MY BENEFIT ADVISOR

2024: Second Quarter

Compliance Digest

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San Francisco HCSO Reporting Due May 3 2024 Reminder

Issued date: 04/03/24

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") need to submit the 2023 Employer Annual Reporting Form by May 3, 2024. The form is completed and submitted online at www.sf.gov/submit-employer-annual-reporting-form-olse.

It is important to note that this annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"), which is not addressed in this article. You can access more information on the FCO on the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE").

Employer Annual Reporting Form

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

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

The Form is normally due on April 30th of the following year, but the OLSE has announced that the deadline to submit the 2023 Form has been extended to May 3, 2024. According to FAQs emailed from the OLSE, no submission will be accepted after that date. The penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2023 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2023 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

The OLSE has posted a sample of the 2023 Form for employers who wish to preview the Form before completing it online (www.sf.gov/sites/default/files/2024-03/2023%20ARF%20PDF%20Preview.pdf). It has also published instructions for completing the 2023 Form (www.sf.gov/sites/default/files/2024-03/2023 ARF Instructions_0.pdf).

HCSO Notice for Employers

If they haven't already, covered employers should make sure to post the official 2024 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at www.sf.gov/sites/default/files/2023-12/2024 HCSO poster_1.pdf.

Massachusetts Releases 2025 MCC Amounts

Issued date: 04/04/24

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 02-24 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage ("MCC") regulation. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2025 and provides those respective dollar amounts.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents aged 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

The 2007 regulations mandated a $2,000/$4,000 deductible limit and a separate prescription deductible limit of up to $250/$500 for in-network covered services. Subsequent regulations required indexing the deductible limits to the annual out-of-pocket maximum ("OOPM") adjustment percentage under federal law, rounded down to the next $50.

Administrative Bulletin 02-24 sets the 2025 maximum MCC deductibles as $2,950/$5,900. If the plan has a separate prescription drug deductible, the amounts cannot exceed $360/$720 and the total maximum deductible applies. These deductible limits are unchanged from 2024.

OOPMs

In 2017, the Health Connector published Administrative Bulletin 02-17, tying the indexed OOPMs under MCC to the federally indexed OOPMs that apply to non-grandfathered plans.

For 2025, the OOPMs under MCC will be $9,200/$18,400. It should be noted that the 2005 federally indexed OOPMs that apply to non-grandfathered plans have not been released.

Effective Dates

Administrative Bulletin 02-24 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2025.

Pennsylvania Aligns Dependent Care Benefits With Federal Tax Rules

Issued date: 04/04/24

The Commonwealth of Pennsylvania recently enacted Act 34, Section 202.3 (HB 1300) ("The Act"), which, among other things, amended Pennsylvania law to allow for employer-provided dependent care assistance, including a Section 125 Dependent Care Assistance Program ("DCAP"), to be excluded from an employees' income for state income tax purposes. The Act is effective retroactively back to January 1, 2023.

Exclusion from Income Taxation

The Act aligns Pennsylvania's tax code with Section 129 of the Internal Revenue Code by allowing employees to exclude dependent care assistance provided by their employers from their personal income tax. For purposes of this exclusion, "dependent care assistance" is considered:

- the fair market value of daycare facility benefits provided by an employer;
- an amount paid directly by the employer to a daycare facility or reimbursed to the employee to subsidize the benefit; and
- benefits from the pre-tax contributions made by the employee under a Section 125 DCAP flexible spending account.

Correcting Inaccurate Form W-2s

Because the Act is effective retroactively, it is likely that employers withheld tax for employer-provided dependent care assistance for the 2023 tax year. This could create issues for employees when they file their 2023 state income tax return. In published guidance, the Pennsylvania Department of Revenue ("DOR") has provided steps to address this issue:

- If an employer has already filed their W-2s with the DOR, they should file corrected W-2s with the dependent care assistance excluded. Employees can exclude up to the federal maximum annual limit ($5,000 for 2024).

The employee(s) should also be provided with a corrected W-2.

- If an employer has not yet filed their W-2s with the DOR, they can file updated W-2s in which the dependent care benefits reported in Box 10 are not included in Box 16 (State Wages). The updated W-2 should also be provided to the applicable employee(s).

- Employers should not file amended W-3s and Annual Withholding Reconciliation Statements (REV-1667s) to remove withholding for dependent care assistance. Only W-2s should be amended.

Employer Action

Employers should file amended W-2s for any applicable employees according to the DOR's guidance. In addition, withholding for dependent care assistance benefits should be stopped as soon as possible. Payroll systems should be adjusted to ensure that dependent care assistance benefits are excluded from employees' taxable wages and are not included in their 2024 Form W-2.

Finally, any employee communications or plan documents which reference the prior taxation of dependent care assistance benefits in Pennsylvania should be updated to remove this language.

Change On The Horizon For Prescription Drugs And EHBs

Issued date: 04/30/24

According to a recent FAQ, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") intend to issue guidance that would require large insured group health plans and self-funded plans to treat all prescription drugs as essential health benefits ("EHBs").

Background

Generally, employers who offer large insured group health plans and self-funded group health plans are not required to cover EHBs. However, if the plan covers EHBs, the plan:

- May not impose annual or lifetime dollar limits on EHBs; and
- For non-grandfathered plans, cost-sharing for EHBs is counted toward the annual out-of-pocket maximum ("OOPM").

Prescription drugs are listed as an EHB.

In recent years, some programs have been designed to designate only certain prescription drugs as "EHBs" and other prescription drugs as "non-EHBs." This practice is often seen in connection with programs that utilize drug manufacture coupons or other copay assistance.

HHS finalized the 2025 Benefit and Payment Parameters regulation. Notably, the rule codifies current policy that prescription drugs that a plan covers in excess of those covered by a state's EHB-benchmark plan are considered EHBs, unless the coverage of the drug is mandated by state action. This rule applies to the individual and small group insured market. It does not apply to large insured group health plans and self-insured group health plans.

FAQ 66 – Proposed Change for Large Insured Plans and Self-Funded Plans

At the same time the final rule was issued, the Departments announced in FAQ 66 their intent to issue rulemaking that would require large insured group health plans and self-funded group health plans to treat all prescription drugs covered by the plan as EHBs, effectively aligning the rules across markets.

As a result:

- Annual and lifetime dollar limits on any covered prescription would be prohibited; and
- Cost-sharing would accumulate to the out-of-pocket maximum in a non-grandfathered plan.

Employer Action

Employers should await further guidance from the regulators on this issue. Employers that have large insured group health plans or self-funded plans that have designated certain prescription drugs as non-EHBs may need to make changes to their plan design when guidance is issued.

IRS Addresses Tax Treatment Of Work-Life Referral Services

Issued date: 05/03/24

In a recent Fact Sheet FAQ, the Internal Revenue Service ("IRS") clarified the tax treatment of certain work-life referral ("WLR") services provided by employers. The FAQ explains that where the WLR services are incorporated into an employee assistance program ("EAP") or otherwise bundled with other types of services, the value of the WLR services may be excluded from employees' income as a de minimis fringe benefit.

Background

WLR Programs

As described in the FAQ, a WLR program is an employer-funded fringe benefit that provides WLR services to eligible employees. WLR services are defined as informational and referral consultations that assist employees with identifying, contracting, and negotiating with life-management resources for solutions to a personal, work, or family challenge. These services are sometimes referred to as caregiver or caretaker navigation services. Examples of WLR services include:

- Identifying appropriate education, care, and medical service providers
- Choosing a child or dependent care program
- Navigating eligibility for government benefits
- Evaluating and using paid leave programs
- Locating home services professionals for family members with special needs
- Navigating private and public service programs
- Connecting employees with local retirement and financial planning professionals

De Minimis Fringe Benefits

In general, for federal tax purposes, a fringe benefit provided by an employer to an employee is presumed to be income to the employee unless it is specifically excluded by a section of the Internal Revenue Code ("Code").

The Code excludes from gross income and employment taxes any fringe benefit that qualifies as de minimis fringe. A de minimis fringe benefit is defined as any property or service, the value of which is (after taking into account the frequency with which similar fringes are provided to employees) so small as to make accounting for it unreasonable or administratively difficult. The Code requires the employer to establish the frequency with which it provides fringe benefits to individual employees (employee-measured frequency). If the employer can establish that it is administratively difficult to determine employee-measured frequency, it may instead reference the frequency by which it provides fringe benefits to the workforce as a whole (employer-measured frequency).

It is important to note that cash and cash equivalents (such as gift cards) do not qualify as de minimis fringes.

Application to WLR Programs

In the FAQ, the IRS explains that the value of employer-provided WLR services can be excluded from employees' gross income as a de minimis fringe benefit, and thus not subject to U.S. income and employment taxes.

The IRS only addressed WLR services when they are incorporated into an EAP or otherwise bundled with other types of services offered by the employer. The FAQ expressly declined to address the direct or indirect payment for life-management services or other non-WLR services offered through an EAP or that may be bundled with a WLR program.

Employer Action

The IRS notes that the Fact Sheet FAQ is intended to provide general information and will not be relied on to resolve any cases. However, if the FAQs turn out to be an inaccurate statement of the law, taxpayers who reasonably relied on them in good faith will not be subject to a penalty that provides a reasonable cause standard for penalty relief.

Employers who offer WLR services through an EAP or bundled with other services may continue to do so without including the value of the services in employees' gross income. However, there may be tax concerns if life-management services are purchased directly through a vendor and provided to employees, or if employees are reimbursed for life-management services that they receive outside of an employer-provided program.

Many vendors promoting life management programs offer benefits that go beyond the WLR services described in this FAQ. Employers offering these benefits should work carefully with their vendor to ascertain the scope of the services offered. Employers may need to consult with their tax advisor to determine the tax implications of offering these benefits.

Annual Out-of-Pocket Maximum Adjustments Announced For 2025

Issued date: 05/07/24

The Department of Health and Human Services (“HHS”) published the “payment parameters” portion of its Annual Notice of Benefit and Payment Parameters for 2025. For purposes of employer-sponsored health plans, the guidance includes the limits on annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for non-grandfathered group medical plans for plan years that begin in 2025.

Change to the Out-of-Pocket Maximums

The out-of-pocket maximum for non-grandfathered group medical plans will be decreased for plan years beginning on or after January 1, 2025, as follows:

- $9,200 for self-only coverage (down from $9,450 for 2024)
- $18,400 for coverage other than self-only (down from $18,900 for 2024).

It is important to note that the out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans (“HDHPs”) that are compatible with health savings account (“HSA”) eligibility.

Employer Action

Non-grandfathered group medical plans should update out-of-pocket limits for plan years beginning on or after January 1, 2025.

New York Provides Paid Prenatal Leave And Sunsets COVID-19 Sick Leave

Issued date: 05/17/24

On April 20, 2024, Governor Kathy Hochul signed the 2025 state budget that includes an amendment to the New York Paid Family Leave ("NYPFL") law requiring employers to provide 20 hours of paid prenatal care. This "first-in-the-nation" prenatal leave effective January 1, 2025, makes available additional paid, protected leave for pregnant employees for prenatal care in addition to existing paid leave entitlements.

In addition, the separate New York COVID-19 paid sick leave law will sunset as of July 31, 2025.

Paid Prenatal Personal Leave

New York employers will be required to provide 20 hours of Paid Prenatal Personal Leave ("prenatal leave") during any 52-week calendar period that can be taken by the employee for pregnancy-related health care services including:

- physical examinations,
- medical procedures,
- monitoring and testing, and
- discussions with a health care provider related to pregnancy.

Prenatal leave may be taken in hourly increments with employees paid at their regular rate of pay, or the applicable minimum wage whichever is greater. An employer is not required to pay an employee for unused prenatal leave at an employee's termination, resignation, retirement, or separation from employment.

Prenatal leave is in addition to leave entitlements provided by other New York leave laws including paid sick leave and NYPFL. Some employees may also qualify for unpaid leave under the Family and Medical Leave Act ("FMLA") for serious health conditions.

Employers shall not retaliate against an employee for exercising their rights to prenatal leave and employees must be restored to their position of employment prior to any prenatal leave with the same pay and other terms and conditions of employment.

Employer Action

New York employers should review and be prepared to update, communicate, and coordinate existing leave policies and paid leave requirements with the new paid prenatal personal leave provisions that become effective January 1, 2025.

Employers should also be prepared for the sunsetting of the COVID-19 paid sick leave, effective July 31, 2025.

2025 Inflation Adjusted Amounts For HSAs HDHPs And EBHRAs

Issued date: 05/20/24

The IRS released the inflation adjustments for health savings accounts (“HSAs”) and their accompanying HSA-compatible high deductible health plans (“HSA-compatible HDHPs”) effective for calendar year 2025, and the maximum annual amount that may be made available under excepted benefit health reimbursement arrangements (“EBHRAs”). All limits increased from the
2024 amounts.

HSA Annual Contribution Maximum

For calendar year 2025, the maximum HSA contribution amount for an individual with coverage under an HSA-compatible HDHP is:

- $4,300 for self-only coverage (up from $4,150 for 2024)
- $8,550 for coverage other than self-only (up from $8,300 for 2024)

It should be noted that Individuals who are age 55 or older and covered by an HSA-compatible HDHP may make an additional HSA catch-up contribution of $1,000 each year until they enroll in Medicare. This catch-up contribution amount has not increased since 2009.

HSA-Compatible High Deductible Health Plan

For calendar year 2025, an HSA-compatible HDHP is a health plan:

- for which the maximum annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed:

- $8,300 for self-only coverage (up from $8,050 for 2024)
- $16,600 for coverage other than self-only (up from $16,100 for 2024), and

- with a minimum annual deductible that is not less than:
  - $1,650 for self-only coverage (up from $1,600 for 2024)
  - $3,300 for coverage other than self-only (up from $3,200 for 2024)

If family HDHP coverage includes an embedded individual deductible, for 2025 that embedded individual deductible cannot be less than $3,300 (the statutory minimum deductible for family HDHP coverage).

Non-calendar year plans: In cases where the HSA-compatible HDHP renewal date is after the beginning of the calendar year (e.g., a fiscal year plan), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Excepted Benefit HRA Adjustment

For plan years beginning in 2025, the maximum amount that may be made newly available for the plan year for an EBHRA is $2,150 (up from $2,100 in 2024).

2024 PCOR Fee Filing Reminder For Self-Insured Plans

Issued date: 06/11/24

The Patient-Centered Outcomes Research ("PCOR") fee filing deadline is **July 31, 2024**, for all self-funded medical plans and some HRAs (including individual coverage HRAs ("ICHRAs")) for plan years (including short plan years) ending in 2023. Carriers are responsible for paying the fee for insured policies.

The plan years and associated PCOR fee amounts due July 31, 2024, are as follows:

Plan Year END Date	PCOR Fee Amount
January 31, 2023	$3.00/covered life/year
February 28, 2023	$3.00/covered life/year
March 31, 2023	$3.00/covered life/year
April 30, 2023	$3.00/covered life/year
May 31, 2023	$3.00/covered life/year
June 30, 2023	$3.00/covered life/year
July 31, 2023	$3.00/covered life/year
August 31, 2023	$3.00/covered life/year
September 30, 2023	$3.00/covered life/year
October 31, 2023	**$3.22/covered life/year**
November 30, 2023	**$3.22/covered life/year**
December 31, 2023	**$3.22/covered life/year**

Employers with self-funded health plan years ending in 2023 should use the 2nd quarter Form 720 to file and pay the PCOR fee by July 31, 2024. The information is reported in Part II.

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

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

Resources

For a copy of Notice 2023-70, visit: www.irs.gov/pub/irs-drop/n-23-70.pdf.

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

For additional information, please visit the following IRS sites:

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

Updated Instructions For Gag Clause Attestations

Issued date: 06/14/24

The Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") recently issued the updated Annual Submission Instructions and User Manual to facilitate the Gag Clause Prohibition Compliance Attestation ("GCPCA") for 2024.

Background

Briefly, group health plans and health insurance carriers are prohibited from entering into an agreement with a health care provider, network or association of providers, third-party administrators ("TPAs"), or other service provider offering access to a network of providers, that directly or indirectly restricts the plan or carrier from:

- disclosing cost or quality of care information or data, and certain other information, to:
  - active or eligible participants, beneficiaries, and enrollees of the plan or coverage,
  - the plan sponsor, or
  - referring providers.
- electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan
  or coverage, upon request and consistent with the relevant privacy regulations, or
- sharing such information with a business associate, consistent with applicable privacy regulations.

A group health plan or carrier must annually attest that, for the period of the attestation, it has not entered into any agreements that violate the gag clause prohibition. The annual attestation is submitted through the Centers for Medicare and Medicaid Services ("CMS") via a webform on the GCPCA homepage. The first attestation was due by December 31, 2023. The next attestation is due by December 31, 2024.

What's New?

There are a handful of changes made to the information as follows:

- In a separate section of the instructions, the agreements that are subject to an attestation of compliance are clarified to include agreements between group health plans (fully insured or self-funded) and carriers (offering group or individual health insurance coverage) with:
    - health care providers,
    - a network or association of providers,
    - TPAs, or
    - other service providers (including vendors) offering access to a network of providers.
- The term "Reporting Entity" has been changed to "Responsible Entity;" however, the definition remains the same.
    - The Responsible Entity is defined as the plan or issuer that has (directly or indirectly) entered into agreements, usually through a TPA or another vendor (like a pharmacy benefit manger ("PBM") or behavioral health manager ("BHM"), with health care providers, a network or association of providers, TPAs or other service providers offering access to a network of providers.
- The terms "Attestation Period" and "Attestation Year" have been clarified.
    - The Attestation Period begins on the day immediately following the date of the prior attestation and extends to the date of the current attestation.
- The year in which the attestation is submitted is the Attestation Year.
- The list of Responsible Entities (those required to attest) has been updated to include Tribal health plans that qualify as ERISA plans or state or local government plans. In addition, a footnote has been added to address who is the Responsible Entity in a Multiple Employer Welfare Arrangement ("MEWA").
- The instructions clarify that a single group health plan with multiple benefit packages (e.g., a single plan using a single ERISA plan number that offers a PPO and an HDHP health plan option) is a single Responsible Entity and may submit one attestation. However, if there are multiple group health plans (such as a PPO plan that uses ERISA plan number 501 and a separate HDHP plan that uses ERISA plan number 502) the Responsible Entity will need to file an attestation for each separate plan.
- Additional changes to the webform submission and GCPCA user manual.

Employer Action

Employers should begin to prepare for compliance with the gag clause attestation for Attestation Year 2024, due no later than December 31, 2024.

For fully insured group health plans, the carrier is responsible for submitting the attestation. The employer should confirm that the carrier will submit on behalf of the plan.

For self-funded group health plans (including level-funded plans), the plan sponsor (the employer) is responsible for compliance and remains legally responsible for the attestation. In many cases, the employer will need to act as the Responsible Entity and submit the annual attestation on behalf of the plan.

In some cases, the TPA or other third party will submit the attestation on behalf of the plan. Employers looking to have a TPA or other third party submit the attestation on the plan's behalf should confirm this in writing with the applicable vendor.

Further, if there are carved out vendors (e.g., PBMs, BHMs) with a contract subject to this provision, employers should confirm no gag clauses exist and either, through written agreement, have the vendor submit the attestation on behalf of the plan or prepare to file on the carve-out portion of the arrangement.

A reminder on the Gag Clause Attestation will be sent out closer to the December 31, 2024, due date.

Kentucky Legislation Regulates PBM Pricing and Provider Networks

On April 4, 2024, the Kentucky Governor signed Senate Bill 188 into law titled "An Act relating to Patient Access to Pharmacy Benefits" ("the Act"), which created new sections of the Kentucky Revised Statutes ("KRS") to address what is described as an unfair playing field between independent pharmacies and pharmacy benefit managers ("PBMs") and to provide expanded access and lower costs for patients and rural clinics. The new Act will regulate the pricing that a PBM charges to pharmacies and costs, fees, and financial benefits received by PBMs. Additionally, the Act attempts to regulate the provision of pharmaceutical providers made available by PBMs and health plans. The new Act will go into effect for new contracts or policies delivered, executed, amended, adjusted, or renewed on or after January 1, 2025.

Network Access, Contract Regulation, and Minimum Reimbursement

The Act sets requirements around what a PBM can charge pharmacies for prescription medication and certain financial incentives that a PBM can receive. While the regulations are broad in scope, there are several points that will be of relevance to group health plans:

- Requires reasonably adequate and accessible network of pharmacies that are not mail-order pharmacies with convenient access within a reasonable distance from the insured's residence, but in no event more than 30 miles of an insured's residence, to the extent that pharmacy services are available.
- Prohibits a PBM or plan from denying a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services that meet the terms and requirements set forth by the insurer under the policy or plan;
- Requires equal access and incentives to all pharmacies within the network;
- Requires identical reimbursement terms to be offered to all pharmacies located in the health plan's geographic coverage area;
- It sets a minimum dispensing fee or floor of $10.64 to fill a prescription for retail independent pharmacies until a study of national average dispensing costs is completed by the Kentucky Department of Insurance (available only to independent pharmacies, not chain pharmacies); and
- Requires annual reporting with the insurance commissioner.

Freedom of Patient Choice

The Act specifically requires that consumers have the freedom of choice related to the provision of pharmacy benefits by prohibiting a PBM or health plan from doing the following:

- Prohibiting or limiting any covered individual from selecting a pharmacy or pharmacist of his or her choice who has agreed to participate in the plan according to the terms offered by the insurer;
- Imposing cost-sharing or other conditions that are greater or more restrictive than what would be imposed if the patient used a mail-order pharmacy;
- Requiring patients to obtain their drugs through mail order or direct patients to a pharmacy owned by the PBM or reimbursing a pharmacy that it owns at a higher rate than a community pharmacy;
- Steering insureds to the PBM preferred pharmacy;
- Preventing a community pharmacy from filling a 90-day prescription for a maintenance drug; and
- Penalizing a community pharmacy for sharing information with patients on the least expensive option to pay for a prescription.

These provisions have the effect of declaring Kentucky as an "any willing provider" state. States that fall under this characterization require insurance carriers, PBMs, and health plans to allow healthcare providers to become members of the carriers' networks of providers if certain conditions are met. In the case of the Kentucky Act, a PBM or health plan will be required to allow a pharmaceutical provider to participate in their network if that provider is able to provide the services required and if they agree to the terms under the policy or plan, including the terms of reimbursement.

In addition to the "any willing provider" provisions, the Act will also prohibit a PBM or benefit plan from steering a participant toward certain providers at the expense of other network providers. Specifically, the applicable parties are not permitted to impose a monetary benefit or penalty (which includes a higher copayment or a reduction in reimbursement for services) to influence a beneficiary's utilization of one provider or method of provision over another.

Which Plans is this Applicable to?

In general, fully insured plans whose policies or contracts are issued by an insurance carrier registered in the Commonwealth of Kentucky will be covered by the provisions under the Act. This will likely be limited to only those health plans situsued in the Commonwealth of Kentucky.

ERISA-covered self-funded health plans are generally excluded from coverage by state insurance regulations through the doctrine of ERISA preemption. Any provision of the Act determined to be preempted by ERISA will not apply to ERISA-covered self-funded plans. ERISA preemption does not apply to fully insured plans. However, the Act defined insurers as including self-funded plans, government plans, church plans, and multiemployer plans, with the stated intent that the Act cover such plans. Moreover, the Act amended provisions of Kentucky law applying to pharmacies, pharmacists, and PBMs to address these provisions.

The U.S. Supreme Court held in Rutledge v. Pharmaceutical Care Management that federal ERISA preemption does not apply to a state regulation that amounts to mere cost regulation. Conversely, the court ruled that ERISA preemption exists where state law impermissibly connects to ERISA through such actions as "require providers to structure benefit plans in particular ways," "bind plan administrators to specific rules for determining beneficiary status," or create economic effects that "force an ERISA plan to adopt a certain scheme of coverage."

In the case of the Kentucky Act, it seems likely that the provisions related to provider adequacy are preempted by ERISA as they force ERISA-covered health plans to administer their benefits in a certain way. On the other hand, the provisions related to the pricing regulation of PBMs are likely not preempted as they appear to be cost regulations and applicable to all PBMs.

The Act does not apply to self-insured health plans provided by a hospital or health system for its employees where the hospital or health system owns a pharmacy.

The Act does not apply to Medicare Part D plans or to fully insured Kentucky student health plans.

Employer Action

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

Self-funded plans should work with independent counsel to determine whether they are subject to ERISA preemption. To the extent they are not subject to preemption, or the provisions of the regulations are not, plans should work with their TPAs and PBMs to determine the impact that the regulations will have on plan costs and to plan and budget accordingly.

Employers should watch for updates as additional regulations are expected.

Maine Publishes Proposed PFML Regulations

The Maine Department of Labor ("Department") has recently published proposed regulations for the Maine Paid Family and Medical Leave ("PFML") program. The proposed regulations provide additional details including program eligibility, how the benefit may be used, and applying for benefits.

The Basics

On June 11, 2023, Maine Governor Janet Mills signed into law the state's budget bill which established a PFML program. The program provides 12 weeks of wage replacement benefits for employees taking family or medical leave. Contribution withholdings under the state program begin January 1, 2025, and claims processing begins May 1, 2026. Employers can opt out of the state program and offer a private plan if certain conditions are met.

Below you will find highlights of new and clarifying information contained in the proposed regulations.

Employer Coverage

All private and public employers who employ one or more employees in Maine are required to provide paid family and medical leave. A "covered individual" is defined as an employee who earned at least 6 times the State Average Weekly Wage during the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year.

The program does not apply to the federal government. Self-employed individuals and tribal governments can opt-in to the program. In addition, the program does not apply to any employer or employee subject to the Railroad Unemployment Insurance Act, incarcerated persons earning wages in a Maine correctional facility or detention facility, and students that are earning wages as part of the Federal Work-Study Program and are enrolled in any University of Maine system, a community college, or any private higher educational institution in the State of Maine.

Uses and Types of Leaves

Covered individuals may take their full 12 weeks of leave in a variety of ways:

- Continuous leave occurs in blocks of consecutive days or weeks.
- Intermittent leave provides for varying periods of leave and returning to work throughout a period of approved covered leave time. Intermittent leave may be planned (e.g., for routine appointments) or unplanned (e.g., for a flare-up of a serious health condition).

- Reduced schedule leave reduces an employee's typical number of days per workweek, or hours per workday, on a planned and consistent basis.

Partial weeks or partial days of leave will be prorated against the employee's scheduled workweek.

Eligibility to Receive Benefits

To receive PFML benefits, a covered individual must:

- Be a covered employee;
- Submit an application for benefits in a manner approved by the Department (which may be submitted online), no more than 60 days before the anticipated start date of family leave and medical leave and no more than 90 days after the start date of family leave and medical leave;
- Have not been declared ineligible due to fraud; and
- Satisfy one of the qualifying reasons under the PFML program.
- Additional provisions regarding eligibility to take leave include:
- The combined medical and family leave may not exceed the 12-week maximum of family and medical leave within a benefit year.
- The 12 weeks of aggregate PFML may be reduced by amounts taken under FMLA or state FMLA unless the leaves are taken concurrently.
- A covered individual taking family leave to care for an individual with whom they have an affinity relationship is limited to one such designated individual per benefit year.

Employee Notice to Employer

Absent an emergency, illness, or other sudden necessity for taking leave, an employee must give reasonable notice (e.g., 30 days) to the employee's supervisor of the intent to use leave. If the request for leave is not foreseeable, an employee must make a good faith effort to provide written notice to the employer of the employee's intent to use leave as soon as possible. Notice provided on behalf of the employee by a family member or health care provider is considered notice provided by the employee.

An employer claiming an undue hardship with respect to the scheduling of foreseeable leave has the burden to prove the undue hardship. "Undue hardship" means a significant impact on the operation of the business or significant expenses, considering the financial resources of the employer, the size of the workforce, and the nature of the industry.

Amount of Benefit

The weekly benefit amount paid to employees and self-employed individuals on family or medical leave is calculated based on a tiered wage system. The calculation is as follows:

- 90% of Average Weekly Wage up to 50% of the State Average Weekly Wage (Tier 1) plus 66% of Average Weekly Wage in excess of 50% of the State Average Weekly Wage (Tier 2).
- The weekly benefit cannot exceed the State Maximum Weekly Benefit.

Premiums

The employer's premium amount and contribution report must be remitted quarterly on or before the last day of the month following the close of the quarter for which premiums have accrued. Beginning January 1, 2025, the premium is set at no more than 1% of wages.

- An employer with 15 or more employees may only deduct up to 50% of the required premium from an employee's wages and must remit 100% of the combined premium contribution to the Paid Family and Medical Leave Insurance Fund ("Fund") (i.e., the required premium may be equally shared between the employee and employer).
- An employer with fewer than 15 employees may only deduct up to 50% of the required premium from an employee's wages and must remit 50% of the premium to the Fund as businesses with fewer than 15 employees are exempt from paying into the state plan.
- The Program caps the amount of an employee's earnings subject to contributions at the same amount of earnings subject to Social Security taxes.

The employer size for the purposes of determining premium liability for calendar year 2025 is determined by the number of covered employees employed for the employer in the State of Maine on October 1, 2024. The number of employees includes full-time, part-time, seasonal, and temporary employees. On October 1, 2025, and October 1 of each year thereafter, the employer must calculate its size for the purpose of determining premium liability for calendar year 2026 and each calendar year thereafter.

The proposed regulations clarify that an employer's determination as to whether to deduct premiums from employees' wages must apply to all employees. If an employer changes that determination, the employer must provide notice to all employees in writing at least 7 days prior to the employees' first affected paycheck.

Employers must include in the employee's pay statement that a premium deduction for PFML has been deducted from the employee's wages.

Approved Private Plan

Employers may apply for a private plan exemption after January 1, 2026, but an exemption may not be effective prior to April 1, 2026. Applications for substantially equivalent private plans must be submitted on a form provided by the Department and may be accepted on a rolling basis. An application fee set by the Department must be included with the submission of the application.

An approved private plan is effective on the first day of the first quarter following approval of the application. The employer is responsible for premiums provided under the PFML program and the regulations until the effective date of substitution. An approved private plan is valid for a period of 3 years.

Employers approved for a private plan may not request cancellation of their private plan prior to the private plan's expiration date except by a demonstration to the Department of good cause. Good cause includes, but is not limited to, evidence of a premium increase. If the Department approves the employer's request for cancellation, the employer may not re-apply for another private plan for three years from the date of cancellation.

Employers must notify the Department of any material changes to an approved private plan at least 60 days in advance of the effective date of the changes and must obtain written approval from the Department regarding the changes.

Employer Action

Employers should review all the available information from the Department and work with employment counsel, leave vendors, payroll processors and any other related business advisors to make sure they are compliant with the PFML program by the requisite dates. In addition, employers should monitor the PFML website for additional guidance and regulations. My Benefit Advisor will continue to keep employers updated on new PFML program developments as applicable.

Maryland's Paid Family and Medical Leave Delayed Again

As previously reported, Maryland passed the Time to Care Act of 2022 ("the Act"), which mandates that covered employers provide paid family and medical leave to their employees in Maryland. On April 25, 2024, the Maryland General Assembly passed SB 485 which further delays the implementation of the Act. In addition to delaying implementation of the Act, the new legislation also provides clarification on the definition of "wages" and allows the Maryland Department of Labor ("MDOL") to set certain fees applicable to private plans.

Legislative Changes and Updates

Employers participating in the State Plan must begin making payroll contributions on July 1, 2025, with benefits beginning on July 1, 2026.

The definition of "wages" now aligns with the definition under Maryland's Unemployment Insurance statute. This alleviates the need to calculate different sets of wages under the two statutes.

The MDOL is permitted to assess application and renewal fees for employers that establish a private plan that satisfies the Act's requirements. Future rulemaking should further address these fees.

Employer Action

Employers should:

- Review and examine their existing paid leave policies (and employee handbooks) to determine whether they will want to utilize these policies to satisfy, or supplement, their requirements under the Act.
- Contemplate whether to participate in the state program or offer a private program (e.g., substitute existing leave or purchase a private insurance policy). Note, employers will need to apply for approval from the MDOL to offer an alternative plan. Guidance on this process is expected in the future.
- Provide written notice to all covered employees of their rights and duties under the Act.
- Ensure that payroll is prepared to begin contributions on July 1, 2025.
- Await future regulations that are expected.

Paid Leave Oregon Benefit and Contribution Amount Adjustments

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

As previously reported in August 2021, leave and benefits under Paid Leave Oregon ("PLO") will become available on September 3, 2023. Recently, the Oregon Employment Department ("ED") announced the adjusted weekly wage replacement benefit amounts based on the State Average Weekly Wage. Additionally, the Oregon Legislature modified PLO to align the wage cap for employee contributions with the social security wage limit.

Background

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

Wage Replacement

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

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

Contribution Limit

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

Employers that do not sponsor approved equivalent plans are required to deduct PLO premiums from employee paychecks and remit those premiums to the Paid Family and Medical Leave Insurance Fund. ED annually sets the maximum wage limit from which employers deduct premiums. Initially, the wage limit was set at $132,900. Recently Oregon enacted SB 913 which aligned the PLO wage cap with the Social Security wage cap beginning January 1, 2024. The Social Security cap has been announced for 2024 and is set at $168,600. ED is required to announce the adjusted contribution limit by November of each year for the following calendar year.

Paid Leave Oregon Website

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

Employer Action

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

Paid Leave Oregon Updates

As previously reported, leave and wage replacement benefits under Paid Leave Oregon ("PLO") became available on September 3, 2023. Recently, the definition of safe leave was expanded to include bias crimes. Additionally, the Oregon Employment Department ("ED") announced a delay in the first annual reporting requirement for equivalent plans.

Background

PLO took effect January 1, 2023 and began providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits. Alternatively, employers may self-administer a PLO equivalent plan provided by insurance or self-funded to comply with PLO requirements.

Safe Leave Expansion

During the 2023 legislative session, the Oregon legislature passed, and the Governor signed House Bill 3443 (HB 3443) that amended the definition of safe leave to include leave for victims of bias crimes. According to PLO:

- Bias is a prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair.
- A bias crime is motivated in part or whole by bias against another person's race, color, disability, religion, national origin, sexual orientation, or gender identity.

The changes in HB 3443 became effective on January 1, 2024. This means that, as of that date, PLO and any equivalent plan should be approving safe leave requests for employees that are victims of bias crimes in addition to leave for reasons related to domestic violence.

Equivalent Plan Reporting Delay

Equivalent plans are required to submit annual aggregate benefits usage reports and aggregate financial information to PLO due no later than the January 31 for the prior year. The reporting period is the calendar year. The aggregate benefit usage report must include for the reporting period:

- the number of benefit applications received and the qualifying leave purpose.
- the number of benefit applications approved, the qualifying leave purpose, and the total amount of leave.

- the number of benefit applications denied, the qualifying leave purpose, the number of denials appealed, and the outcome of the appeals.
- If the equivalent plan is funded by employee contributions, a separate annual report for the same reporting period is required to report the following:
- the total amount of employee contributions withheld.
- total plan expenses paid including benefit amounts and total administrative costs.
- The balance of employee contributions held in trust at the end of the reporting period.

Both the annual aggregate benefit report and financial information reports may require additional information and the employer should respond within ten calendar days of a notice from ED requesting information about the equivalent plan.

The reporting period for equivalent plans that were effective in 2023 is the period between the effective date of the plan and December 31, 2024. The reporting period for equivalent plans that were effective in 2024 is the period between the effective date of the plan and December 31, 2024. This means that the first annual reporting for all equivalent plans that became effective in 2023 or 2024 will be due by January 31, 2025.

Equivalent Plan Reapproval

Equivalent plans are required to apply for reapproval annually for the first three years that they offer PLO benefits to employees. The application is due 30 days before the anniversary of the effective date of the plan. Equivalent plans that were effective Sept. 3, 2023, must submit their reapproval applications no later than August 3, 2024.

Employer Action

Employers sponsoring equivalent plans should confirm their carriers or administrators have incorporated the expanded definition of safe leave into their approval process.

Equivalent plan sponsors should also confirm their carriers or administrators are preparing the information required for the annual reporting and they will timely provide the information before the reporting deadline.

Employers should also confirm their carriers or administrators will provide the required equivalent plan information needed to timely submit the application for reapproval.

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