COMMONWEALTH BENEFITS GROUP

Employee Benefits Compliance Briefing

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This Issue

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United Benefit Advisors® (UBA) is the nation's leading independent employee benefits advisory organization with more than 200 offices throughout the United States, Canada, and Europe. UBA empowers 2,000+ advisors to maintain independence while capitalizing on each other's shared knowledge and market presence to provide best-in-class services and solutions.

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Fisher Phillips

Do You Know Where Your Employees Are? Managing Taxes for a Growing Remote Workforce

Remote work remains a growing focus of employers with employees increasingly seeking jobs that permit remote or hybrid work arrangements. Though the flexibility and benefits of remote work for employees is highly desired, it comes with some additional considerations and potential tax complications for the employer.

State Income Tax Withholding Considerations

State income tax requirements, as a general matter, are governed by the state laws where the employee works. This means that the states that collect income tax from residents (all states except Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Washington, and Wyoming) will generally impose withholding obligations on employers who pay wages subject to tax within that state, including wages to remote workers. Employers with remote workers may not be set up for payroll withholding and taxes in states where employees are working. In some cases, employers may not even know what states their remote employees are working in.

However, it is increasingly important for employers to ensure that their payroll practices are updated to reflect remote or hybrid work arrangements. It may be difficult for employers to determine the proper states for withholding and income tax, particularly for employees with hybrid work arrangements where more than one state is involved. Most states follow the "source taxation" rule, requiring withholding based on where an employee earns the taxable wages. Accordingly, employees who work from home would be taxed in their home state for time spent working at home. But if the employee works in an office in a neighboring state on certain days of the week, the employee may also have a tax obligation in that state and the employer may need to allocate wages to both states for withholding purposes.

To make it even more challenging, some states require withholdings based on residency or the "convenience of the employer" rule, which states that if a remote work arrangement is for the employer's convenience, then state income taxes will be withheld in the state of the employee's assigned office location rather than their remote worksite. Currently, six states – New York, Delaware, Connecticut, Nebraska, Oregon, and Pennsylvania – as well as some major cities have adopted some form of the convenience of the employer test. Employers may also be obligated to withhold state taxes for

non-residents who travel to various states throughout the year. This requirement may be based on the amount of time spent in the state or on the amount of money earned while working in the state.

Unemployment Tax Withholding Considerations

In addition to payroll taxes, employers must consider where to pay unemployment taxes. Fortunately, the unemployment tax situs rules are more uniform. Generally, all states follow "localization of work" rules to determine where employee wages must be reported and therefore where unemployment insurance taxes must be paid. For remote workers, an employee is "localized" in the state in which they are physically present, unless that work is incidental to work in another state. While determining localization of an employee's work can be highly fact specific, the general rule of thumb is that an employee's remote work is localized to where they live and therefore unemployment insurance taxes must be paid in that state.

Corporate Tax Considerations

Beyond ensuring compliance with state income and unemployment withholdings, the presence of remote workers in states where the employer is not located may create additional corporate tax obligations. The types of corporate tax liability that may be implicated include corporate income taxes, sales and use taxes, business personal property taxes, and local taxes and fees on businesses. Allowing employees to work remotely and move freely throughout the country (or even internationally) can create a slew of unforeseen tax liabilities and reporting requirements that the company must be prepared to address.

Action Items for Employers

Remote work arrangements are certainly a benefit to both employees and the employer in many cases. But prior to entering into such arrangements, employers should consider the various employment law requirements of each state where employees are located, registration requirements, and other implications of having employees in a particular jurisdiction. The tax issues as discussed in this article are just one aspect of remote work compliance. The following steps are recommended for employers with remote workers:

- Conduct a survey of employees to determine the locations where they work.
- Develop a remote work policy and, if necessary, individual agreements to require notice of any change in work location by a remote employee.
- Consider whether there are business or compliance reasons for limiting the jurisdictions in which remote work is allowed.
- Review payroll and state law compliance issues for the states with remote workers.
- Ensure handbooks and employment agreements comply with the applicable state laws for the states in which there are remote workers.

A New Approach to Ensure Compliance with the ACA Contraceptive Mandate

On January 22, 2024, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services (collectively, "the Departments") issued FAQs on Part 64 of the Affordable Care Act (ACA), addressing compliance with the ACA Contraceptive Mandate. This guidance is in response to reports of group health plans and insurers employing unreasonable medical management techniques, so employers should ensure their plans are reasonable in light of the guidance below.

ACA Contraceptive Mandate Review

The ACA requires non-grandfathered group health plans to cover, without cost sharing, any contraceptive services and FDA-approved, -cleared, or -granted products that are deemed to be medically necessary for the covered individual. Previous guidance issued by the Departments clarified to insurers and plans that they are required to cover, without cost sharing, (1) at least one form of contraceptive in each of the Health Resources and Services Administration (HRSA) Women's Preventive Service Guidelines categories; and (2) contraceptive services and products determined to be medically necessary for the individual, even if not specifically identified in the HRSA Guidelines.

Issues

To comply with the ACA contraceptive mandate and HRSA Guidelines, the Departments have allowed plans to use medical management techniques to determine what contraceptive products or services to cover if multiple similar, medically appropriate, products or services are available. However, the Departments are reporting widespread barriers to contraceptive coverage created by medical management techniques the Departments deem unreasonable. The Departments have identified the following as examples of potentially unreasonable medical management techniques:

- Step therapy protocols (i.e., the "fail first" technique)
- Age-related restrictions

- Unduly burdensome administrative requirements as part of an exceptions process
- Cost sharing requirements for services that are integral to the contraceptive service (i.e., cost sharing for anesthesia during a sterilization surgery)

Therapeutic Equivalence Approach

To address the reports of unreasonable medical management techniques, the Departments issued this guidance to outline the therapeutic equivalence approach to compliance with the ACA contraceptive mandate, with specific focus on contraceptive drugs and drug-led devices.

Under the therapeutic equivalence approach, the Departments will generally view medical management techniques as reasonable so long as (1) the plan or insurer covers, without cost sharing, all FDA-approved drugs or drug led devices within an HSRA Guidelines category *unless* there is at least one therapeutic equivalent drug within the same category; and (2) there is a reasonable exceptions process to cover, without cost sharing, the therapeutic equivalent drugs that are not offered under the plan if the individual's attending physician determines the drug or device to be medically necessary. To determine if a therapeutic equivalent drug exists, the Departments refer to the FDA "Orange Book."

Action Items for Insurers and Group Health Plans

- Review your plan's covered contraceptive services and products.
- Determine if the forms of contraception offered have a therapeutic equivalent, as outlined in the "Orange Book." Note: if a form of contraception is not listed in the Orange Book, there is no therapeutic equivalent and the product or service with no therapeutic equivalent must be covered without cost sharing.
- Ensure that your plan is offering, without cost sharing, at least one form of contraception in each of the categories identified in the HRSA Guidelines.
- Develop a non-burdensome exceptions process for an individual to obtain coverage, without cost sharing, for a contraceptive service or FDA-approved, -cleared, or -granted contraceptive product that is medically necessary but not otherwise covered under your plan.
- Connect with your benefits consultant to ensure that changes made to covered services and products and to the exceptions process are compliant with the ACA contraceptive mandate.

Insurers Are Not Obligated to Inform Terminated Employees of their Life Insurance Conversion Rights

A recent case in an Indiana federal court serves as a reminder to employers that insurers are generally not obligated to inform terminated employees of their conversion rights. In *Estate of Maribeth Presnal v. Dearborn National Life Insurance Company et al* (the "Presnal Case"), the district court affirmed that insurers do not owe a duty to terminated employees of informing them of their rights to convert their life insurance policies. It is typically the responsibility of the employer to provide such notice. However, the court also held that the employer's summary plan description (SPD) was sufficient notice of the right, but that mental incapacity could constitute an "extraordinary circumstance," warranting am extension of the deadline to convert to a personal policy or make premium payments.

As a reminder, ERISA plans are generally considered contracts between employers and employees. So, if an employer fails to meet its responsibilities and the insurer is not obligated to pay the benefits as a result, the liability for such payment could be the responsibility of the employer. It is a common issue that employers fail to notify terminating employees of the conversion right regarding life insurance, leading to disputes over benefit payments upon the death of former employees.

In the Presnal Case, the employee, who was enrolled in the employer's group term life insurance policy at $145,000, resigned from her position due to cognitive decline. However, following her termination, she never converted her life insurance policy to a personal policy or paid the premiums on the policy to continue coverage. The former employee's estate brought an action against the insurer and the employer alleging that Dearborn and Beacon breached its fiduciary duties regarding the requirement to notify the employee of her conversion right in an exit interview. In addition, the estate also argued that the insurance policy's time limits for conversion or making premium payments should be equitably tolled (i.e., extended) because of the former employee's mental incapacity.

Equitable Tolling of Conversion Under ERISA

ERISA permits equitable tolling of contractual time limits in "extraordinary circumstances." Mental incapacity may be considered an "extraordinary circumstance" if it prevents an individual from managing their affairs or acting upon their legal rights. The court in the Presnal Case held that the Decedent's "progressive neurodegenerative disease (which) causes

executive dysfunction and impairs a patient's judgment, insight, and decision-making abilities" could constitute an "extraordinary circumstance," warranting equitable tolling and therefore discovery was needed to determine if her incapacity prevented her from managing her affairs or acting upon her legal rights.

Conversion of Policy after Employee Termination or Resignation

Finally, the court affirmed what has been understood as it relates to life-insurance conversion notice obligations: the obligation to inform departing employees of their right to convert their life insurance policy to a personal policy falls on the employer, not the insurer. However, the Court also emphasized the dangers of overburdening ERISA plan administrators with requirements to meet individually with each departing employee to specifically inform them of their right to convert a group term life insurance policy to individual coverage following termination unless the employee specifically asked for further information and clarification. Because the employee never sought clarification from the employer and there was no evidence the SPD was deficient regarding the notice of the right to convert the life insurance policy, the Court refused to impose liability on the employer for failing to inform the employee personally of her rights to convert her policy after termination of her employment.

Action Items for Employers

To avoid litigation and potential liability for failure to notify employees of their conversion rights, employers should take the following actions.

- Verify the duration between the time when an employee is no longer "actively at work" and when their life insurance coverage expires, as defined in the relevant life insurance policies. Employers may not unilaterally decide to extend life insurance coverage during extended leaves.
- Ensure the ERISA SPD provided to employees clearly notifies the employees of their rights to convert their life insurance policies after termination of employment (or a leave longer than the "actively at work" timeline) and includes the deadlines and steps to convert such coverage in a timely manner.
- Ensure that exit packages include the SPD or other notice to reference the SPD for terminating employees regarding the conversion rights.
- Be aware of any mental incapacity that may render an employee unable to manage their affairs or act upon their legal rights, resulting in equitable tolling of contractual time limits.

New Florida Law Impacting Prescription Drug Plans and Programs

The Florida Prescription Drug Reform Act that went into effect on July 1, 2023, requires prescription drug manufacturers to disclose reportable prescription drug price increases to be published on Florida's prescription drug price portal. Additionally, it requires pharmacy benefit managers (PBMs) to obtain a certificate of authority for an administrator under the Florida Insurance Code on or before January 1, 2024. Parts of the new law impact plan sponsors of group health plans and create new compliance obligations. This law is creating much confusion for multi-state plan sponsors, and questions regarding whether the Florida law is preempted as to plan sponsor group health plan obligations by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Pharmacy Benefit Managers

The Prescription Drug Reform Act redefines what is considered a PBM under Florida law. A PBM, under the new law, means a person or an entity doing business in Florida state which contracts to administer prescription drug benefits on behalf of a pharmacy benefits plan or program. The term includes, but is not limited to, persons or entities performing one or more of the following services on behalf of a pharmacy benefits plan or program:

- Pharmacy claims processing
- Administration or management of a pharmacy discount card program and performance of any other service listed in the law
- Paying or managing claims for pharmacist services provided to covered persons
- Developing or managing a clinical formulary, including utilization management or quality assurance programs
- Pharmacy rebate administration
- Managing patient compliance, therapeutic intervention, or generic substitution programs
- Administration or management of a mail-order pharmacy program

New Requirements for PBMs

The Prescription Drug Reform Act was designed to create more transparency in prescription costs and protect independent pharmacies from potential anticompetitive practices. Highlights of the Prescription Drug Reform Act impacting a PBM contract with a pharmacy benefit plan or program include:

- Requiring PBMs to obtain a license to act as an insurance administrator (or third-party administrator) as of January 1, 2024.
- Requiring plan sponsors to make an attestation of compliance on an annual basis.
- Updating requirements for contracts between PBMs and the plan sponsors including, but not limited to, the requirement that PBMs use a "pass-through" pricing model, prohibiting "spread pricing," and passing all rebates to the plan sponsor if the contract delegates rebate negotiation to the PBM.
  "Pass through" pricing means that a PBM (1) must charge the plan the amount the PBM pays to the pharmacy for pharmacist services and (2) must reimburse the pharmacy the full amount that the plan paid to the PBM for those pharmacist services.
  "Spread pricing" means a situation in which a PBM charges a plan a different amount for pharmacist services than the amount that the PBM pays the pharmacy for those service.
- Prohibiting requirements for plan participants to use a mail-order pharmacy, unless the drug cannot be acquired in any in-network retail pharmacy. Mail-order pharmacy programs may remain on an opt-in basis.

Action Items for Employers

Employers with pharmacy or prescription drug programs covering employees in Florida should review existing contracts with PBMs to ensure that they comply with the new Florida Prescription Drug Reform Act standards. Any new contracts with PBMs should also be evaluated in terms of compliance with the new standards. Employers with employees in Florida, but contracts issued in other states will want to consult their advisors for guidance.

This is of particular importance since employer plan sponsors will be required to provide an attestation to the Florida Office of Insurance Regulation (OIR) that their PBM agreements meet the new Florida standards. This attestation must be made on an annual basis under the penalty of perjury.

Under the Prescription Drug Reform Act, PBMs are directed to notify any pharmacy benefit plans or programs of the requirement to make this annual attestation but it is the plan or program that must make the attestation. OIR has provided a sample attestation form (available under the "Agreements with Pharmacy Benefit Plans or Programs" tab) that may be used, though the deadlines for making an attestation are currently unclear.

Timely Responses Required for Requests under HIPAA's Right of Access Rule

On December 15, 2023, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), announced a settlement under the Health Insurance Portability & Accountability Act (HIPAA) Right of Access Rule. This penalty illustrates that the Right of Access Rule remains a focus of HHS and that health plans, health care providers, and other covered entities should confirm their own organization's timely delivery of documents upon request.

The Right of Access Rule

HIPAA requires that individuals or their personal representatives have timely access to their protected health information for a reasonable cost. This rule generally requires that a health plan or other covered entity provide copies of (or other acceptable access to) requested protected health information within 30 days of receiving the request if that information is considered part of a "designated record set."

A "designated record set" is generally defined to include protected health information that is maintained, collected, used, or disseminated by a health plan or other covered entity that consists of:

- Medical records and billing records about individuals maintained by or for a covered health care provider
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan
- Other records that are used, in whole or in part, by or for the covered entity to make decisions about individuals

There are two narrow exceptions to the Right of Access Rule for psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or certain administrative actions.

Recent Settlement

In 2022, OCR initiated an investigation of six separate complaints that Optum Medical Care of New Jersey failed to provide timely access to medical records when requested by an adult patient or by the parent of minor patients. OCR determined that patients received the requested records up to 231 days after submitting their requests, which exceeded

the permitted response time under the Right of Access Rule. Accordingly, OCR determined this failure was a potential HIPAA violation and entered into a resolution agreement for a $160,000 penalty and implementation of a corrective action plan.

Action Items for Employers

In light of the requirements of the Right of Access Rule and continued complaints received by OCR, health plans, health care providers, and other covered entities should:

- Review current policies and notices to ensure compliance with HIPAA requirements.
- Review and verify that appropriate procedures are in place to ensure that requested documentation can be produced in a timely fashion upon request.
- Verify the current contact information for the party responsible for receiving and responding to protected health information requests.
- Ensure appropriate processes, procedures, and training are in place to ensure all necessary staff understands and is able to comply with the Right of Access Rule.

Inflation Adjusted Penalties for Health and Welfare Plans

The Department of Labor (DOL) recently released a final rule providing the adjusted civil penalty amounts for certain health and welfare plan violations assessed after January 15, 2024.

The Employee Retirement Income Security Act (ERISA) provides for the imposition of penalties for a number of plan-related failures or administrative errors and further provides that penalties are subject to annual adjustment for inflation.

Adjusted 2024 Penalty Amounts

The following chart shows the adjusted penalty amount for certain health and welfare plan violations assessed after January 15, 2024.

	Maximum Penalty	
Type of Health & Welfare Plan Failure/ ERISA Violation	New Penalty after Jan. 15, 2024	Penalty Jan. 15, 2023, to Jan. 15, 2024
Failure to file annual report (Form 5500) ERISA § 502(c)(2)	$2,670/day late	$2,586/day late
Failure to file multiple employer welfare arrangement (MEWA) annual report (Form M-1) ERISA §502(c)(5)	$1,942/day late	$1,881/day late
Failure to furnish plan documents to DOL within 30 days after request ERISA §502(c)(6)	$190/day late Capped at $1,906/request	$184/day late Capped at $1,846/request
Failure to inform employee of Children's Health Insurance Program (CHIP) coverage opportunities ERISA §502(c)(9)(A)	$141/day late	$137/day late

Type of Health & Welfare Plan Failure/ ERISA Violation	Maximum Penalty New Penalty after Jan. 15, 2024	Maximum Penalty Penalty Jan. 15, 2023, to Jan. 15, 2024
Failure to timely provide to any state information about coverage coordination with Medicaid or CHIP ERISA §502(c)(9)(B)	$141/day late	$17/day late
Failure to meet ERISA requirement for genetic information restrictions (including discriminating in eligibility, coverage, or premiums; requesting or requiring genetic tests; and collection genetic information ERISA §502(c)(10)(B)(i)	$141/day of noncompliance	$137/day of noncompliance
De minimis failure to meet genetic information requirements not corrected before notice from DOL ERISA §502(c)(10)(C)(i)	Minimum $3,550	Minimum $3,439
Non-*de minimus* failure to meet genetic information requirements not corrected before notice from DOL ERISA §502(c)(10)(C)(ii)	Minimum $21,310	Minimum $20,641
Unintentional failure to meet genetic information requirements ERISA §502(c)(10)(D)(iii)(II)	Capped at $710,310	Capped at $688,012
Failure to provide Summary of Benefits and Coverage ERISA §715	$1,406/failure	$1,362/failure

Action Items for Employers

To minimize the risk of incurring penalties, health plans, health plan administrators, and health plan service providers should:

- Review notice obligations to employees and plan participants.
- Verify the current contact information for the party responsible for receiving and responding to participant, DOL, or other agency requests for information.
- Review internal procedures in place to ensure timely compliance with notice obligations and filing requirements.