CBP
Creative Benefit Plans
INSURANCE MADE EASY

2021: First Quarter

Compliance Digest

Compliance Bulletins Released January-March

2021 Compliance Bulletins

January

February

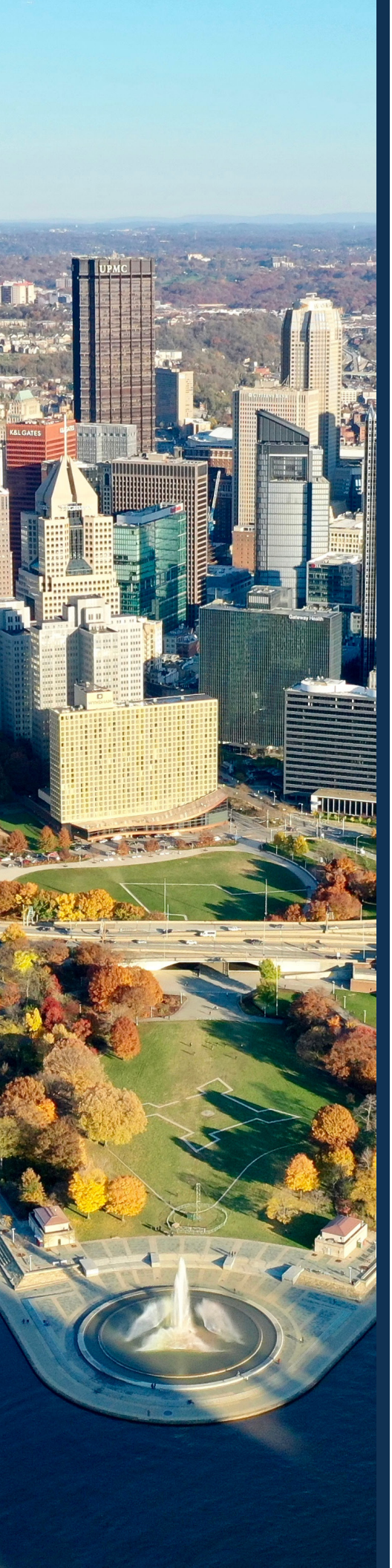
March

2021 State Bulletins

Arkansas

Virginia

Washington



Pittsburgh COVID-19 Paid Sick Leave Ordinance Enacted

Published: January 8, 2021

In response to the COVID-19 pandemic, on December 9, 2020, the City of Pittsburgh adopted a Temporary COVID-19 Emergency Paid Sick Leave Ordinance (the "Ordinance") which gives certain workers up to 80 hours of paid sick leave due to COVID-19. The Ordinance was effective immediately and amends the Pittsburgh Paid Sick Days Act. It will remain effective until one week after the expiration of the public health emergency.

Background

Effective on March 15, 2020, the Pittsburgh Paid Sick Days Act ("PSDA") requires all employers of employees located within the City of Pittsburgh to provide their full-time and part-time employees paid sick leave. Employers with 15 or more employees are required to provide up to 40 hours of paid sick leave per year (24 hours if less than 15 employees), at a rate of one hour of leave for every 35 hours worked in Pittsburgh. Covered employees must have been employed for a minimum of 90 days in order to use this sick time. While the Families First Coronavirus Response Act ("FFCRA") provides mandatory family and medical leave and paid sick leave for employees for COVID-19 reasons (where the employer has less than 500 employees), the FFCRA expired at the end of 2020 and employees are not permitted to use FFCRA leave after December 31, 2020. The Ordinance was introduced to amend the PSDA so that employees can continue to have COVID-19-related paid sick leave.

PSDA

Employers with 50 or more employees within the City of Pittsburgh must immediately provide COVID-19 sick time to covered employees without any waiting period or accrual requirements. Employees are covered if they have been employed by the employer for a minimum of 90 days and they (i) work in Pittsburgh, (ii) normally work in Pittsburgh, but are currently teleworking from any other location as a result of COVID-19, or (iii) work for the employer from multiple locations or from mobile locations so long as 50% or more of the employee's time is spent within the City of Pittsburgh. COVID-19 sick time must be in addition to any paid or sick leave provided by the employer. Employers are prohibited from changing any paid leave policies on or after the effective date of the Ordinance to avoid compliance.

Employees who work 40 hours or more per week must be provided up to 80 hours of COVID-19 sick time. If an employee works less than 40 hours per week, the amount of COVID-19 sick time shall be equal to the amount of time the employee is otherwise scheduled to work or works on average in a 14-day period, whichever is greater. For employees working variable hours, the amount can be equal to the average number of hours the employee was scheduled to work over the past 90 days of work, including any hours taken for any type of leave. Of course, employers may designate a higher amount of sick time if they choose.

Covered employees are eligible for COVID-19 sick time for the following reasons:

- Determination by a public official or public health authority, health care provider or the employee's employer that the employee's or employee's family member's presence on the job or in the community would jeopardize the health of others because of the employee's or employee's family member's exposure to COVID-19 or because the individual is exhibiting symptoms that might jeopardize the health of others, regardless of whether the individual has been diagnosed with COVID-19;

- The employee's need to (a) self-isolate and care for oneself because the employee is diagnosed with COVID-19; (b) self-isolate and care for oneself because the employee is experiencing symptoms of COVID-19; (c) seek or obtain medical diagnosis, care or treatment if experiencing symptoms of an illness related to COVID-19; or

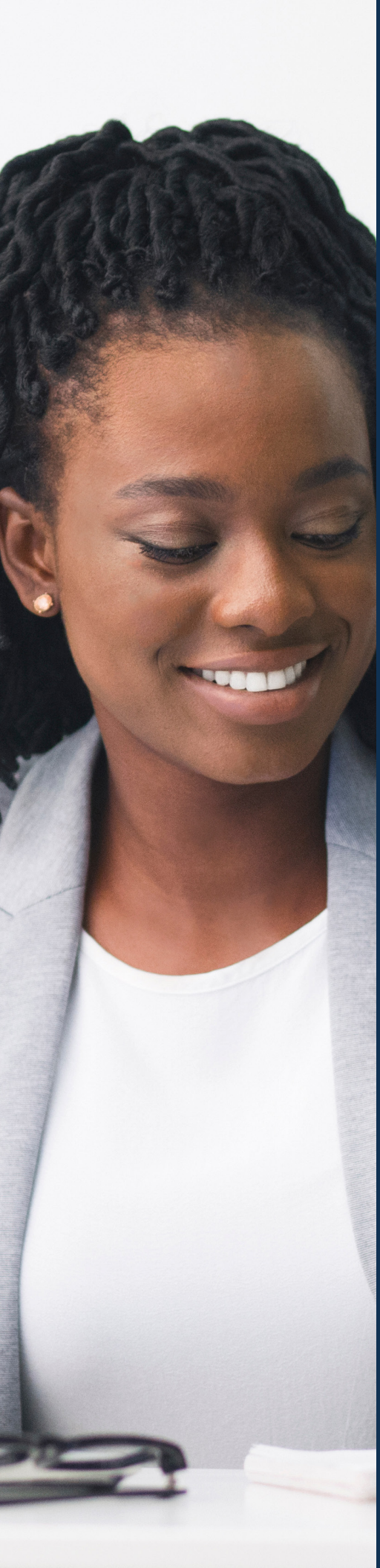
- Care of a family member who (a) is self-isolating due to being diagnosed with COVID-19; (b) is self-isolating due to experiencing symptoms of COVID-19; (c) needs medical diagnosis, care, or treatment if experiencing symptoms of an illness related to COVID 19.

Covered employees must provide notice to their employers of the need for the above leave as soon as practicable, but there is no prescribed time set forth in the Ordinance. Employers cannot require that employees find a replacement worker to cover their hours.

Unless federal or state law requires, employers may not require employees to use other employer-paid leave prior to using the COVID-19 sick time. To the extent that federal or state laws require employers to provide paid leave or paid sick time related to COVID-19, employers are permitted to substitute leave under the federal or state law for their obligations under the Ordinance to the extent they coincide and the federal/state law allows concurrent use of paid leave. Additionally, if an employer has adopted a paid sick time policy specifically for use during COVID-19 after March 13, 2020 (the declaration of emergency), employers are permitted to substitute leave under such employer policy for the leave required under the Ordinance, to the extent they coincide.

Employer Action

Employers should review the Ordinance, as well as their paid leave policies and procedures and ensure they are complying with the Ordinance. Further guidance regarding notice obligations and required documentation would be welcome. It is important to note that the Ordinance does not provide tax incentives for employer, thus, employers will bear the burden of this cost.



DOL FAQs Address Expiration of FFCRA Leave

Published: January 12, 2021

On the last day of 2020, the Wage and Hour Division of the Department of Labor ("DOL") issued two additional FAQs (#104 and #105) related to the Families First Coronavirus Response Act ("FFCRA"), addressing the three-month voluntary extension of FFCRA leave into 2021, and clarifying payment of leave taken during 2020.

The FFCRA required most employers with less than 500 employees to provide paid sick leave and paid family leave to employees who are unable to work or telework due to COVID-19 specific reasons. In addition, the FCRA provided refundable tax credits that reimburse employers, dollar for dollar (up to a prescribed limit), for the cost of providing sick and family leave wages to their eligible employees for leave related to COVID-19.

The paid leave provisions of the FFCRA expired on December 31, 2020. The Consolidated Appropriations Act, 2021 ("the Act"), signed into law on December 27, 2020, provides that eligible employers may voluntarily extend FFCRA paid leaves through March 31, 2021, and receive associated tax credits. Notably, the Act does not require the extension of paid FFCRA leave beyond December 31, 2020.

FAQ #104 makes clear that applicable employers are not required to extend FFCRA leave to employees after December 31, 2020. However, it reiterates that employers may decide to provide such paid leave on a voluntary basis and are eligible for the tax credits associated therefrom through March 31, 2021.

FAQ #105 clarifies that all qualified FFCRA leave taken on or before December 31, 2020 must be paid to the employee, even if such payments are made in 2021. The DOL also reiterated that the statute of limitations for bringing a claim of a violation of FFCRA is two years (or three years in the case of a willful violation) and that employees may potentially bring a private right of action for alleged violations.

EEOC Provides Proposed Wellness Rules

Published: January 15, 2021

On January 7, 2021, the Equal Employment Opportunity Commission ("EEOC") released two notices of proposed rulemaking ("Proposed Rules") on wellness programs under the Americans with Disabilities Act ("ADA") and the Genetic Information Nondiscrimination Act ("GINA"). Briefly, if finalized in their current form, the Proposed Rules:

- generally align ADA rules to existing rules applicable to "health contingent" wellness programs under the Health Insurance Portability and Accountability Act ("HIPAA").
- restrict incentives tied to "participatory" wellness programs, such as those that provide incentives for individuals to disclose health information through health risk assessments or biometric screenings, to "de minimis" amounts. Examples of de minimis amounts are "a water bottle or gift card of modest value."
- under the GINA rules, apply restrictions to incentives related to a spouse's participation in health risk assessments.

Background

There are three sets of laws governing wellness programs and incentive limits currently in effect: HIPAA rules, ADA rules and GINA rules.

HIPAA

The HIPAA rules contain five requirements health contingent programs must satisfy, one of which involves incentives. When rewards are used in a group health plan to promote involvement in an activity (e.g., walking, diet, or exercise program) or to attain a certain outcome (e.g., not smoking or achieving certain results on biometric screenings), incentives cannot exceed 30% of the total cost of coverage under the group health plan (or up to 50% when the program is tobacco-related).

ADA

A wellness program involving a medical test or disability-related inquiries of an employee must be "voluntary." EEOC regulations issued in 2016 had generally provided that incentives could not exceed 30% of the total cost of self-only coverage in the lowest cost plan option offered to an employee in order for the program to be considered voluntary. However, the incentive portion of the 2016 regulations was vacated by court order, effective January 1, 2019.

GINA

As with the ADA rules, a wellness program involving a medical test or disability-related inquiries of a spouse must be "voluntary." GINA regulations had generally provided that incentives could not exceed 30% of the total cost of self-only coverage in the lowest cost plan option offered to an employee in order for the program to be considered voluntary. Those too were partially vacated by court order, effective January 1, 2019.

Proposed Rules

Health contingent programs continue viability under HIPAA requirements

For health contingent wellness programs (activity based or outcomes based), the Proposed Rules will permit incentives that align with the rules under HIPAA (currently 30% of the total cost of coverage or 50% to the extent the wellness program is designed to prevent or reduce tobacco use), as long as the program is part of, or qualifies as, a group health plan and complies with the HIPAA five factor requirements for such plans.

For this purpose, the Proposed Rules set forth four factors that are helpful in determining when a wellness program is part of the group health plan:

- The program is offered only to employees who are enrolled in an employer-sponsored group health plan;

- Any incentives offered are tied to cost-sharing or premium reductions (or increases) under the group health plan;
- The program is offered by a vendor that has contracted with the group health plan or insurer; and,
- The program is a term of coverage under the terms of a group health plan.

Participatory programs would be subject to severe limitations

For participatory programs, the Proposed Rules would sharply reduce the value of incentives many employers have historically utilized, such as a reduction in employee health insurance premiums for meeting wellness criteria. A participatory program is typically a wellness program that simply collects employee health information through health risk assessments or biometric screenings without tracking results and requiring employees to achieve certain health goals in order to earn an award or avoid a penalty. Under the ADA Proposed Rule, those programs are subject to a "de minimis" incentive standard. To be considered voluntary, a wellness program may offer no more than a de minimis incentive (such as a water bottle or gift card of modest value) in exchange for the employee participating in the wellness program.

According to the Proposed Rules, charging an employee $50 per month more for health insurance (or a total of $600 per year) for not completing a health risk assessment as part of a participatory wellness program would not be a de minimis incentive and would violate the ADA because the employee would be treated less favorably with respect to the cost of health insurance than employees who chose to provide their health information. This is much more stringent than the 2016 ADA regulations which would have allowed participatory programs that included medical exams or disability related inquiries to offer up to a 30% incentive based on the cost of self-only coverage in the lowest plan option.

GINA rules would subject participatory programs for spouses to severe limitations

Under the original rule, there was an exception to the general prohibition on providing incentives in return for genetic information that allowed limited incentives (up to 30%) to spouses who provide information (via risk assessment) about their manifestation of a disease or disorder to a wellness program. Under the Proposed Rule, wellness programs would be limited to de minimis incentives to all family members (not just spouses) in exchange for family members providing information about their manifestation a disease or disorder (which is considered the employee's genetic information). As described above, de minimis means very low value incentives such as a water bottle or gift card of modest value.

ADA Notice Not Required

The Proposed Rule would remove the unique ADA notice requirement that currently exists under the 2016 regulations.

Employer Action

At this time the above rules are simply proposed and employers are not required to rely on them or to comply with them. There will be a 60-day notice and comment period before the Proposed Rules are finalized and the finalized version may be different from what is included in the Proposed Rules. Typically, new regulations will apply prospectively starting at a future date (e.g., plan years starting in 2022). Further, the change to a new administration under President Biden may also have an impact. It is also possible that the rules may be challenged by others, such as the AARP, since they are so aggressive towards incentives. Additionally, the EEOC is seeking comments on the regulations. Employers should review their existing wellness programs in light of the EEOC's guidance. We will keep you apprised on new developments.

HHS Extends the Public Health Emergency Again

Published: January 19, 2021

On January 7, 2021, the Secretary of Health and Human Services ("HHS") announced the administration will renew the COVID-19 pandemic Public Health Emergency, scheduled to expire on January 21, 2021. This will once again extend the period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

It should be noted that there is a difference between the emergency period and the outbreak period as follows:

Emergency Period: HHS Secretary issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire April 21, 2021 (unless further extended or shortened by HHS).

Outbreak Period: The Outbreak Period runs from March 1, 2020 until 60 days after the announced end of the National Emergency (note that the end of the National Emergency may not be the same date as the end of the Public Health Emergency period). The Departments are expected to announce the end date; at this time, no end date has been announced. According to the regulations, a period of "up to one year" may be disregarded. Therefore, it appears the latest the Outbreak Period may end is February 28, 2021. However, further guidance would be helpful.

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

Benefit Plan Changes in Effect through the End of the EMERGENCY PERIOD

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

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

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

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

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

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

Benefit Plan Changes in Effect through the End of the OUTBREAK PERIOD

Group health plans, disability, and other employee welfare benefit plans will disregard the period from March 1, 2020 until the end of the Outbreak Period when determining the following:

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

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

ERISA Claims Deadlines. Timeframe to submit a claim and appeal of an adverse benefit determination. For non-grandfathered medical plans, timeframe to request external review and perfect an incomplete request. This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans. A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

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

New Jersey Issues 2020 Individual Mandate Reporting Requirements

Published: January 27, 2021

The State of New Jersey has provided information for employer reporting for the 2020 calendar year under New Jersey's individual health insurance mandate that went into effect January 1, 2019. All employers (including out-of-state employers) who provided health coverage to New Jersey residents should review their obligations to issue participant statements and file health coverage information with the state. Reporting obligations differ depending on whether the coverage is provided under an insured or self-funded arrangement.

Employers, insurers and other coverage providers must:

- Transmit 1095 health coverage forms (1095-B, 1095-C or NJ-1095) to the New Jersey Division of Taxation no later than March 31, 2020.
- Issue a 1095 health coverage form no later than March 2, 2020 to each primary enrollee who was a New Jersey resident and to whom minimum essential coverage was provided during 2020.

Background

Beginning January 1, 2019, the New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance. Failure to do so, absent an exemption, will result in an individual penalty imposed by the state when a person files his or her 2020 New Jersey Income Tax return. This New Jersey individual insurance mandate essentially replaces the individual mandate imposed under ACA, which was effectively eliminated beginning January 1, 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report to covered individuals and to the state affirming such individuals maintained health coverage during the calendar year.

Required Forms

Forms are required to be issued to all primary enrollees no later than March 2, 2021 and filed with the state no later than March 31, 2021 on behalf of all part-year and full-year New Jersey residents for 2020. A part-year resident is an individual who lives in the state for at least 15 days in any month in 2020.

Certain employers and other providers of minimum essential health insurance coverage such as insurance carriers, multiemployer plans, government entities, etc. must electronically file the forms with the New Jersey Division of Taxation no later than March 31, 2021 as paper forms will not be accepted. Insurers or employers can file 1095 forms in two ways:

- Registered filers can use the Division of Revenue and Enterprise Services' (DORES) MFT SecureTransport (Axway) service. MFT (Axway) is the required system for filers of 100 or more forms. Taxpayers who have MFT SecureTransport (Axway) service user credentials use them to submit the required health insurance coverage returns. Those without a current account should request account setup.

- As an alternative to MFT SecureTransport (Axway), coverage providers with under 100 forms can use Form NJ-1095 to file one form at a time. New Jersey will post a link to the NJ-1095 form for 2020 before the 1095 filing deadline. The NJ-1095 form is valid for federal filers of either 1095-B or 1095-C forms.

Employers should only send Forms 1095-C to the state for individuals subject to New Jersey's individual mandate. While the state will accept 1095 data files containing records for individuals who are not New Jersey residents, employers should be cognizant that privacy and other laws may limit or prohibit

Employers with Fully Insured Coverage

The insurance carrier will generally be required to file form 1095-B with the state for each covered member of the plan and furnish Form 1095-B to NJ residents. However; an employer must file if its insurer or multi-employer plan does not file the required 1095 forms on time.

Employers with Self-Insured Coverage

The employer files with the state a fully completed 1095-C, 1095-B or NJ-1095 form for each primary enrollee (employee, COBRA participant, retiree, non-employee member) covered under the plan for at least one month of the calendar year and furnishes a form to NJ residents.

Employers Participating in a Multiemployer Arrangement

The plan sponsor should file Form 1095-B (or 1095-C) for each primary enrolled although an employer must file if the multi-employer plan does not file and furnish the required 1095 forms on time.

Separate 1095 forms to spouses, dependents, or adult children of primary enrollees are not required.

Employer Action

Employers with fully insured plans (especially employers with insured coverage issued outside of New Jersey) should confirm that the insurer will issue Forms 1095-B to New Jersey primary enrollees by March 2, 2021. It's important to note that the IRS again has issued guidance relaxing the ACA reporting rules for insurance carriers who are no longer required to automatically issue Forms 1095-B to plan participants, although carriers must still file Forms 1095-B with the IRS.

Employers with fully insured plans (especially employers with insured coverage issued outside of New Jersey) should confirm that the insurer will file the Forms 1095-B with the state no later than March 31, 2021.

Employers with self-insured plans should discuss with their payroll vendor or forms provider to determine if they will file the forms with the state and issue participant statements on the employer's behalf.

As New Jersey will not require that separate forms be prepared for adult children who were covered under their parents' group health plan, the state suggests that employees provide a copy of Form 1095-B or 1095-C to their adult children who reside in New Jersey.

New York Issues Guidance Expanding COVID-19 Sick Leave

Published: January 29, 2021

On January 20, 2021, the New York State Department of Health (the "Agency") issued guidance on the use of COVID-19 sick leave, which appears to expand the ability of individuals to access COVID-19 sick leave beyond the scope of the original New York legislation. However, the guidance prohibits an employee from qualifying for sick leave under New York's COVID-19 sick leave law for more than three orders of quarantine or isolation.

It should be noted that this guidance is not a regulation and there is some concern that the Agency may be exceeding its authority by expanding the scope of the enacted legislation, which limits COVID-19 sick leave to up to 14 days for larger employers and does not include provisions for multiple quarantines or absences from work. Thus, the guidance may be challenged.

Background

On March 18, 2020, Governor Cuomo signed legislation (the "Act") that implements emergency sick leave benefits to employees subject to a mandatory or precautionary order of quarantine or isolation issued by a governmental entity duly authorized to issue such order due to COVID-19 ("Quarantine Period"). The legislation provides impacted employees these benefits through the termination of the Quarantine Period.

As a reminder, employers cannot require employees to use existing sick leave accruals or other accruals (e.g., paid time off) for a COVID-19 quarantine. Employers required to provide paid COVID-19 sick leave must provide leave separate from any accruals.

Generally speaking, the minimum amount of leave is based on the employer's size as of January 1, 2020 and is as follows:

Employer Size	Minimum Sick Leave Requirements
Up to 10 employees* with net income of $1M or less in the prior tax year	Unpaid leave during the Quarantine Period
Up to 10 employees* with net income greater than $1M in the prior tax year	5 days of paid sick leave and unpaid leave thereafter**
11 – 99 employees*	5 days of paid sick leave and unpaid leave thereafter**
100 or more employees* and public employers	14 days of paid sick leave

*Counting employees both within and without the city.

**Following the expiration of the Minimum Sick Leave Requirements, employees may also be eligible for benefits under the New York Paid Family Leave and Disability Leave Law.

What has Changed?

New York employers now appear to be required to provide COVID-19 paid sick leave for up to three orders of quarantine or isolation if the employee is under a subsequent order of quarantine or isolation because they test positive for COVID-19. This latest guidance states that additional COVID-19 sick leave may be available in the following three instances:

- An employee who returns to work following a period of mandatory quarantine or isolation, who subsequently receives a positive diagnostic test result for COVID-19 (precluding a return to work) shall be deemed to be subject to a mandatory order of isolation from the Department of Health and shall be entitled to COVID-19 sick leave whether or not the employee already has received sick leave as required by the law for the first period of quarantine or isolation.

- An employee who is subject to an order of quarantine or isolation but continues to test positive for COVID-19 after the end of such quarantine or isolation period (precluding a return to work) shall also be deemed to be subject to a second mandatory order of isolation from the Department of Health and shall be entitled to COVID-19 sick leave for the second period of isolation.

- If an employer mandates that an employee who is not otherwise subject to a mandatory or precautionary order of quarantine or isolation to remain out of work due to exposure or potential exposure to COVID-19, regardless of whether such exposure or potential exposure was in the workplace, the employer shall continue to pay the employee at the employee's regular rate of pay until such time as the employer permits the employee to return to work or the employee becomes subject to a mandatory or precautionary order of quarantine or isolation. At that time, the employee shall receive COVID-19 sick leave for the period of time the employee is subject to such mandatory or precautionary order of quarantine or isolation.

Employer Action

Employers should review their obligations with employment counsel to ensure the appropriate amount of COVID-19 sick leave as well as other New York paid leave is available to employees.

DOL Penalties Increase for 2021

Published: February 1, 2021

The Department of Labor (DOL) published the annual adjustments for 2021 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2021

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

Description	2020 Penalty	2021 Penalty
Failure to file Form 5500	Up to $2,233 per day	Up to $2,259 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,625 per day	Up to $1,644 per day
Failure to provide CHIP Notice	Up to $119 per day per employee	Up to $120 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$119 per day per violation (per participant/beneficiary)	$120 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,176 per failure	Up to $1,190 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL on request	$159 per day $1,594 cap per request	$161 per day $1,613 cap per request
Genetic information failures	$119 per day (per participant/beneficiary)	$120 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$2,970 minimum	$3,005 minimum
Failure to meet genetic information requirements – not de minimis failures	$17,824 minimum	$18,035 minimum
Cap on unintentional failures to meet genetic information requirements	$594,129 maximum	$601,152 maximum

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.

Reminders for Medicare CMS Notice and 1094-1095 filing

Published: February 9, 2021

Medicare Part D – CMS Notification Reminder

Employers sponsoring a group health plan are required by federal law to inform the Centers for Medicare and Medicaid Services within 60 days after the beginning of the plan year about the creditable status of the plan's prescription drug coverage.

Reminder: Final 2020 Forms 1094-C and 1095-C Issued

Applicable large employers must furnish the 2020 Forms 1095-C to its full-time employees by no later than Tuesday, March 2, 2021.

Medicare Part D – CMS Notification Reminder

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, 2021) must complete this reporting no later than Monday, March 1, 2021.

Additional guidance on completing the form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

Reminder: Final 2020 Forms 1094-C and 1095-C Issued

The IRS released final 2020 Forms 1094-C, 1095-C, and applicable instructions. 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., COBRA qualified beneficiaries).

Due to the COVID-19 pandemic and challenges to business operations, ALEs may have variations to their reporting for 2020 due to furloughs and/or layoffs. ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2020 in preparation to complete, furnish and file these forms for 2020.

As a reminder, IRS Notice 2020-76 provided the following extended relief related to 2020 reporting:

- Extension of due date to furnish Form 1095-C. 2020 Forms 1095-C are due to employees by March 2, 2021 (instead of January 31, 2021).
  Filing the 2020 Form 1094-C and all Forms 1095-C with the IRS has not been extended and is due March 31, 2021 (for filing electronically) or March 1, 2021 (for paper filing, as permitted).

- Extension of good faith relief for reporting and furnishing. The IRS will not impose a penalty for incorrect or incomplete information on Form 1095-C, if there is a good faith effort to comply

What's New?

For 2020, there are some notable changes to the Forms, specifically addressing individual coverage health reimbursement arrangements ("ICHRAs"). For employers that do not sponsor an ICHRA, much of the reporting remains the same.

- On Form 1095-C, Part II the "Plan Year Start Month" is a required field. An ALE must enter a two-digit number to reflect the plan year start month (e.g., for January 2020, use "01", for June 2020, use "06"). In previous years, this was optional.

- To accommodate reporting associated with ICHRAs:
  In Part II, there is a new reference to the "Employee's Age on January 1" and "Line 17 Zip Code".
  - If an ICHRA is not offered, do not complete these fields.

  In Part II, there are new Codes (used in Line 14) used to report offers of ICHRAs. The new Codes are 1L, 1M, 1N, 1O, 1P, 1Q, 1R, 1S, 1T, and 1U.
  - If an ICHRA is not offered, these new codes should not be used.

  There is also information in the instructions on how to calculate the amount reported on Form 1095-C, Line 15 for an ICHRA offer of coverage.
  Part III must be completed with respect to coverage through an ICHRA.

Note to non-ALEs. While small employers (non-ALEs) are not subject to reporting for purposes of the employer mandate, if offering a self-insured group health plan or ICHRA, reporting under Section 6055 to the IRS and to covered employees or other primary insured individuals who have coverage provided through a self-insured group health plan is required. In most cases, a non-ALE will use Forms 1094-B and 1095-B to satisfy this requirement. If a non-ALE is offering an ICHRA,

that coverage is considered a self-insured health plan and is subject to this reporting requirement. According to the instructions, a new code "G" must be entered on Form 1095-B, line 8 to identify an ICHRA.

Penalties

Failure to furnish a correct Form 1095-C may result in penalties of $280/form with an annual calendar year maximum of $3,392,000. Failure to file correct Forms 1095-C and 1094-C with the IRS may result in penalties of $280/form with an annual calendar year maximum of $3,392,000.

As announced in Notice 2020-76, there is good faith penalty relief available with respect to incorrect or incomplete information on the applicable Forms.

In addition, penalties may be waived if the failure was due to reasonable cause and not willful neglect.

Forms and Instructions

2020 Form 1094-C, https://www.irs.gov/pub/irs-pdf/f1094c.pdf

2020 Form 1095-C, https://www.irs.gov/pub/irs-pdf/f1095c.pdf

2020 Instructions for Forms 1094-C and 1095-C, https://www.irs.gov/pub/irs-pdf/i109495c.pdf

Marketplace Special Enrollment Period Announced

Published: February 21, 2021

On January 28, 2021, in response to the COVID-19 pandemic, President Biden issued an executive order requiring the U.S. Department of Health and Human Services ("HHS") to consider having a mid-year special enrollment period for the federally-facilitated Marketplace ("FFM") to enable uninsured and under-insured consumers to obtain healthcare coverage. As a result, HHS designated February 15 to May 15, 2021, as a special enrollment period for consumers to obtain individual health insurance coverage from the FFM without a qualifying event (such as birth of a child).

The President's executive order also requires federal agencies to review their existing actions for the purpose of protecting and strengthening Medicaid and the Affordable Care Act ("ACA"), and for the purpose of making high-quality healthcare accessible and affordable.

Mid-Year Marketplace Special Enrollment Period

HHS announced that consumers in 36 states served by the FFM have a special enrollment period from February 15 to May 15, 2021 to apply for and enroll in an individual health insurance policy (also called a "qualified health plan") from the FFM. The following rules apply during the mid-year special enrollment period:

- Consumers in any of the 36 states served by the FFM can apply for an individual health insurance policy or plan by accessing the HealthCare.gov platform directly, or by telephoning the FFM's call center, or through direct enrollment channels.
- Consumers are not required to provide documentation of a qualifying event (such as loss of a job or birth of a child), which is typically required to elect coverage during a special enrollment period.
- Consumers have 30 days after they submit their application to choose a plan. Healthcare coverage begins prospectively on the first day of the month after plan selection.
- Current enrollees can change to any available plan in their area without restriction to the same level of coverage as their current plan.

The President's executive order does not apply to the 14 states (which include New York, New Jersey, Pennsylvania and California) and the District of Columbia that have their own state-based Marketplace. However, states with a state-based Marketplace are expected to adopt a similar mid-year special enrollment period. To date, California and New Jersey have adopted a similar special enrollment period. Each state-based Marketplace may impose different restrictions on the mid-year special enrollment period (for example, regarding whether consumers can switch from one plan to another). Consumers with access to a state-based Marketplace should be advised to contact the Marketplace directly with any questions that they may have.

As a reminder, IRS Notice 2014-55 allows for an optional plan amendment that would permit employees to make a mid-year election under a section 125 cafeteria plan to revoke coverage for the employee and related individuals under a group health plan (other than a health flexible spending arrangement), if the following requirements are met:

1. The employee and related individuals are eligible for a special enrollment period to enroll in an individual health insurance policy or plan from an insurance marketplace; and

2. The employee and related individuals are enrolling in the marketplace plan; and

3. The new coverage from the marketplace constitutes "minimum essential coverage" for purposes of the ACA and is effective beginning no later than the day immediately following the last day of the group coverage that is being revoked.

According to IRS Notice 2014-55, the employer may rely on the employee's reasonable representation that the above requirements have been met. Cafeteria plan documents must include this permitted election change provision and carrier approval would be necessary.

Review of Past Agency Actions

The President's executive order directs all federal agencies to review existing regulations, orders, guidance documents, policies, and any other similar agency actions to determine whether they are inconsistent with the policy of protecting and strengthening Medicaid and the ACA and making high-quality healthcare accessible and affordable. The agencies are also directed to consider – as soon as practicable and appropriate – whether to suspend, revise, or rescind past agency actions that are inconsistent with the above policy.

Guidance Issued on Outbreak Period

Published: February 26, 2021

On February 26, 2021, the Departments of Labor and the Treasury ("the Departments") issued guidance addressing the COVID-19 Outbreak Period – specifically, the associated period of "up to one year" that may be disregarded for certain benefit plan deadlines. Unexpectedly, they have taken the interpretation that these benefit plan deadline extensions generally apply on an individual-by-individual basis. Individuals with timeframes that are subject to the extensions will have until the following deadlines to make benefit elections, payments, file a claim or benefit appeal as follows:

- one (1) year from the date they were first eligible for relief, or
- 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

This is a different approach to what most practitioners thought, which would have had the clock start running on the disregarded timelines after February 28, 2021. Note, under this latest guidance, employers must notify affected individuals as to the end of the relief period. You will find further details follow.

Background

In May of 2020, the Departments issued a final rule that required all group health plans, disability plans, and other employee welfare benefit plans to disregard the period ("the Outbreak Period") from March 1, 2020 until 60 days after the announced end of the National Emergency relating to the coronavirus pandemic with respect to the following periods and dates:

	Plans Affected	What's Extended
Special enrollment rights	Medical Only	Date to exercise a special enrollment right (30 days for loss of eligibility or acquisition of a dependent, 60 days for Medicaid/CHIPRA eligibility or premium assistance)
COBRA	Medical, Dental, Vision, Health FSA, EAPs, Onsite Clinics	• Date for the plan to provide COBRA election notice • 60-day election period • Due date for timely COBRA premium payments • Due date to notify of a qualifying event or disability determination
Claims for benefits	All ERISA covered benefits	Date to file a benefit claim
Appeals of denied claims	All ERISA covered benefits	Date to file an appeal of an Adverse Benefit Determination ("ABD")
External review	Non-grandfathered medical plans	• Date to request an external review after receipt of an ABD • Date to file information to perfecta request for external review

In addition, under Disaster Relief Notice 2020-01 deadlines to furnish certain required notices to plan participants, beneficiaries and other persons were likewise extended. A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document that must be furnished between March 1, 2020 and the end of the Outbreak Period if the plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances.

Importantly, according to the regulations, the Departments could only prescribe "up to one year" that can be disregarded for these purposes. So, while the Outbreak Period remains ongoing, the one-year mark, February 28, 2021, has almost arrived.

What's New?

The Departments issued joint guidance on the application of the one-year expiration limitation as it applies to employee benefit plans. The Departments have determined:

- Individuals and plans with timeframes that are subject to the deadline extensions (as noted above) will have the applicable periods disregarded until the earlier of:
  one (1) year from the date they were first eligible for relief, or
  60 days after the announced end of the National Emergency (the end of the Outbreak Period).

On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under COVID-19 relief will resume. In no case will a disregarded period exceed one year. The agencies provide the following examples:

- If a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the relief delays that requirement until February 28, 2021, which is the earlier of one year from March 1, 2020 or the end of the Outbreak Period (which remains ongoing).

- If a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the relief delays that election requirement until the earlier of one year from that date (i.e., March 1, 2022) or the end of the Outbreak Period.

If a plan would have been required to furnish a notice or disclosure by March 1, 2020, the relief would end with respect to that notice or disclosure on February 28, 2021. The plan fiduciary would be required to ensure that the notice or disclosure was furnished on or before March 1,

2021. The Department of Labor understands that many plans may have already returned to normal compliance procedures for furnishing notices and disclosures. Notices and disclosures properly furnished without relying on the relief in Notice 2020-01 do not need to be re-furnished.

Similarly, to the extent the plan can demonstrate that a notice or disclosure was actually received, it would not need to be refurnished even if it was initially furnished in reliance on the relief in Notice 2020-01.

Employer Action

The Departments stress that employers should make every effort to ensure that benefits to which employees and other individuals are entitled are made available. Importantly the latest guidance requires employers/plans to affirmatively send a notice regarding the end of the relief period to impacted individuals.

Employers should work closely with their plan administrators and COBRA vendors to:

- Provide notice regarding the end of the relief period to affected individuals.

- Reissue or amend any plan disclosures that were issued prior to or during the pandemic if the earlier disclosures failed to provide accurate information regarding the time in which participants and beneficiaries were required to take action, (e.g., COBRA election notices and claims procedure notices).

- Ensure that group health plans, consider ways to ensure that participants and beneficiaries who are losing coverage under their group health plans are made aware of other coverage options that may be available to them, including the opportunity to obtain coverage through the Health Insurance Marketplace in their state.
  There is a special enrollment period in the 36 states that use the HealthCare.gov platform starting on February 15 and continuing through May 15. At least 13 states plus the District of Columbia, which operate their own Marketplace platforms, are offering a similar opportunity.

We will continue to monitor guidance in this area and provide updates as they become available.

COBRA Subsidy in the Works

Published: March 04, 2021

A COBRA subsidy is included in early drafts of the proposed fiscal year 2021 budget reconciliation package. If finalized, the COBRA subsidy would apply to workers who have lost group coverage during the COVID-19 pandemic due to involuntary termination or reduction in hours of employment.

Briefly,

- The COBRA premium subsidy will be available to assistance eligible individuals beginning the first month following the date of enactment through September 30, 2021.
  The proposed definition of an assistance eligible individual means, with respect to a period of coverage beginning on the first day of the month follow the date of enactment and ending on September 30, 2021, a qualified beneficiary who:
  - Is eligible for COBRA continuation of coverage due to involuntary termination or a reduction in hours (excludes voluntary termination); and
  - Elects such coverage.

- Assistance eligible individuals pay 15% of their total COBRA premium during this period.

- A payroll tax credit will subsidize 85% of the total COBRA premium.

- An extended election period is available to allow workers who previously experienced a COBRA qualifying event to enroll in coverage and take advantage of this relief.

- Employers will be required to provide clear and understandable written notices about the availability of the COBRA subsidy.

Under the proposed reconciliation bill, additional ACA Marketplace premium assistance would also become available to individuals not eligible for COBRA.

Employer Action

The legislation is in the early stages and is not final. However, if finalized "as-is," the COBRA subsidy, extended COBRA election period and notification requirements would raise a host of additional compliance issues and responsibilities for employers. Coordination between COBRA vendors, insurance carriers (including stop loss) and third-party administrators will be important to ensure compliance with this requirement (if enacted).

We will continue to monitor developments and provide additional details if the COBRA subsidy is enacted into law.

Departments Issue Guidance

Re: FFCRA and CARES Act

Published: March 11, 2021

On February 26, 2021, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ 44 addressing health coverage issues related to COVID-19.

Briefly, the new FAQs focus on diagnostic testing and coverage for testing and clarify previous guidance in FAQs.

Background

Section 6001 of the FFCRA requires group health plans (including grandfathered health plans) and health insurance issuers to provide coverage for certain items and services related to testing or the diagnosis of COVID-19 without any cost-sharing requirements, prior authorization or other medical requirements. Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic items and services that must be covered the same way. Since the FFCRA and CARES Act have been enacted, the Departments have issued several sets of FAQs to help people better understand the laws.

The guidance clarifies that:

- medical screening criteria may not be used to deny (or impose cost sharing on) a claim for COVID-19 diagnostic testing for an asymptomatic person who has no known or suspected exposure to COVID-19. Plans and carries may still distinguish between asymptomatic people and general workplace testing.

- referrals for COVID-19 testing that come from a licensed or authorized health care provider are assumed to reflect an "individualized clinical assessment" and the test should be covered without cost sharing, prior authorization, or other medical management requirements.

- providers may limit eligibility for testing based on clinical risk or management of testing supplies

- plans and issuers are not required to provide coverage for testing for employment purposes (though they may)

- there is no distinction between point-of-care testing (i.e., drive through) and other testing for coverage purposes

- all COVID-19 vaccines recommended by Centers for Disease Control and Prevention ("CDC") must be covered without cost sharing. As of the date of this bulletin, the Pfizer and Moderna vaccines must be covered. The Johnson and Johnson vaccine is expected to require coverage by March 18, 2021.

- COVID-19 vaccines must be covered without cost sharing regardless of how it is billed and regardless of whether the vaccine requires the administration of multiple doses in order to be considered a complete vaccination

- coverage of a recommended COVID-19 vaccine may not be denied because an individual is not in a category recommended for early vaccination – the coverage must be provided regardless of priority set by states and local jurisdictions.

- although on-site medical clinics are always excepted benefits, COVID-19 vaccines may be offered at on-site medical clinics as excepted benefits.

- an Employee Assistance Plan (an "EAP") will not be considered an excepted benefit solely because it offers benefits for COVID-19 vaccines and their administration but there must be no cost-sharing.

- The Departments will not take enforcement action against any plan or issuer that does not provide at least 60 days' advance notice of a change affecting the SBC to reflect the addition of coverage for qualifying coronavirus preventive services, as such services must be covered on an expedited timeframe. However, plans and issuers must provide any required notice of the changes as soon as reasonably practicable.

Employer Action

Plan sponsors should review the Departments' new guidance and confirm with their carriers or TPAs that the plans they sponsor are meeting the requirements contained in the new FAQs.

New COBRA Subsidy

Published: March 12, 2021

Congress passed the American Rescue Plan Act of 2021 ("the Act") on March 10, 2021 and it was signed into law on March 11, 2020. The Act includes a 100% COBRA subsidy available to certain COBRA qualified beneficiaries who lose group health plan coverage as the result of an involuntary termination or reduction in hours. This is different from the original House legislation, which included an 85% subsidy (with the COBRA beneficiary responsible for 15% of the COBRA premiums). Employers will be able to claim a credit against payroll taxes to reimburse the cost of the subsidy.

The COBRA subsidy begins April 1, 2021 (the first day of the month following enactment) and last through September 30, 2021.

While this subsidy provides welcome relief for many COBRA qualified beneficiaries, it will be administratively challenging for employers, especially given other relief afforded to COBRA elections and premiums payments under the Outbreak Period guidance.

The following FAQs explain the Act's COBRA subsidy in more detail.

Who Qualifies for a Subsidy?

An assistance eligible individual ("AEI") qualifies for the subsidy.

An AEI is, for the period of April 1, 2021 – September 30, 2021, an individual who is eligible for COBRA due to an involuntary termination of employment or a reduction in hours and who elects COBRA continuation of coverage. Individuals who voluntarily terminate from employment are not AEIs.

AEIs include:

- **New COBRA qualified beneficiaries.** Individuals who become COBRA qualified beneficiaries due to involuntary termination of employment or reduction in hours on or after April 1, 2021 but before September 30, 2021.

- **Existing COBRA qualified beneficiaries.** COBRA qualified beneficiaries due to an involuntary termination of employment or reduction in hours who currently have COBRA coverage and continue COBRA between April 1, 2021 – September 30, 2021.

- **Second chance COBRA qualified beneficiaries.** Individuals who were COBRA qualified beneficiaries due to an involuntary termination of employment or reduction in hours but, either (1) did not elect COBRA or (2) elected then dropped COBRA. Had they elected COBRA (or not dropped the coverage), they would have had COBRA coverage between April 1, 2021 – September 30, 2021.

How Much is the Subsidy?

The COBRA subsidy is 100%. This means AEIs will not pay any portion of their COBRA premium during the subsidy period (April 1, 2021 – September 30, 2021) so long as they remain subsidy eligible.

Employers are allowed a credit against Medicare payroll taxes to be reimbursed for the subsidy.

Is There a "Second Chance" to Elect COBRA?

Yes. There is a second chance for an individual who otherwise would be an AEI except the individual:

- Does not have a COBRA election in effect on April 1, 2021; or
- Elected COBRA coverage and later dropped the coverage.

In this case, the AEI may elect COBRA coverage (and the subsidy) beginning April 1, 2021. The maximum COBRA coverage period will be measured from their original qualifying event date had they elected COBRA (or not dropped the coverage).

As described later, a special notice will need to be provided and, upon receipt, these "second chance" individuals will have 60 days to elect COBRA continuation of coverage (retroactive to April 1, 2021).

This is likely to get very complicated with delayed election relief for the Outbreak Period which permits retroactive enrollment back to the original qualifying event date. Note, however, that subsidized premiums are only available beginning April 1, 2021. An individual who is eligible for both types of relief would be permitted to enroll in the subsidized coverage April 1, 2021 going forward. That said, more guidance on the interaction of the Outbreak period and COBRA subsidy would be helpful.

When Does the Subsidy End?

The subsidy naturally expires September 30, 2021. After that date, the full COBRA premium will be owed to continue COBRA coverage or to elect new COBRA coverage. Employers must provide notice within a specific window prior to expiration of the subsidy.

Additionally, if an AEI becomes eligible for other group health plan coverage or Medicare, the subsidy is no longer available. Mere eligibility (versus enrollment) is all that is required.

An AEI must notify the group health plan when the AEI is no longer eligible for the subsidy due to other coverage. Regulations will provide guidance as to the time and manner of this notification. A penalty of $250 applies for failure to notify. There is an exception when the failure is due to reasonable cause and not willful neglect. Note that It is possible for Congress to extend the subsidy beyond September 30, 2021 through future legislation.

How Far Back will we Have to Look for AEIs?

COBRA coverage due to a termination of employment or reduction in hours runs 18 months. Thus, individuals who experienced an involuntary termination of employment or reduction in hours and were in their COBRA election window beginning in November 2019 (or later) may be eligible for the subsidy relief.

What Coverage does the COBRA Subsidy Apply to?

The statute defines group health plan coverage broadly to include an employee welfare benefit plan providing medical care. While further guidance is likely to clarify this, we expect a subsidy to be available with respect to the following coverage:

- Major medical
- Dental
- Vision

This includes fully insured and self-funded group health plans.

Can AEIs Change their COBRA Coverage?

An employer may, but is not required to, allow an AEI to enroll in a different, lower cost plan option than the coverage the individual was enrolled in at the time the qualifying event occurred. The different plan option must be offered to similarly situated active employees of the employer at the time the election to change the plan is made. The different plan option cannot be excepted benefits (e.g., dental coverage), a qualified small employer health reimbursement arrangement (QSEHRA) or a health flexible spending account (health FSA).

An AEI has 90 days after the date of notice of this plan enrollment option to elect to enroll in the different coverage option.

Employers considering allowing enrollment in a lower cost plan option should obtain carrier (including stop loss carrier) approval. Not all carriers may allow for this flexibility.

Are there Notice Requirements?

There are multiple notice requirements associated with the subsidy.

Election Notice

COBRA election notices for AEIs who become entitled to COBRA coverage between April 1, 2021 – September 30, 2021 must be updated to include information on the availability of premium assistance and, if applicable the ability to enroll in a lower cost plan option. Employers may use a separate document that includes the required information.

In addition, notice must be provided to AEIs who have a "second chance" to elect COBRA and obtain the subsidy. This notice must provide by May 31, 2021 (60 days from April 1, 2021 – first of the month following enactment). Failure to provide such notice will be treated as a failure to meet the notice requirements under COBRA.

Briefly, the notice must include:

- forms necessary to establish eligibility for the subsidy;
- contact information for the employer or other entity maintaining information in connection with the subsidy;
- a description of the:
  extended election period;
  obligation of qualified beneficiaries to notify the plan when no longer eligible for the subsidy and the penalty for failure to notify;
  qualified beneficiaries' right to a subsidized premium and any conditions on entitlement to the subsidy (displayed prominently); and
  option (if available) for the qualified beneficiary to enroll in a different coverage option.

A model notice will be available within 30 days after the date of enactment. It is possible the Departments will require additional notifications as part of their guidance.

Notice of Option to Change COBRA Coverage

If an employer allows AEIs to change to a different, lower cost plan option notice must be provided to inform the AEI of this option.

Notice of the Expiration Period for Premium Assistance

A notice must be provided to an AEI about the upcoming expiration of the available subsidy except in cases where the subsidy is no longer available due to eligibility for other group health plan coverage or Medicare.

The notice must be provided beginning on the date that is 45 days before the subsidy ends and ending on a day that is 15 days before the expiration and must be written in clear and understandable language. It must be provided to the AEI and indicate that the AEI's subsidy will expire soon and include the date of the expiration in a prominent manner.

A model notice will be available 45 days after enactment.

Who May Claim the Tax Credit?

The "person to whom premiums are payable" may claim the tax credit. In the case of a group health plan that is subject to COBRA, this is the employer maintaining the plan.

Employers may apply to credit against Medicare payroll taxes to reimburse the cost for the COBRA subsidy.

What Should Employers Do Now?

- Connect with your COBRA vendor to discuss administration for this new COBRA subsidy. This will include:
  - issuing notices to the "second chance" AEIs by May 31, 2021;
  - updating election notices to reflect the subsidy for COBRA events between April 1, 2021 and September 20, 2021; and
  - issuing notice to AEIs when their individual subsidy is set to expire in accordance with required timeframes.

- Identify all individuals who may qualify as AEIs. This will include individuals who may not have elected COBRA (or dropped COBRA) but are still within the 18-month maximum COBRA period. Employers may need to look back to individuals who experienced an involuntary termination of employment or reduction and were otherwise eligible for COBRA beginning in November 2019.

- Discuss the COBRA subsidy with payroll departments and await further guidance for clarification on claiming the tax credit.

- Await further guidance and model notices. Hopefully, any guidance or notices will address the COBRA deadlines impacted by the Outbreak Period and how this intersects with the COBRA subsidy and applicable notices.

IRS Guidance on Health FSA and DCAP Relief

Published: March 16, 2021

Section 214 of the Consolidated Appropriations Act, 2021 ("CAA") included optional and temporary relief for health flexible spending accounts ("health FSAs") and dependent care assistance programs ("DCAPs") offered in a Section 125 cafeteria plan ("cafeteria plan"). On February 18, 2021, the Internal Revenue Service ("IRS") issued Notice 2021-15 providing guidance addressing these optional plan changes.

Briefly, highlights from the guidance include:

- **Sec. 214 Health FSA and DCAP carryovers and extended grace period.**
  The Sec. 214 carryover and extended grace period are only available for plan years that end in 2020 and/or 2021.
  The amount available to carry over may be less than the full unused amount at the end of the plan year.
  The length of the extended grace period may be shorter than the allowable 12 months.
  The carryover or grace period extension will not affect the maximum FSA and DCAP salary reductions for the year.

- **Improved coordination with HDHP/HSA arrangements.** Notice 2021-15 provides welcome relief to help participants preserve eligibility to contribute to a health savings account ("HSA") when a health FSA includes a carryover or extended grace period. Employees would be able to "opt-out" of the traditional health FSA or make a mid-year election change to an HSA-compatible FSA.

- **NEW: Mid-year election change relief for group health plan coverage.** The guidance extends 2020 relief permitting mid-year election changes to prospectively enroll, disenroll, or change benefit options for group health plan coverage (medical, dental or vision) for plan years ending in 2021. Note, prior to adopting this relief, employers should obtain carrier (including stop loss carrier) approval.

- **Form W-2 Reporting for DCAPs.** Employers adopting the carryover or extended grace period relief for DCAPs will report the yearly salary reduction amount elected by the employee for the DCAP (plus any

employer matching contributions). Employers are not required to adjust the amount reported in Box 10 due to the carryover or grace period.

- **NEW: Retroactive amendment permitted for health FSAs or HRAs that offer over-the-counter ("OTC") drugs and menstrual care products.** Plans may be retroactively amended to allow reimbursement of expenses incurred on or after January 1, 2020, for menstrual care products and OTC drugs without a prescription.

Additional details on the above are below.

Sec. 214 Health FSA and DCAP Carryovers & Extended Grace Periods

Traditional Rules

A health FSA may permit a carryover of unused amounts remaining in the health FSA as of the end of the plan year (up to $550). A carryover is not permitted in a DCAP.

A health FSA and/or DCAP may permit a participant to apply unused amounts at the end of a plan year to pay expenses incurred for qualified benefits during a period of up to two (2) months and fifteen (15) days immediately following the end of the plan year. This is known as the "grace period."

While inclusion of a carryover or grace period is not required, a health FSA may not have both a carryover and a grace period.

Sec. 214 Carryover and Extended Grace Period Relief

The Sec. 214 carryover relief allows an employer to amend the cafeteria plan to provide a carryover of all (or part of) the unused amounts remaining in a health FSA (including an HSA-compatible health FSA) or a DCAP as of the end of a plan year ending in 2020 and/or 2021 to the immediately subsequent plan year.

Under the extended grace period relief, an employer may amend the cafeteria plan to permit employees to apply unused amounts remaining in a health FSA or a DCAP as of the end of a plan year ending in 2020 and/or 2021 to reimburse expenses incurred for the same qualified benefit (medical care or dependent care) up to 12 months after the end of the plan year.

With respect to both the Sec. 214 carryover and the extended grace period, the following rules apply:

- The carryover and grace period are available to plans that currently have a grace period or provide for a carryover as well as plans that do not currently have these features. However, a plan may not have both a carryover and grace period. The plan amendment must specify which option is adopted for the applicable years.

- The amount available for carryover may be limited to less than all unused amounts and/or the employer may limit the carryover to apply only up to a specific date during the plan year.

- An employer may adopt an extended grace period that is less than 12 months.

- Amounts available because of the carryover and extended grace period will not impact the maximum salary reduction amount permitted in the calendar year.

  For example, funds carried over from the 2020 plan year to a health FSA or DCAP will not impact an employee's ability to elect $2,750 and $5,000 respectively, for 2021.

- The employer may require employees to enroll in the health FSA or DCAP at a minimum election amount to have access to unused amounts from the Sec. 214 carryover or extended grace period.

- Amounts carried over or available during an extended grace period are not taken into account for purposes of the nondiscrimination rules.

- If the employer adopts the carryover or extended grace period for the health FSA, the COBRA premium associated with the health FSA may not include unused amounts carried over or available during the extended grace period.

Coordination with HDHPs and HSAs

Generally, a carryover or grace period in a "traditional" or "general-purpose" health FSA is an extension of coverage by a health plan that is not a qualified high deductible health plan ("HDHP") for purposes of determining whether an individual qualifies to make contributions to an HSA, except in the case of an HSA-compatible health FSA, such as a limited-purpose health FSA.

Notice 2021-15 provides welcome relief that allows an employer to amend the cafeteria plan in one of several ways to allow employees to maintain HSA eligibility as follows:

- Permit employees to opt out of the carryover or grace period on an employee-by-employee basis.
- Provide a mid-year election change that allows the employee to be covered by a general-purpose health FSA for part of the year and an HSA-compatible health FSA for part of the year.
- Permit each employee to choose between an HSA-compatible health FSA or general-purpose health FSA during the period when the Sec. 214 carryover or extended grace period applies.
- Automatically enroll employees who elect an HDHP into an HSA-compatible health FSA.
- To the extent changes result in an employee being ineligible for an HSA mid-year on a prospective basis, the employee would not be considered HSA ineligible for the earlier part of the plan year.

Mid-Year Election Changes

Health FSA and DCAPs

Employers have the option to amend their cafeteria plan to permit employees to make prospective mid-year election changes for health FSAs and DCAPs for plan years ending in 2021 without a specific change in status event.

If adopted, an employee may make the following changes on a prospective basis with respect to health FSA and/or DCAP election for plan years ending in 2021:

- revoke an election,
- make one or more elections; or
- increase or decrease an existing health FSA or DCAP election.

A prospective election change may include an initial election to enroll in the health FSA and/or DCAP for the year. For example, an employee who initially declined to enroll in the health FSA, may make a prospective election to enroll in the health FSA to use a newly available Sec. 214 carryover or extended grace period.

The following applies with respect to these mid-year election changes:

- There is no "cash out" of the health FSA or DCAP permitted.
- Employers may limit mid-year election changes to amounts no less than amounts already reimbursed and to certain types of mid-year election changes, such as decreases in elections only.
- Employers may allow mid-year election changes without a status change up to a certain date (e.g., by March 31, 2021) during the plan year, but require a status change after that date.
- Employers may limit the number of election changes during the plan year that are not associated with a status change (e.g., allow only one election change in the 2021 plan year without a status change).

- Although salary reductions may only be applied prospectively under any revised election, employers may allow amounts contributed to the health FSA or DCAP after the revised election to be used for any medical care expense or dependent care expense, respectively, incurred during the first plan year that begins on or after January 1, 2021 through the end of the 2021 plan year.

If an employee's election under a health FSA or DCAP is revoked, then the employer may adopt one of the following rules on a uniform basis:

- Amounts contributed before the election is revoked remain available to reimburse healthcare expenses or dependent care expenses (respectively) incurred for the rest of the plan year; or

- The amounts will be available only to reimburse eligible expenses incurred before the revocation takes effect (and not expenses incurred later).

Group Health Plan Coverage

While not included in the CAA, the IRS is again granting relief permitting employers to amend their cafeteria plan to allow employees to make prospective election changes for group health plan coverage (medical, dental or vision coverage) to:

- Enroll if the employee initially declined to elect employer-sponsored health coverage for the plan year;

- Enroll in a different level of health coverage (e.g., self-only or family) and/or modify their health coverage plan option (e.g., HMO to PPO) under the employer's plan; or

- Revoke an existing election provided that the employee attests in writing that the employee is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer that is not coverage solely for dental or vision benefits. The Notice provides an example of an acceptable attestation that may be used.

Employers may also determine a timeframe and the extent to which prospective election changes are permitted and applied (provided such changes comply with the Section 125 nondiscrimination rules) and may limit election changes to circumstances where the employee's coverage will be increased or improved to avoid adverse selection.

The additional relief relating to employer-sponsored health coverage applies to employers who sponsor fully insured health coverage as well as those who sponsor self-funded health coverage.

It is important to note that nothing in the IRS guidance requires carriers or self-funded health plans (including stop loss insurance) to permit mid-year enrollment and/or coverage changes. Prior to implementing any mid-year election changes to the group health plan coverage, it is important to understand whether the carrier (including stop loss insurers) will allow for such changes mid-year.

Health FSA Spend Down

An employer may amend the health FSA to permit employees who cease participation in the health FSA during calendar year 2020 or 2021 to "spend down" their unused health FSA contributions through the end of the plan year in which participation ceased, plus any grace period thereafter (including an extended grace period). However, the Sec. 214 carryover relief (if adopted) will not apply after the end of the plan year in which participation ceased.

Notice 2021-15 clarifies:

- For this purpose, an employee may cease to be a participant because of a termination of employment, change in employment status, or a new election during calendar year 2020 or 2021.

- The employer may limit the unused amounts in the health FSA to the amount of salary reduction contributions the employee had made for the plan year through termination.

- If the employer offers this spend down feature, COBRA obligations still exist in the event the health FSA has a positive balance and the individual loses eligibility for the health FSA due to a termination of employment or reduction in hours.

Special Age Limit Relief- DCAP

Under this rule, if a dependent child reaches age 13 during the last plan year with respect to which the end of the regular enrollment period for the plan year was on or before January 31, 2020 (the "first plan year"), the employee can continue to receive reimbursements for such child's dependent care expenses for:

- the remainder of the first plan year and, to the extent a balance remains at the end of the first plan year,
- the following plan year until the child turns age 14 (but only with respect to the unused amount from the first plan year).

This relief appears rather limited. For a calendar year plan, it only applies with respect to the January 1, 2020 – December 31, 2020 plan year (the last plan year where the enrollment period was before January 31, 2020), and, with respect to the 2021 plan year, to any unused amounts from 2020.

This special age limit relief for certain dependents is separate from the Sec. 214 carryover relief and extended grace period relief. An employer that adopts the special age limit relief is not required to adopt the carryover or grace period extensions in order to adopt the special age limit relief.

The special age limit relief does not permit a DCAP to reimburse expenses for a child who is age 14 or older.

In addition, Notice 2021-15 affirms that employers are permitted under a DCAP to limit reimbursements to expenses incurred for the care of a dependent child who is under a specified age that is less than age 13.

Reporting Requirements for DCAPs

Generally, amounts contributed to a DCAP are required to be reported in Box 10 of Form W-2. Under existing guidance, employers may report in Box 10 the yearly salary reduction amount elected by the employee for the DCAP (plus any employer matching contributions) and are not required to adjust the amount reported in Box 10 to take into account amounts that remain available in a grace period.

Notice 2021-15 extends this rule for Sec. 214 carryover and the extended grace period and will treat amounts carried forward or extended as an amount that remains available in the grace period.

The Treasury Department and the IRS anticipate that for the 2021 and 2022 Forms W-2 and 2441, instructions will provide for similar rules that DCAP amounts carried forward from prior years under this relief will be treated as amounts remaining available during a grace period for reporting purposes and no change to the reporting requirements will be necessary. Clarification as to how the individual may be taxed when the total benefits used in a calendar year exceed IRS thresholds would be welcome.

Plan Amendments

If any of the changes described in the CAA and Notice 2021-15 are implemented, the cafeteria plan must be amended no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective.

- For a January 1, 2020 to December 31, 2020 plan year, this means an amendment must be adopted no later than December 31, 2021.
- For a non-calendar year plan that begins in 2020 (e.g., June 1, 2020 – May 31, 2021), this means an amendment must be adopted by December 31, 2022.

In addition:

- The plan must be operated in a manner consistent with the terms of such amendment during the period

beginning on the effective date of the amendment and ending on the date the amendment is adopted.

- The employer must inform all employees eligible to participate in the plan of the applicable changes being adopted. In addition, ERISA notification requirements may apply to any amendment of a health FSA or group health plan that is subject to ERISA.

Retroactive Amendments for OTC Drugs and Menstrual Care Products

In general, retroactive amendments are not permitted in a cafeteria plan, health FSA, or health reimbursement arrangement ("HRA"). Notwithstanding this general prohibition, Notice 2021-15 allows for a retroactive amendment in a health FSA and/or HRA to provide for reimbursements of expenses incurred on or after January 1, 2020 for menstrual care products and OTC drugs without a prescription. This relief includes amendments made prior to the issuance of this Notice.

Employer Action

Employers should:

- Consider what, if any, changes they wish to implement to their Section 125 plans in accordance with the CAA and this guidance.
- Work closely with FSA vendors to ensure any adopted provisions are being administered in accordance with the requested changes.
- Communicate all amended provisions, terms, and conditions with employees and consider incorporating limits on the allowable changes.
- Confirm with insurance carriers, third party administrators and stop loss insurers (if applicable) if you are considering allowing a mid-year change in elections under the group medical, dental and/or vision plans that the changes can be implemented.

DCAP Update and Other Highlights from the ARPA

Published: March 18, 2021

Along with the COBRA subsidy discussed in the alert issued March 11, 2021, the American Rescue Plan Act of 2021 ("ARPA" or the "Act") provides the following additional relief:

- For calendar year 2021 only, an increase in the amount of pre-tax salary reduction election for a dependent care assistance plan ("DCAP" or "dependent care FSA") to $10,500;
- Expansion of tax credits available to employers who voluntarily extend paid sick and family leave under the Families First Coronavirus Response Act (the "FFCRA") through September 30, 2021; and
- An increase in premium tax credits for calendar year 2021 and 2022 for coverage purchased in the Marketplace.

While the COBRA subsidy is the most significant requirement for group health plans pursuant to the ARPA, this additional relief is discussed in more detail below.

Dependent Care Assistance Plan Relief

For 2021 only, the maximum pre-tax contribution limit to a DCAP has been increased from $5,000 to $10,500 (and from $2,500 to $5,250 for married filing individual returns).

Employers may amend their cafeteria plans to increase the pre-tax salary reduction to this higher limit for 2021 only. DCAP contributions are tracked on a calendar year. An amendment reflecting this change must be adopted not later than the last day of the plan year to which the amendment is effective (for a calendar year plan, by December 31, 2021). This change appears to be optional, rather than mandatory.

This change does not affect the ability for a plan to offer an unlimited carryover or grace period from the DCAP that ended in 2020 to 2021.

Voluntary Extension of Tax Credits for Emergency Paid Sick and Family Leave Through September 31, 2021

As of December 31, 2020, employers are no longer required to provide emergency paid sick leave and emergency family and medical leave. While the Consolidated Appropriations Act of 2021 did not extend the requirement to offer FFCRA emergency leave beyond December 31, 2020, it did extend the availability of tax credits for employers voluntarily providing this paid sick leave and expanded family and medical leave through March 31, 2021.

ARPA again extends the availability of these tax credits for up to an additional 10 days of paid sick leave taken between April 1, 2021 and September 31, 2021. The additional tax credits are allowed even if an employer obtained the maximum amount of tax credits and an employee previously exhausted paid sick leave or family leave days allowed under the FFCRA prior to April 1, 2021. Providing such leave remains voluntary as ARPA did not reinstate the required leave under FFCRA.

ARPA adds two additional reasons to the original six reasons where emergency sick leave may be provided by employers where:

- the employee is seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 and such employee has been exposed to COVID-19 or the employee's employer has requested such test or diagnosis; and

- the employee is obtaining immunization related to COVID-19 or recovering from any injury, disability, illness, or condition related to such immunization after medical diagnosis thereof.

Employers may now receive tax credits for all the original reasons plus the above additional two reasons for taking leave.

Under ARPA, these tax credits are not available to employers that discriminate in favor of highly compensated employees, full-time employees or employees on the basis of employment tenure in providing the leave. on the basis of tenure.

Where the tax credit is claimed for family leave, ARPA increases the aggregate amount of wages that may be claimed from $10,000 to $12,000, removing the two-week waiting period on the emergency FMLA leave.

It is important to note that only private sector employers with fewer than 500 employees are eligible for these tax credits.

Increased Marketplace Subsidies

ARPA increases the premium subsidies that certain individuals who purchase health insurance coverage through the Marketplace exchange will receive and makes certain individuals newly eligible for subsidies for 2021 and 2022. Individuals who make more than 400% of the Federal Poverty Level (the "FPL") will have a cap on their premium costs of 8.5% of their household income. Ordinarily, individuals who make more than 400% of the FPL do not qualify for premium assistance. Given the expansion of subsidies available to individuals above 400% of FPL, some large employers (50 or more full-time employees) may see increased exposure to penalty assessments under the ACA's employer mandate to the extent coverage is not offered to full-time employees or is not affordable and full-time employees receive subsidies in the Marketplace to purchase coverage.

Employer Next Steps

- Employers should consider whether they want to increase the maximum pre-tax contribution limit to dependent care FSAs and, if so, must amend their cafeteria plans accordingly.

- Employers should determine whether it makes sense to voluntarily provide paid sick leave and paid family medical leave to continue to receive tax credits and should review and revise their policies. Remember that state laws may offer additional leave protections and should be reviewed.

- Large employers subject to the ACA's employer mandate should be aware that more of their employees may be eligible for subsidies in the Marketplace for 2021 and 2022. This may increase the risk of penalty assessment when the employer is not offering group health plan coverage to at least 95% of full-time employees, offering unaffordable coverage or excluding up to 5% of full-time employees from an offer of coverage. Employers should continue to regularly review their exposure to penalties under the ACA.

New York Requires Paid Leave for COVID-19 Vaccinations

Published: March 19, 2021

To encourage New York employees to schedule and receive their COVID-19 vaccinations, Governor Cuomo signed legislation on March 12, 2021 requiring all New York public and private employers to provide employees up to four (4) hours of paid leave per required dose of the COVID-19 vaccine. Employees requiring two separate injections (e.g., the Pfizer and Moderna COVID-19 vaccines) will be entitled to up to eight (8) hours of paid leave. This legislation took effect immediately and will be in effect through December 21, 2022.

Briefly, the legislation provides the following:

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

The law does not address timing of employee notification of the need for this leave and what, if any, documentation an employer can request from employees to verify proof of vaccination. We hope to receive further guidance from the NYS Department of Labor.

Employer Action

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

California Enacts 2021 COVID-19 Supplemental Paid Sick Leave Law

Published: March 30, 2021

On March 19, 2021, California Governor Newsom signed Senate Bill No. 95 ("SB 95") into law. SB 95 adds a new section 248.2 to the California Labor Code which requires employers to provide 2021 COVID-19 Supplemental Paid Sick Leave that is broader-reaching than the previous version that expired on December 31, 2020.

Under the new 2021 COVID-19 Supplemental Paid Sick Leave provisions, employers with more than 25 employees are required to provide up to two weeks of additional paid sick leave to employees who are not able to work or telework for expanded reasons related to COVID-19 between January 1, 2021 and September 30, 2021.

The California Department of Industrial Relations has published additional guidance on 2021 COVID-19 Supplemental Paid Sick Leave in the form of Frequently Asked Questions ("2021 FAQs"), and a side-by-side comparison of paid leave options under California law (both linked below).

It should be noted that SB 95 also adds a new section 248.3 to the California Labor Code which provides special COVID-19 supplemental paid sick leave requirements for employees of in-home supportive service providers and waiver personal care service providers. Those requirements are not addressed in this Compliance Update.

Period of Coverage

Effective March 29, 2021, employers are required to provide 2021 COVID-19 Supplemental Paid Sick Leave to covered employees during the period beginning January 1, 2021 and ending September 30, 2021. Refer below to the section entitled "Payment of Retroactive Benefits" for guidance on handling retroactive benefits for leave taken between January 1, 2021 and March 28, 2021.

There is an important exception to SB 95's sunset date: If an employee is taking 2021 COVID-19 Supplemental Paid Sick Leave at the time the state law requirement to provide such leave expires, the employee must be allowed to continue and complete the full amount of paid leave.

Covered Employees

All public and private employers that employ more than 25 employees are required to provide 2021 COVID-19 Supplemental Paid Sick Leave to "covered employees." It is not clear from the text of SB 95 whether for this purpose an employer counts all employees nationwide or only those who work within California. A "covered employee" is an employee who:

- is unable to work or telework for the employer because of a reason listed in the following section entitled "Reasons for Taking Leave," and
- is working in California and subject to the Healthy Workplaces, Healthy Families Act of 2014.

Reasons for Taking Leave

An employer is required to provide 2021 COVID-19 Supplemental Paid Sick Leave to a covered employee if the employee is unable to work or telework for the employer because of any of the following reasons:

- **Caring for Self:** The covered employee is subject to a quarantine or isolation period related to COVID-19 (see note below), or has been advised by a healthcare provider to quarantine due to COVID-19, or is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- **Caring for a Family Member:** The covered employee is caring for a family member who is either subject to a quarantine or isolation period related to COVID-19 (see note below) or has been advised by a healthcare provider to quarantine due to COVID-19, or the employee is caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.
- **Vaccine-Related:** The covered employee is attending a vaccine appointment or cannot work or telework due to vaccine-related symptoms.

It should be noted that the quarantine or isolation period related to COVID-19 is the period defined by an order or guidelines of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer with jurisdiction over the workplace.

According to the 2021 FAQs, an employer may not deny 2021 COVID-19 Supplemental Paid Sick Leave to a covered employee based solely on a lack of certification from a health care provider. However, it may be reasonable in certain circumstances to ask for documentation before paying sick leave to an employee, when the employer has other information indicating that the employee is not requesting sick leave for a valid purpose. For example, if a covered employee informs the employer that the employee is subject to a local quarantine order and qualifies for 2021 COVID-19 Supplemental Paid Sick Leave, but the employer subsequently learns that the employee was out at a park, the employer could reasonably request documentation.

Number of Hours of Leave

The covered employee determines how many hours of 2021 COVID-19 Supplemental Paid Sick Leave to use, up to the total number of hours that the employee is entitled to take (as calculated below). When the covered employee makes an oral or written request to the employer to take 2021 COVID-19 Supplemental Paid Sick Leave, the employer is required to make the leave available to the employee for immediate use.

The total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that a covered employee is entitled to take is calculated as follows:

Covered Employee	Entitlement to 2021 COVID-19 Supplemental Paid Sick Leave
A covered employee who is an active firefighter and scheduled to work more than 80 hours for the employer in the two weeks preceding the leave	The total number of hours the covered employee was scheduled to work for the employer in the two weeks preceding the leave
Any other covered employee: • who is considered by the employer to work "full-time," or • who worked (or was scheduled to work) an average of at least 40 hours per week for the employer in the two weeks preceding the leave	80 hours
A covered employee who does not satisfy any of the above criteria	If the covered employee has a normal weekly schedule: • The total number of hours that the employee is normally scheduled to work for the employer over two weeks, but not more than 80 hours If the covered employee works a variable number of hours, and has worked for the employer for: • More than 14 days: 14 times the average number of hours that the employee worked each day for the employer in the six months preceding the leave (or the entire period worked for the employer, if less than six months), but not more than 80 hours • 14 days or fewer: the total number of hours the employee worked for the employer

Rate of Pay During Leave

2021 COVID-19 Supplemental Paid Sick Leave is paid at the following rate of pay (subject to limits set forth after the chart):

Covered Employee	Rate of Pay
A covered employee who is an active firefighter and scheduled to work more than 80 hours for the employer in the two weeks preceding the leave	The regular rate of pay to which the covered employee would be entitled as if the employee had been scheduled to work those hours, pursuant to existing law or an applicable collective bargaining agreement
A covered employee who does not satisfy the above criteria and who is classified as exempt under applicable wage-hour laws	Calculated in the same manner as the employer calculates wages for other forms of paid leave time
A covered employee who does not satisfy the above criteria and who is classified as nonexempt under applicable wage-hour laws	The highest of the following rates: • The employee's regular rate of pay for the workweek in which the covered employee uses the leave • The rate calculated by dividing the employee's total wages (not including overtime premium pay) by the total hours worked in the full pay periods of the prior 90 days of employment • The state minimum wage • The local minimum wage

However, an employer is not required to pay more than $511 per day or $5,110 in the aggregate to a covered employee for 2021 COVID-19 Supplemental Paid Sick Leave taken by the employee. If this limit applies, the employee may utilize other paid leave available to the employee in order to be fully compensated for the leave taken by the employee.

Coordination with Other Paid Leave

The employer is prohibited from requiring a covered employee to use any other paid or unpaid leave, paid time off, or vacation time provided by the employer before the employee uses 2021 COVID-19 Supplemental Paid Sick Leave or in lieu of such leave. For example, an employer cannot require covered employees to use State Disability Insurance (SDI) benefits before or in lieu of 2021 COVID-19 Supplemental Paid Sick Leave.

The total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave available to a covered employee is in addition to any paid sick days that may be available to the employee under the Healthy Workplaces, Healthy Families Act of 2014.

Important Exception: If the employer pays another supplemental benefit to a covered employee for leave taken on or after January 1, 2021, the employer may count the hours of other paid benefit or leave towards the total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that the employer is required to provide to the employee, as long as all of the following requirements are met:

- The other supplemental benefit is payable for one of the qualifying reasons listed above in the section entitled "Reasons for Taking Leave."

- To pay for the other supplemental benefit, the employer did not require the covered employee to use any other paid leave or paid time off available to the employee under a policy that is not specific to COVID-19, or vacation time.

- The other supplemental benefit compensates the employee at a rate of pay equal to or greater than the rate of pay for 2021 COVID-19 Supplemental Paid Sick Leave (as discussed above in the section entitled "Rate of Pay During Leave"). If the employer paid for the supplemental benefit at a lesser rate than what is required for 2021 COVID-19 Supplemental Paid Sick Leave, then the employer may make a retroactive payment to make up the difference between what was paid and what is required for 2021 COVID-19 Supplemental Paid Sick Leave, to satisfy this "rate of pay" requirement.

The other supplemental benefit may include paid leave provided by the employer under any federal or local law in effect or that became effective on or after January 1, 2021, if the paid leave is provided to the covered employee under the law for any of the same reasons set forth above in the section entitled "Reasons for Taking Leave."

The other supplemental benefit does not include paid sick days under California's Healthy Workplaces, Healthy Families Act of 2014, California's expired COVID-19 food sector supplemental paid sick leave law, or California's expired COVID-19 supplemental paid sick leave law.

Payment of Retroactive Benefits

The requirement to provide 2021 COVID-19 Supplemental Paid Sick Leave applies retroactively to January 1, 2021 for covered employees who took leave for one of the qualifying reasons listed above in the section entitled "Reasons for Taking Leave."

If a covered employee makes an oral or written request on or after March 29, 2021 for retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits, and the leave taken by the employee between January 1, 2021 and March 28, 2021 for a qualifying reason was:

- unpaid, the employer must provide the employee with retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits to cover the leave.
- covered by another supplemental benefit (as discussed under the above section entitled "Coordination with Other Paid Leave") that did not compensate the covered employee in an amount equal to or greater than the amount of compensation for 2021 COVID-19 Supplemental Paid Sick Leave that the employee is entitled to receive, the employer must provide the employee with a retroactive benefit that provides for such additional compensation.
- covered by the employee's regular paid sick or vacation days, the employer must provide the employee with retroactive 2021 COVID-19 Supplemental Paid Sick Leave benefits for those days and restore the used sick or vacation days to the employee's bank of available days.

The retroactive benefit must be paid on or before the pay date for the next full pay period after the covered employee's oral or written request. For any retroactive payment of benefits, the number of hours of leave corresponding to the amount of the retroactive benefit will count towards the total number of hours of 2021 COVID-19 Supplemental Paid Sick Leave that the employer is required to provide to the covered employee.

The 2021 FAQs provide the following example of a retroactive benefit payment: If a covered employee had to take two hours off for a vaccine appointment on February 15, 2021, the employee can make an oral or written request to the employer to be paid for that time off in February, because it is a qualifying reason for taking 2021 COVID-19 Supplemental Paid Sick Leave. The oral or written request must be made on or after March 29, 2021 (the date when SB 95 is effective for employers). A request made before March 29 does not count. After the employee makes the request, the employer will have until the payday for the next full pay period to pay the retroactive 2021 COVID-19 Supplemental Paid Sick Leave.

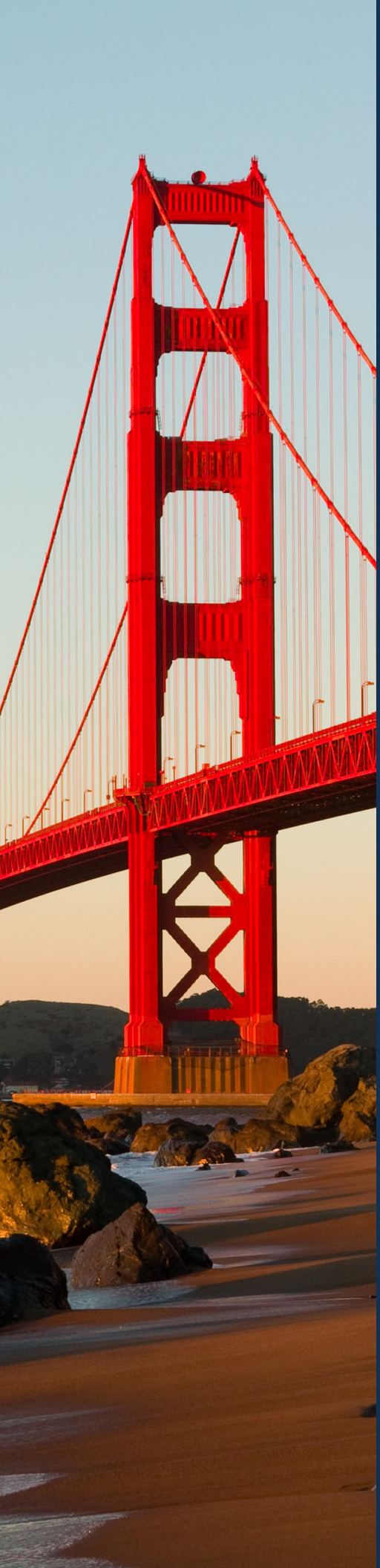
Administrative Tasks for Employers

Posted Notice

The California Labor Commissioner has published a model notice (linked below) that employers must post in a conspicuous location in the workplace. If an employer's covered employees do not frequent a workplace, the notice requirement may be satisfied by delivery through electronic means, such as by e-mail.

Notice of Available 2021 COVID-19 Supplemental Paid Sick Leave

The employer is required to provide each employee with written notice of the amount of 2021 COVID-19 Supplemental Paid Sick Leave available to the employee either on the employee's itemized wage statement or in a separate writing on each payday, beginning with the next full pay period following March 29, 2021. The amount of available 2021 COVID-19 Supplemental Paid Sick Leave must be listed separately from the amount of other paid sick days or paid time off available to the employee.



San Francisco HCSO 2020 Reporting Delayed

Published: March 31, 2021

The San Francisco Office of Labor Standards Enforcement (OLSE) has postponed the requirement for employers to submit the 2020 Annual Reporting Form for the San Francisco Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance (FCO) for a minimum of six months, at least until October 31, 2021. This form would otherwise have been due by April 30, 2021.

The San Francisco Board of Supervisors is currently considering proposed legislation that would cancel the 2020 employer reporting requirement altogether (as it did last year for the 2019 employer reporting requirement), due to the on-going COVID-19 public health crisis.

All other requirements of the HCSO remain in effect. Covered employers must continue to make health care expenditures on behalf of their covered employees, generally within 30 days of the end of each quarter. The deadline for expenditures in the first quarter of 2021 is April 30, 2021.

As a reminder, the official HCSO Notice should be posted in a conspicuous place at any workplace or job site where covered employees work. The updated 2021 Notice is available in 6 languages at:
https://sfgov.org/olse//sites/default/files/Document/HCSO%20Files/2021%20HCSO%20Poster%20Final.pdf

Arkansas PBM Law Upheld

On December 10, 2020, the U.S. Supreme Court unanimously held in Rutledge v. Pharmaceutical Care Management that federal ERISA law does not preempt a state law that regulates the price at which pharmacy benefit managers ("PBMs") reimburse pharmacies for the cost of drugs.

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 amount a PBM reimburses a pharmacy for a drug is not necessarily tied to how much the pharmacy paid to purchase that drug. Instead, PBM contracts with pharmacies typically set reimbursement rates according to a list specifying the maximum allowable cost ("MAC") for each drug. PBMs normally develop and administer their own unique MAC lists. Similarly, the amount that prescription drug plans pay PBMs for a drug is a matter of contract between a given plan and a PBM. A plan's payment to a PBM often differs from and exceeds the amount of the PBM's reimbursement to the pharmacy. That difference generates a profit for PBMs.

In Arkansas, the pharmacy reimbursement rates set by PBMs were often too low to cover pharmacies' costs, and many pharmacies – particularly rural and independent ones – were at risk of losing money and closing. So, in 2015, Arkansas passed Act 900, which effectively requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than the pharmacy's wholesale cost.

Supreme Court Case

The Pharmaceutical Care Management Association ("PCMA"), a national trade association representing the 11 largest PBMs in the country, filed a lawsuit against Arkansas, claiming that Act 900 is preempted by federal ERISA law.

ERISA generally preempts state laws that relate to employee benefit plans. The U.S. District Court and the U.S. Court of Appeals both concluded earlier that Act 900 relates to employee benefit plans and is therefore preempted by ERISA. However, the U.S. Supreme Court reached a different conclusion on the case.

The Court held that Act 900 had neither an impermissible connection with nor reference to ERISA and was therefore not preempted by ERISA, noting that Act 900:

- is merely a form of cost regulation that does not force plans to adopt any particular scheme of substantive coverage.
- does not refer to ERISA or apply exclusively to ERISA plans.
- does not interfere with central matters of plan administration as the responsibility for offering the pharmacy a "below-acquisition reimbursement" lies first with the PBM.
- fails to cause any "operational inefficiencies" that are sufficient to trigger ERISA preemption.

Employer Considerations

The Rutledge decision gives pharmacies more leverage to obtain higher reimbursements from PBMs for drugs purchased by participants in an employer-sponsored group health plan. PBMs have the choice of absorbing these additional costs or passing them along to the employer plan. It is not clear whether PBMs can require plans to pay these higher amounts unilaterally, or whether PBMs will need to negotiate new contracts with employer plans to obtain higher payments from the plans.

Because of the Rutledge decision, employers and plan participants can expect to pay more for prescription drugs. This financial effect will be felt across the entire country (not just in Arkansas) as more states adopt laws similar to Act 900.

Virginia Requires Maternity Benefits in Short-Term Disability Coverage

Beginning July 1, 2021, any policy delivered or issued in Virginia which provides for short-term disability ("STD") coverage will be required to include minimum benefits for childbirth.

The new regulations, signed into law on April 9, 2020, include the following:

- STD policies must provide a minimum maternity benefit of at least 12 weeks duration immediately following the birth of a child.
- Covered policies may not use an elimination period to reduce the required payable benefit of 12 weeks.
- If the policy imposes a maximum benefit per policy period, an insured may exhaust benefits prior to a childbirth and not be eligible for a full 12 months of payable benefits for a new child. However, where a policy imposes a maximum benefit period per disability, then the policy must provide the required 12 weeks of payable benefit for a childbirth.

The new requirements will only apply to new policies providing STD benefits issued or delivered on or after July 1, 2021. Policies providing long-term disability coverage are not covered by the new requirements.

This update is based upon interim guidelines from the Virginia Bureau of Insurance. Final guidelines are expected in the future.

Update on the Washington Long Term Care Program

In 2019, the State of Washington enacted H.B. 1087 (amended by S.S.B. 6267) to establish the Long-Term Services and Supports Trust Program ("LTC Program") that creates a state-run long-term care benefit for certain qualified individuals. The LTC Program will be funded by a new premium assessment on employee wages that takes effect January 1, 2022.

Rulemaking associated with the LTC Program is underway. Recently, Washington's Employment Security Department ("ESD") issued proposed and draft rules offering the first guidance on these new requirements. ESD also released a timeline for implementation.

In the 2021 legislative session, the House passed S.H.B. 1323 proposing changes to the LTC Program, including when an employee must obtain a long-term care insurance policy to qualify for an exemption from the payroll deduction for the premium assessment. Currently the bill is in the Senate awaiting a vote. All indications are that the bill is likely to pass. USI continues to monitor the progress of this legislation.

This article summarizes the LTC Program, including some changes proposed by S.H.B. 1323. The following is subject to change as guidance develops.

Premium Assessment

Beginning January 1, 2022, a 0.58% premium assessment applies on wages of all Washington employees to fund the LTC program. All wages are subject to the premium assessment; there is no cap.

What are wages?

The law defines wages as "all remuneration paid by an employer to an employee." According to the draft rules, examples of wages include:

- Salary or hourly wages;
- Cash value of goods or services given in the place of money;
- Commissions or piecework;
- Bonuses;
- Cash value of gifts or prizes;
- Cash value of meals and lodging when given as compensation;
- Holiday pay;
- Paid time off, including vacation leave and sick leave, as well as associated cash outs, (but not supplemental benefit payments provided by the employer);
- Separation pay including, but not limited to, severance pay, termination pay, and wages in lieu of notice;
- Value of stocks at the time of transfer to the employee if given as part of a compensation package;
- Compensation for use of specialty equipment, performance of special duties, or working particular shifts; and
- Stipends/per diems unless provided to cover a past or future cost incurred by the employee as a result of the performance of the employee's expected job function.

Do all employees working in Washington pay the premium assessment?

Yes. While the guidance has not specifically addressed this issue, it appears that all employees who work in Washington will be subject to the premium assessment unless an exception applies. The following individuals are exempt from the premium assessment:

- Employees who qualify for an exemption.
- Self-employed individuals (opt-in available).
- Employees of a federally recognized tribe (under S.H.B. 1323 an opt-in may be available).
- Employees of the federal government.

Note that while employees working in Washington must pay into the LTC program, only eligible Washington residents will be able to access benefits when available.

Special rules for parties to a collective bargaining agreement in existence on October 19, 2017

Parties to a collective bargaining agreement in existence on October 19, 2017, are not subject to the LTC program requirements (including premium assessments) until the existing agreement is reopened or renegotiated by the parties or expires. Employers must inform ESD immediately upon the reopening, renegotiation, or expiration of a collective bargaining agreement that was in effect prior to October 19, 2017.

Parties to a collective bargaining agreement in existence on October 19, 2017, that has not been reopened or renegotiated by the parties or expired may elect to be subject to the LTC program (including premium assessments) prior to the expiration, reopening or renegotiation of the agreement. Parties seeking to do so must submit to the department a memorandum of understanding, letter of agreement, or a similar document signed by all parties.

Reporting and Paying the Premium Assessment

Employers will be required to collect the premium assessment from Washington employees via after-tax payroll contributions and remit the premiums to ESD. This includes employers located outside of Washington with Washington employees. Employers are not required to contribute to the LTC Program. Employers will submit quarterly reports to ESD and make quarterly premium payments by the last day of the month following the end of the calendar quarter being reported. More guidance on premium payments and reporting is expected in future rulemaking.

Exempt Employees

An employee who is at least 18 years of age, has long term care insurance and attests to this may apply to ESD for an exemption from the premium assessment. The employee must apply for the exemption between October 1, 2021 and December 31, 2022. Applications for exemption will be available on ESD website or in another approved format. If approved, the exemption is effective the quarter immediately following approval. Exempt employees are not entitled to a refund of any premium deductions made before the effective date of an approved exemption.

An employee with an approved exemption must notify any current or future employer of their exempt status by providing a copy of their approval letter to the employer. If the employee fails to notify the employer of the exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification was provided.

If an employer deducts premiums after the employee provides notification of the employee's exempt status, the employer must refund the deducted premiums to the employee. An employer is not entitled to a refund for any premiums remitted to ESD that were deducted from exempt employees.

The employer must maintain a copy of the approval letter provided by the employee.

What is long term care insurance for purposes of the exemption?

To qualify for an exemption, the employee must attest to having long-term care insurance. The proposed rules define long term care insurance for this purpose as defined under RCW 48.83.020. Employees looking to claim the exemption should discuss with their carrier whether their long-term care insurance policy meets this definition.

If enacted, what is the effect of S.H.B. 1323 on the exemption?

S.H.B. 1323 proposes a significant change that will limit those employees who may qualify for an exemption. Only employees who purchased long term care insurance before the effective date of S.H.B. 1323 would be eligible for an exemption.

Note that under the current law, the employee must have long term care insurance and attest to that fact when applying for an exemption (between October 1, 2021 – December 31, 2022). S.H.B. 1323 requires such coverage to be in place by a certain date.

If enacted, the effective date would likely be July 24, 2021. Employees looking to claim an exemption would need to purchase coverage before the effective date.

Will there be opportunities to qualify for an exemption later?

As currently written, the only window to qualify for an exemption is between October 1, 2021 – December 31, 2022. Once an employee is exempt, the employee is permanently ineligible for coverage through the LTC Program.

Benefits

Benefits become available January 1, 2025 to qualified individuals. Qualified individual means:

- Washington resident at least 18 years of age;
- Has paid into the Program for the equivalent of either:
  - A total of 10 years without interruption of 5 or more consecutive years, or
  - 3 years within the previous 6 years (S.H.B. 1323 would add “from the date of application” after 6 years).
- Has worked at least 580 hours during each of the 10 years or each of the 3 years.
- Determined by the Department of Social and Health Services to require assistance with at least 3 activities of daily living (e.g., eating, bathing, dressing)

The available benefit is $100/day with a lifetime maximum of $36,500. An exempt employee may never be a qualified individual for this purpose.

Employer Action

Employers should:

- Coordinate with payroll to address the upcoming tax, reporting and filing requirements.
- Set up a process to accept notice of employee exemptions and maintain records accordingly.
- Await further guidance later this year.

Washington State Considers a Covered Lives Assessment

The Washington State legislature is considering a bill that would create a new Covered Lives Assessment ("CLA") on health insurers and third-party administrators providing coverage to individuals residing in the state. Funds generated from this assessment would serve to strengthen the public health system.

As proposed:

- Beginning March 1, 2022, and annually thereafter, each health carrier, Medicaid managed care organization (MCO) and third-party administrator (TPA) must file a statement of covered lives with the Office of the Insurance Commissioner (OIC).

- For Fiscal Year (FY) 2023, the OIC will assess carriers, MCOs, and TPAs a per member per month (PMPM) CLA of $3.25.

- Beginning FY 2024, health carriers, MCOs, and TPA's must pay a pro rata share of the total CLA based on the number of covered lives reported to the state.
  - For FY 2024, the total CLA will be $143M (or, as projected, $2.27 PMPM).
  - FY 2025 (and each FY thereafter) the total CLA will be $200M (or, as projected, $3.18 PMPM).

- Covered lives for purposes of the CLA means all persons residing in Washington state who are:
  - Covered under an individual or group health plan that is issued or delivered in Washington state or an individual or group health plan that otherwise provides health benefits to Washington residents;
  - Covered under a self-funded multiple employer welfare arrangement (MEWA); or
  - Enrolled in a group health plan administered by a TPA.

- Annually, before July 1, the OIC will calculate and bill the amount of CLA due from each entity. The assessment is payable by July 15. Penalties may apply to entities for failure to pay the CLA.

- TPAs will be required to register with the OIC by December 31, 2021. TPAs failing to register or renew their registration (or providing incorrect, incomplete, or misleading information) may be fined up to $5,000/violation.

As proposed, the CLA applies to health insurance carriers and TPAs. While employers sponsoring group health plans will not be directly responsible for the CLA, carriers and TPAs are likely to pass the cost on to employers through increased premiums and administrative costs.

The bill was introduced January 12, 2021 and will go through the lengthy process toward enactment. It will have to be approved by both the state House and Senate and then signed into law by the Governor. We are monitoring the legislation and will keep you apprised.

28 West Railroad Avenue
Jamesburg, NJ 08831
heatherb@cbplans.com