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2022: First Quarter

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

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New PCOR Fee Announced

Published: January 11, 2022

On December 21, 2021, the IRS released Notice 2022-04, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2021 and before October 1, 2022 is $2.79.

The PCOR filing deadline is August 1, 2022 for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2021. Carriers are responsible for paying the fee for insured policies.

2022 Form 720, due August 1, 2022:

Plan Year	Amount of PCOR Fee
February 1, 2020 – January 31, 2021	$2.66/covered life/year
March 1, 2020 – February 28, 2021	$2.66/covered life/year
April 1, 2020 – March 31, 2021	$2.66/covered life/year
May 1, 2020 – April 30, 2021	$2.66/covered life/year
June 1, 2020 – May 31, 2021	$2.66/covered life/year
July 1, 2020 – June 30, 2021	$2.66/covered life/year
August 1, 2020 – July 31, 2021	$2.66/covered life/year
September 1, 2020 – August 31, 2021	$2.66/covered life/year
October 1, 2020 – September 30, 2021	$2.66/covered life/year
November 1, 2020 – October 31, 2021	$2.79/covered life/year
December 1, 2020 – November 30, 2021	$2.79/covered life/year
January 1, 2021 – December 31, 2021	$2.79/covered life/year

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in Summer 2022 of the fee and additional information for filing and paying the PCOR fee with the IRS.

Guidance Issued on Broker Compensation Disclosure

Published: January 11, 2022

As reported earlier, beginning December 27, 2021, covered service providers (brokers and consultants) of ERISA-covered group health plans, regardless of size, must provide responsible plan fiduciaries information on direct and indirect compensation in writing.

On December 30, 2021, the DOL released Field Assistance Bulletin No. 2021-03, which provides guidance on this new broker transparency law. While many questions remain unanswered, there is some helpful relief and clarification. The following summarizes the key points.

Good Faith Relief

The DOL indicated that it expects that covered service providers will adopt various methods to make the required disclosure regarding their services and compensation in a way that complies. It will not treat them as having failed to make required disclosures to a responsible plan fiduciary as long as the person makes disclosures in accordance with a good faith, reasonable interpretation of the law. The DOL further indicated that a good faith and reasonable step for a group health plan service provider would be to take into account the DOL's guidance on its regulation for pension plans, as applicable.

Covered Benefits

The covered group health plans include both insured and self-insured group health plans, including grandfathered health plans and stand-alone dental and vision benefits, but do not include qualified small employer health reimbursement arrangements. A covered group health plan also includes "excepted benefits" that are group health plans. While not expressly called out, this likely includes certain excepted benefits like EAPs and onsite clinics.

Effective Date

Only contracts or arrangements for services which are entered into, extended, or renewed on or after December 27, 2021 are required to comply with the disclosure requirements. The date on which a contract or arrangement is entered into between a broker and a plan fiduciary is considered to be the date the contract or arrangement was "executed." For example, if a plan fiduciary enters into a new service contract with a broker on December 15, 2021 for the plan year beginning on January 1, 2022, the service contract will be treated as having been "executed" on December 15, 2021, which is prior to December 27, 2021, so that the contract is not subject to the new compensation disclosure requirements.

Also, pending further guidance, in the case of a broker that enters into a contract or arrangement with a plan fiduciary through use of a broker of record ("BOR") agreement, the date the contract or arrangement will be considered entered into is the earlier of:

- the date on which the BOR agreement is submitted to the insurance carrier; or
- the date on which a group application is signed for insurance coverage for the following plan year provided that the submission or signature is done in the ordinary course and not to avoid its disclosure obligations.

Unknown Compensation

ERISA Sec. 408(b)(2)(B) requires covered service providers to make the required disclosures to responsible plan fiduciaries reasonably in advance of the date they enter

into a contract or arrangement with a covered group health plan. The DOL recognizes that covered service providers may be unable to state with precision the amount of compensation they expect to receive for services, because the methodology by which certain components of their compensation is determined will depend on decisions or variables that are not known before, or even at the time, the contract or arrangement is entered into and, in fact, may change over the term of the contract or arrangement. The DOL takes the view that disclosure of compensation in ranges may be reasonable in circumstances when the occurrence of future events or other features of the service arrangement could result in the service provider's compensation varying within a projected range. The DOL indicates that the following language in the preamble to the DOL's final regulation for covered service provider disclosures to pension plan fiduciaries is relevant:

> *… such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue. To ensure that covered service providers communicate meaningful and understandable compensation information to responsible plan fiduciaries whenever possible, the DOL cautions that more specific, rather than less specific, compensation information is preferred whenever it can be furnished without undue burden.*

No matter the methodology used to disclose compensation, the adequacy of the disclosure should be measured against a principal objective of the statutory provision which is to provide the responsible plan fiduciary with sufficient information about the compensation to be received by covered service providers to allow the fiduciary to evaluate the reasonableness of the compensation, and the severity of any associated conflicts of interest. The duties of prudence and loyalty in ERISA Sec. 404 apply to a responsible plan fiduciary's decisions to hire service providers and to monitor service provider arrangements. What constitutes adequate disclosure for a specific compensation arrangement will depend on the facts and circumstances of the service contract or arrangement.

Covered Service Providers

The bulletin confirms that the definition of a covered service provider is not limited to service providers who are licensed as or who market themselves as "brokers" or "consultants." Pending further guidance, the DOL's enforcement policy will apply to parties who reasonably and in good faith determine their status as a covered service provider. Whether a person acts reasonably and in good faith depends on the facts of the particular situation. Service providers who reasonably expect to receive indirect compensation from third parties in connection with advice, recommendations, or referrals regarding any of the listed services in footnotes 1 and 2 should be prepared, if the DOL is auditing their compliance, to be able to explain how a conclusion that they are not covered service providers is consistent with a reasonable good faith interpretation of the statute.

Future Guidance

The DOL does not believe that comprehensive implementing regulations are needed. However, the department will monitor feedback from stakeholders to assess whether additional guidance may be necessary to assist covered service providers and plan fiduciaries in complying with the new disclosure requirements.

Guidance Issued Expanding Coverage for COVID-19 Testing

Published: January 14, 2022

On January 10, 2022, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued FAQ Part 51 requiring group health plans to cover, without cost-sharing, over-the-counter ("OTC") COVID-19 diagnostic tests obtained without the involvement of a health care provider. This provision is effective for OTC COVID-19 tests purchased on or after January 15, 2022, and continues for the duration of the Public Health Emergency (currently set to expire January 16, 2022 – however another 90-day extension is expected).

Briefly:

- Group health plans (and health insurance carriers) must cover diagnostic OTC COVID-19 tests obtained without the involvement of a health care provider without cost-sharing, prior authorization, or other medical management requirements.
- Plans can either reimburse members for their OTC COVID-19 test purchases after manually submitting a claim, or the plan may arrange to pay the merchant directly ("direct coverage") allowing plan members to receive the OTC COVID-19 tests with no cost sharing at the point-of-sale.
    - If the plan provides direct coverage, reimbursement for OTC COVID-19 tests purchased outside a preferred network may be limited to the lesser of $12/test or the actual cost of the test.
    - Plans that do not provide for direct coverage must reimburse the individual for the full cost of the test.
- Plans must cover 8 individual at-home OTC COVID-19 tests per person enrolled in the plan per month. That means a covered family of 4 can obtain 32 tests per month for free.
- Plans are not required to cover the cost of OTC COVID-19 tests for employment and surveillance purposes.

Frequently Asked Questions

Q: Are group health plans required to cover OTC COVID-19 tests without an order or individualized clinical assessment by a health care provider?

A: Yes. Beginning January 15, 2022, group health plans (and health insurance carriers) must cover diagnostic OTC COVID-19 tests obtained without the involvement of a health care provider without cost-sharing, prior authorization, or other medical management requirements.

Under the existing law, diagnostic OTC COVID-19 tests are covered without cost-sharing when an individual has an order or individualized clinical assessment from a health care provider. Such coverage remains in effect. The limits described in this article as they relate to OTC COVID-19 tests obtained without a health care provider (e.g., 8 tests/month, $12/test when direct coverage is an option) do not

apply when an individual has an order or individualized clinical assessment from a health care provider.

Q: How is the coverage provided?

A: Plans and carriers may choose whether to provide "direct coverage" for OTC COVID-19 tests to participants by reimbursing sellers directly without requiring individuals to provide upfront payment or require participants to purchase the OTC COVID-19 test and then submit a claim for reimbursement from the plan.

The Departments strongly encourage plans and carriers to adopt a "direct coverage" approach.

Q: What is "direct coverage"?

A: Direct coverage for OTC COVID-19 tests means that a participant is not required to submit a claim to seek reimbursement from the plan for the purchase of the test. Instead, the plan makes systems and technology changes necessary to process the plan's payment to the preferred pharmacy or retailer directly (including direct-to-consumer shipping programs) with no upfront out-of-pocket expenditure.

A plan must take reasonable steps to ensure that participants have sufficient access to OTC COVID-19 tests, through an adequate number of retail locations (including both in-person and online). Whether there is adequate access should be determined based on all relevant facts and circumstances, such as the locality of participants under the plan and current utilization of the plan's pharmacy network. Plans should communicate with members to ensure that participants are aware of key information needed to access OTC COVID-19 tests, such as dates of availability of the direct coverage program and participating retailers or other locations.

If the plan is unable to meet the requirements of the direct coverage safe harbor, the plan must provide for the full reimbursement of OTC COVID-19 tests. This may occur, for example, when there are substantial delays for obtaining a COVID-19 test through a direct-to-consumer shipping program versus obtaining other items through this same program.

Q: Can the plan limit coverage only to OTC COVID-19 tests that are provided through preferred pharmacies or other retailers?

A: No. Generally, a plan or carrier may not limit coverage only to tests that are provided through preferred pharmacies and other retailers.

A plan that provides for direct coverage of OTC COVID-19 tests in accordance with the guidance may limit reimbursement for OTC COVID-19 tests from non-preferred pharmacies and other retailers to the lesser of (1) the actual price, or (2) $12/test.

Example:

Plan provides direct coverage

If a plan has set up a network of preferred stores, pharmacies, and online retailers at which a participant can obtain a test with no out-of-pocket expense at the point-of-sale, the participant can still obtain tests from other retailers outside of that network. The plan may reimburse at a rate of up to $12 per individual test (or the cost of the test, if less than $12).

Plan does not provide direct coverage

If a plan has not set up a network of preferred stores, pharmacies, and online retailers at which a participant can obtain a test with no out-of-pocket expense at the point-of-sale, the participant will be reimbursed the full cost of the test. For example, the participant buys a two-pack of tests for $34, the plan would reimburse $34 (as opposed to $24 had the plan set up a network for individuals to obtain the test without an out-of-pocket expense).

Q: How many OTC COVID-19 tests must the plan provide without cost-sharing?

A: A plan or carrier may limit the number of OTC COVID-19 tests purchased by a participant without the involvement of a health care provider to no less than 8 tests per 30-day period (or per calendar month). For a covered family of 4, this means the plan must provide for up to 32 tests in a month.

Q: What is the effective date?

A: Plans and carriers are required to cover OTC COVID-19 tests purchased on or after January 15, 2022. Plans and carriers may, but are not required to, provide such coverage for OTC tests purchased before January 15, 2022.

The guidance confirms that the non-enforcement relief for mid-year changes to an SBC remains available with respect to this change.

Q: Are plans permitted to address suspected fraud or abuse?

A: Yes. Plans and carriers may take reasonable steps to prevent, detect, and address fraud and abuse.

For example, a plan may require:

- An attestation that the OTC COVID-19 test was purchased by the participant for personal use, not for employment purposes, has not been (and will not be) reimbursed by another source, and is not for resale.
- Documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test (e.g., the UPC code for the OTC COVID-19 test and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC COVID-19 test).

Q: Are plans required to cover OTC COVID-19 tests that are for employment purposes?

A: No. Consistent with earlier guidance, plans are not required to provide coverage of testing (including an OTC COVID-19 test) that is for employment purposes.

Q: How can plans facilitate access to, effective use of, and prompt payment for OTC COVID-19 tests?

A: Plans and carriers may provide education and information resources to support consumers seeking OTC COVID-19 testing, provided the resources make clear that the plan or carrier provides coverage for, including reimbursement of, all OTC COVID-19 tests under the guidance. This may include:

- information on the difference between OTC COVID-19 tests and other tests ordered by a provider or processed in a laboratory,
- quality and reliability information for specific testing products,
- how to obtain a test directly from the plan without cost-sharing (the direct coverage option, if applicable), and
- how to submit a claim (paper or electronically) and receive reimbursement directly from the plan.

Employer Action

Employers should:

- Discuss this expanded coverage with their carriers and TPAs, including whether the carrier or plan will provide for direct coverage of OTC COVID-19 tests.
- Consider notifying participants of the expanded coverage and how to obtain free OTC COVID-19 tests.

Supreme Court Effectively Ends OSHA Vaccination Emergency Temporary Standard

Published: January 18, 2022

In a 6-3 decision issued on January 13, 2022, the Supreme Court reimposed a legal stay that prevents OSHA from enforcing its vaccination Emergency Temporary Standard (ETS). And while the matter is being sent back to the 6th Circuit Court of Appeals for further review, the conclusions drawn by the Court almost certainly means the end of the ETS.

How did we get here?

The ETS was formally published on November 5, 2021, with initial compliance dates of December 5, 2021, and January 4, 2022. Shortly thereafter, the 5th Circuit Court of Appeals issued a legal stay that put the ETS on pause and temporarily prevented OSHA from enforcing it. There were numerous legal challenges to the ETS, which were quickly consolidated and given to the 6th Circuit Court of Appeals for adjudication. The 6th Circuit lifted the legal stay and allowed OSHA to move forward with enforcement. In response, OSHA issued new compliance dates of January 10, 2022, and February 9, 2022, while the case was appealed to the Supreme Court.

What did the Supreme Court say?

The primary question before the Supreme Court was whether the scope of the vaccine ETS exceeded the statutory authority given to OSHA to issue emergency temporary standards. The Court started its analysis by acknowledging that OSHA has the power to regulate occupational risks and dangers. It then asked the question whether the ETS targeted occupational hazards, or whether it was actually regulating public health more broadly, which would exceed OSHA's authority. While the court recognized that OSHA has the power to regulate COVID-19 risks in environments that may be uniquely susceptible to transmission (such as COVID-19 research labs, cramped workspaces, etc.), it concluded that the breadth of the ETS went beyond clearly identifiable occupational hazards, and thus was tantamount to an impermissible public health measure:

Although COVID-19 is a risk that occurs in many workplaces, it is not an occupational hazard in most. COVID-19 can and does spread at home, in schools, during sporting events, and everywhere else that people gather. That kind of universal risk is no different from the day-to-day dangers that [we] all face from crime, air pollution, or any number of communicable diseases. Permitting OSHA to regulate the hazards of daily life—simply because most Americans have jobs and face those same risks while on the clock—would significantly expand OSHA's regulatory authority without clear congressional authorization.

As a result, the Court decided that the parties opposing the ETS "are likely to succeed on the merits of their claim that [OSHA] lacked authority to impose the mandate", so it reimposed the stay and sent the matter back down to the 6th Circuit for further review of the merits of the case. However, the Supreme Court's reasoning and analysis all but ensures that the 6th Circuit will come to the same conclusion.

What does this mean for employers?

Employers will no longer have to comply with the ETS, which means that they will now have greater latitude to decide what COVID-related practices are best for their workplaces. Employers that have already started complying with the provisions of the ETS can continue to do so, if they choose, or they can discontinue some or all of the measures they've adopted at this point. Employers that

were holding off on compliance while waiting for the Supreme Court's decision will now have to decide whether they want to modify any of their existing safety practices. As employers make these decisions, a few things should factor into the consideration process:

- The Supreme Court's focus was on whether OSHA exceeded its statutory authority, which has nothing to do with what workplace practices individual employers can choose to adopt. As a result, the decision does not impact the vaccination, testing, and masking practices options that employers can choose from.

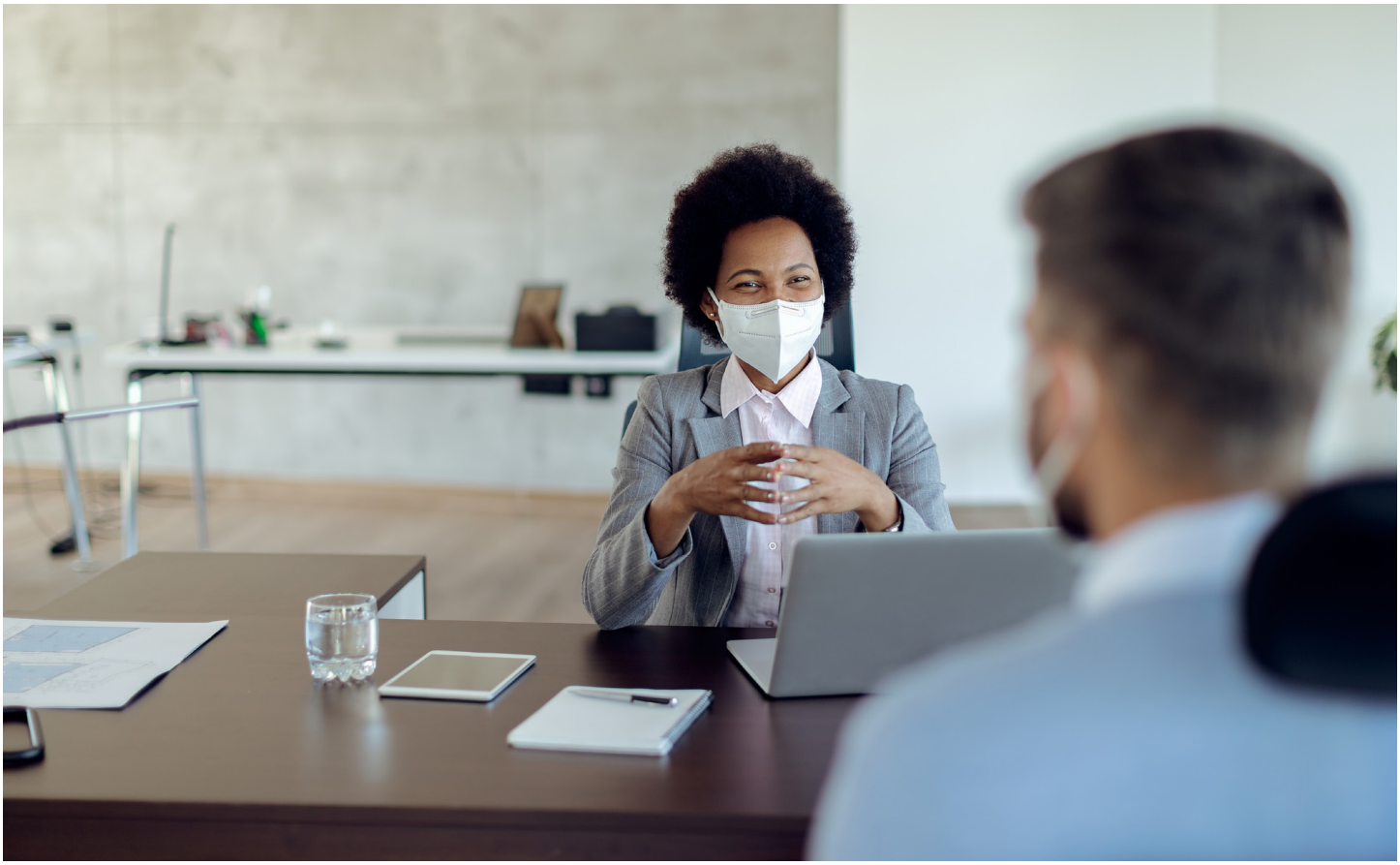
- OSHA still has authority under its General Duty Clause to inspect and penalize what it considers to be unsafe COVID-related practices, although its scope and power under the General Duty clause is much narrower than under the ETS. Indeed, in response to the Supreme Court's decision, OSHA has put employers on notice of its continuing commitment to address COVID-19 safety in the workplace:

  Regardless of the ultimate outcome of these proceedings, OSHA will do everything in its existing authority to hold businesses accountable for protecting workers, including under the COVID-19 National Emphasis Program and General Duty Clause.

- States that have approved state OSHA programs could independently choose to pursue implementation of their own versions of the ETS, and even states without their own OSHA programs may have Departments of Health or other agencies that have made specific recommendations for COVID-related workplace safety practices.

- Employers covered by the vaccination mandates imposed on federal contractors (the federal contractor mandate) and certain recipients of Medicare and/or Medicaid funds (the CMS mandate) may still have to comply with those requirements, since in a separate opinion the Supreme Court upheld the CMS mandate and is expected to eventually weigh-in on the federal contractor mandate.

In other words, the ETS was not the only variable that might influence employer practices, which means that employers should be mindful as they decide what COVID-related practices to adopt going forward. In doing so, it will be important to work with trusted advisors and vendors to help make the best decisions for each workplace.



HHS Extends Public Health Emergency until April 16, 2022

Published: January 21, 2022

On January 14, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective January 16, 2022. This will once again extend the Public Health Emergency period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period: HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire April 16, 2022 (unless further extended or shortened by HHS).

Outbreak Period: The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, and 2) 60 days after the announced end of the National Emergency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 testing and vaccinations and other 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.

DOL Penalties Increase for 2022

Published: January 26, 2022

The Department of Labor (DOL) published the annual adjustments for 2022 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2022

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

Description	2022 Penalty (New)	2021 Penalty (Old)
Failure to file Form 5500	Up to $2,400 per day	Up to $2,259 per day
Failure of a MEWA to file reports	Up to $1,746 per day	Up to $1,644 per day
Failure to provide CHIP Notice	Up to $127 per day per employee	Up to $120 per day per employee
Failure to disclose CHIP/Medicare coordination to the State	$127 per day per violation (per participant/beneficiary)	$120 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,264 per failure	Up to $1,190 per failure
Failure to furnish plan documents (including SPDs/SMMs)	$171 per day $1,713 cap per request	$161 per day $1,613 cap per request
Genetic information failures	$127 per day (per participant/beneficiary)	$120 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,192 minimum	$3,005 minimum
Failure to meet genetic information requirements – not de minimis failures	$19,157 minimum	$18,035 minimum
Cap on unintentional failures to meet genetic information requirements	$638,152 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.

Additional Guidance Addresses ACA Preventive Care Mandate

Published: January 31, 2022

As part of FAQ 51, the Departments of Labor, Health and Human Services, and the Treasury (together, the "Departments") issued guidance clarifying several Affordable Care Act ("ACA") preventive care coverage issues applicable to non-grandfathered group health plans.

As background, non-grandfathered group health plans must cover certain in-network preventive care items and services without cost-sharing.

FAQ 51 addresses preventive care requirements that relate to colonoscopies and coverage for female contraceptives as follows:

- Colonoscopy coverage. For plan years that begin on or after May 31, 2022, a group health plan (or carrier) must cover without any cost-sharing a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography).

- Contraceptives. The Departments have received a number of complaints and reports that covered individuals are being denied otherwise mandated contraceptive coverage. Examples include: denying brand name contraceptives when the provider determines the product is medically necessary for the individual, imposing onerous fail-first requirements before the plan will cover a medically necessary contraceptive product, and failing to provide an easily accessible, transparent and expedient exception process that is not unduly burdensome.

The Departments are reminding plans to comply with the contraceptive services coverage requirements. This includes the requirement that, if an individual and their attending provider determine that a particular service or FDA-approved, cleared, or granted contraceptive product is medically appropriate for the individual (whether or not the item or service is identified in the current FDA Birth Control Guide), the plan or issuer must cover that service or product without cost sharing.

The Departments are actively investigating complaints and may initiate enforcement or other corrective measures.

Employer Action

Employers should ensure their plans will comply with the additional coverage requirements for colonoscopies effective for plan years that begin on or after June 1, 2022. Plans should also review coverage of contraceptive services considering the Departments latest FAQ.

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

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

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

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

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

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

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 testing and vaccinations and other 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.

Guidance Issued on New York Paid Sick Leave

Published: February 07, 2022

On December 22, 2021, the New York Department of Labor ("NYDOL") issued guidance in response to stakeholder comments about the New York Sick Leave Law ("NYSLL"). This guidance provides clarity on a variety of implementation topics and does not alter or amend prior NYSLL regulations issued in December 2020.

Background

All New York employers are subject to the NYSLL. The amount of sick leave that must be made available is determined based on the size of the employer as follows:

- Employers with less than 100 employees nationwide will be required to provide up to 40 hours of paid sick time per calendar year, although unpaid sick leave is required for employers with fewer than five employees and income less than $1 million in the prior tax year.

- Employers with 100 or more employees nationwide will be required to provide 56 hours of paid sick time per calendar year.

Employees will accrue 1 hour of sick time for every 30 hours worked and begin to accrue hours toward sick leave beginning as of their date of hire. Sick time may be used for an employee's own, or a family member's mental or physical illness, preventive care or care and services related to domestic violence.

Recent Guidance

Summarized below are highlights from the recent guidance to address stakeholder comments:

- All employees of the employer nationwide are to be considered in determining employer size for the application of the NYSLL, although sick leave rights only apply to employees in New York state.
- Employees may carry-over an unlimited number of unused sick leave hours to the following year. Employers however are permitted to limit the leave taken in any year to the maximum amount required to be provided to such employee (e.g., 40 hours for midsized employers and 56 hours for large employers).
- While the statute requires that employers carry over unused sick leave to the next calendar year, employers have the option to: (1) give employees the choice to voluntarily elect to use and receive payment for paid sick leave prior to the end of a calendar year or carry over unused sick leave; or (2) only allow employees to carry over unused sick leave.
- Employees must be allowed to use sick leave time upon accrual of the sick leave hours. No additional waiting period may be imposed. Employers that front-load sick time hours must permit newly hired employees to utilize their sick leave at date-of-hire.
- An employer may not deny an employee leave while attempting to confirm the basis for the leave. If the employer discovers the request to be false or fraudulent, disciplinary action may be taken against the employee. Employers are cautioned to not penalize or otherwise retaliate against an employee for submitting such a request or attestation.
- The NYDOL does not believe a documentation requirement for leave less than three days is necessary for investigation into potential employee abuse of sick leave and otherwise believes documentation requirements are sufficient.
- The NYDOL intends to publish a template that employees may use to attest to the need for sick leave

Employer Action

Employers with New York employees should review the latest guidance and work with counsel to ensure adherence to the sick leave statute, implementing regulations and the latest guidance.

State Health Coverage Reporting Requirements for CY 2021

Published: February 08, 2022

The IRS has made permanent an automatic 30-day extension to March 2, 2022 for furnishing Affordable Care Act ("ACA") Forms 1095-C (or 1095-B) to full-time employees and other individuals to demonstrate proof of health insurance coverage for each month in the 2021 calendar year ("CY"). Form 1094-C and all Forms 1095-C for the prior CY must be furnished to the IRS by March 31 each year (unless eligible for paper filing, then by February 28).

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

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

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

These requirements and deadlines may (or may not) align with the federal requirements. Below is a chart summarizing the important deadlines related to 2021 coverage for employers with employees in individual mandate states. Some of these deadlines may change as states consider whether to extend relief similar to federal reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2022	March 31, 2022. No penalties will be assessed if filed by May 31, 2022
District of Columbia	March 2, 2022	April 30, 2022 (30 days after federal deadline)
Massachusetts	January 31, 2022	January 31, 2022
New Jersey	March 2, 2022	March 31, 2022
Rhode Island	January 31, 2022	March 31, 2022
Vermont	N/A	N/A

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

- State residents: Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.

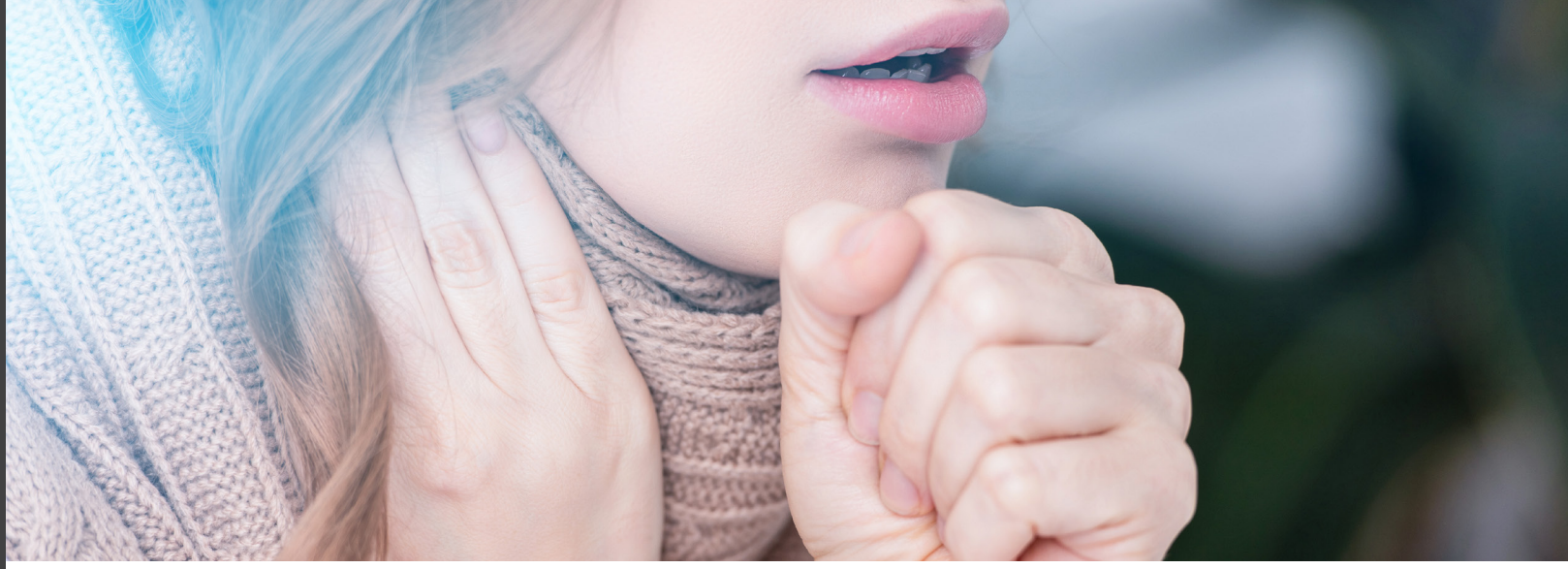
- Employers with fully insured plans: Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency. The District of Columbia also has reporting obligations for certain employers sponsoring fully insured plans. It is important to note that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.

- Employers with fully insured plans issued out-of-state: Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.

- Employers with self-funded plans: Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

Employer Action

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



Allegheny County, Pennsylvania Implements New Paid Sick Leave Requirements

Published: February 11, 2022

On September 14, 2021, the Allegheny County Council passed the Allegheny County Sick Leave Ordinance ("the Ordinance"). The new paid leave rules will require covered employers to allow up to 40 hours per year of paid sick leave to eligible employees. The Ordinance was effective as of December 15, 2021, with fines for violations suspended until December 15, 2022.

Who is Covered by the Ordinance?

Covered employers are defined broadly to include any entity (public or private) situated or doing business within Allegheny County which employs at least one or more compensated employees. Only employers with 26 or more employees (performing services anywhere) are required to provide paid leave. In making this determination, all employees, excluding the owner(s) should be counted. Part-time employees should be counted as one employee rather than as a fraction of an employee.

What Individuals are Eligible for Paid Leave?

The Ordinance applies to all part-time and full-time employees performing compensated services for the employer within Allegheny County. Independent contractors, state and federal employees and seasonal employees, and members of a construction labor union covered by a collective bargaining agreement are not eligible.

How are Leave Benefits Accrued?

Beginning December 15, 2021, current employees must be permitted to accrue at least one (1) hour of paid sick leave for every 35 hours worked within Allegheny County, up to a maximum of 40 hours of paid sick leave in a calendar year. Employees hired after December 15, 2021, will begin accruing leave as of their date of hire. Employees must be allowed to carry over accrued, unused paid sick leave from one calendar year to the next calendar year; however, employers are not required to permit carryover where the employer front-loads 40 hours of paid sick leave at the beginning of each calendar year.

When Can Paid Sick Leave be Used?

Covered employees may use accrued sick leave beginning on the 90th calendar day following their date of employment. Accrued sick leave may be used for any of the following reasons:

- An employee's own mental or physical illness, injury, or health condition, including diagnostic, treatment, and preventive medical care for the illness, injury, or health condition;
- Care of a family member with a mental or physical illness, injury, or health condition including diagnostic, treatment, and preventive medical care for the illness, injury, or health condition;
- Closure of the employee's place of business by order of a public official due to a public health emergency;
- An employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; and
- Care for a family member when it has been determined by the health authorities having jurisdiction over or by a health care provider that the family member's presence in the community would jeopardize the health of others because of the family member's exposure to a communicable disease, whether or not the family member has actually contracted the communicable disease.

How is Paid Leave Requested?

Covered employees must request paid sick leave from their employers.

- Where possible, the request must include the anticipated duration of the leave.
- An employer may require reasonable advance notice (not to exceed 7 days) of a leave request where the need for the use of paid leave can be foreseen by the employee (for example, a previously scheduled appointment with a health care provider). Where 7-days advance notice is not possible, employees must give notice as soon as possible.
- Where the need for sick leave is foreseeable, the employee must make a reasonable effort to schedule the use of such leave in a manner not unduly disruptive to the employer's operations.
- For paid leave lasting 3 or more days, an employer may require reasonable documentation to prove that the paid leave was used for a permissible purpose.

Can an Employer Substitute Other Paid Leave to Meet the Ordinance's Requirements?

Yes. An employer that provides covered employees with other forms of paid sick leave, such as PTO, that meets the requirements of the Ordinance (including accruals, reasons for leave, and other conditions) will not be required to provide additional paid sick leave.

Are Employers Required to Distribute a Notice to Covered Employees?

Yes. Employers must give written notice (in English, Spanish, and any other primary language used in the workplace) to covered employees. This notice must include:

- the employees' entitlement to leave;
- the amount of paid sick leave;
- the terms of its use;
- the prohibition against retaliation for the use of paid leave; and
- that each employee has a right to file a complaint for any violation or denial of sick leave by an employer.

This notice should be displayed in a conspicuous and accessible location at the worksite or, if working remotely, the notice may be provided on an individualized basis in the employees' primary language in a physical or electronic format that is reasonably conspicuous and accessible.

A sample notice can be found on the website.

Are Employers Required to Distribute a Notice to Covered Employees?

Employers must keep records documenting the number of hours worked and paid sick time taken by employees for two (2) years.

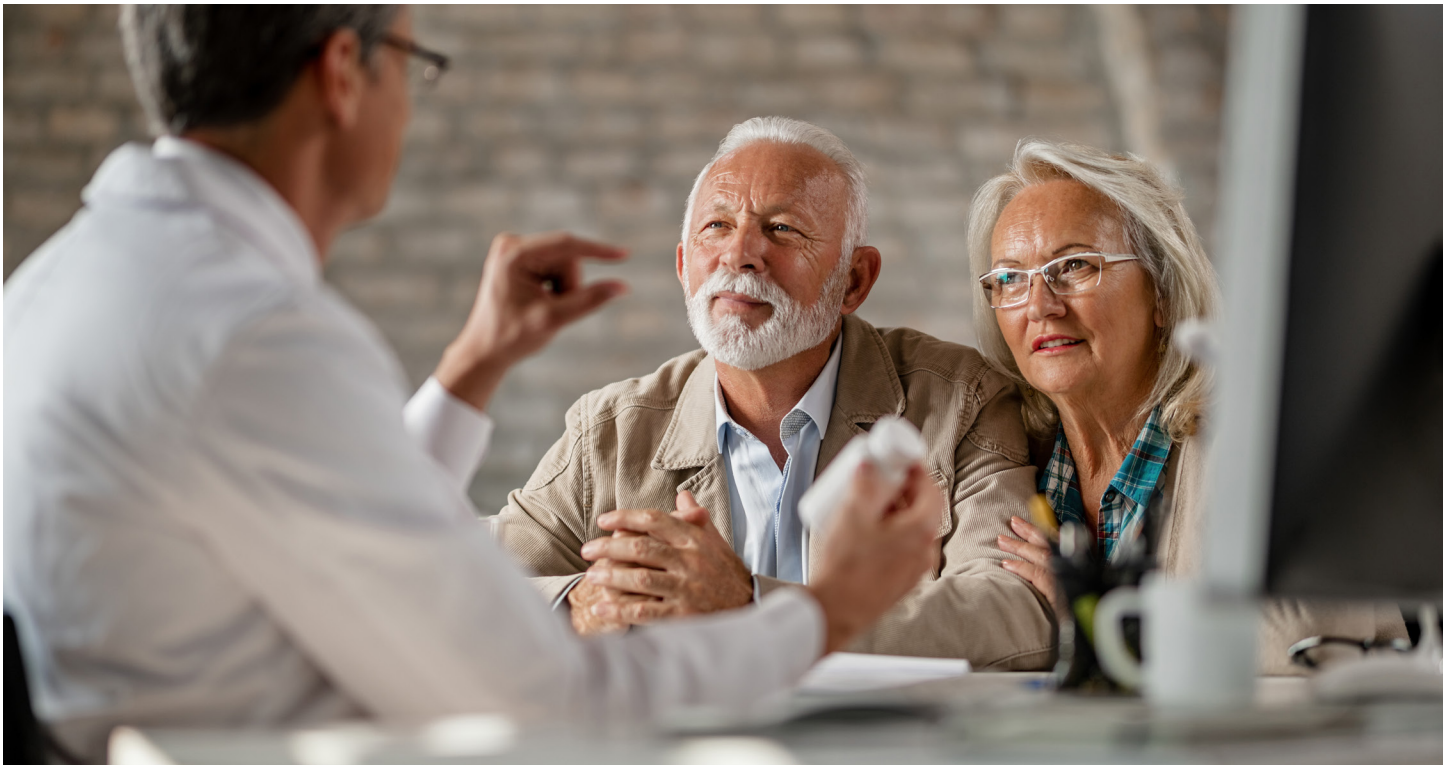
Employers should choose a reasonable system for providing notification of accrued sick leave. Suggested methods include making accrued leave available on pay stubs or in an online system that is accessible by covered employees.

Failure to adhere to the recordkeeping requirements will result in a presumption that the employer has violated the Ordinance (absent clear and convincing evidence to the contrary).

Employer Next Steps

Covered employers should:

- evaluate any existing paid sick leave to determine whether it meets the minimum requirements under the Ordinance and, if it does not, work to amend their existing leave policies to align with these new requirements.
- unionized construction employers should review their sick leave polices to ensure only non-unionized employees are covered.
- begin documenting hours worked and paid sick leave earned back to December 15, 2021.
- provide any paid sick time earned and requested.
- post the notice in a conspicuous and accessible location.



Medicare Part D – CMS Notification Reminder

Published: February 14, 2022

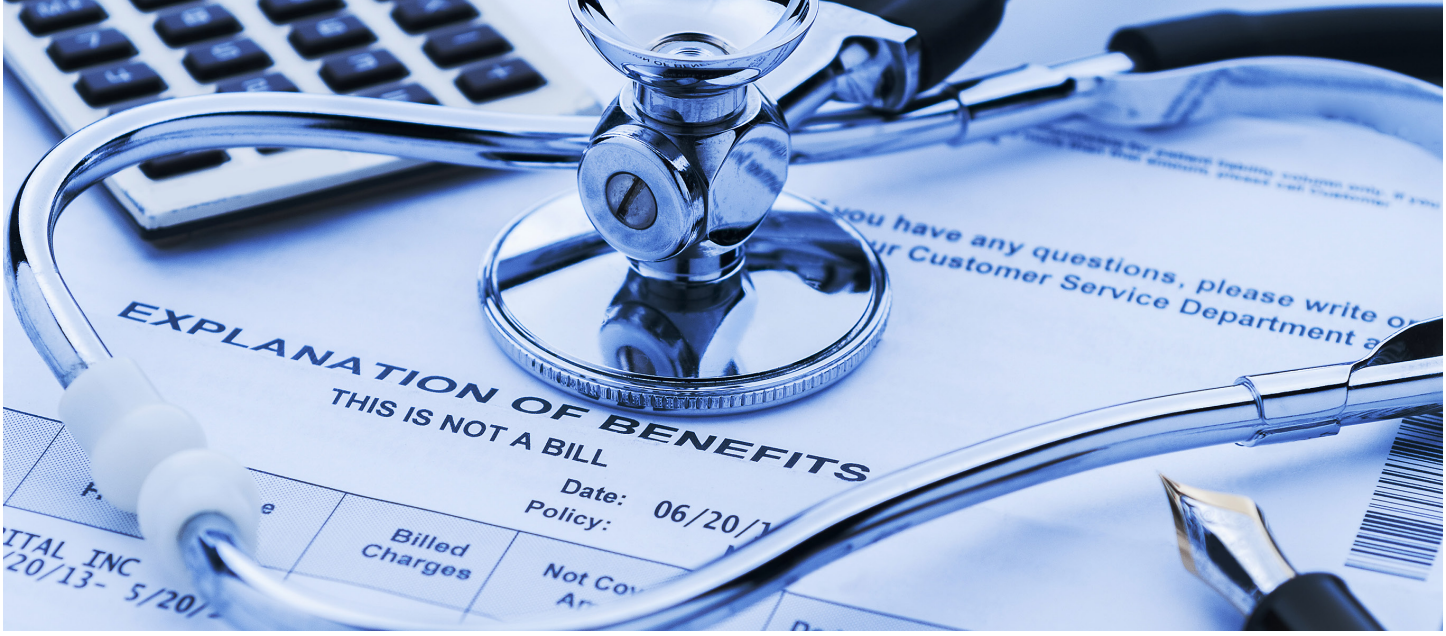
Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access 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, 2022) must complete this reporting **no later than Tuesday, March 1, 2022**.

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



Annual Out-of-Pocket Maximum Adjustments Announced for 2023

Published: February 14, 2022

On December 28, 2021, the Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2023 ("the Notice"). HHS historically publishes the Notice as a proposed rule and then finalizes the rule. The guidance clarifies that, beginning with the 2023 calendar year, the payment parameters portion of the Notice will be published by January of the year preceding the applicable calendar year. This guidance is considered a final rule that addresses certain provisions of the Affordable Care Act ("ACA").

For purposes of employer-sponsored health plans, the final rule includes caps on out-of-pocket dollar limits for non-grandfathered group health plans with plan years that begin in 2023.

Change to the Out-of-Pocket Maximums

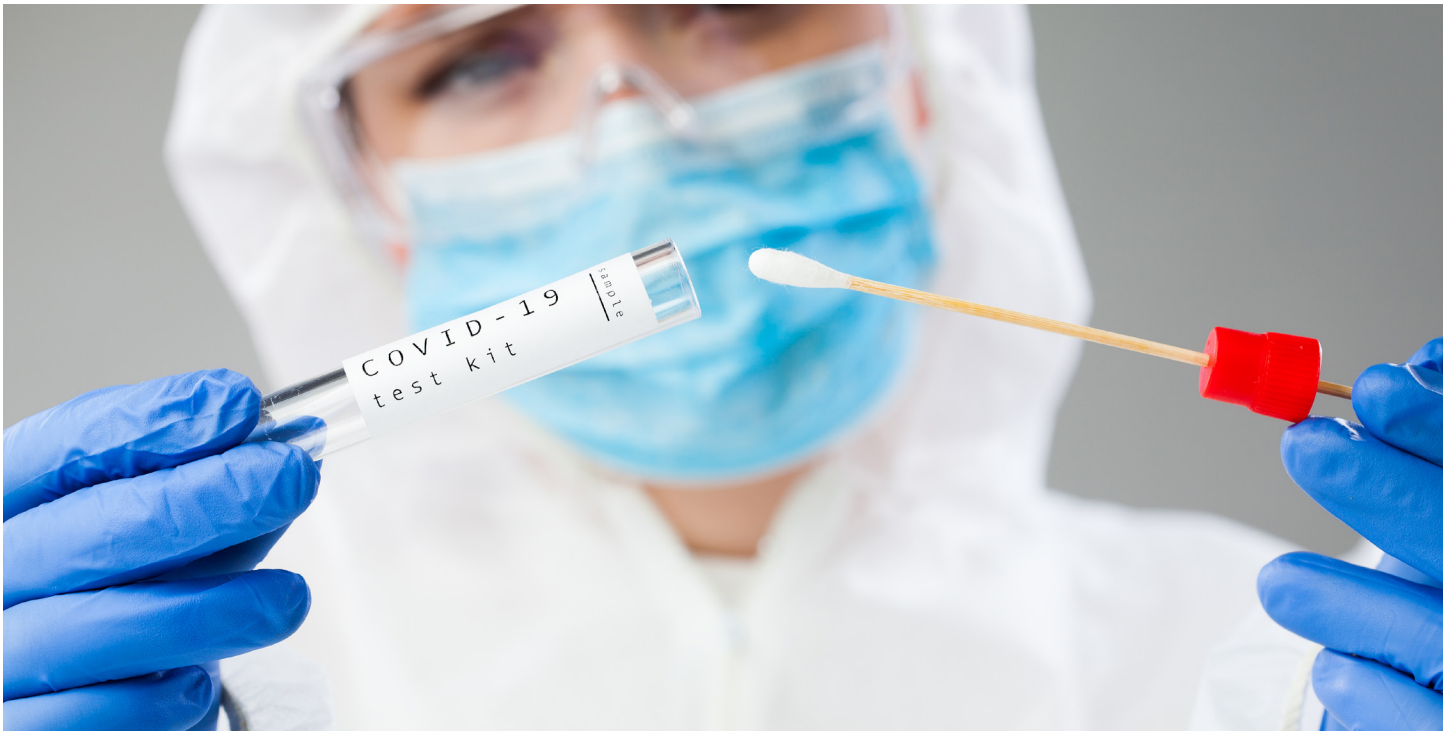
Under the final rule, non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2023 as follows:

- $9,100 for self-only coverage (up from $8,700 in 2022); and
- $18,200 for coverage other than self-only (up from $17,400 in 2022).

Note that different out-of-pocket limits apply to qualified high-deductible health plans, for purposes of making contributions to a health savings account ("HSA"). The 2023 HSA thresholds will likely be announced in June 2022.

Employer Action

Employers should update out-of-pocket limits for plan years beginning on or after January 1, 2023.



New OTC COVID-19 Testing Coverage Guidance Published

Published: February 17, 2022

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") released additional guidance to assist group health plans in implementing the over-the-counter ("OTC") COVID-19 testing coverage requirements previously discussed in FAQs Part 51. FAQs Part 52 were published on February 4, 2022, in response to stakeholder questions.

Briefly, the FAQs provide the following guidance:

- Group health plans have flexibility in establishing their direct coverage program.
- A plan will not be out of compliance with the direct coverage safe harbor because there is a temporary testing shortage, provided that the plan offers a direct coverage option.
- To prevent fraud and abuse, plans may limit reimbursements to established retailers and disallow the reimbursement of tests purchased from a private individual, online auction, or resale marketplace.
- The relief does not apply to COVID-19 OTC tests that are self-administered but require processing by a laboratory.
- If funds from a tax-advantaged account, such as an HSA or health FSA, are used to purchase an OTC test, these tests are not eligible for reimbursement from the health plan.

Additional Information

Q. Is there flexibility in how group health plans establish their direct coverage program to satisfy the requirements of the safe harbor in FAQs Part 51, Q2?

Yes, the guidance clarifies that group health plans will have significant flexibility in the design of their direct coverage program if the program provides adequate coverage through both a direct-to-consumer shipping mechanism and an in-person mechanism. Direct coverage for OTC COVID-19 tests means that a participant is not required to submit a claim to seek reimbursement from the plan for the purchase of the test. Instead, the plan makes systems and technology changes necessary to process the plan's payment to the preferred pharmacy or retailer directly (including direct-to-consumer shipping programs) with no upfront out-of-pocket expenditure.

Regarding the direct-to-consumer shipping mechanism, this requirement can be met by:

- Any program which provides direct coverage of OTC COVID-19 test for enrollees in the health plan without the individual being required to purchase the test at an in-person location;
- Utilizing a pharmacy or other retailer's online or telephone ordering system; and
- Paying all reasonable shipping costs and sales taxes in a manner consistent with how the plan covers other items supplied through mail order (for example, pharmacy benefits).

Adequate access to an in-person mechanism will depend on an examination of all relevant facts and circumstances. The guidance has clarified that such facts include:

- The locality of enrollees under the plan;
- Current utilization of the plan's pharmacy network by enrollees (when utilizing the pharmacy network as part of the direct coverage option);
- How enrollees are notified of network retail locations; and
- Which tests are covered by the plan under the direct coverage option.

Plans are not required to provide coverage for all manufacturers of COVID-19 testing but may instead limit coverage to specific manufacturers that the plan has a contractual relationship with or from whom the plan is able to secure tests directly.

Q. Will a temporary testing supply shortage cause a plan to be out of compliance with the safe harbor in FAQs Part 51, Q2?

No, a plan will not be considered out of compliance due to a temporary testing supply shortage which impacts its ability to offer adequate coverage as long as the plan otherwise meets the requirements for the safe harbor.

Q. Is a plan permitted to address suspected fraud or abuse?

Yes. FAQs Part 51, Q4 specifically allowed for plans to address suspected fraud and abuse and this new guidance provides welcome suggestions on how this can be accomplished.

Plans are permitted to take reasonable steps to prevent and detect fraud and abuse by limiting reimbursements to tests purchased from established retailers and denying reimbursements for tests purchased from a private individual, online auction, or resale marketplace.

Plans may require documentation of the product and seller's identity, such as:

- UPC codes;
- Serial numbers; or
- Original receipt.

If implementing such a limitation, the plan should communicate necessary information to the plan's enrollees regarding retailers covered by the plan, as well as those tests or retailers which will be denied a reimbursement.

Q. Are COVID-19 tests which are self-administered, but require the sample to be sent to a laboratory for processing required to be covered by a plan pursuant to this guidance?

No. A test must be both self-administered and self-read (without the involvement of a healthcare provider) for a health plan to be required to cover it, pursuant to the requirements in FAQs Part 51. Importantly, a COVID-19 test which is not self-administered and/or not self-read but is prescribed by a physician and otherwise meets the requirements under the Families First Coronavirus Response Act ("FFCRA") must be covered by the plan according to the FFCRA's terms.

Q. How are health plan reimbursements affected by the usage of HSAs, health FSAs, and HRAs to initially purchase the tests?

While COVID-19 OTC tests are considered a qualified medical expense under the Internal Revenue Code, tests purchased from tax-advantaged accounts, such as HSAs, health FSAs, and HRAs, are not eligible for reimbursement by a health plan. IRS rules prevent an individual from being reimbursed more than once for the same medical expense (often referred to as "double dipping").

Health plans may wish to notify enrollees not to utilize such tax-advantaged funds to purchase OTC COVID-19 test for which they will later seek reimbursement from the health plan.

Employer Action

Employers should:

- Discuss with carriers, TPAs, and PBMs how this new guidance affects any direct coverage options which have already been established.
- Communicate any limitations on OTC test points of sale.
- Consider notifying enrollees to avoid utilizing an HSA, health FSA, or HRA to purchase OTC COVID-19 tests that they wish the plan to later reimburse.

No Surprises Act IDR Process Altered by Court Order

Published: March 21, 2022

Under the No Surprises Act ("NSA"), when out-of-network ("OON") providers cannot agree to a payment amount from insurers, the payment amount is determined by an Independent Dispute Resolution ("IDR") process.
On February 23, 2022, the United States District Court for the Eastern District of Texas invalidated portions of the interim final rules regarding IDR that presumed the qualified payment amount ("QPA") to be the proper payment amount. The court order does not affect any other rules under the NSA.

Background

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

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

The law also establishes a pathway for resolving payer-provider payment disputes using negotiation and arbitration. If entities are unable to come to an agreement, the IDR process requires each party to submit a final payment offer and the arbiter will select one of these offers as the final payment amount. The arbitrator's decision is final and generally may not be appealed. The Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively, "the Departments") published interim final rules implementing the NSA.

The interim final rules at issue in this case required the certified IDR entity to begin with the presumption that the QPA is the basis for the appropriate OON amount, and generally it must select the offer closest to the QPA. If a party submits additional permissible information, then the certified IDR entity must consider this information if it is credible. The IDR entity should deviate from the offer closest to the QPA only if submitted information clearly demonstrates that the value of the item or service is.

The Court's Decision

The Texas Medical Association had filed suit seeking to block the rules from taking effect. They argued that the NSA did not include the deference to the QPA that the interim final rule required. The court determined that the presumption that the QPA should be the proper payment amount was contrary to the plain language of the statute and therefore exceeded the rulemaking authority of the Departments. The court invalidated the deference to the QPA in the IDR process but did not affect any other parts of the NSA.

DOL Memorandum and Future Outlook

On February 28, 2022, the DOL issued a memorandum explaining that the guidance relating to the QPA presumption for IDR was being withdrawn to be updated and reissued. The Memorandum also emphasized that consumers continue to be protected from surprise medical bills for OON emergency services, OON air ambulance services, and certain OON services received at in-network facilities.

The Departments may appeal the Texas court's decision to the 5th Circuit Court of Appeals. Further, there are similar cases pending before other federal courts on this issue. It is possible a future ruling could create a split in the circuits which ultimately may need to be resolved by the Supreme Court.

Employer Action

Carriers are generally responsible for compliance in the fully insured market.

Employers sponsoring self-funded group health plans will want to review the NSA requirements with their TPAs for compliance with the IDR process. The presumption that the QPA was the proper payment amount may have made the IDR process more predictable and may have served to avoid some disputes from being resolved through IDR. The court order does not affect any other aspect of the IDR process.

Temporary Telehealth Relief for HSA Plans

Published: March 25, 2022

On March 15, 2022, the President signed government funding legislation, the Consolidated Appropriations Act, 2022 ("CAA-22"), into law. The legislation includes a prospective extension of relief that allows first dollar coverage of telehealth services from April 1, 2022 through December 31, 2022. This relief allows individuals with High Deductible Health Plans ("HDHPs") to receive free telehealth services prior to the satisfaction of their minimum deductible and remain eligible to make Health Savings Account ("HSA") contributions.

Background

Individuals may contribute to an HSA if they are covered by a qualifying HDHP and do not have other disqualifying coverage. Generally, telehealth or other remote health care services are considered other health care coverage that, if provided before satisfaction of the required deductible, may be disqualifying for purposes of contributing to an HSA.

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") was signed into law on March 27, 2020. Among other things, the CARES Act offered temporary relief related to telehealth and other remote care services when offered with an HDHP and HSA. Specifically, for plan years beginning on or before December 31, 2021, telehealth and other remote care services could be offered before satisfaction of the deductible without jeopardizing an individual's eligibility to contribute to an HSA.

Consolidated Appropriations Act, 2022

CAA-22 prospectively extends the CARES Act relief for the months of April – December 2022. The relief is permissive (not mandatory). As such, employers are not required to provide free or reduced-cost telehealth services to employees.

Importantly, because the relief is not retroactive or tied to when a plan year begins (or ends), it creates a few administrative complexities for employers to consider. For example:

- **Calendar year plans (January 1, 2022 – December 31, 2022):** The CARES Act relief expired after December 31, 2021. Therefore, telehealth services that are provided for free or at a reduced cost before satisfaction of the deductible between January 1, 2022 – March 31, 2022 may be disqualifying coverage for purposes of HSA eligibility. This would mean no HSA contributions are permitted between January 1, 2022 and March 31, 2022. Beginning April 1, 2022 free or reduced cost telehealth (or other remote services) may be provided until December 31, 2022.

- **Non-calendar year plans:**

    - Example: March 1, 2021 – February 28, 2022 plan year. The CARES Act relief expired after February 28, 2022. Therefore, telehealth services that are provided for free or at a reduced cost before satisfaction of the deductible in the month of March 2022 may be disqualifying coverage for purposes of HSA eligibility and no HSA contributions would be permitted. Beginning April 1, 2022 free or reduced cost telehealth (or other remote services) may be provided until December 31, 2022.

    - Example: July 1, 2021 – June 30, 2022 plan year. The CARES Act relief expires after June 30, 2022. However, under CAA-22, telehealth or other remote care services may continue to be provided for free (or at a reduced cost) without jeopardizing HSA eligibility until December 31, 2022. The relief expires after December 31, 2022.

The examples above indicate no HSA contributions should be made for the months where an individual has disqualifying coverage. While this is generally correct, there is a special rule, the "last-month rule," which may permit an individual to make a full years' worth of HSA contributions without tax consequences if the individual is considered HSA eligible on Dec. 1 and remains HSA eligible for the following 13 months. Individuals should review their circumstances with tax advisors to understand whether this rule may be applicable.

Employer Action

Employers offering HDHPs with HSAs should consider whether to re-implement (or continue) free telehealth as part of a benefit offering. Employers with calendar year plans may have already re-introduced a cost associated with telehealth for HDHP/HSA participants once the CARES Act relief expired and should consider whether to waive those costs again given the temporary nature of this relief. Additionally, employers with non-calendar year plans should consider the administrative and communication burdens that may be imposed by providing relief that may expire prior to the end of the current plan year.

It is important that employers review these changes with their carriers, TPAs and telehealth vendors to understand their approach and communicate any changes with participants.

Illinois Consumer Coverage Disclosure Act Update

Last year, Illinois passed the Consumer Coverage Disclosure Act that requires employers with employees in Illinois to distribute certain information regarding their group health plan to all employees eligible for the plan in Illinois.

As a reminder, the law requires employers to distribute information to employees comparing the essential health benefits covered on the Illinois individual marketplace (the "Benchmark Plan") with the benefits covered on the group health plan. The comparison must state whether the group health plan covers each of the essential health benefits that plans are required to cover on the Illinois individual marketplace. The Illinois Department of Labor (the "Department") has clarified certain provisions of the law and provided a template for employers to use as well answered certain frequently asked questions. Both can be found at: https://www2.illinois.gov/idol/Laws-Rules/FLS/Pages/Consumer-Coverage-Disclosure-Act.aspx.

The distribution must be made to all employees eligible for the group health plan that work in Illinois, regardless of where those employees reside. Whether an employee works in Illinois will be determined using a base of operations test and considers all relevant factors.

Employers must provide this information to Illinois employees upon hire, annually, and upon request. At this point, no guidance suggests an employer would be precluded from including the distribution with regular open enrollment disclosures and notices on an annual basis prospectively.

If an employer offers multiple group health plans to employees working in Illinois, a disclosure must be made with respect to each plan option (e.g., HDHP and PPO). If the health coverage offered by the employer covers some of the benefits on the Benchmark Plan but not to the extent required by the Benchmark Plan, the disclosure should indicate "partial" coverage and explain how the coverage differs.

For example: The Benchmark Plan covers cardiac rehabilitation therapy for up to 6 months after a heart attack. If the employer's group health plan covers cardiac rehabilitation therapy for 3 months after the heart attack, the template should reflect "partial" coverage and explain how the group health plan differs from the Benchmark Plan.

Failure to comply with this disclosure requirement may result in penalties. For employers with 4 or more employees the penalties are:

1st offense = not to exceed $1,000

2nd offense = not to exceed $3,000

3 or more offenses = not to exceed $5,000

The amount of the penalty will also consider good faith efforts made by the employer to comply and the gravity of the violation. In assessing any applicable penalty, the Department will count all employees across the country (i.e., to determine if an employer has 4 or more employees), but employers will not be required to distribute the disclosure to any employees that do not work in Illinois and are eligible for the employer's group health plan.

Employer Action

- Employers should work to complete and distribute the disclosure as soon as practicable.
- Employers may satisfy the distribution requirements by providing the information via email to employees or providing the information on a website that an employee is able to regularly access.
    - It is important to distribute the information in a trackable format; the Department requires employers to be able to demonstrate that each employee received the information, and such records must be retained for a period of one year.
- We also recommend discussing with your insurance carrier(s) to determine what assistance they may be able to provide.

Should you have any questions regarding the completion of the or the application of the Illinois Consumer Coverage Disclosure Act to your company, reach out to your legal counsel or contact your service team.

New Louisiana Law Impacts HSA Eligibility

Under LA. R.S. 22:976.1, effective June 21, 2021, when calculating an enrollee's contribution to any applicable cost-sharing requirement under a medical plan, a health insurance issuer must include any amounts paid by the enrollee or on behalf of the enrollee by another person. "Cost-sharing requirement" means any copayment, coinsurance, deductible, or annual limitation on cost-sharing in order to receive a specific healthcare service, including a prescription drug.

This law does not apply to self-funded plans. It appears to apply only to policies written in Louisiana and not to policies written outside Louisiana as to insureds in Louisiana.

While this new law reduces health care costs for consumers, it could render any individuals enrolled in a high-deductible health plan ("HDHP") ineligible to have contributions made to a health savings account ("HSA"). This is because HSA-eligible individuals generally must meet the statutory minimum deductible ($1,400 self-only/$2,800 family for 2022) without help from outside sources other than an HSA.

On February 14, 2022, the Louisiana Department of Insurance acknowledged the conflict and issued Bulletin 2022-01 to inform health insurance issuers offering HDHPs of the potential tax consequences created by this statute. It cautioned that this requirement is mandatory and may not be waived by either party. Therefore, it concludes, consumers enrolled in HDHPs with HSAs are advised to avoid the use of third-party payments, such as pharmacy discount cards.

Discount cards that entitle holders to obtain discounts for health care services or products at managed care market rates will not disqualify an individual from being an eligible individual for HSA purposes if the individual is required to pay the costs of the health care (taking into account the discount) until the deductible of the HDHP is satisfied. Although the answer is not clear, use of a manufacturer coupon program should not affect HSA eligibility, provided the support is not credited toward the deductible.

Employers offering insured HDHPs to their employees and all health insurance issuers carrying HDHP products in Louisiana are advised to notify insureds enrolled in HDHPs with HSAs to avoid such use.

It does not appear that the Louisiana Department of Insurance has authority over employers. However, employers may have a general fiduciary duty to so inform employees.

Employer Action

Employers with insured plans written in Louisiana should consider communicating to HDHP enrollees with HSAs the consequences of using third party payments when paying for prescriptions.

New Oklahoma Law Impacts HSA Eligibility

Under Oklahoma HB 2678, beginning November 1, 2021, a health insurer or a pharmacy benefits manager is required to "include any amount paid by an enrollee or on behalf of an enrollee by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement." This includes drug manufacturers' coupons, cash from charities, discount cards, vouchers, and other payments from third parties.

This law does not apply to self-funded plans. It appears to apply only to policies written in Oklahoma and not to policies written outside Oklahoma as to insureds in Oklahoma. Insurers are continuing to evaluate the application.

While this new law reduces health care costs for consumers, it could render any individuals enrolled in a high deductible health plan ("HDHP") ineligible to have contributions made to a health saving account ("HSA"). This is because HSA-eligible individuals generally have to meet the statutory minimum deductible ($1,400 self-only/$2,800 family for 2022) without help from outside sources other than an HSA.

The Oklahoma Insurance Department acknowledged the conflict and is actively seeking clarification regarding the interaction of the two laws, but stated:

In the interim, the administration of pharmacy claims must be in compliance with state law, which will require the issuer to combine all payments made toward a prescription when calculating the enrollee's total contribution.

Employer Action

Employers with insured plans written in Oklahoma should consider communicating to HDHP enrollees with HSAs the consequences of using third party payments when paying for prescriptions. Employers with insured plans written outside Oklahoma should look for information from their carriers should they determine that compliance with this law is required.

Washington Payroll Tax Delayed until 2023 and Other Developments

On January 27, 2022, Governor Inslee signed into law two bills (SHB 1732 and ESHB 1733) that make significant changes to the state's Long-Term Services and Supports Trust Program (the "Trust Program" also referred to the "WA Cares Fund"). As previously reported, the governor and state legislative officials announced a delay in the collection of premium assessments until some adjustment to the program can be made during the 2022 legislative session.

The two bills modify the WA Cares Fund as follows:

SHB 1732 – takes effect immediately upon enactment.

- Delays the collection of premium assessment for the WA Cares Fund until July 1, 2023. Originally, the 0.58% payroll tax began on January 1, 2022. Any premiums collected from employees before July 1, 2023 must be refunded to the employee within 120 days of collection
- Delays the availability of approved services under the program until July 1, 2026 (originally available January 1, 2025).
- Allows individuals born before January 1, 1968 who do not meet the 10-year minimum for paying premiums to receive partial benefits based on the number of years of premium payments.

ESHB 1733 – takes effect June 8, 2022 (90 days after adjournment of the session).

- Establishes four new categories of employees who may be eligible for a voluntary exemption from the payment of premiums under the WA Cares Fund. Employees eligible for one of these exemptions must still apply with the state.
    - **Disabled veterans.** An employee who is a veteran of the United States military who has been rated by the United States Department of Veterans Affairs as having a service-connected disability of at least 70 percent.
    - **Spouse or registered domestic partners of an active duty service member.** An employee who is the spouse or registered domestic partner of an active duty service member of the United States Armed Forces. The exemption must be discontinued within 90 days of either the employee's spouse or registered domestic partner being discharged or separated from military service, or the dissolution of the employee's marriage or registered domestic partnership.

- **Temporary employee with a nonimmigrant visa.** An employee who holds a nonimmigrant visa for temporary workers who is employed by an employer in Washington. The exemption must be discontinued within 90 days of an employee's nonimmigrant visa for temporary workers status being terminated and the employee becoming a permanent resident or citizen employed in Washington

- **Employee resides outside of Washington.** An employee who is employed in Washington but maintains a permanent residence outside of Washington as the employee's primary location of residence. The exemption must be terminated within 90 days of the employee establishing a permanent address within Washington as the employee's primary location of residence.

It should be noted that SHB 1732 and ESHB 1733 do not include a new window for individuals to obtain private long-term care insurance and qualify for an exemption (an amendment to this effect was voted down). Under the current law, employees who are at least 18 years of age needed to secure a private long-term care insurance policy before November 1, 2021 in order to apply for an exemption from the premium assessment and permanent exclusion from the WA Cares Fund. There are other bills introduced in the legislature to establish a voluntary exemption from the payment of premiums due to hardship (HB 1597)), for recent graduates who obtain private long-term care insurance within 36 months of the date of graduation (HB 1599), and for retired veterans and retirement eligible veterans (SB 5611). It is unclear whether these (or other) exemptions will pass this session.

Employer Action

Employees will not begin contributions toward the WA Cares Fund until July 1, 2023.

Employers that decided to collect WA Cares Fund premiums beginning January 1, 2022 will need to make sure those premiums are timely refunded to employees.

Washington State Lowers PAL Assessment

On January 25, 2022, the Washington Health Care Authority ("HCA") approved a reduction in the PAL assessment amount. The WAPAL Fund announced a lower monthly assessment amount of $0.07 per covered life effective for payments due on February 15, 2022.

Background

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

The 2022 WAPAL Fund monthly assessment rate was previously set at $0.13 per covered life. The assessment amount is based on the number of covered lives each month. The WAPAL Fund Advisory Council reviewed the fiscal operations of the WAPAL Fund and determined that the rate could be reduced based on reported covered lives exceeding initial estimates.

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

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

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services. The next reporting and payment deadline is February 15, 2022 for the months of October, November, and December 2021.

The WAPAL Fund is administered by KidsVax. In the event that an employer pays the PAL assessment for February at the higher monthly rate of $0.13 per covered life, KidsVax will automatically process refunds of any overpayments.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at the reduced rate for the payment due February 15, 2021. A third-party administrator ("TPA") may be assisting with this process. Employers that make their February payment at the higher rate should watch for a refund of excess funds from KidsVax. If not refunded within 30 days of payment, employers are directed to notify KidsVax.

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

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