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New Jersey New Poster Requirements

Published: October 7, 2022

On August 1, 2022, the New Jersey Division on Civil Rights (DCR) finalized regulations to increase the visibility and effectiveness of posters required by the State of New Jersey. Among other things, these regulations require employers to display posters informing people of their rights under New Jersey's Law Against Discrimination ("NJLAD") and Family Leave Act ("NJFLA"). The regulations went into effect immediately.

Background

The NJLAD protects New Jersey employees from discrimination in the workplace. It prohibits all employers in the State of New Jersey from discriminating against and harassing employees (and prospective employees) based on their protected status (including, but not limited to, race, national origin, age, sex, gender identification, sexual orientation, marital status, religion, disability, pregnancy, military status). Under the law, employers cannot refuse to hire, fire, or otherwise discriminate against an individual in compensation or other terms, conditions or privileges of employment based on the individual's protected status.

The NJFLA permits eligible employees to take up to 12 weeks of family leave in a 24-month period without losing their jobs. Employers with at least 30 employees are subject to the NJFLA.

Who Must Display the Posters?

All employers of employees covered by the NJLAD and NJFLA must display the required posters. Employers with prior versions of these posters already displayed should remove them and replace them with the new, updated and amended posters. mTo assist employers in determining which posters apply to them, DCR has created an employer flowchart which can be found at https://www.njoag.gov/wp-content/uploads/2022/07/Flowchart_Employment.pdf

Where Are These Posters Found?

The posters can be found on DCR's website and can be both downloaded and printed. The Employment Poster can be found at https://www.njoag.gov/wp-content/uploads/2022/07/Employment.pdf and the Family Leave Act Poster can be

found at https://www.njoag.gov/wp-content/uploads/2022/07/Family-Leave-Act.pdf. Any poster printed from the website must be printed on no smaller than letter size paper (8½ by 11 inches) and contain text that is fully legible and large enough to be easily read. The posters can also be found at any of DCR's offices.

How Should the Posters be Displayed?

The updated posters must be displayed in a place that is easily accessible to all employees and prospective employees.

What if Employees Only Work Remotely?

In the event an employer does not have a physical location, employers should display the required posters on an internet site or intranet site that is accessed by all employees and where other notices are customarily displayed to employees.

Employers are also required to distribute copies of the NJLAD and NJFLA posters to each employee annually, on or before December 31 of each year, and upon the first request of an employee. The posters can be distributed in the following ways:

- Printed material, including, but not limited to, paycheck inserts, a brochure or similar informational packet provided to new hires, an attachment to an employee manual or policy book, or a flyer distributed at an employee meeting.

- An internet or intranet website, if the site is for the use of all employees, can be accessed by all employees, and the employer provides notice to the employees of its posting.

What is the Penalty for Not Complying?

Failure to display the required posters can result in fines up to $10,000.

Where Can More Information on the Regulations be Found?

DCR has posted Frequently Asked Questions on its website regarding the regulations. The FAQs can be found at: https://www.njoag.gov/wp-content/uploads/2022/08/Poster-Regulations-FAQ.pdf

Employer Action

Employers should ensure they are properly posting and distributing (where applicable) all of the required updated posters.

Final Regulations To Fix The ACAs Affordability Family Glitch

Published: October 17, 2022

On October 11, 2022, the Treasury Department and Internal Revenue Service ("IRS") finalized regulations that expand the availability of Marketplace premium tax credits for employees' family members. The final rule generally follows the proposed rule issued in April 2022. To qualify for a premium tax credit, the final rule provides that:

- Affordability of employer-sponsored coverage for family members would be determined based on the employee's cost to cover the employee and the family members.
- The determination of whether employer-sponsored coverage for family members provides minimum value would also be based on the coverage available to family members.

The rule takes effect for plan years beginning on and after January 1, 2023.

These regulations do not affect the affordability determination for purposes of the Affordable Care Act's ("ACA") employer mandate; however, they may indirectly impact employer plans as more family members may qualify for premium tax credits and choose to enroll in coverage through the Marketplace.

Simultaneously, the IRS released Notice 2022-41, creating a new permitted election change under the Section 125 cafeteria plan rules. The Notice permits, but does not require, an employer with a non-calendar year plan to allow an employee to prospectively revoke a pre-tax election for family coverage under a group health plan to enable one or more family members to enroll in Marketplace coverage.

Additional details follow.

Background

Currently, individuals are not eligible for Marketplace premium tax credits if they are offered employer-sponsored group health plan coverage that is "affordable" and provides "minimum value."

For this purpose, employer-sponsored coverage is deemed "affordable" if an employee is required to pay no more than 9.5% (indexed each year – 9.61% for 2022 and 9.12% for 2023) of household income for self-only coverage. Coverage is considered affordable for both the employee and the employee's family members, regardless of how much the employee must pay to cover those family members under the employer's group health plan. This is known as the "family glitch."

An employer-sponsored plan provides "minimum value" if the plan's share of the total allowed cost of benefits provided is at least 60% and includes substantial coverage of inpatient hospital services as well as physician services. Under current rules, when self-only coverage offered by an employer provides minimum value to an employee, the coverage offered to the employee's family is also considered to provide minimum value.

Affordability

Consistent with the proposed changes, the final rule refines the definition of affordable coverage to make it easier for family members to qualify for premium tax credits. Employer-sponsored coverage would be considered affordable for family members (thereby disqualifying them from eligibility for premium tax credits) only if the portion of the annual premium the employee must pay for the family coverage does not exceed 9.5% of household income (as indexed).

As a result, when assessing whether an individual has received an affordable offer of employer-sponsored coverage, the Marketplace would look separately at the employee's cost of self-only coverage (to determine the employee's own eligibility for premium tax credits) and at the employee's cost to cover the family (to determine the family members' eligibility for premium tax credits). There will likely be scenarios wherein an employee has an offer of self-only coverage that is affordable, but the offer of coverage to the family members is considered unaffordable (thus potentially qualifying those family members for new premium tax credits).

For this purpose, family coverage means all employer plans that cover any related individual other than the employee, including a self-plus-one plan for an employee enrolling one other family member in the coverage. The final rule provides various examples that may arise to determine whether employer coverage is affordable, including situations where an individual has offers of coverage from multiple employers or where covered family members are not part of the employee's tax family (e.g., a non-tax dependent child or a spouse filing separately).

The final rule does not affect the affordability test for employees. Employees remain ineligible for premium tax credits in the Marketplace if offered affordable self-only coverage from their employer.

Minimum Value

The final rule also amends the premium tax credit eligibility rules related to minimum value. An employer-sponsored plan would be considered to provide minimum value for family members if the plan's share of the total allowed costs of benefits provided to family members is at least 60%. Note that it would be unusual to have a plan design where an employer offers minimum value coverage to an employee but not the family members.

The final rule also confirms that, to provide coverage of minimum value, the plan must include substantial coverage of inpatient hospital services as well as physician services.

The final rule does not affect the minimum value test for employees.

Implementation

The Department of Health & Human Services ("HHS") will revise the Marketplace application process to include new questions about offers of employer coverage to family members and will work with the individual state marketplaces to ensure that the entities take necessary steps to educate the public. The IRS also expects to update forms and publications ahead of the 2023 Marketplace annual enrollment season.

Although a model notice was requested during the comment period, the final rule imposes no new notice requirements on employers. The preamble also confirms that the IRS does not intend to update Forms 1095 to require additional data elements.

Corresponding Cafeteria Plan Changes – IRS Notice 2022-41

Under existing Section 125 cafeteria plan rules, an employee may not revoke a pre-tax salary reduction election associated with family group health plan coverage during the plan year and elect self-only coverage (or another form of family coverage, such as employee plus one) solely to allow one or more family members the ability to enroll in the Marketplace. This restriction applies even if the family member is newly eligible to enroll due to a special enrollment opportunity or during the Marketplace annual open enrollment. This tends to be an issue for non-calendar year plans.

To address this situation, the IRS issued Notice 2022-41 which permits (but does not require) an employer with a non-calendar year plan to adopt an amendment to the cafeteria plan to allow an employee to prospectively revoke a pre-tax election for family coverage under a group health plan when:

- one or more related individuals are eligible for a special enrollment period to enroll in Marketplace coverage or one or more already-covered related individuals seeks to enroll in the coverage during the Marketplace's annual open enrollment period; and

- the revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual(s) in the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. If the employee does not enroll in Marketplace coverage, the employee must elect self-only coverage (or family coverage including one or more already-covered related individuals) under the group health plan.

A cafeteria plan may rely on the reasonable representation that the employee and/or related individuals have enrolled or intend to enroll in the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

To allow for this change, the cafeteria plan must be amended on or before the last day of the plan year in which the election
is allowed and the amendment may be effective retroactively to the first day of the plan year provided the cafeteria plan operates in accordance with the Notice, and the employer informs participants of the amendment.

For a plan year that begins in 2023, an employer may amend a cafeteria plan to adopt the new permitted election change at any time on or before the last day of the plan year that begins in 2024.

In no event may an employer amend a cafeteria plan to allow an election to revoke coverage on a retroactive basis. In addition, the health FSA election may not be changed under this provision.

Employer Action

The final rule does not impact the determination of whether employer-sponsored coverage is affordable for purposes of avoiding a shared responsibility penalty under the ACA's employer mandate. Whether the coverage is affordable for this purpose continues to be based solely on the cost of self-only coverage in the lowest-cost minimum value plan.

The rule confirms that there will be no changes or additional information required on the ACA forms 1095-B and 1095-C as a result of the changes made under the final rule.

However, employers may see employees more closely evaluate options for family members in the Marketplace during this open enrollment season. Employees may find Marketplace coverage more cost effective than the employer plan and remove their family members from the group health plan.

What to do?

- Employers may consider outreach and communication to employees and their families to educate them on the premium tax credits that may newly be available on the Marketplace.

- Employers with non-calendar year plans should consider whether to adopt this discretionary cafeteria plan provision allowing employees the opportunity to revoke prospective elections in response to the premium tax credits available on the Marketplace. Employers adopting this change should update their plan documents accordingly and communicate the change with participants.

HHS Extends Public Health Emergency Until January 11

Published: October 17, 2022

On October 13, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency. This will once again extend the Public Health Emergency Period (the Emergency Period) for an additional
90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period	HHS issued a Public Health Emergency beginning January 27, 2020. The Emergency Period is now set to expire January 11, 2023 (unless further extended or shortened by HHS). HHS should provide at least 60 days advance notice if the Emergency Period will not extend again. We should know by November 12, 2022, if this is the last extension.
Outbreak Period	The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, or 2) 60 days after the announced end of the COVID-19 National Emergency. As of now, the National Emergency is set to expire after February 28, 2023, unless the President announces another continuation.

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

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

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

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

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

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network. Note, COVID-19 vaccines are considered mandatory preventive care under the ACA and will need to be covered in-network at 100% even after the Emergency Period expires.

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

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

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

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

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

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

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

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

- **ERISA Claims Deadlines.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.

  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

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

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

Employer Action

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

2023 Cost Of Living Adjustments

Published: October 25, 2022

The IRS recently released cost of living adjustments for 2023 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2023, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $2,850 to $3,050.

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

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins
in 2023 that can be carried over to the following plan year is $610 (up from $570 in 2022).

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

Qualified Transportation Fringe Benefits

For calendar year 2023, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $280 to $300.

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

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

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $135,000 to $150,000 for 2023.

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

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2023 increased from $200,000 to $215,000.

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

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

As previously reported, the 2023 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $9,100 for self-only coverage and $18,200 for family coverage.

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

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2023, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $5,850 ($11,800 for family coverage) (increased from 2022).

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2023, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $1,950 (increased from $1,800 in 2022).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts (HSAs) for 2023 were provided by the IRS in Rev. Proc. 2022-24.

Annual contribution limitation

For calendar year 2023, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $3,850; the limitation on deductions for an individual with family coverage under a high deductible health plan is $7,750.

High deductible health plan

For calendar year 2023, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,500 for self-only coverage or $3,000 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $7,500 for self-only coverage or $15,000 for family coverage.

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

Catch-up contribution

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

Prescription Drug Reporting Reminder

Published: October 31, 2022

As previously reported, plan sponsors of group health plans must submit information annually about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services (“CMS”). The first deadline is December 27, 2022 for reporting on calendar years 2020 and 2021.

Most commonly:

- The carrier will submit on behalf of an insured medical plan.
- The TPA will file on behalf of a self-funded plan (includes a level funded plan) with an integrated medical/drug plan.
- The TPA and PBM will partially file on behalf of a self-funded plan with a carved-out drug program, but the employer may have responsibility for the other parts of the filing.

However, the exact process will depend on the carrier/TPA/PBM and their processes may not yet be announced or may have changed since the last communication. So, there are two important action items:

1. All employers should check with their carriers/TPAs/PBMs now to find out what level of assistance they will provide. Carriers/TPAs/PBMs may need information from plan sponsors and the deadline may be fast approaching, well in advance of the actual deadline.
2. In some cases, employers will have to submit at least part of the filing. For example:

a. All UHC ASO Key Accounts and some of the Blues require employers to submit a partial file (P2; D1) for both integrated and carved-out self-funded programs.

b. CVS will submit the files in a carve-out drug plan if the employer was with CVS for the full reporting year. If not, CVS will prepare the reports, but the employer must submit them.

If an employer must submit some of the files on behalf of the group health plan, the employer must register with HIOS before filing and receive account information which can take up to two weeks. These employers will need to appoint two individuals, with at least one of those individuals designated as the "RxDC Submitter," and should start the process now. CMS has resources available to assist in this process:

- HIOS Portal RxDC Quick Guide, https://regtap.cms.gov/uploads/library/HIOS-Portal-RxDC-Quick-Guide-09-06-2022.pdf

- HIOS RxDC User Manual, https://regtap.cms.gov/uploads/library/HIOS-RxDC-User_Manual-10-18-2022.pdf

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

Additionally:

- Employers with insured medical plans should enter into written agreements with their insurance carriers to transfer the reporting obligation and liability to the carrier.

- Employers with self-funded plans should enter into written agreements with TPAs/PBMs to ensure the vendor will provide the required reporting to CMS. As the self-funded plan remains liable for reporting, employers should monitor the reporting efforts of the TPA or other third party to help minimize the exposure to liability for any reporting violation.

- The next deadline for RxDC reporting is June 1, 2023 for 2022 calendar year.

San Francisco HCSO Expenditures and Reporting Update for 2023

Published: November 4, 2022

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2023 have been released, and the HCSO Annual Reporting Form for calendar year 2022 is due on May 1, 2023.

2023 Minimum Expenditure Rates

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

Employer Size	Number of Employees	2022 Health Care Expenditure Rate	2023 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.30 per hour payable	$3.40 per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.20 per hour payable	$2.27 per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2023 the maximum required health care expenditure for a covered employee of a large employer is $584.80 per month ($3.40/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $390.44 per month ($2.27/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2022, the earnings threshold for these employees to be exempt from the HCSO is $109,643 per year (or $52.71 per hour). As of January 1, 2023, the new threshold will be $114,141 per year (or $54.88 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement (OLSE) HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2022 is expected to become available on the HCSO website by April 1, 2023, and is due by May 1, 2023 (the next business day after the normal April 30 deadline, which falls on a Sunday in 2023).

It should be noted that, due to the COVID-19 pandemic, OLSE did not require employers to submit the HCSO Annual Reporting Form for calendar years 2019 and 2020, although employers were still obligated to make minimum health care expenditures under the HCSO. This waiver was not extended, and employers were required to submit the HCSO Annual Reporting Form for calendar year 2021 by May 2, 2022 (the next business day after the normal April 30 deadline, which fell on a Saturday in 2022).

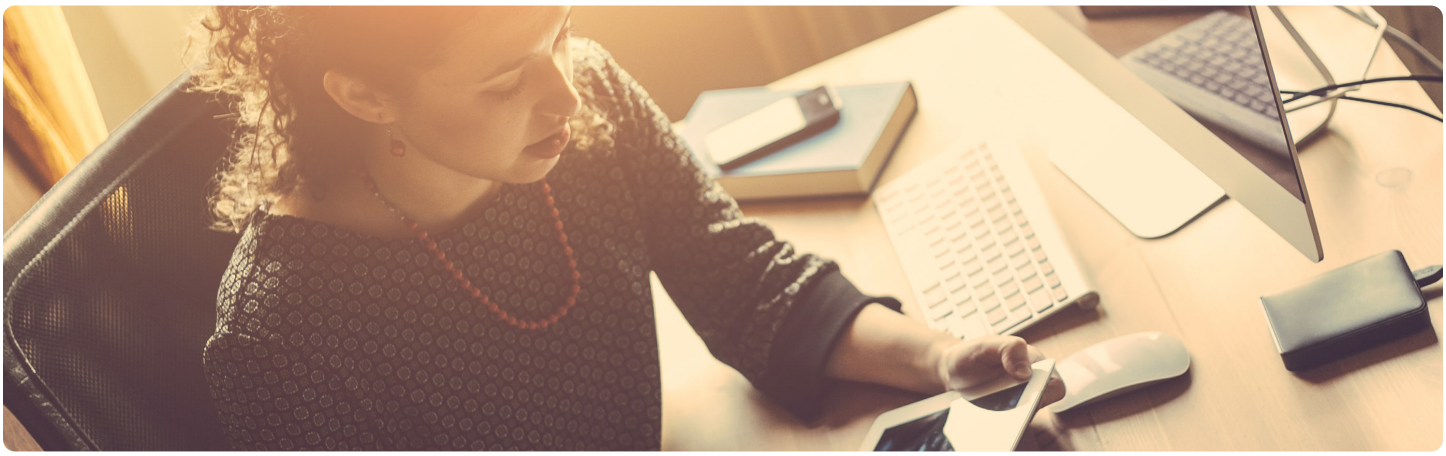
Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2023 at the new rates for employees in San Francisco.

The 2023 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2022. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2023 version of the poster by January 1, 2023.

https://sfgov.org/olse/employer-annual-reporting-form-instructions

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2022 no later than May 1, 2023.



California Extends 2022 COVID-19 Paid Leave Program, Adds Grants

Published: November 18, 2022

On September 29, 2022, California Governor Newsom signed Assembly Bill No. 152 ("AB 152") into law. AB 152 extends the 2022 COVID-19 Supplemental Paid Sick Leave provisions through December 31, 2022. In addition, AB 152 makes up to $50,000 of grant money available to reimburse a qualifying small business or nonprofit organization for COVID-19 Supplemental Paid Sick Leave provided to employees.

Background

Beginning January 1, 2022, public and private employers that employ more than 25 employees are generally required to provide 2022 COVID-19 Supplemental Paid Sick Leave to employees working in California who are unable to work or telework for the employer because of specified reasons relating to COVID-19. Covered employees can generally take up to 80 hours of 2022 COVID-19 Supplemental Paid Sick Leave.

New Expiration Date

The 2022 COVID-19 Supplemental Paid Sick Leave provisions, as originally enacted into law, expired on September 30, 2022. AB 152 extends the 2022 COVID-19 Supplemental Paid Sick Leave provisions for an additional three months. The new expiration date is December 31, 2022.

AB 152 does not provide employees with any new allotment of paid leave; it merely gives employees more time to use any unused hours of 2022 COVID-19 Supplemental Paid Sick Leave.

The California Labor Commissioner has published a model notice that contains the new expiration date (linked below), which 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. The model notice can be found as follows:

- English – https://www.dir.ca.gov/dlse/COVID19resources/2022-COVID-19-SPSL-Poster.pdf
- Spanish – https://www.dir.ca.gov/dlse/COVID19resources/Spanish/2022-COVID-19-SPSL-Poster.pdf

Administrative Changes

In addition to the new expiration date, AB 152 makes several changes to the administrative requirements for 2022 COVID-19 Supplemental Paid Sick Leave.

According to the original provisions (which continue to apply under AB 152), a covered employee qualifies for 2022 COVID-19 Supplemental Paid Sick Leave when the employee is unable to work or telework because of a positive COVID-19 diagnostic test. When that happens, the employer can require the employee to submit to a follow-up COVID-19 diagnostic test (paid for by the employer) on or after the fifth day after the original positive test.

AB 152 adds that if the follow-up test is positive, the employer may require the employee to submit to another COVID-19 diagnostic test (paid for by the employer) within no less than 24 hours. The employer has no obligation to provide 2022 COVID-19 Supplemental Paid Sick Leave to an employee who refuses to submit to these tests.

Availability of Grant Money

Included within AB 152 is the California Small Business and Nonprofit COVID-19 Supplemental Paid Sick Leave Relief Grant Program, which can provide up to $50,000 of grant money to a qualifying small business or nonprofit organization to reimburse it for COVID-19 Supplemental Paid Sick Leave provided to employees between January 1, 2022 and December 31, 2022.

To qualify for grant money under this program, a small business or nonprofit organization must meet several requirements, including the following:

- It has 26 to 49 employees.
- It began operating before June 1, 2021, is currently active and operating, and has a physical presence in California.
- For a small business, it is organized as a "C" corporation, an "S" corporation, a cooperative, a limited liability company,
  a partnership, or a limited partnership.
- For a nonprofit organization, it is a registered 501(c)(3) (i.e., a charitable organization), 501(c)(6) (i.e., a business league, chamber of commerce, or trade association), or 501(c)(19) (i.e., a veterans' organization).

Certain businesses and organizations are ineligible to receive grant money under the program, including government entities (other than Native American tribes); businesses primarily engaged in political or lobbying activities; passive businesses and investment companies; financial institutions and businesses primarily engaged in the business of lending (such as banks, finance companies, and factoring companies); businesses engaged in any activity that is unlawful under federal, state, or
local law; and businesses that restrict patronage for any reason other than capacity.

To apply for grant money under the program, small businesses and nonprofit organizations should contact the California Office of Small Business Advocate (known as "CalOSBA"), which is part of the California Governor's Office of Business and Economic Development (known as "GO-BIZ"). The program remains in effect until January 1, 2024.

New PCOR Fee Announced

Published: November 29, 2022

On November 14, 2022, the IRS released Notice 2022-59, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2022 and before October 1, 2023 is $3.00.

The PCOR filing deadline is July 31, 2023 for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2022. Carriers are responsible for paying the fee for insured policies.

PCOR Fee due July 31, 2023:

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

Employer Action

No action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in mid-2023 of the fee and additional information for filing and paying the PCOR fee with the IRS.

Updated Guidance on Election Changes to Include Calendar Year Plans

Published: November 29, 2022

Recently, the Treasury Department and Internal Revenue Service ("IRS") finalized regulations to fix the "family glitch" and expanded Marketplace premium tax credits for employees' family members when employer-sponsored coverage is not affordable. Simultaneously, the IRS issued Notice 2022-41, creating a new, permitted election change under the Section 125 cafeteria plan rules related to the "family glitch" fix. As originally published, the guidance was limited to non-calendar year cafeteria plans.

However, the IRS (quietly) updated Notice 2022-41 to remove the limiting language.

As a result, plan sponsors of calendar year (and non-calendar year) section 125 cafeteria plans are now permitted, but not required, to amend their section 125 plan document to allow plan participants to prospectively revoke a pre-tax election for family coverage under a group health plan to enable one or more family members to enroll in Marketplace coverage.

Employer Action

Now that the new permitted election change includes calendar year plans, applicable plan sponsors should consider whether to adopt this discretionary cafeteria plan provision allowing employees the opportunity to revoke prospective elections in response to the premium tax credits available on the Marketplace. Employers adopting this change should update their plan documents accordingly and communicate the change with participants.

RxDC Reporting Due December 27 2022

Published: November 29, 2022

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

Most commonly:

- The carrier will submit on behalf of an insured medical plan.
- The TPA will file on behalf of a self-funded plan (includes a level funded plan) with an integrated medical/drug plan and stop loss insurance.
- The TPA and PBM will partially file on behalf of a self-funded plan with a carved-out drug program and/or carved-out stop loss, but the employer may have responsibility for the other parts of the filing.

However, the exact process will depend on the carrier/TPA/PBM and their processes may not yet be announced or may have changed since the last communication. It is important to know how your carriers, TPAs and PBMs will assist in this process.

Recently, some TPAs of self-funded plans have changed direction and indicated that if the plan has any carve-out arrangements (e.g., pharmacy and/or stop loss) the employer may be responsible for filing a P2 and partial D1 to reflect stop loss premium and/or pharmacy information that is not captured in the TPA's system. The TPA may not collect this information to include in the D1 that it files with CMS.

If an employer must submit some of the files on behalf of the group health plan, the employer must register with HIOS and receive account information before filing which can take up to two weeks. These employers will need to appoint two individuals, with at least one of those individuals designated as the "RxDC Submitter," and should start the process now.

CMS has resources available to assist in this process:

- HIOS Portal RxDC Quick Guide, https://regtap.cms.gov/uploads/library/HIOS-Portal-RxDC-Quick-Guide-09-06-2022.pdf
- HIOS RxDC User Manual, https://regtap.cms.gov/uploads/library/HIOS-RxDC-User_Manual-10-18-2022.pdf

RxDC Reporting Relief and Submission Grace Period for 2020/2021

Published: December 28, 2022

As previously reported, group health plans must submit information annually about prescription drugs and health care spending to the Centers for Medicare and Medicaid Services ("CMS"). This is known as the RxDC reporting requirement and the first deadline is **December 27, 2022**, for reporting on calendar years 2020 and 2021.

Very late on December 23, 2022, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") issued FAQ Part 56 addressing this requirement.

Specifically, as it relates to the 2020/2021 data, the guidance announces:

1. **Good Faith Relief.** The Departments will not take enforcement action with respect to any plan or issuer that uses a good faith, reasonable interpretation of the regulations and the RxDC Reporting Instructions in making its submission.

2. **Submission Grace Period.** A plan or issuer will not be considered to be out of compliance with these requirements provided that a good faith submission of the 2020 and 2021 data is made on or before **January 31, 2023**.

3. **Limited Email Submission Option.** Where the plan (or the reporting entity) is submitting only the plan list (P2), premium and life-years data (D1), and narrative response, and is not submitting any other data, it may submit the file by email to RxDCsubmissions@cms.hhs.gov instead of submitting in HIOS.

    - The emailed submission must include the plan list file, premium and life-years data (data file D1), and a narrative response. The submission may include optional supplemental documents. The name of each file should include the reference year of the submission, the plan list or data file type (e.g., P2, D1), and the name of the group health plan sponsor.

It should be noted that, if an employer, as the plan sponsor, must submit a P2 and D1 on behalf of the group health plan (often the case where the plan has a stop loss or pharmacy carveout), this relief is helpful as the employer will not need to create a HIOS account. Rather, the employer should be able to complete the files and submit them via email to CMS, in accordance with the instructions.

The guidance also includes flexibility as it relates to multiple submissions by the same reporting entity, submission of the same data file by multiple reporting entities, and a suspension of certain aggregation rules, among other guidance.

While these flexibilities apply only to the submission of data for the 2020 and 2021 reference years, the Departments will monitor stakeholder compliance efforts to determine whether to extend these flexibilities for future reporting deadlines. Any extension of these flexibilities will be communicated through guidance in advance of the relevant reporting deadline.

Employer Action

Generally, carriers are filing the RxDC on behalf of fully insured group health plans. With respect to self-funded health plans the TPA may assist with some, or all, of the reporting. Where a self-funded health plan has carve-out benefits (such as stop loss or pharmacy), the employer/plan sponsor may be required to file certain data files.

Employers required to file should do all of the following:

- Continue to comply with RxDC reporting requirements for 2020/2021 data, understanding that they have relief for good faith mistakes and have until January 31, 2023 to submit the 2020/2021 data (instead of December 27, 2022).
- Where applicable, consider taking advantage of the email submission option for P2, D1, and narrative response versus the HIOS platform.
- Await further guidance on the next deadline – June 1, 2023 – for calendar year 2022 RxDC reporting. While the relief announced in FAQ 56 pertains only to 2020/2021 data, it will be interesting to see if any of the relief carries over into future reporting.

Telehealth Relief for HSAs Extended in Last Minute Funding Package

Published: December 28, 2022

On December 23, 2022, the House passed a 4,155-page funding bill, the Consolidated Appropriations Act of 2023 ("CAA-23"), that includes a two-year extension on telehealth relief for high deductible health plans ("HDHPs") offered with health savings accounts ("HSAs"). Included as a safe harbor, the bill provides that for plan years beginning after December 31, 2022 and before January 1, 2025:

- a plan shall not fail to be an HDHP if telehealth or other remote care services are offered before satisfaction of the minimum deductible; and
- coverage for telehealth or other remote care services is considered disregarded coverage for purposes of HSA eligibility.

The bill now goes to the President, who is expected to sign it into law.

Background

As background, the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") offered temporary relief related to telehealth and other remote care services when offered with an HDHP and HSA for plan years that began before December 31, 2021. The Consolidated Appropriations Act, 2022 ("CAA-22") prospectively extended this relief, but only for the months of April through December 2022. Barring congressional action, the relief was set to expire December 31, 2022.

This latest extension under CAA-23 provides for two more years of relief based on the plan year's start date. The relief is optional; employers are not required to offer free or reduced cost telehealth or other remote care services as part of their plan design.

Other Changes

The year-end funding bill also:

- Eliminates the opt-out opportunity for compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA") for nonfederal governmental health plans; and
- Includes new grants for states to ensure compliance and enforcement of MHPAEA in the carrier market.

Employer Action

Employers with telemedicine (or other remote care services) and HSA-compatible HDHPs should consider whether to offer free (or reduced cost) services with their HDHPs for plan years beginning after December 31, 2022. It should be noted that employers with non-calendar year plans are not technically eligible for this new relief until the first plan year that begins after December 31, 2022. As such, free (or reduced cost) telehealth or other remote care services could be disqualifying coverage from January 1, 2023 to the day before the first day of the 2023 plan year. It is not clear whether this gap was intentional.

Employer should also communicate any changes to the telehealth or remote care benefits to participants as soon as possible.

Annual Out-of-Pocket Maximum Adjustments Announced for 2024

Published: December 30, 2022

On December 13, 2022, the Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2024 ("the Notice"). For purposes of employer-sponsored health plans, the guidance includes the caps on out-of-pocket dollar limits for non-grandfathered group health plans with plan years that begin in 2024.

Elimination of Transitional Good Faith Relief

Non-grandfathered group medical plans will see an increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2024, as follows:

- $9,450 for self-only coverage; and
- $18,900 for coverage other than self-only.

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 2024 HSA thresholds will likely be announced in June 2023.

Employer Action

Employers should update out-of-pocket limits for plan years beginning on or after January 1, 2024.

Final Rule on ACA Reporting and 2022 Forms and Instructions

Published: December 30, 2022

On December 12, 2022, the Internal Revenue Service ("IRS") released final regulations with respect to ACA reporting requirements. These rules are substantially similar to the proposed rule issued in November last year.

The final rule:

- Eliminates the good faith relief from reporting penalties associated with incorrect or incomplete reporting.
- Makes permanent an automatic extension of 30 days to furnish IRS Forms 1095-C (and 1095-B) to individuals. Effectively, this moves the due date for furnishing these forms to full-time employees and other individuals from January 31 to March 2 each year (or the next business day if March 2nd falls on a weekend or holiday).
- Creates an alternative method for furnishing individuals with IRS Form 1095-B as proof of minimum essential coverage (MEC).

Applicable large employers ("ALEs") have until March 2, 2023 (rather than January 31, 2023) to furnish Forms 1095-C for calendar year 2022 to full-time employees and other individuals.

The final rule does not extend the deadline to file completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) with the IRS. The due date remains March 31, 2023 (or February 28, 2023 for paper filing if filing fewer than 250 forms).

On December 15, 2022, the final instructions for 2022 Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) were issued without substantive change from the prior year.

Additional details on the final rule follow.

Elimination of Transitional Good Faith Relief

Since 2015, the IRS provided reporting entities with relief from penalties if those entities could show they made good faith efforts to comply with the information reporting requirements. The relief allowed employers flexibility to correct filed forms without penalty. While this relief had been extended each year, the IRS announced that 2020 would be the last year that transitional good faith relief would be available.

The final rule confirms that the good faith relief from penalties for reporting incorrect or incomplete information on Forms 1094-C, 1095-C, 1094-B and 1095-B is **no longer available** after 2020. For 2022, penalties for incorrect or incomplete forms furnished to individuals can be $290/return. Additionally, incomplete or incorrect forms filed with the IRS may trigger a $290/return penalty.

This means that an employer that requests corrections in response to an IRS inquiry related to Forms 1094-C or 1095-C may be liable for penalties based on the number of forms that are corrected.

While the reasonable cause exception remains available and may provide relief from penalties for entities that can show a reasonable cause for failing to timely or accurately complete their reporting requirements, with the elimination of the good faith relief employers will want to take steps to ensure the accuracy of their forms and filings.

Automatic Extension of Time for Furnishing ACA Statements

Under the ACA, January 31 is the deadline to furnish IRS Forms 1095-C and 1095-B to certain individuals (such as full-time employees, in the case of IRS Form 1095-C) with respect to the preceding calendar year. The final regulations make permanent an automatic extension of 30 days in which to furnish these statements to individuals. This means Wednesday March 2, 2023, is the deadline to furnish individuals with a 2022 Form 1095-C or 1095-B.

The extension is automatic; employers or other reporting entities are not required to file a request with the IRS, or to demonstrate reasonable cause to justify the extension.

While the IRS has provided the automatic extension of time to furnish the Form 1095-C (or Form 1095-B), if operating in a state with an individual mandate, the timing to furnish proof of coverage to covered residents may be different.

Alternative Method for Furnishing ACA Statements

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

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

- Health insurance carriers and plan sponsors (other than ALEs) that are using IRS Form 1095-B to provide proof of MEC

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

- Small employers (not ALEs) with a self-funded health plan that are using IRS Form 1095-B to provide proof of MEC

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

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

- A clear and conspicuous notice that meets certain technical requirements must appear on the reporting entity's website

- The notice must state that covered individuals may receive a copy of IRS Form 1095-B upon request, and informs them how the request may be made

- The notice must appear in the same website location through October 15 (or the next business day if October 15 falls on a Saturday, Sunday, or legal holiday) following the end of the calendar year to which the form relates

- IRS Form 1095-B must be furnished to the requesting individual within 30 days after the request is received; the ACA statement may be furnished electronically if certain requirements are met.

Employer Action

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

Employers should take extra care that Forms 1094-C and 1095-C are complete and accurate as the transitional good faith relief is no longer available.

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

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

Supreme Court Denies Challenge to Seattle's Hotel Ordinance

Under the City of Seattle's Improving Access to Medical Care for Hotel Employees Ordinance, employers are required to provide hourly, non-supervisory employees working in large hotels and certain ancillary hotel businesses with increased access to medical care by mandating a monthly healthcare expenditure or direct payment. This type of law is often referred to as "pay or play."

The law went into effect for most covered employers on July 1, 2020, or at the earliest annual open enrollment period for health coverage after July 1, 2020 (if the employer offers health coverage to employees). The required monthly contribution rates vary based on family size and are adjusted annually for inflation. For 2023 the required monthly expenditure for a single employee is $518, for an employee with a spouse/partner and dependents is $1,555.

Legal Challenges

Since 2018, the ERISA Industry Committee ("ERIC") on behalf of affected members, has been challenging the Ordinance in federal courts, arguing the law is preempted by ERISA. The lower courts in the 9th Circuit held in favor of the City. In January 2022, ERIC filed a petition for certiorari with the U.S. Supreme Court to weigh in whether ERISA preempts this type of "pay or play law" and resolve a split between the circuits on this issue. On November 21, 2022, the Supreme Court declined to hear the petition.

Employer Action

This decision by the Supreme Court not to take the case effectively ends challenges to Seattle's Ordinance. Employers subject to the Ordinance should continue to comply with these requirements.

WA Cares Opt-out for Private LTC Insurance Closes Dec. 31, 2022

For individuals who purchased a private long-term care policy ("LTC") before November 1, 2021, the window to apply for a permanent exemption from the WA Cares Fund is quickly coming to an end. If they haven't already done so, eligible individuals must submit an exemption application to the Washington Employment Security Division ("ESD") no later than December 31, 2022. After this date, applications for this exemption will no longer be accepted or approved.

Additional information follows.

Background

Beginning July 1, 2023, a 0.58% premium assessment applies on wages of all Washington employees to fund the Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund"). WA Cares Fund will provide long-term care benefits to eligible Washington residents (up to $36,500). All wages are subject to the premium assessment; there is no cap.

If eligible, employees with private long-term care insurance may apply to the ESD for a permanent exemption from the premium assessment. If approved, the employee is permanently excluded from the state's long-term care coverage and benefits.

Private LTC Exemption Application

To qualify for this permanent exemption, an individual must:

- Have purchased a qualifying private long-term care insurance plan before November 1, 2021;
- Be at least 18 years of age; and
- Submit an exemption application to ESD.

The last day to apply for this exemption is December 31, 2022. After that date, this application window is permanently closed. There is no new opportunity to apply for this exemption.

Employees can go to the WA Cares Fund website to apply for an exemption. There are several steps to follow, which are outlined on the website here. Employers cannot apply for an exemption on behalf of employees.

ESD will review applications and notify individuals who are eligible for an exemption. The exemption will take effect the quarter after the application is approved by ESD.

Employees will need to provide current (and future) employers with a copy of the exemption approval letter to avoid the premium assessment.

New Exemptions

Beginning January 1, 2023, Washington workers will be eligible for exemptions from WA Cares if any of the following apply to them:

- Live outside of Washington.
- Are spouses or domestic partners of active-duty military personnel.
- Have non-immigrant visas.
- Are veterans with a 70% service-connected disability rating or higher (this is a permanent exemption).

Workers will only qualify for these exemptions as long as these circumstances apply. Workers will no longer qualify for an exemption if:

- They change their permanent residence to within Washington.
- Their immigration status changes, and they become a permanent resident.
- Their spouse is separated from military service or the marriage/partnership is dissolved.

Unlike the exemption for private long-term care insurance purchased before November 1, 2021, these new exemptions will be available on an ongoing basis beginning Jan. 1, 2023. Additional information on the application process is expected from ESD after the first of the year.

Employer Action

Employees who qualify for an exemption must apply for the exemption no later than December 31, 2022. In the Appendix below, provides a sample communication to employees reminding them of this deadline. This can be used as a starting point should you want to remind employees of the application deadline.

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

Employers with Washington employees should coordinate with payroll to begin collecting WA Cares premiums from employees who do not have an exemption beginning July 1, 2023.

District of Columbia Requires Employers to Offer Parking Cashout

In April 2020, the District of Columbia passed the D.C. Transportation Benefits Equity Amendment Act of 2020 ("The Act"). The effective date of the Act was delayed pending a period of congressional review. It was recently announced that the Act will become effective for certain employers on January 15, 2023.

What Does the Act Require?

The Act requires that certain employers who offer a "parking benefit" to an employee must offer the employee a parking cashout. A parking cashout is provided as an incentive to an employee, in the form of compensation or alternative transportation benefit, to forgo the parking benefit provided by the employer.

Who is Required to Offer a Parking Cashout?

D.C. employers with 20 or more covered employees who offer a parking benefit to employee(s) must comply with the requirement to provide a parking cashout.

A covered employee (for purposes of determining whether an employer is considered a "covered employer") is a full-time or part-time employee who:

- Performs 50% or more of their work in D.C., or
- Whose employment is based in D.C. and a substantial amount of their work is performed in D.C. with less than 50% of their work performed in any other state.

Importantly, "covered employee" appears to apply only to the determination of whether an employer is a "covered employer," not for purposes of determining who must receive a parking cashout.

Exemptions

An employer that would otherwise be considered a covered employer can be exempted from these requirements if:

- They owned (and continue to own) their parking before October 1, 2020;
- They are under a current parking lease which was entered into prior to October 1, 2020. These employers are exempt

- until the lease expires (regardless of any possible extensions); or

- They are a hospital or university with pre-existing campus plans.

Who Must Receive An Offer Of A Parking Cashout?

Any employee who is offered a parking benefit by a covered employer must receive the offer of a parking cashout.

What Must Be Offered As The Parking Cashout?

An employee who receives an offer of a "parking benefit" must receive an offer of a "parking benefit equivalent." This equivalent benefit may be provided as one of the following:

- A Clean Air Transportation Fringe Benefit in an amount equal to or greater than the monthly market value of the parking benefit offered to the employee;

- Pay the D.C. Department of Transportation ("DDOT") a Clean Air Compliance Fee of $100 per month for each employee who is offered a parking benefit; or

- Implement a transportation demand plan.

Clean Air Transportation Fringe Benefit?

A Clean Air Transportation Fringe Benefit is a benefit equivalent to the market value of the parking benefit offered by the employer and may be offered through a qualified mass transit transportation ("transit passes"), vanpooling, or bicycle commuting expense reimbursement benefit.

- A covered employer choosing this route must notify employees of their rights to cashout their parking benefit by accepting the Clean Air Transportation Fringe Benefit.

- Employees accepting the cashout fringe benefit must then (on an annual basis) estimate the amount of the offered benefit that will be used for transportation purposes.

- If an employee estimates that they will utilize less than the full market value of the parking benefit (and/or if the market value of the benefit exceeds the statutory limits imposed under Code §§132(f)(5)(2)) (for 2023, $300/month) the employer must still pay the difference in the form of additional compensation, an increase to the employer's health insurance contribution, or a combination of both.

An employee cannot accept both the parking benefit and a Clean Air Transportation Fringe Benefit.

Transportation Demand Management ("TDM") Plan

An employer can comply with the Act by developing a TDM plan and submitting the plan to DDOT for review and approval. The TDM plan must provide strategies and a timeline for the employer to reduce the number of commuter trips made by car by at least 10% from the previous year and continuing until total commuter trips made by car are 25% or less than the original amount.

- DDOT has provided a template for employers to utilize in developing their TDM plan.

- The TDM plan must be submitted to DDOT through their reporting platform. Once submitted, the DDOT will either approve or reject the TDM plan.

- TDM plans must be submitted to DDOT by the reporting deadline of January 15, 2023.

What if an Employer Chooses to Pay a Clean Air Compliance Fee?

An employer can choose to comply with the Act by paying DDOT a compliance fee equivalent to the number of employees offered a parking benefit multiplied by $100 per month.

Reporting Requirements

Employers are required to submit a report to DDOT every two (2) years with the first reporting requirement due on

January 15, 2023.

Employers providing a Clean Air Fringe Benefit must provide DDOT with the following information:

- Total number of employees;
- The number of employees:
    - Offered a parking benefit;
    - Using a parking benefit;
    - Offered a Clean Air Transportation Fringe Benefit;
    - Using a Clean Air Transportation Fringe Benefit; and
- The market value of the Clean Air Transportation Fringe Benefit offered by the employer.

Employers with approved TDM plans must provide the DDOT with evidence demonstrating the employer's implementation of the plan within 90 days of the approval.

- Additionally, employers must submit annual reports regarding the form of commuter transportation for the previous calendar year.
- DDOT will conduct an annual audit to ensure employer compliance.

Employers complying with the Act by paying a Clean Air Compliance Fee must submit proof of payment every two (2) years to the DDOT. This must include the number of employees that the employer is paying the Clean Air Compliance Fee for.

Exempt employers must still report their exemption to DDOT every two (2) years.

Employer Action

- Determine whether you are a covered employer under the Act, and if so, determine which method of compliance you will implement.
- If choosing the Transportation Demand Management Plan approach ensure that your plan is submitted to the DDOT for approval by January 15, 2023.
- If you are a covered employer (or an exempt employer), ensure that you are prepared to submit any required reporting to DDOT by January 15, 2023.

Multiple Updates to Colorado FAMLI Paid Leave

As previously reported, Colorado has implemented a new paid family leave program to be administered by the state's FAMLI Division ("the Division") with contributions for the program paid equally by employers and employees.

In general, employers with at least one employee that works in Colorado must register with the FAMLI Division and commence payment into the state system as of January 1, 2023. Employer registration is expected to start in early December 2022. Registration is available at: **https://famli.colorado.gov/my-famli-employer**. Employees will be able to begin using FAMLI leave effective January 1, 2024.

Private Plan Option

Employers will have an option to submit their own or carrier sponsored private plan to the state instead of using the FAMLI system. All employers subject to FAMLI Paid Leave must register and pay the 2023 contributions, regardless of the intent to eventually implement an approved private plan. If a private plan is approved, the 2023 employer and employee contributions received by the Division will be eligible for reimbursement to the employer.

The Division has indicated that it expects to start accepting applications for private plans sometime between the first and third quarters of 2023. Additional guidance on what is required for a compliant private plan is available at the Division's website.

FAMLI Leave Updates

Notices and Toolkits

The FAMLI Division has prepared notices and an employer toolkit to assist employers with their reporting and payment duties. Employers are required to notify their employees about the FAMLI program by January 1, 2023.The employer toolkit includes the following documents in English and Spanish:

- Employer Required 2023 Program Notice Poster which must be posted in a prominent workplace location beginning January 1, 2023;
- Breakroom Poster;
- Paycheck Stuffer;
- 2023 Employee FAMLI Handbook;
- Pay Stub Sample;
- HR Fact Sheet; and
- Local Government Fact Sheet

Interaction with Other Leave Benefits

The Division has also released guidance on how FAMLI Paid Leave will interact with other types of leave including paid, unpaid, and required leave has been disclosed. As coordination can have an impact on any of these benefits, it is imperative that employers review their existing leave policies and handbooks to ensure proper communication on how these benefits interact. Below is guidance that we have received from the Division.

FAMLI and Workers' Compensation

FAMLI benefits do not run concurrent with Workers' Compensation. Furthermore, if the work absence would

be eligible for coverage under Workers' Compensation, then FAMLI leave is not available. To assist with this process, the employee's application requesting FAMLI leave must disclose if their serious health condition was caused by or related to a workplace injury or illness. The application must also include medical certification, which will also affirm the injury's origin. If the employee's condition is denied under Workers' Compensation, the employee can reapply or reopen their FAMLI leave application for the same health condition.

a. FAMLI and Unemployment Benefits

FAMLI benefits and unemployment benefits do not run concurrently. If the employee's absence from work entitles them to unemployment benefits, the individual is not eligible for FAMLI leave.

The employee must inform the FAMLI Division if they apply for or receive unemployment benefits while on FAMLI leave and, if so, the FAMLI benefit will be classified as an overpayment.

Failure to comply with these requirements can result in the employee's disqualification from FAMLI benefits.

b. FAMLI and Employer Paid Leave

While the FAMLI Act and its regulations do not entitle an employee to receive both paid leave from the employer and FAMLI benefits for the same leave, an employer and employee may mutually agree to allow the employee to use any accrued employer-provided paid leave to supplement the FAMLI benefit. Absent written documentation of the mutual agreement, the FAMLI Division will presume that such an agreement to supplement the FAMLI leave benefit is present

However, a mutual agreement between the employer and employee is not necessary for the employee to use paid sick leave prior to receipt of FAMLI benefits.

The supplemental pay amount cannot exceed the difference between the FAMLI benefit and the employee's average weekly wage.

c. FAMLI and Employer Provided Benefits

The FAMLI Act and regulations only require a participating employer to maintain health care benefits. All other benefit continuation is subject to the employer's existing rules and policies.

Premiums for health care can be collected by the employer by any of the following:

- Deductions from the employer-provided paid leave used to supplement the FAMLI benefits;
- Deductions from wages upon the employee's return to work;
- Establishment of a repayment plan as agreed upon by the employer and employee; or
- Any other legal means (e.g., lawsuit).

a. FAMLI and Short-Term Disability ("STD")/Long-Term Disability ("LTD")

If the employer satisfies the FAMLI notice requirement, the employer can count the amount and duration of the FAMLI benefit against the amounts and duration provided under the applicable STD/LTD policies. An employer can require FAMLI benefits to run concurrent with STD/LTD and the terms of the STD/LTD policy will govern who provides notice about the benefits received by the employee to the policy's plan administrator – employer, employee, or both.

b. FAMLI and Family and Medical Leave Act ("FMLA")

FAMLI leave that also qualifies for federal FMLA must run concurrently.

Pre-Paying for FAMLI Benefits

The Division also addressed how employers can pre-pay FAMLI benefits before an employee is approved for leave by the FAMLI Division. An employer may register as a "pay-in-pending" employer with the FAMLI Division and any FAMLI benefits awarded to an employee would be paid directly to the employer as a reimbursement. An employee, however, is not required in this regard to apply for FAMLI benefits.

If the reimbursement to the employer is less than what the employer paid to the employee, the employer may not recoup the difference from the employee. The registered employer retains the right to appeal the FAMLI Division's determination of benefits.

For employers that choose not to register as a pay-in-pending employer but still pre-pay the employee's FAMLI benefit:

- The employer would not be entitled to reimbursement of the employer-provided paid leave;
- The employer may lawfully recoup from the employee the amount it paid and the amount that it was reimbursed by the FAMLI Division; and
- The employer does not have appeal rights to the FAMLI Division's determination of benefits.

Employer Action

As the state continues to provide additional information about the FAMLI program (with contributions set to begin January 1, 2023), employers should regularly check the FAMLI Division's main website and subscribe to their newsletter for updates.

New Hampshire Paid Family and Medical Leave Approaching

As previously reported, New Hampshire established the New Hampshire Paid Family and Medical Leave ("NH PFML") Plan which provides 60% of wages up to 6 weeks of work per year for personal health or family reasons. State employees will automatically be covered with the state paying the full cost of coverage. All other public and private New Hampshire employers and individuals may voluntarily enroll in the state-sponsored plan. Employers should note they will have responsibilities under both the employer sponsored and individual insurance options. The coverage will be effective January 1, 2023.

What's New?

There are two ways to participate in the NH PFML Plan: employer sponsored or individual coverage.

Employer Sponsored

Employers can purchase a fully insured plan through a state-approved carrier or provide benefits through self-insured employer equivalent benefit coverage.

Employers can choose between a 6-week or 12-week paid benefit that includes a 7-calendar day unpaid elimination period per year. The leave can be taken all at once (continuous) or in partial days (intermittent) with a minimum of 4-hour increments.

Insured plans will be individually underwritten by the carrier. An employer may fully fund the NH PFML Insurance premium cost on their employees' behalf, split the premium cost with employees or pass on the full cost to employees.

Employers purchasing NH PFML Insurance through MetLife (the state's NH PFML insurance partner) qualify for a Business Enterprise Tax ("BET") Credit equal to 50% of the NH PFML Insurance 6-week premium the employer pays. Employers will need to complete and submit the most recent Schedule of Business Profits Tax ("BPT") Credit (Form DP-160) to the New Hampshire Department of Revenue Administration to claim the NH business tax credit. Employers who purchase NH PFML Insurance from insurance carriers other than MetLife will not qualify for the BET Credit.

Individual Insurance

Individuals who work in New Hampshire for employers who choose not to offer NH PFML coverage or employer equivalent benefit coverage can purchase a NH PFML individual plan for themselves. The NH PFML Plan for individuals provides a 6-week paid benefit that includes a 7-month waiting period before a claim may be submitted and a single unpaid work week before benefits may be paid. The leave can be taken all at once (continuous) or in partial days (intermittent) with a minimum of 4-hour increments.

Premiums will be $5 maximum per week or $260 annually. Employers with 50 or more employees will be required to set up payroll deductions to support individuals who have purchased NH PFML through the state's insurance partner, MetLife. If an employee enrolls as an individual, the employer will be contacted by MetLife to set up the payroll deductions and will be given remittance instructions. Employers with fewer than 50 employees may have individuals who enroll for individual coverage. These employees will be responsible for premium payments.

Claims Process

All employers must participate in the claims process for their covered employees. Covered employees submit NH PFML insurance claims directly to MetLife; however, employers are obligated to address employee questions and direct workers to MetLife.

Employers must also provide wage and leave information, work schedules and other benefits information to MetLife to support NH PFML insurance claims processing.

Coordination of Benefits

NH PFML Insurance is designed to coordinate with other types of leave and employee benefits:

- If employees qualify for short-term disability, they will not qualify for NH PFML Insurance benefits for the same days absent;
- If employees are eligible to receive workers' compensation, they will not qualify for NH PFML Insurance benefits;
- NH PFML Insurance will run concurrently with the federal Family and Medical Leave Act (FMLA) when a worker is eligible for qualifying leave under both programs; or
- Any other paid benefit coordination is based on employer policy, NH statute and rules of the MetLife agreement.

Key Dates

NH PFML Plan: Begins January 1, 2023

Employer Open Enrollment: Begins December 1, 2022

Individual Open Enrollment: Begins December 1, 2022

Employer Action

With the NH PFML start dates rapidly approaching, employers should review their current leave programs, discuss with their employment and labor counsels, leave management vendors, payroll departments and payroll vendors how this law will impact their current programs. Employers should note they will have responsibilities under NH PFML whether or not they choose to offer an employer sponsored benefit.

Oregon and Washington Issue Joint Paid Leave Guidance

On October 7, 2022, the Oregon Employment Department ("OED") and the Washington Employment Security Department ("ESD") issued a joint letter providing welcomed guidance assisting Washington and Oregon employers in determining which leave program employees are subject to when they work in multiple states. Employees should only be covered by one program and the premiums paid to that program would be based on all wages paid.

Background

Paid Leave Oregon ("PLO") and Washington Paid Family and Medical Leave ("WAPFML," and collectively, "the Programs") are separate paid leave programs that provide wage replacement benefits for certain protected family, medical, and safe (domestic violence) leaves to employees working in Oregon and Washington. The programs are funded by employer and employee contributions. Employee contributions are deducted from employee paychecks. Visit the following websites for Frequently Asked Questions:

https://paidleave.oregon.gov/employers/Pages/frequently-asked-questions.aspx

https://paidleave.wa.gov/help-center/employers/

Joint Letter Guidance

PLO and WAPFML require contributions to their programs for all covered employees. For both PLO and WAPFML, employee coverage is based on where work is performed. While both PLO and WAPFML define place of performance and localization of work for purposes of coverage under the Programs, it was not clear how employers were to determine which program covered an employee when an employee worked in both states. For example, if an employee worked at an employer worksite location in Washington and also from home in Oregon, was the employee covered by PLO, WAPFML, or both Programs?

The Joint letter provides helpful guidance for employers to resolve the coverage question.

Where is the work performed?

Both states tell employers to first consider where the work is performed, before looking at other aspects of employment. If all work is performed in one state, then the employee is covered by that state's program and all of the employee's wages are reportable to that state.

Example: If all the work is physically performed in Oregon, all of the employee's wages associated are reportable to Oregon.

Is work performed in more than one state?

If the work is performed in multiple states, the employer should look to the state that is the base of operations. If there is no base of operations, then look to where the direction and control comes from.

Examples:

- If the base of operation or direction and control comes from Oregon, all of the employee's wages associated are reportable to Oregon.
- If the base of operation or direction and control comes from Washington, all of the employee's wages and hours associated are reportable to Washington.

Is work performed in multiple states and direction or control of work is located in a state where the employee does not work?

In this instance, the employee is covered by the program from their state of residence and all of the employee's wages are reportable to that state.

The joint letter also provides some common scenarios to further illustrate the application of the guidance to different employee situations.

Employer Action

Employers that have not determined whether their employees are covered by PLO or WAPFML should consider their employee's specific situations in light of the additional guidance. Once coverage under PLO or WAPFML is determined, then all wages earned are reportable with that state's program. An employee covered under PLO that happens to work some time in WA would still have all wages earned reported to Oregon. In no event should an employee be covered by both PLO and WAPFML.

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