (assuming the violation occurred on or after November 2, 2015, when the Inflation Adjustment Act was enacted).

Updated Penalties

The following chart contains the updated penalties applicable to group health plans:

Description	2022 Penalty (Prior)	2023 Penalty (New)
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$174 per violation $43,678 annual cap	$187 per violation $47,061 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision without knowledge	$127 min. $63,973 max. $1,919,173 annual cap	$137 min. $68,928 max. $2,067,813 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision with reasonable cause and not due to willful neglect	$1,280 min. $63,973 max. $1,919,173 annual cap	$1,379 min. $68,928 max. $2,067,813 annual cap

February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$12,794 min. $63,973 max. $1,919,173 annual cap	$13,785 min. $68,928 max. $2,067,813 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$63,973 min. $1,919,173 max. $1,919,173 annual cap	$68,928 min. $2,067,813 max. $2,067,813 annual cap
Failure to provide the Summary of Benefits and Coverage ("SBC")	$1,264	$1,362
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$10,360	$11,162
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the plan was primary payer to Medicare	$1,325	$1,428

Employer Action

Covered entities (health care plans, health care clearinghouses and health care providers) must ensure proper application and compliance with HIPAA's Privacy and Security Rules.

Employers should avoid using incentives to discourage Medicare/Medicaid eligible employees from enrolling in the employer's health plan.

Employers should be aware of the SBC disclosure requirement and ensure employees receive SBCs in a timely fashion (e.g., in connection with open enrollment).

Final 2023 ACA Reporting Instructions and Forms Issued

Issued date: 10/31/23

The IRS released final instructions and forms for calendar year 2023 ACA reporting, including Forms 1094-C, 1095-C, 1094-B, and 1095-B. As a reminder, it is important to ensure the forms are filed accurately and timely with both the IRS and as distributed to employees, as good faith relief from penalties is no longer available.

Forms 1094-C/1095-C

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

The calendar year 2023 Form 1095-C must be furnished to full-time employees and other individuals by **Friday, March 1, 2024**. This deadline usually falls on March 2, except in a leap year when the date is March 1. The Form 1094-C and all Forms 1095-C must be filed with the IRS electronically by **Monday, April 1, 2024**.

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2023 in preparation to complete, furnish and file these forms for 2023.

Forms 1094-B/1095-B

Employers that are not ALEs and offer self-funded group health plan coverage (including level-funded plans) must furnish and file forms regarding minimum essential coverage. Specifically, as the provider of the self-funded plan, the employer reports to the IRS and all covered individuals (e.g., employees, COBRA qualified beneficiaries, spouses, dependents) the coverage they had during the calendar year. To meet this requirement, employers use Forms 1094-B and 1095-B.

The calendar year 2023 Form 1095-B must be furnished to covered individuals by **Friday, March 1, 2024**. The Form 1094-B and all Forms 1095-B must be filed with the IRS electronically by **Monday, April 1, 2024**. Very few employers will be able to file by paper with the IRS, as set forth below. If eligible, paper filing is due by February 28, 2024.

Employers should coordinate with payroll or other reporting vendors to assist in this process.

What's New

While there are no significant changes to the 2023 forms, most employers will be required to file the forms electronically with the IRS. In addition, the penalties for failures have increased.

Electronic Filing Required (10+ Forms)

Employers required to file 10 or more information returns (e.g., Forms W-2, 1094-C, 1095-C, 1094-B, 1095-B) during the year must file these forms electronically on or after January 1, 2024. Previously, the IRS allowed employers filing fewer than 250 returns to file hard-copy (paper) forms.

The IRS also encourages employers filing fewer than 10 returns to consider electronic filing.

2023 Penalties

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. Good faith relief is no longer available. However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2023, the following penalties may apply:

- Failure to file a correct return is $310/statement (total calendar year penalty not to exceed $3,783,000).
- Failure to furnish a correct statement is $310/statement (total calendar year penalty not to exceed $3,783,000).

It should be noted that an employer that fails to both file and furnish a correct statement is subject to a combined penalty of $620/statement with a maximum penalty of $7,566,000.

Employer Action

It is important to identify vendors, like payroll or other reporting administrators, to assist in this process especially as most employers will be required to file forms electronically with the IRS. A health plan carrier typically does not prepare this reporting.

ALEs should begin preparing and ensure that Form 1095-C is furnished to full-time employees and other individuals by **March 1, 2024**. Form 1094-C and all Forms 1095-C should be electronically filed with the IRS by **April 1, 2024**.

Employers that are not ALEs but offer self-funded group health plan coverage should ensure a process is in place for furnishing and filings Forms 1094-B and 1095-B. Form 1095-B must be furnished to covered individuals by **March 1, 2024**, and all forms 1095-B along with Form 1094-B must be electronically filed with the IRS by **April 1, 2024**.

Employers should be certain the statements are complete and accurate since good faith relief is no longer available.

Employers may have additional reporting obligations for employees residing in states with an individual mandate (California, Massachusetts, New Jersey, Rhode Island, Vermont, Washington D.C.). Ensure vendors will assist with state reporting obligations.

Minnesota's New Leave Laws

Issued date: 11/01/23

On May 25, 2023, Minnesota became the 12th state to provide paid family and medical leave ("PFML"). Starting January 1, 2026, eligible employees will be able to apply for up to 20 weeks of paid leave with the Minnesota Department of Employment and Economic Development ("DEED").

In addition, beginning January 1, 2024, most employees that work within Minnesota will become eligible for a new paid sick leave benefit under the Minnesota Earned Sick and Safe Time Leave Law ("ESST"). ESST will supplant the prior Minnesota paid leave law, which allowed an employee the option to use their own personal sick leave benefits for related purposes and will sunset effective December 31, 2023.

Minnesota Paid Family and Medical Leave Law

Covered Employers

Any employer with at least one employee working within Minnesota must provide PFML. This includes most private and public employers such as school districts and city/county public entities. Self-employed individuals and independent contractors may opt into the program. Seasonal hospitality employees (i.e., those that work less than 150 hours per year) are not eligible for PFML benefits.

Eligible Employees

Eligible employees have work and wage requirements. Eligible employees are those persons that either:

- Work at least 50% of their time within Minnesota;
- Do some of their work in Minnesota and reside within Minnesota for at least 50% of the calendar year; or
- Neither work or reside in Minnesota but the place where their work is directed from is located in Minnesota.

In addition, Minnesota employees must earn at least $3,500 in wages (from a single employer or multiple employers) within a period of 12 consecutive months prior to applying for paid leave.

Types of Leaves

The law classifies eligible leave into two categories (i) family leave, and (ii) other leave, with each providing up to 12 weeks of leave in a benefit period, although an employee may take up to 20 weeks of combined leave in a 12-month benefit period. The qualifying leave events are:

Family leave:

- Serious health condition for the employee.
- Pregnancy and parental leave, including bonding with a new biological, adopted or foster child.
- Care of family member's or military member's serious health condition.

Other leave:

- To care for self or family member's domestic assault, sexual assault, and/or stalking (includes legal assistance and household relocation).
- Qualifying exigencies, such as imminent departure of family member to active military duty.

To be eligible, the qualifying event must have an expected duration of at least seven days (except for bonding with a new child) and will be considered to be taken consecutively unless the event is identified as intermittent on the PFML application.

PFML defines "family member" as the employee's:

- spouse, domestic partner, child (including in loco parentis, legal guardian, and "de facto" parent), parent/legal guardian, sibling, grandparent (including spouse's grandparent), grandchild, son/daughter-in-law; and
- an individual who has a relationship with the applicant that creates an expectation and reliance that the applicant cares for the individual, whether or not the applicant and the individual reside together.

Additional guidance will be necessary on how to properly test or confirm the existence of such a relationship. Presumably, this broad definition incorporates leave for such persons as domestic partners, which is something that FMLA does not cover.

Contributions and Benefits

Starting mid-2024, covered employers will commence submitting wage detail reports to DEED. These reports will outline the quarterly wages paid to PFML eligible employee and their hours worked.

In 2025, employers will be required to provide notices to employees that outline the PFML, including eligibility requirements and how to request leave. DEED will provide language for these notices closer to their distribution deadline.

Starting January 1, 2026, employers will contribute 0.7% of employee wages, although employers can opt to pay the entire amount or elect to have employees pay up to 50% of the required premiums.

The PFML benefit is based upon a percentage of the employee's wages and the state's average weekly wage. Workers can expect to receive:

- 90% of their weekly wages that are less than or equal to 50% of the stage's average weekly wage);
- 66% of their weekly wages that is greater than 50% of the state's average weekly wage but less than 100% of the state average weekly wage; or
- 55% of their weekly wages that is more than 100% of the state average weekly wages.

An employer cannot require that the employee use their accrued PTO, sick and/or vacation time at the same time as PFML or instead of PFML Employees can however choose to use their accrued paid time off ("PTO"), sick and/or vacation time instead of the PFML and the PFML protections will still be in effect for the individual. An employer can choose to provide supplemental benefit payments to compensate employees to their normal compensation amounts.

Starting July 1, 2025, employers will be able to substitute state-approved private plans instead of participating in the state program. Additional guidance on the process will be forthcoming but private plans are expected to include a surety bond.

Notice Requirements and Retaliation Prohibition

Employers are required to post a notice in the workplace about the PFML in both English and the primary language of 5 or more employees. Employers are also required to provide newly hired employees with written notice on their expected PFML benefit amount and instructions on how to apply for the benefits. DEED is expected to produce a template for employers.

Employees are required to provide notice to the employer at least 30 days in advance of their intent to apply for a foreseeable leave or as soon as practicable for an unforeseeable leave. The employer can still require the employee to follow their normal call-in/reporting procedures if they do not unnecessarily interfere with the employee's ability to apply for the leave.

Employers are prohibited from retaliating against employees for utilizing their paid leave. Employees that were hired at least 90 days prior to using their leave have the right to be reinstated with their employer into either their same job or an equivalent job. Similar to FMLA, employees retain access to their health insurance while on paid leave.

Minnesota's Earned Sick and Safe Time Leave

As mentioned above, beginning January 1, 2024, most employees that work within Minnesota will become eligible for a new paid sick leave benefit under the ESST. It should be noted that the cities of Bloomington, Duluth, Minneapolis, and St. Paul already have their own paid leave laws that are like ESST. If there is an overlap between an existing paid leave law and ESST, the more protective law is required to apply.

Covered Employers and Employees

Any employer with employees that work within Minnesota is subject to ESST.

Most employees that work at least 80 hours in a year in Minnesota will be eligible for this paid sick leave benefit. However, ESST does provide eligibility exceptions for some persons, such as:

- Independent contractors,
- Federal employees,
- Individuals employed by an air carrier, such as flight deck and cabin crew members, and
- Building and construction employees that are represented by a trade labor organization or union that has submitted a valid waiver of the requirements due to similar paid leave already present in their existing collective bargaining agreement.

Staffing agencies are responsible for providing ESST to their leased employees, not the employer that has contracted for their services.

An employee that is rehired within 180 days of termination must regain their ESST accrued but unpaid balance that existed prior to their departure unless the ESST accrued but unpaid hours were paid to them upon their termination. Employees that are terminated due to a merger and acquisition will retain their accrued but unpaid ESST balance if they are hired by the new owners within 30 days of the ownership change.

Leave Benefit

Starting January 1, 2024, for every 30 hours that an eligible employee works, including overtime hours if the employee is eligible for such time, they earn an hour of paid sick leave, up to 48 hours per year. Any unused and accrued benefits must be carried over into the next year up to an 80-hour maximum. An employer may choose to be more generous than the law requires and allow for additional time to accrue but they cannot choose an amount lesser than what ESST provides.

An employer can also choose to frontload the 48 hours per year instead of having employees accrue the amounts over time. Therefore, the employee would immediately have access to their entire ESST benefit as of the first day of the specified year. If an employer uses the frontload option, the carryover requirement does not apply but an employer may choose to pay out any unused amounts.

Lastly, an employer can choose a different benefit method (e.g., accrual or frontload) for their part-time employees compared to their full-time employees.

Reasons for Leave

Eligible employees will be able to request the paid leave benefit for the following reasons:

- Their own or a family member's mental or physical illness, treatment or preventive care need;
- Their own or a family members domestic abuse, sexual assault or stalking;
- Workplace closure due to weather or public emergency, including closure of a family member's school or care facility for the same reasons;
- Health authority or professional's determination that the employee or their family member is at risk of infecting others with a communicable disease.

The term “family member” under the Law includes the following persons:

- Child (biological, foster child, adult child, legal ward, of whom employee is legal guardian or in loco parentis);
- Spouse or registered domestic partner;
- Sibling, step sibling or foster sibling;
- Biological, adoptive or faster parent, stepparent or person who was loco parentis for employee when they were a minor child;
- Grandchild, foster grandchild or step grandchild;
- Grandparent or step grandparent;
- Child of a sibling of the employee (e.g., employee’s niece/nephew);
- Sibling of the employee’s parents (e.g., employee’s aunt/uncle);
- Child-in-law or sibling-in-law;
- Any other family members listed above of an employee’s spouse or registered domestic partner;
- Any other individual related by blood or whose close association with the employee is equivalent to a family relationship; and
- One person designated on an annual basis by the employee.

Notice and Disclosure Requirements

At the end of each payroll period, employers must provide a tally to each employee of the ESST hours that they have accrued, currently available, and those used. This information must be reported in the employees’ earnings statements.

By January 1, 2024, employers must provide their existing employees with notice of their ESST rights and benefits. This notice will be due to new hires at the start of their employment. The notice must be made available in English and other language if the employee’s primary language is not English. The employer must also include this notice in their employee handbook if the employer provides one to employees.

Employer Action

PFML

Employers should begin to determine if they have employees that will be eligible for this future leave benefit. Creating a process to track eligibility would be prudent and to develop a process to provide the required written notice to new hires.

Employers may want to review their existing leave policies and handbooks to see if there is any potential overlap with the new requirements. This may be especially important for multi-state employers that have attempted to create uniform leave policies to satisfy the different leave laws in these jurisdictions.

DEED is currently drafting frequently asked questions and additional guidance for employers and employees. Employers may want to sign up for their newsletters to keep up with the most recent updates.

ESST

Employers should take the following steps now:

- Update their existing payroll systems with the ability to calculate ESST time as it is accrued and used. Further, the system should be updated so that payroll stubs provide an ongoing balance for employees of what ESST time is earned, used and still available.

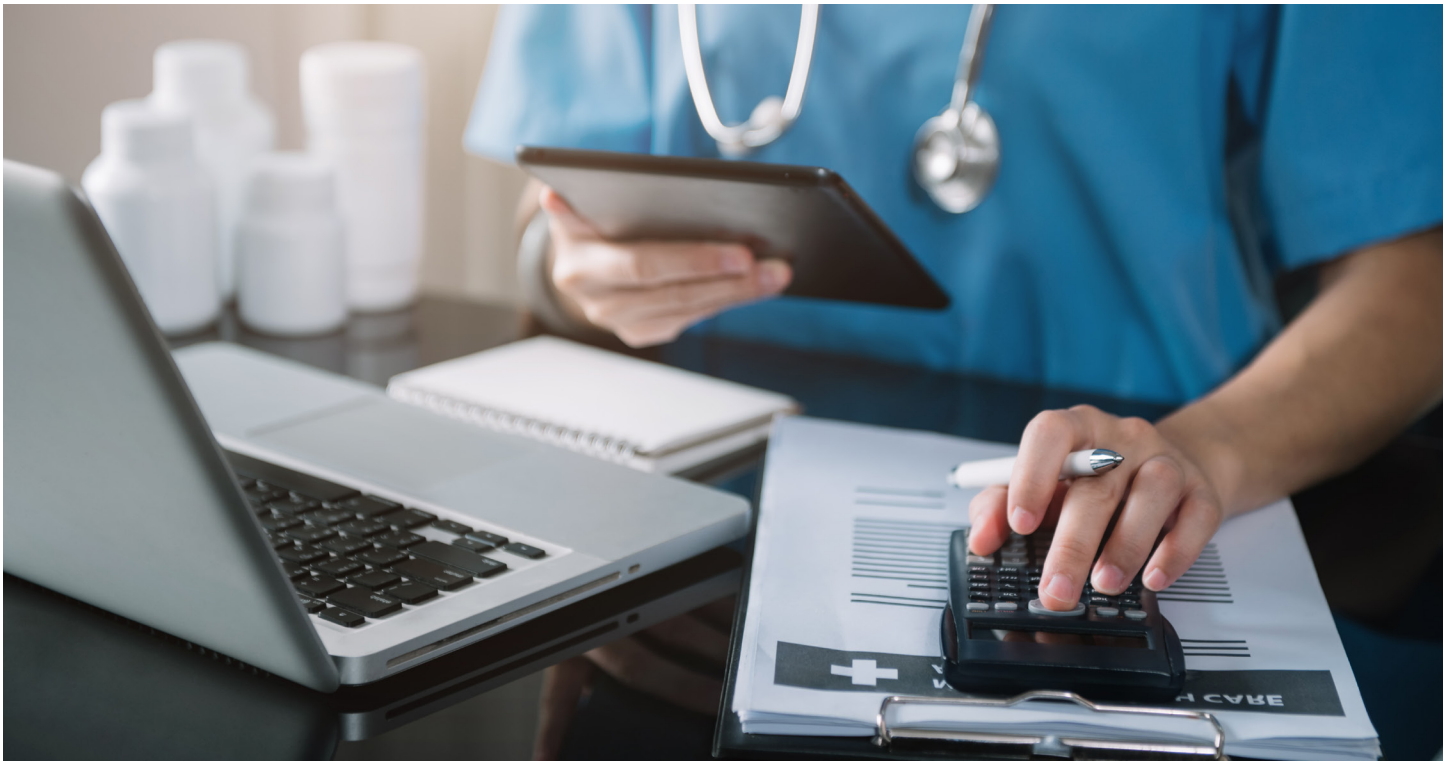
- Develop rehire and termination processes to track the termination reason and the amount of time that has lapsed since the date of termination and rehire. It may be prudent to incorporate information on the status of their ESST benefits (e.g., either returned to them or ineligible for return) in correspondence to the rehired employee.

- For employees that work in Minneapolis and are subject to the Minneapolis Wage Theft Prevention Ordinance, include ESST benefits in their pre-hire notices for new hires and any compensation change notices for existing employees.

- Modify handbooks to incorporate the required ESST language. Distribute the required notice to new hires and existing employees.

- Update existing leave policies to see if they are already sufficient to cover ESST requirements or if additional benefits must be provided. Identify any type of concurrent leaves that may apply with ESST (e.g., Family Medical Leave Act ("FMLA") and ESST).

- Educate managers on the ESST requirements and the proper process for employees to request such leave.



New Guidance on the No Surprises Act and IDR Process

Issued date: 11/03/23

On October 6, 2023, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") issued updated guidance in response to court decisions that vacated some of the regulations governing the independent dispute resolution ("IDR") process under the No Surprises Act ("NSA").

The Departments issued FAQ Part 62 which modifies prior guidance on:

- the proper methodology to determine the qualifying payment amount ("QPA"); and
- plan or issuer disclosure requirements of the initial payment or notice of denial of payment to out-of-network ("OON") air ambulance service providers.

Additionally, it was announced that the federal IDR portal has reopened for the initiation of new single disputes.

Background

The NSA, enacted as part of the Consolidated Appropriations Act, 2021, and subsequent guidance generally limit OON cost sharing and prohibit balance billing when participants in a group medical plan receive (1) emergency services from an OON healthcare provider, (2) non-emergency services from an OON healthcare provider at an in-network medical facility, or (3) OON air ambulance services.

Unless a state law or the All-Payer Model Agreement applies, a participant's cost-sharing and how much the plan will pay to the provider for these services is generally based on the lesser of the provider's billed charge or a QPA. The QPA is the

median of the contracted rates for a particular item or service plus an inflation adjustment; the rules for calculating the QPA are complicated.

The federal IDR process 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. There are provisions for batching items and services, which allow multiple qualified items and services for IDR disputes to be considered jointly as a single determination by the IDR entity.

Court Decisions

The IDR rules were challenged in multiple courts on various grounds. In these cases, the courts vacated portions of the IDR guidance, including (1) those dealing with batching claims, (2) those related to the methodology for calculating QPAs, and (3) certain provisions pertaining to air ambulance disputes, including the timeframe for sending an initial payment or notice of denial of payment to the provider. In response to these rulings, HHS temporarily suspended all federal IDR process operations effective August 25, 2023, in order to make changes necessary to comply with the Court's opinions and orders.

As of September 21, 2023, the federal IDR process was open to single and bundled disputes initiated on or before August 3, 2023 (but not batched disputes). The IDR portal has remained unavailable for all new disputes.

Recent Developments

On October 6, 2023, the Departments issued additional guidance in response to the Court's decisions, as summarized below.

FAQ About Consolidated Appropriations Act, 2021, Implementation Part 62

Methodology to Determine QPA and Enforcement Discretion

The Departments disagree with the court's decision to vacate some of the provisions of the methodology for calculating QPAs, and plan to appeal. However, in the meantime, they maintain that plans and issuers must determine the QPA in a good faith and reasonable interpretation of the remaining portions of the guidance. This is because the court's decision did not create a standardized QPA process for issuers and plans to follow for NSA compliance.

Because this lack of certainty may create additional compliance complications for plans and issuers, the Departments will exercise enforcement discretion until May 1, 2024 (the first day of the calendar month that is 6 months after the issuance of these FAQs) for an entity that uses a QPA calculated in accordance with the methodology guidance in effect immediately prior to the court's decision for purposes of:

- patient cost sharing;
- providing required disclosures with an initial payment or notice of denial of payment; and
- providing required disclosures and submissions pursuant to the federal IDR process.

HHS will extend this enforcement discretion to providers, facilities, or providers of air ambulance services that bill or hold liable a participant, beneficiary or enrollee for a cost-sharing amount based on a QPA determined using the methodology that was before the court's decision. HHS also encourages states that enforce these NSA provisions to adopt a similar

enforcement approach regarding QPAs.

Certified IDR entities can continue to rely on alternative non-prohibited information and factors to decide which party's offer best represents an appropriate value for the item or service at issue.

Disclosures to OON Air Ambulance Providers

Plans and issuers are still required to determine whether OON air ambulance services are covered and provide an initial payment or notice of denial of payment within 30 calendar days of receipt of the bill for the ambulance services.

Plans and issuers subject to ERISA are also reminded to follow the ERISA claims procedure regulation and the ACA internal claims and appeal regulations, which include the option to request additional information from the claimant if necessary to complete the claim's processing. If a plan or issuer is unable to determine coverage within the 30-calendar-day timeframe, a notice of benefit denial due to an adverse benefit determination should be provided, disclosing that the denial was due to insufficient information.

The Departments reiterate that an adverse benefit determination due to insufficient information does not allow OON providers of air ambulance services to balance bill a participant, beneficiary, or enrollee. Instead, such providers will need to resubmit or appeal a claim to the plan or issuer, since balance billing would violate the NSA.

No Surprises Act (NSA) Independent Dispute Resolution (IDR) Partial Reopening of Dispute Initiation Frequently Asked Questions (FAQs)

As of October 6, 2023, the Departments reopened the federal IDR portal for the initiation of most new single disputes, including single disputes involving bundled payment arrangements.

However, the federal IDR portal still remains temporarily unavailable for:

- new disputes involving air ambulance services, and
- batched disputes (regardless of whether new or previously initiated).

The Departments say they are working quickly to issue updated guidance and make system changes that would allow the federal IDR portal to become available for these items. Updates will be provided to the public at www.cms.gov/nosurprises as they become available.

Employer Action

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

For self-funded group medical plans, the third-party administrator ("TPA") should be handling compliance with the final rules, although employers or other plan sponsor are ultimately liable for any noncompliance. Employers should work with their TPAs to make sure they are processing claims in accordance with this latest guidance. Importantly, claims that go through the IDR process will likely experience further delays, given the opening/closing/reopening of the process and the various changes required to the system. Employers with self-funded plans will want to discuss this issue with their TPAs and stop loss carriers to ensure sufficient coverage for claims that are caught up in delays related to the IDR process.

New York City Amends Earned Safe and Sick Time

Issued date: 11/01/23

The New York City Department of Consumer and Worker Protection published a final rule amending the regulations governing NYC's Earned Safe and Sick Time Act ("ESSTA"). These changes provide guidance to clarify and update various ESSTA provisions. The final rule became effective on October 15, 2023.

Background

The New York City Earned Sick Time Act, now known as the ESSTA, took effect on April 1, 2014 and required covered employers to provide eligible employees with paid time off to care for themselves or a qualifying family member. The ESSTA has been amended several times, which amendments included adding "safe" time as a covered absence, and aligning the ESSTA with the New York State Paid Sick Leave Law. In October 2022, proposed amendments were published, but left employers with limited formal guidance regarding the new law. The amended rule takes effect on October 15, 2023.

Highlights of the Final ESSTA Rule

- Employer size which is used to determine the accrual and amount of ESSTA leave available is based on the number of full-time and part-time employees ***nationwide*** and not on those employed in New York City ("NYC"). This should not have a material impact on NYC employers as the statewide paid sick leave requirement already determines employer size based on the total national workforce.

- Employees who "regularly perform or are expected to regularly perform work in NYC during a calendar year" will be entitled to ESSTA leave.

- Accrual of ESSTA hours will be based on all hours an employee physically works within NYC. When an employee works less than 30 hours per week (accrual standard to earn an hour of leave), employers must allow for fractional safe and sick time accruals that may be rounded to the nearest five minutes, one-tenth of an hour, or one-quarter of an hour.

- Employees who exclusively work remotely for a NYC employer will not be entitled to such leave.

- A definition of "foreseeable leave," has been incorporated in the rules stating that "a need is foreseeable when the employee is aware of the need to use safe/sick time seven days or more before such use."

- Employers must have a written policy that outlines the procedures and notification process employees may take to request any foreseeable need for leave. In addition, the policy must now include a statement that the employer "will not ask the employee to provide details about the medical condition that led the employee to use sick time, or the personal situation that led the employee to use safe time, and that any information the employer receives about the employee's use of safe/sick time will be kept confidential and not disclosed with anyone without the employee's written permission or as required by law."

- Employers must reimburse an employee for any fees incurred in obtaining necessary documentation from a health care provider to substantiate the request for leave.

- The new rules expand enforcement by "reasonable inference" when as "a matter of official or unofficial policy or practice, [the employer] does not provide or refuses to allow the use of accrued safe/sick time in violation of the Administrative Code". Specifically, if an employer fails to maintain or distribute a written safe/sick time policy, fails to maintain adequate records of employees' accrued safe/sick time use and balances, or when there is additional evidence that an employer maintains a policy or practice of not providing or refusing to allow the use of accrued safe/sick time, penalties shall
  be imposed.

Employer Action

New York City employers, with their counsel, should review and update their NYC safe and sick time policies and procedures to ensure compliance with these latest rules.

Massachusetts Paid Family Leave 2024 Contributions and Benefits and Updates

Issued date: 11/06/23

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2024. The DFML has also published the FY2023 Annual Report for the PFML program.

In addition, recent legislative changes to the PFML program will allow employees to supplement (or "top off") their weekly PFML benefit amount with accrued paid leave under an employer policy or collective bargaining agreement. The changes take effect for claims filed on or after November 1, 2023.

Contributions

The 2024 contribution rate on eligible wages will be **0.88%** (adjusted up from the 2023 rate of 0.63%). Individual contributions are capped by the Social Security income limit. The 2024 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2023 limit which is currently set at $160,200.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2024:

- **Medical Leave Contribution:** 0.70% of eligible wages allocated as follows:

- Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
- Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).

- **Family Leave Contributions:** 0.18% of eligible payroll deduction
- May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2024 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- The portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- The portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2024:

- The MAAWW will be $1,796.72, an increase of 1.8% from the 2023 MAAWW of $1,765.34.
- The maximum weekly PFML benefit will be $1,149.90, an increase of 1.3% from the maximum weekly benefit of $1,129.82 in 2023.

FY2023 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2023. The annual report can be found at https://www.mass.gov/doc/fy2023-dfml-annual-report/download

Topping Off

Topping off allows employees on PFML to supplement their weekly PFML benefit with their accrued vacation pay, sick pay, or other paid leave, up to the employee's Individual Average Weekly Wage ("IAWW"). The state provides the following example: An employee's IAWW = $2,000 and they have an approved PFML application that pays $1,100 per week. The employee may top off that amount with PTO up to $900, if available.

As a reminder, under the state program, an employee's IAWW is calculated by the DFML from the amount an employee earned in the last four completed calendar quarters before the start of the employee's benefit year. The IAWW is the average amount the employee earned per week in the two quarters when the employee earned the most money (or the one quarter with the most money if the employee only worked in two or fewer quarters).

Employer Responsibilities under the State Program

Prior to these changes, employees were only allowed to top-off benefits under an approved private plan; employees who received PFML benefits through the state program were not allowed to use accrued paid leave during any leave period in which the employee was receiving PFML benefits from the state. Employers will now be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee's IAWW. Employers do not need to report top off amounts to the DFML.

Employers with a registered Leave Administrator can determine an employee's weekly PFML benefit rate and their IAWW by accessing the employee's PFML Approval Notice. The DFML stresses that employers who do not have a registered Leave Administrator will not be able to access this information. Employers must have a registered Leave Administrator on file with DFML.

Employer Responsibilities under a Private Plan Exemption

Prior to these changes, employers who administered an approved private plan could allow their employees to top off their PFML benefits with accrued paid leave. Under the new rules, employers with a private plan exemption must allow for top offs.

Employer Action

Employers should prepare for the 2024 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2024. Updated workplace posters and notifications for the 2024 contribution rates and benefit amounts will be available to employers on the PFML website soon.

Employers should also review the guidance and resources released by the DFML and should review and update their PFML policies and procedures to comply with these recent changes effective November 1, 2023.

2024 Cost of Living Adjustments

Issued date: 11/10/23

The IRS has released cost of living adjustments for 2024 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2024, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $3,050 to $3,200.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health FSA, subject to inflation for plan years beginning after December 31, 2013.

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins in 2024 that can be carried over to the following plan year is $640 (up from $610 in 2023).

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a static maximum of $500 to 20% of the currently indexed heath FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2024, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $300 to $315.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $150,000 to $155,000 for 2024.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). *Prop. Treas. Reg. 1.125-7(a)(9).*

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2024 increased from $215,000 to $220,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. *Prop. Treas. Reg. 1.125-7(a)(10).*

Non-Grandfathered Plan Out-of-Pocket Cost-Sharing Limits

As previously reported, the 2024 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $9,450 for self-only coverage and $18,900 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2024, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $6,150 ($12,450 for family coverage), which increased from $5,850/$11,800 in 2023.

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2024, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,100 (increased from $1,950 in 2023).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts (HSAs) for 2024 were provided by the IRS in *Rev. Proc. 2023-23.*

Annual contribution limitation

For calendar year 2024, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $4,150; the limitation on deductions for an individual with family coverage under a high deductible health plan is $8,300.

High deductible health plan

For calendar year 2024, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,600 for self-only coverage or $3,200 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $8,050 for self-only coverage or $16,100 for family coverage. It should be noted that for family HDHP coverage, an individual embedded deductible cannot be less than $3,200.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See *IRS Notice 2004-50, 2004-33 I.R.B. 196*, Q/A-86 (Aug.16, 2004).

Catch-up contribution

Individuals who are age 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code Section 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Delaware Publishes Rules on Paid Family and Medical Leave

Issued date: 11/10/23

As previously reported, the Healthy Delaware Families Act ("HDFA") was signed into law on May 10, 2022. On July 11, 2023, the Delaware Department of Labor ("DDOL") released the first set of anticipated rules implementing the HDFA. While payroll contributions will not go into effect until 2025 and benefits do not begin until 2026, there are several upcoming deadlines for employers to be aware of, and decisions that need to be made prior to January 1, 2024.

Specifically, plans should be aware of the following deadlines:

- October 1, 2023 – January 1, 2024: Grandfathered paid time off plan applications available through online portal.
- January 1, 2024: Must notify the Division of Paid Leave of intent to temporarily reduce parental leave from 12 weeks to 6 weeks.
- December 1, 2024: Must notify employees of intent to temporarily reduce parental leave from 12 weeks to 6 weeks.
- September 1, 2024 – December 1, 2024: Private plan opt-out form available through online portal.

Below you will find a summary of the rules.

Background

The HDFA requires Delaware employers to provide paid family and medical leave to eligible employees. The program is funded through employer and employee contributions and will provide eligible employees with 80% of their average weekly

wages earned during the 12-months prior to their application for benefits, up to a maximum benefit of $900 per week. Employees are permitted to take paid leave for:

- *Parental Leave*. Due to the birth, adoption, or placement through foster care of a child or for caring for the child during the first year after the birth, adoption, or placement of the child.
- *Family Caregiving Leave.* Caring for a family member with a serious health condition.
- *Medical Leave*. Due to their own serious medical condition.
- *Qualified exigencies*. Due to time off needed for qualified issues arising from military deployment.

Covered employers are permitted to apply to the state for an exemption from the contribution requirements when offering a private plan, provided the plan benefits are at least as generous as those required by the statute.

Employer and employee contributions are scheduled to begin January 1, 2025, with benefit payments beginning January 1, 2026.

Regulations

The DDOL released the first in what's expected to be multiple rounds of regulations clarifying various requirements under the HDFA. This first set of regulations clarifies requirements as follows:

Covered Employers and Employees

The HDFA requires that to be eligible for paid leave, employees must have been:

- Employed for at least 12 months by the employer from whom leave is being requested;
- Worked a minimum of 1,250 hours over the 12-month period prior to the request; and
- Worked at least 60% of their work hours at a worksite in Delaware (determined quarterly).

The type of paid benefits that a covered employer must provide is determined based on employer size:

- Employers with 25 or more Delaware employees must provide all paid family and medical leave benefits.
- Employers with 10-24 Delaware employees are only required to comply with the parental leave requirements.

An employer meets the employee threshold determination based on the preceding 12-month period and once this determination has been made, they are subject to the requirements of the applicable classification for a subsequent 12-month period. If the employer's classification changes, they must provide notice to employees that gain or lose paid leave benefits due to the change in classification within 30 days of the change.

Benefit Amount

The amount of an employee's benefit will be 80% of their average weekly wage calculated as the average gross weekly wages for the 52-week period prior to their claim submission. If the employee is salaried, it is determined based on the employee's gross wages divided by 52 weeks.

Employees must receive at least a minimum paid leave benefit of $100 per week but no more than $900 per week.

Duration of Leave

Employees are eligible for:

- Parental leave: 12 weeks in the applicable year.
- Medical, family caregiving, or qualified exigencies leave: 6 weeks in any 24-month period.

Employers with 10-24 Delaware employees may temporarily reduce the amount of parental leave available from 12 weeks to 6 weeks for claims submitted prior to January 1, 2031. To do so, employers must notify the Division of Paid Leave ("Division") by January 1, 2024, and must notify their employees in writing by December 1, 2024.

Payroll Contributions

If a covered employer chooses to participate in the public plan, contributions must be paid at least quarterly to the Division and will be assessed against wages paid on or after January 1, 2025 (the date that payroll contributions begin). For 2025 and 2026, the contribution rates, as a percentage of an employee's FICA wages, are as follows:

- Parental Leave: 0.32%
- Medical Leave: 0.40%
- Family Caregiving and Qualified Exigency Leave: 0.08%

Payroll contributions will begin the first day of the pay period after an employee is hired and for an employer who rises above an employee threshold, will begin the first day of the payroll period after the employer rises above the threshold.

The HDFA defaults to a 50/50 split of the contributions between the employer and employee, however an employer can choose to pay more than 50% (but not less than 50%) of the required contribution. Notice of such a variation from the default split must be given to employees and to the Division through its online portal.

No contributions are required when an employee is on HDFA leave.

Notice Requirements

When an application for leave is received, an employer, insurance carrier, or third-party administrator has 5 business days to approve or deny the application. An employer must provide the employee with written notice of the claim's approval or denial. If approved, the notice must include:

- the amount of the benefit payment;
- the party to whom the benefit payment is being made;
- the party that the payment was sent to;
- the address of the party that the payment was sent to; and
- the date that benefit payments begin and their expected end date.

If the claim is denied, the notice must explain the reason for the denial and that the employee has a right to appeal the decision including instructions on how to file an appeal.

Coordination with Other Leave Programs

The Division has deferred issuing rules concerning coordination with other leave programs (e.g., FMLA, short and long-term disability, etc.) for future rulemaking.

Private Plans

Covered employers may offer a private plan by purchasing an approved insured plan or by self-insuring the leave benefits.

If opting for an insured private plan, an employer must notify the Division through its online portal of the decision to opt out of the public plan by indicating their intention to purchase an approved insured plan.

Similarly, if an employer wishes to opt-out of the public plan and use a self-insured plan, they must notify the Division of their intent to opt-out. To maintain a self-insured plan, there must be 100 covered individuals at all times and provide the Division with a surety bond. For a self-insured plan to be approved, the benefits offered must meet the requirements of the HDFA. Note that if a self-insured plan falls below 100 covered individuals, they will be decertified at renewal and required to enroll in the public plan. Additionally, the employer will be required to pay to the fund the amount that would have been due under the public plan for the previous 12 months.

For both the insured and self-insured private plan option and for 2025 only, the opt-out form will be available on the Division's online portal from September 1, 2024 through December 1, 2024. For subsequent years, an employer can opt-out of the public plan or renew their insured or self-insured plan from October 1 through December 1 of the applicable year.

Grandfathered Plans

If a covered employer had a voluntary paid time off plan in place prior to May 10, 2022, that is considered "comparable" to the public plan, it can apply for an exemption from the public plan to continue its paid time off plan through December 31, 2029. A "comparable plan" will be deemed to exist if:

- the 3 main benefit components (benefit percentage, maximum benefit, and benefit duration) are within 10% of the equivalent public plan components;
- it provides coverage for birth, adoption, and fostering a child (and provides benefits regardless of the parent's gender or marital status); and

- employees covered under the existing plan cannot be required to contribute more to the existing plan than they would under the public plan.

In addition, an employer must submit a sworn affidavit to the Division through their online portal that the plan was in writing and had been available to all employees as of May 10, 2022. A copy of the paid time off plan must be submitted with the application as well. Any grandfathered plan cannot be altered unless the change is to improve the benefits under the plan.

Applications to grandfather an existing paid time off plan can be submitted through the Division's online portal from October 1, 2023, through January 1, 2024.

Employer Action

Employers will need to determine whether they are considered a covered employer and which employee threshold applies. Employers with 10-24 covered employees will need to determine whether they intend to temporarily reduce the parental leave benefit from 12 weeks to 6 weeks and submit notice to the Division.

If a covered employer wishes to opt-out of the public plan by using an insured plan, self-insured plan, or grandfathered plan, the employer should be prepared to submit a notice of opt-out or application of grandfathering by the applicable deadlines.

California Requires Employers to Provide More Paid Sick Leave

Issued date: 11/15/23

California has enacted a new law that requires employers to make changes to their mandatory paid sick leave programs effective January 1, 2024, including the following:

- California employees may use up to 40 hours (or five days) of accrued paid sick leave in a year, which is an increase from 24 hours (or three days) per year.
- The total accrued paid sick leave for a California employee may be limited to 80 hours (or ten days), which is an increase from 48 hours (or six days).
- New employees in California are generally required to have accrued no less than 40 hours (or five days) of paid sick leave by the 200th calendar day of employment, if the employer does not use the standard accrual method of one hour of paid sick leave for each 30 hours worked.

Below you will find highlights of the new law.

Background

California's mandatory paid sick leave law, known as the "Healthy Workplaces, Healthy Families Act of 2014," applies to employers that employ an individual who works in California for at least 30 days in a year for the same employer, regardless of the employer size or the location of the employer's principal place of business.

Under current state law, employees performing services in California are generally entitled to accrue at least one hour of paid sick leave for every 30 hours worked. Employees may begin using accrued paid sick leave on their 90th day of employment.

An employer may limit an employee's use of paid sick leave in a year to 24 hours or three days. Under the accrual method, accrued but unused paid sick leave must carry over to the next calendar year; however, the employer may limit the overall amount of paid sick leave that an employee may accrue to 48 hours or six days.

Alternatively, instead of tracking accruals and carryovers, an employer may choose to credit employees with the full 24 hours or three days of paid sick leave in a lump sum at the beginning of each year.

Changes to the Mandatory Paid Sick Leave in California

Area	Current Law	Requirements Effective January 1, 2024
Use	An employer may limit an employee's use of paid sick leave accruals to 24 hours per year (or three days)	An employer may limit an employee's use of paid sick leave accruals to 40 hours per year (or five days)
Carryover and accruals	Accruals must be carried over from year to year, but an employer may cap accruals at 48 hours (or six days)	Accruals must be carried over from year to year, but an employer may cap accruals at 80 hours (or ten days)
Alternative lump sum method	As an alternative to tracking accruals and carryovers, an employer may instead grant employees a lump sum of not less than 24 hours (or three days) of paid sick leave accruals at the beginning of each year of employment, calendar year, or 12-month period. In the case of a new employee, an employer may instead grant a lump sum of not less than 24 hours (or three days) of paid sick leave accruals upon completion of the 120th calendar day of employment	As an alternative to tracking accruals and carryovers, an employer may instead grant employees a lump sum of not less than 40 hours (or five days) of paid sick leave accruals at the beginning of each year of employment, calendar year, or 12-month period. In the case of a new employee, an employer may instead grant a lump sum of not less than 24 hours (or three days) of paid sick leave accruals upon completion of the 120th calendar day of employment, AND not less than 40 hours (or five days) of paid sick leave accruals upon completion of the 200th calendar day of employment
Alternative accrual method	An employer may use a different accrual method (other than one hour of paid sick leave for every 30 hours worked), as long as the accrual is on a regular basis so that the employee accrues not less than 24 hours (or three days) of paid sick leave by the 120th calendar day of employment or in a calendar year or in a 12-month period.	An employer may use a different accrual method (other than one hour of paid sick leave for every 30 hours worked), as long as the accrual is on a regular basis so that the employee accrues not less than 24 hours (or three days) of paid sick leave by the 120th calendar day of employment or in a calendar year or in a 12-month period AND not less than 40 hours (or five days) of paid sick leave by the 200th calendar day of employment or in a calendar year or in a 12-month period.

Existing paid sick leave or paid time off policy	An employer with an existing paid sick leave or paid time off (PTO) policy does not have to provide additional paid sick leave, as long as the program meets the accrual, usage, carryover, and reinstatement requirements of California law, **AND** provides at least 24 hours (or three days) of annual paid sick leave within the first nine months of employment	An employer with an existing paid sick leave or paid time off (PTO) policy does not have to provide additional paid sick leave, as long as the program meets the accrual, usage, carryover, and reinstatement requirements of California law, **AND** provides at least 40 hours (or five days) of annual paid sick leave within the first six months of employment

The new California law also extends certain employment law protections under the paid sick leave law to employees covered by a valid collective bargaining agreement, and exempts certain railroad employees from the mandatory paid sick leave law.

Employer Action

Employers have a relatively short time (until January 1, 2024) to make appropriate changes to their paid sick leave or PTO policy for California employees to comply with the requirements of the new law. Employers should work with their employment-law attorney or resource to understand and implement the details of these new rules.

Employers will need to update their payroll systems to correctly track and report employees' paid sick leave accruals.

In addition, employers should consider how to educate and communicate their paid sick leave policy to human resources personnel, managers, and employees. For example, employers may need to update their employee handbook for this purpose.

Life Insurance Carriers Agree to Claim Reforms in DOL Settlements

Issued date: 11/20/23

Two recent settlement agreements between the Department of Labor ("DOL") and group life insurance carriers highlight the potential liabilities for carriers and employers if life insurance claims are denied due to missing evidence of insurability ("EOI") even though employee premiums were collected for the coverage.

Background

Many employers provide basic life insurance coverage to their employees at no cost. Basic life insurance is usually "guaranteed issue" up to a certain amount, which means the employee is covered without having to provide an EOI as proof of good health.

Employees can often purchase additional life insurance coverage for themselves and/or their dependents and pay for the coverage with payroll deductions. However, this supplemental coverage is generally conditioned upon the carrier receiving and approving an EOI submitted by the insured individual. Some employers assist with the administration of the supplemental coverage by collecting the employees' EOIs and premiums for the insurer.

DOL Investigations

Regional offices of the DOL's Employee Benefits Security Administration ("EBSA") conducted investigations into the administration of life insurance plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA").

As a result, the DOL found that several life insurance carriers, including the Prudential Insurance Company of America ("Prudential") and United of Omaha Life Insurance Company ("United"), had a pattern of denying supplemental coverage

claims due to missing EOIs, despite having continually accepted employee premiums for the coverage. In many cases, the employers had assumed the duties of collecting the EOIs and premiums for the insurer. The premiums were forwarded, but the EOIs were never collected. Neither the employer nor the insurer informed the participants that the required EOIs were missing and that the failure to provide the information could result in denial of their claims. Unfortunately, the beneficiaries or the employee became aware of the deficiency only after the insured individual passed away and the life insurance claim was denied.

For example, according to the DOL, Prudential had denied more than 200 supplemental coverage claims due to missing EOIs from 2017 to 2020, despite having collected premiums for this supplemental coverage – in some cases back to at least 2004.

Although the DOL has not pursued actions against the participating employers, the agency believes that the insurer and the employers jointly have ERISA fiduciary responsibility for these arrangements. Specifically, the DOL determined that failing to properly administer a plan, including a failure to collect required documentation, confirm eligibility, or provide proper and timely notice to applicants of their eligibility, can result in a breach of fiduciary duty by both entities.

Settlement Agreements

Both Prudential and United entered into settlement agreements with the DOL earlier this year to resolve these issues without litigation. The settlement agreements are similar, but not identical.

Under the agreements, the carriers agreed to implement new procedures for handling supplemental coverage claims when EOIs are missing:

- Claims received within ninety (90) days of the first premium payment can be denied due to a missing EOI. The insurer must provide a denial notice indicating that the denial is due to the missing form and return all premiums to the employee or the beneficiary that it has received to date for the coverage.

- Claims received after ninety (90) days of the first premium payment will not be denied due to a missing EOI.

- If an enrolled employee or dependent is still alive, and the carrier discovers that the required EOI is missing, it can request the missing information if the inquiry is made within one year of the receipt of the first premium payment for supplemental coverage. The carrier cannot request or make its coverage decision on any information other than the applicant's health status as of the date the first premium payment for coverage was received. If eligibility for coverage is ultimately denied, the insurer must return all collected premiums to the employee.

The carriers also agreed to notify existing and new group life insurance policyholders (e.g., employers) that if the policyholder collects premiums from an employee for coverage that requires EOI without first confirming that the carrier has approved the EOI, the policyholder may be liable for the benefit.

Both carriers have advised the DOL that they are voluntarily reprocessing previously denied claims to provide benefits for claims denied based solely on a missing EOI; Prudential back to June 2019, and United back to February 2018.

Employer Action

Because employers could be liable for an ERISA breach of fiduciary duty if they assist in the administration of these supplemental life insurance coverages, employers should:

- Confirm the employee or dependent's coverage status before submitting any premiums to the carrier. If the employer collects premiums from the employee before a determination is made, the employer should have a set time period (e.g., 60 days) from the date of the receipt of the first payment until confirmation of coverage with the insurer. If the insurer fails to comply with this timeline, the employer would then return the premiums to the employee with notice that the carrier failed to confirm coverage and encourage the employee to communicate with the carrier.

- Create a process to confirm with the carrier on a regular basis (e.g., quarterly) which employee coverages are in effect. This will help stop premium collection from employees whose coverage has lapsed, as well as provide an opportunity for the carrier to request required information from the employees, such as missing EOIs.

Employers that outsource their EOI administration should confirm their vendors' processes in light of the DOL settlement agreements. As open enrollment season has begun, now is a good time to review existing practices.

New Chicago Paid Leave Ordinance Takes Effect Soon

Issued date: 12/01/23

On November 9, 2023, Chicago passed a new Paid Leave and Paid Sick Leave Ordinance that takes effect on December 31, 2023. This new ordinance replaces the current ordinance in effect. Under the new ordinance, every 12-month accrual period, Covered Employees will be able to accrue:

- 40 hours of Paid Sick Leave
- 40 hours of Paid Leave usable for any purpose

The ordinance applies to all employers with employees in Illinois. Covered Employees are employees who, within any two-week period, perform two hours or more of work while physically present within the geographic boundaries of Chicago ("the City"). The 40 hours of Paid Leave usable for any purpose is similar to the Illinois Paid Leave for All Workers Act which takes effect January 1, 2024.

Accruing and Using Leave

Covered Employees will accrue one hour of Paid Sick Leave and one hour of Paid Leave for every 35 hours worked. The ordinance requires that the time accrued be in whole-hour increments and no fractions. Exempt or non-hourly employees accrue time based upon the presumption that they work 40 hours per work week unless their regular work week schedule is less than 40 hours. If the work week is less than 40 hours, then the accrual is based upon the hours of the employee's regular work week. Nothing in the ordinance impacts an employer's policy that is more generous.

In lieu of calculating accruals, employers can front-load the 40 hours of Sick Leave and 40 hours of Paid Leave. If the full hours of Paid Leave are front-loaded at the beginning of the 12-month accrual period, then any unused time does not

carry over to the next period. However, if the employer implements policies or denies access to the Paid Leave hours that prevents the employee from having meaningful access, then those denied hours must carry over. Front-loading the Paid Sick Leave never eliminates the employer's obligation to carry over up to 80 hours of unused Paid Sick Leave from one accrual period to the next.

If the employer has an unlimited paid time off policy and this policy is available immediately on an employee's first date of employment or at the beginning of each 12-month accrual period, the employer does not need to track any unused time to carry over. Additionally, employers with these policies may not require preapproval for the paid time off. An unlimited paid time off policy does not exempt an employer from paying out 40 hours of paid time off minus the hours used in the 12-month accrual period after a termination, resignation, retirement, separation, or transfer outside geographic limits of the City (see discussion below).

The ordinance requires that if a Covered Employee has accrued Paid Sick Leave prior to January 1, 2024, and the employer's current policy does not comply with the new ordinance, the Covered Employee is entitled to roll over Paid Sick Leave from one 12-month accrual period to the next.

Covered Employees can begin using Paid Sick Leave by the 30th day of employment (or 30 days from the effective date of the ordinance) and Paid Leave by the 90th day of employment. An employer cannot set a policy with greater restrictions as to when employees can begin using leave. However, an employer can set minimum hour requirements as long as those requirements do not exceed four hours for Paid Leave or two hours for Paid Sick Leave per day.

Requesting Leave and Requirements and Restrictions on Leave

Paid Leave may be used for any reason and an employer cannot require the employee to provide a reason for the leave or request document or proof in support of the leave. An employer may require an employee to provide reasonable notice of Paid Leave, but not to exceed seven days' notice prior to the leave and may require reasonable preapproval to maintain continuity of operations for the employer.

An employee can use Paid Sick Leave for:

- When the employee is sick, injured or receiving professional or diagnostic care;
- When a family member is sick, injured, ordered to quarantine or receiving professional or diagnostic care;
- When the employee or a family member is a victim of domestic violence;
- When the employee's place of business is closed due to a public health emergency or an employee's family member's school or place of care has been closed;
- When an employee is following an order issued by the Mayor, Governor, Chicago Department of Public Health or a treating healthcare provider to remain at home or quarantine.

Employers may require notice, up to seven days in advance, if the Paid Sick Leave is foreseeable. Otherwise, employers may require notice as soon as possible on the day the employee intends to use the Sick Leave. However, any requirement for advance notice will be waived if the employee is unable to provide notice due to being unconscious or otherwise medically incapacitated. If there is an absence of more than three consecutive days with the use of Paid Sick Leave, then the employer may require reasonable documentation or certification that the leave was used for a permitted purpose.

The employee, not the employer, gets to choose which documentation to provide if requested or required by the employer. An employer cannot require more than one document per incident. Additionally, the employer cannot delay the use of the Paid Sick Leave or the employee's wages until the employer receives certification or documentation.

Noteworthy is that the ordinance requires that any unused Paid Sick Leave and Paid Leave be "…retained by the Covered Employee if the Employer sells, transfers, or otherwise assigns the business to another Employer and the Employee continues to work in the City."

Upon a termination, resignation, retirement or other separation from the employer, the employer must pay the monetary equivalent for all unused, accrued Paid Leave as part of the employee's final compensation. There is limited relief from this requirement for small and medium sized employers:

- **Small employers (50 or fewer Covered Employees)** are not required to pay out Paid Leave when there is a termination, resignation, retirement, or separation or if the employee ceases to meet the definition of a Covered Employee.

- **Medium employers (51 to 100 Covered Employees)**, the maximum of 16 hours of Paid Leave will be paid out until December 31, 2024, unless the medium employer sets a higher limit. On or after January 1, 2025, medium employers will be required to pay out the monetary equivalent of all unused and accrued Paid Leave.

The ordinance does not require that any Paid Sick Leave be paid out upon an employee's termination, resignation, retirement, or other separation from the employer unless the terms of an applicable collective bargaining agreement specify otherwise.

Employer Action

Given the approaching deadline, employers should:

- Assess current paid time off and sick leave policies to determine compliance with the new ordinance;

- Determine if any hours accrued need to be carried over;

- Review and update any postings and pay stub notification requirements;

- Update handbooks as necessary; and

- Train staff regarding new requirements and updated policies.

While further guidance is expected from the City, affected employers should work with their employment counsel or other advisors to comply with these new requirements.

House Passes Health Care Transparency Law

Issued date: 12/15/23

The U.S. House of Representatives voted 320-71 to pass the Lower Costs, More Transparency Act ("the Act") on December 11, 2023. The legislation aims to lower health care costs by increasing transparency in the market. The Act includes changes that would impact employers sponsoring group health plans.

For group health plans, the bill:

- Codifies the current transparency in coverage regulations (related to posting machine-readable files ("MRF") and making certain cost information available) into statute with some changes (e.g., specific timing to post the MRF – 10th day of such month). This provision, if enacted, would apply to the first plan year on or after January 1, 2026.

- Requires Pharmacy Benefit Managers ("PBMs") to provide semi-annual reporting to a group health plan that includes detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. PBMs who fail to comply may face penalties of $10,000/day. If enacted as is, it would apply to the first plan year on or after a date that is 2 years after the date of enactment.

- Enhances transparency requirements to ensure health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan. Penalties for noncompliance may be assessed against TPAs and PBMs of $10,000/day. If enacted as is, it would apply effective for the first plan year on or after the date of enactment.

- Amends ERISA 408(b)(2) compensation disclosure requirements to directly include PBMs and TPAs as service providers that must disclose their compensation. If enacted as is, it would apply to contracts entered into on or after January 1, 2025.

- Prohibits gag clauses in pharmacy contracts that would restrict a pharmacy from disclosing to a covered participant or beneficiary cost information related to a drug. The effective date of this provision is unclear.

While the House was successful in passing this bipartisan legislation, it is unlikely the Senate will consider or pass this bill as a standalone piece of legislation. However, the House and Senate will need to pass government funding bills in early 2024 and it is possible that components of this legislation could make it into one of those spending bills that are ultimately enacted into law. We will continue to monitor developments.

House Passes Health Care Transparency Law

Issued date: 12/28/23

On December 13, 2023, the Chicago City Council voted to delay the Paid Leave and Paid Sick and Safe Leave Ordinance ("Paid Leave"), which was enacted on November 9, 2023, and was originally to take effect on December 31, 2023. The Ordinance will now take effect on **July 1, 2024.**

Changes to the Ordinance

In addition to the delay in effective date, the Council modified the Ordinance in other aspects. Importantly, the definition of a covered employee was amended. The amended ordinance defines a Covered Employee as an individual who works at least 80 hours for an employer within any 120-day period while physically present within the geographic boundaries of the City of Chicago. Previously, the Covered Employee only had to work at least two hours within any particular two-week period. The amended ordinance clarifies that once that threshold is met, that individual will remain a Covered Employee for their entire employment.

While the underlying notice requirements were not modified, employers must now provide their time off policy in writing to each of their Covered Employees in that employee's primary language.

Additionally, regardless of whether an employee meets the definition of a Covered Employee, if their regular work duties occur within the geographical boundaries of the City, then the employer must comply with all recordkeeping requirements for that employee as explained below.

The partial payout period for medium-sized employers has been postponed until July 1, 2025. Previously, medium-sized employers needed to pay out a maximum of 16 hours of Paid Leave until December 31, 2024, and then, effective January 1, 2025, were required to pay out all accrued, unused Paid Leave.

The last modification was adding a prerequisite to the private cause of action for an employee to sue an employer. The prerequisites are explained in more detail below and are set to expire on July 1, 2026.

Record Retention and Private Cause of Action

Every employer must maintain records for at least five years containing the following information for each employee:

- Name and address
- Hours worked
- Pay rate
- Wage agreement
- Number of paid time off hours earned each year
- Date on which paid time off hours were taken and paid
- Any other records or documents necessary to demonstrate compliance with this law

A Covered Employee can sue an employer in a civil action if the Covered Employee is not allowed to obtain or use benefits as entitled under the Ordinance. The Covered Employee can seek damages equal to three times the full amount of any leave denied or lost by reason of the alleged violation as well as any interest and reasonable attorney's fees. Until July 1, 2026, before bringing a civil action the Covered Employee can only bring a suit if: (1) an alleged violation occurs and (2) the payday for the next regular payroll period or 16 days after the alleged violation occurred passes, whichever is the shorter period.

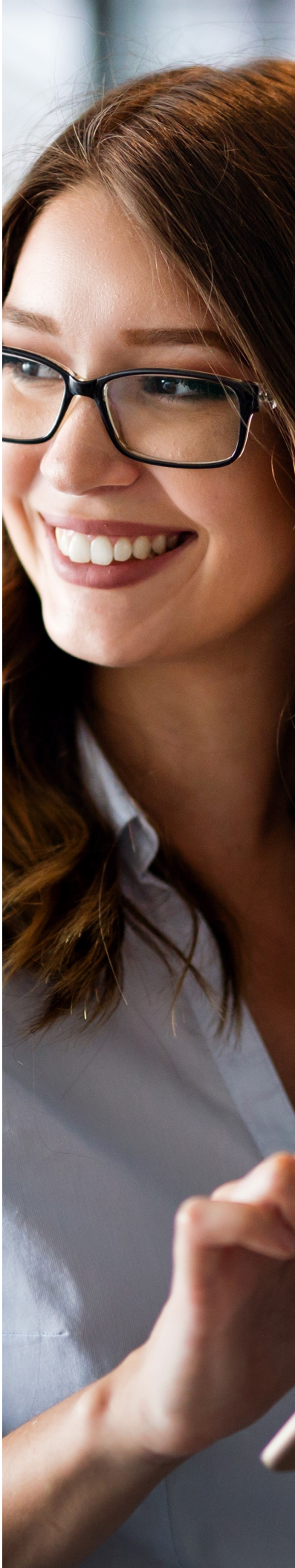
Employer Action

In addition to the recommended action steps in our prior guidance, employers should also:

- Identify if the change in definition for covered employee has any impact on which employees that PLSSPL must be provided. Some employers may find that the modified definition decreases the number of covered employees that are subject to this law.
- Update their recordkeeping and payroll systems to adjust to the new effective date in July.
- Access resources that will allow for translation of the employer's written policy in the employee's primary language. If there are existing resources, it may be prudent to inquire if they already have a template or boilerplate policy that the employer can easily modify, if necessary.
- Assess current paid time off and sick leave policies to determine compliance with the new ordinance;
- Determine if any hours accrued need to be carried over;
- Review and update any postings and pay stub notification requirements;
- Update handbooks as necessary; and
- Train staff regarding new requirements and updated policies.

While further guidance is expected from the City, affected employers should work with their employment counsel or other advisors to comply with these new requirements.

2023 State-Based Compliance: Quarter Four



REMINDER: Upcoming Deadline to Apply for 2024 Colorado FAMLI Private Plan

As previously announced, Colorado will commence paid family medical leave for eligible employees starting January 1, 2024. The deadline for employers who wish to establish a private plan effective January 1, 2024 is fast approaching on October 31, 2023.

More information follows.

Background

Since January 1, 2023, covered employers have registered with the Colorado Paid Family and Medical Leave program ("FAMLI") and provided quarterly wage reports and employer and employee contributions.

Employers can choose to either participate in the state sponsored FAMLI program or initiate their own private plan. Private plan options are both fully insured via carriers or self-funded by holding the employer and employee contribution in a separate account that is backed by a surety bond.

Private Plan Option

Any type of private plan must be approved by FAMLI. FAMLI has provided list of approved plans offered by fully insured carriers which can be found at: https://famli.colorado.gov/employers/private-plans. Other carrier and self-funded plans have until October 31, 2023, to submit an application for approval for their private plan if they want to have it in effect as of January 1, 2024. Employers will use My FAMLI+ Employer at: https://famli.colorado.gov/employers/my-famli-employer to submit their applications which will include proof of purchase documentation.

Upon approval of the employer's private plan, FAMLI will refund any contributions that they have received to the employer based upon the employer's preference on how they would like to receive the refund (ACH credit or paper check). For those employees that no longer work for the employer but did contribute to FAMLI, FAMLI will forward those refunds to the employees directly. While employers do not need to do anything to initiate the refund, they may proactively request the refund by calling FAMLI at 1-866-CO-FAMLI (1-866-263-2654).

Once the private plan is approved, employers have 30 days to send written notice to employees of their decision to use a private plan instead of the state program. The notice can be provided electronically, in person, or via mail. Subsequent new hires will receive the notice immediately upon hire. Additional information is available at: https://famli.colorado.gov/employers.

Recently, FAMLI issued several proposed guidance documents for the public and held a public hearing on October 17, 2023. Once the guidance is finalized, additional information will be provided, especially as the guidance relates to the administration of private plans and other key elements of the FAMLI program.

Updates to Maryland's Paid Family and Medical Leave Requirement

As previously reported, Maryland passed the Time to Care Act of 2022 ("the Act"), which mandates that covered employers provide paid family and medical leave to their employees in Maryland. On May 3, 2023, Governor Wes Moore signed SB 828, amending the Act. The Legislature's notable modifications include a delay in implementation as well as providing clarification on how the Act will coordinate state benefits with existing federal Family and Medical Leave Act ("FMLA") requirements and employer paid time off.

Separately, on September 29, 2023, the Maryland Department of Labor ("DOL") announced the initial contribution rate for the Family and Medical Leave Insurance State Plan.

Legislative Changes and Updates

- Employers participating in the State Plan will begin making payroll contributions starting on October 1, 2024 (a delay of one year from the original date). Similarly delayed one year, benefits payments will begin on January 1, 2026.
- Where an employee is eligible for leave under both federal FMLA and under the Act, the DOL can consider the use of FMLA to offset the duration of available leave under the Act where:
    - An employer designates a period of leave taken by an employee as FMLA leave and it is also eligible under the Act;
    - The employer provides the employee notice that the leave is eligible under the Act; and
    - The employee does not apply for benefits under the Act.
- Contrary to the language in the original Act, the amendments now prohibit an employer from requiring an employee to use up all available vacation, sick, or other employer-provided paid leave prior to applying for (or while receiving) benefits under the Act.
- On September 29, 2023, the DOL announced the initial contribution rate for the Act would be a rate of 0.90% of covered wages and will be divided equally between employees and employers with more than 15 workers. The contribution rate will be split evenly between employers and employees, each paying a 0.45% share.

This contribution rate will continue through at least June 20, 2026.

Employer Action

Employers should

- Review and examine their existing paid leave policies (and their employee handbook) to determine whether they will want to utilize these policies to satisfy, or supplement, their requirements under the Act.
- Contemplate whether to participate in the state program or offer a private program (e.g., substitute existing leave or purchase a private insurance policy). Note, employers will need to apply for approval from the DOL to offer an alternative plan. Guidance on this process is expected in the future.
- Provide written notice to all covered employees of their rights and duties under the Act.
- Ensure that payroll is prepared to begin contributions on October 1, 2024.
- Future regulations are expected and employers should continue to await their release.

Oklahoma PBM Law Preempted by ERISA

The 10th Circuit Court of Appeals ruled in favor of ERISA preemption in *Pharmaceutical Care Management Association ("PCMA") v. Mulready*, finding that Oklahoma's Patient's Right to Pharmacy Choice Act ("the Act") regulating pharmacy benefit managers ("PBMs") is preempted by ERISA. This decision reversed the lower court's finding that the Act was not preempted.

Briefly, the court considered the Act's following requirements in its analysis of ERISA preemption:

- Network Restrictions:
    - Access Standards. A PBM must comply with network access standards and may not use mail-order pharmacies to meet these standards.
    - Discount Prohibition. An individual's choice of in-network provider may include a retail pharmacy or a mail-order pharmacy. A PBM may not restrict such choice and may not require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy.
    - AWP Prohibition. A PBM cannot deny a provider the opportunity to participate in any pharmacy network at preferred participation status if the provider is willing to accept the terms and conditions that the PBM has established for other providers as a condition of preferred network participation status.
- Probation Prohibition. A PBM may not deny, limit, or terminate a provider's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy.

Finding in favor of ERISA preemption, the court held that:

- The network restrictions effectively abolish the two-tiered network structure, eliminate any reason for plans to employ mail-order or specialty pharmacies, and oblige PBMs to embrace every pharmacy into the network. These limits are state law mandated benefit structures which are not permitted under ERISA.
- The probation prohibition acts like a network restriction, dictating which pharmacies must be included in a plan's PBM network. An ERISA plan that chooses to hire a PBM is limited by state statute to using PBM networks of a certain structure – one that would include a pharmacist on probation. Such a state restriction is also preempted by ERISA.

The court distinguished its ruling from the U.S. Supreme Court's decision finding an Arkansas PBM law was not preempted by ERISA as the law regulated cost (reimbursement-rate regulation). The court found that the Oklahoma law goes further than Arkansas's PBM law in it regulates aspects of plan administration and design and therefore has an impermissible connection with ERISA plans.

> "Unlike Arkansas's reimbursement-rate regulations, Oklahoma's network restrictions do more than increase costs. They home in on PBM pharmacy networks—the structures through which plan beneficiaries access their drug benefits. And they impede PBMs from offering plans some of the most fundamental network designs, such as

preferred pharmacies, mail-order pharmacies, and specialty pharmacies. In sum, PCMA is not resisting the Act's imposing higher costs, but Oklahoma's attempting to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration."

Mulready, the insurance commissioner of Oklahoma, has already expressed his intent to appeal the 10th Circuit ruling and indicates that enforcement of the Act will continue to the maximum ability of state law. Most likely the Supreme Court will be asked to weigh in on this issue.

Employer Action

For now, employers should carefully monitor developments in the state PBM space. Federal courts may take a closer look at the state PBM laws for areas of overreach consistent with the 10th Circuit ruling. Ultimately, the U.S. Supreme Court may be asked to weigh in again on the intersect between state PBM regulations and ERISA preemption.

Oregon Expands Domestic Partner Registration Eligibility

Currently, Oregon registered domestic partnership is limited to same sex couples. Effective January 1, 2024, Oregon will allow opposite sex couples to register their domestic partnership. Employers that sponsor fully insured plans[1] that cover registered domestic partners of employees may have more employees enrolling a registered domestic partner in the group health plan.

Background

Under Oregon law, domestic partners who are registered with the state's domestic partner registry are generally afforded the same rights, protections, and benefits as are granted to spouses.[2]

Fully insured group health plans in Oregon as well as non-ERISA plans sponsored by state and local government employers that cover spouses of Oregon employees are required to provide coverage to registered domestic partners.

Self-funded plans covered by ERISA are not required to provide coverage for registered domestic partners. However, an employer sponsoring a self-funded plan may voluntarily choose to extend coverage to domestic partners, whether they are registered or based on the plan's domestic partner eligibility criteria.

Under Oregon law, in order to register a domestic partnership, a couple must file a notarized Declaration of Oregon Registered Domestic Partnership form with an Oregon county clerk. The form attests that the couple meets certain criteria at the time of filing. Until December 31, 2023, one requirement is that the couple are both members of the same sex.[3]

HB 2032

On April 6, 2023, Oregon Governor Tina Kotek signed HB 2032 amending Oregon law to expand eligibility for Oregon Registered Domestic Partnerships.[4] This new law eliminates the requirement that both domestic partners be of the same sex in order to register their domestic partnership. This change is effective January 1, 2024; opposite sex couples must wait until that date to file the required declaration form with a county clerk.

Employer Next Steps

Employers with fully insured plans in Oregon must treat registered domestic partners on the same basis as spouses in the group health plan. This will extend to opposite sex couples who register under the expanded definition.

Employers with Oregon employees should review the eligibility terms in their plan documents, summary plan descriptions, employee handbook, open enrollment material, and other communications to see if there is a domestic partner definition that needs to be updated. No change to the term "registered domestic partner" is necessary, but any listing of the criteria to register a domestic partnership in Oregon will need to reflect the eligibility of opposite sex couples effective January 1, 2024.

Employers sponsoring a self-funded plan that has voluntarily extended coverage to domestic partners, and whose domestic partner eligibility allows same sex couples only, may consider amending the criteria to reflect the upcoming change in the eligibility for an Oregon registered domestic partnership.

Additionally, newly registered domestic partners would become eligible for coverage under a fully insured group health plan and would likely qualify for mid-year enrollment on the group health plan. However, the tax treatment of the employee cost for this coverage is subject to different rules at the state and federal level. Employers will want to confirm that their payroll tax reporting and cafeteria plan deductions comply with these tax rules.

As noted above, the requirement to cover registered domestic partners applies to all state and local governmental plans that are not covered by ERISA.

RESOURCES

- Oregon State Legislature website for HB 2032, https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/HB2032

- Oregon Registered Domestic Partnership Website, https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/dp.aspx

[1]The requirement to cover registered domestic partners applies to state and local governmental plans that are not ERISA covered.
[2]ORS 106.340
https://oregon.public.law/statutes/ors_106.340#:~:text=Any%20privilege%2C%20immunity%2C%20right%20or,granted%20on%20equivalent%20terms%2C%20substantive
[3]Couples must meet the following requirements to file for Oregon Registered Domestic Partner status:
1. the couple must be 18 years of age or older,
2. one partner must be a resident of Oregon,
3. neither partner can presently be in a marriage or a legally recognized registered domestic partnership; and
4. (a) Until December 31, 2023 – both partners must be of the same sex (b) on or after January 1, 2024 partners may be of any sex.
https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/dp.aspx

[4]https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2032/Enrolled

Paid Leave Oregon Benefit and Contribution Amount Adjustments

December 21, 2023 Update: The Social Security wage cap has been released for 2024. The "Contribution Limit" section below includes several updates to reflect this and additional related information.

As previously reported in August 2021, 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

The total contribution amount of 1% of eligible wages is split between employees and employers. Employees pay 60% and employers pay 40%. For example, $1,000 in wages would equal $10 in premiums paid to PLO of which, the employee would pay $6, and the employer would pay $4.

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. The Social Security cap has been announced for 2024 and is set at $168,600. ED is required to announce the adjusted contribution limit by November of each year for the following 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.

Washington Decreases 2024 Paid Family and Medical Leave Premium

The Washington Employment Security Department ("ESD") announced a decrease in the premium rate for Washington Paid Family and Medical Leave ("WA PFML"). The premium rate will decrease to 0.74% of employee wages, down from the current 0.8%. The decrease is effective for the first quarter of 2024 and should be reflected in contributions and reporting for all pay dates on or after January 1, 2024.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family and medical leave through the state insurance fund or an approved voluntary plan. WA PFML benefits are funded by premiums paid by employers and employees. Premiums are funded by employee and employer contributions based on employee wages up to the social security cap ($168,600 in 2024). Employers are also required to report employee wages and hours when premiums are remitted to ESD.

2024 Premium Changes

Effective for payrolls on or after January 1, 2024:

- The premium amount is decreasing to 0.74% of employee wages.
- The wages subject to premiums are increasing to $168,600 to reflect the higher social security wage cap for 2024.
- The employer portion of the premium is increasing to 28.57% and the employee portion is decreasing to 71.43%.

Employers with fewer than 50 employees are not required to pay the employer portion.

Example of annual premium amount for an employee earning $75,000 in 2023 and 2024:

- Total annual premium in **2023**: $75,000 x 0.8% = **$600**
  Employee cost: $436.56
  Employer cost: $163.44
- Total annual premium in **2024**: $75,000 x 0.74% = **$555**
  Employee cost: $396.44
  Employer cost: $158.56

Employer Action

Employers should confirm their payroll systems are prepared to deduct the new lower rates from employee paychecks beginning January 1, 2024. Employers are prohibited from deducting more than the maximum allowable employee portion of the premium from wages paid in a pay period.

This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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