COMPLIANCE EDGE

JULY 7, 2023

Welcome to the Compliance Edge bringing you employee benefits updates from legislation, federal agency guidance, state updates and reminders of approaching deadlines.

APPROACHING DEADLINES

July 31 – Form 5500 for calendar year plans

July 31 – PCORI Fee for self-funded plans including HRAs

ELEVENTH CIRCUIT AFFIRMS BENEFITS FOR MILITARY LEAVE AND PAID ADMINISTRATIVE LEAVE MUST BE SIMILAR

On June 8, 2023, the Eleventh Circuit in *Myrick v. City of Hoover* affirmed a trial court's ruling that denying certain employment benefits to police officers on military leave while providing the same benefits to other employees on nonmilitary paid administrative leave violates the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

From 1998 through 2018, four police officers from the city of Hoover, Alabama, were on active-duty service on 13 separate occasions for a collective total of 4,571 days on military leave. The city offered paid military leave to these employees, including holiday pay and the accrual of benefits. However, it was limited to only 168 hours per year, with excess time treated as standard unpaid leave without benefits accrual. Meanwhile, employees on nonmilitary paid administrative leave, including those under internal investigation, earned holiday pay and had their benefits accrue throughout the duration of their leaves.

The officers argued that this discrepancy violated USERRA's requirement that "a person who is absent from a position of employment by reason of service in the uniformed services" shall be "entitled to such other rights and benefits not determined by seniority as are generally provided by the employer of the person to employees having similar seniority, status, and pay who are on furlough or leave of absence."

The trial court agreed and awarded summary judgment to the plaintiff officers, reasoning that the employees on paid administrative leave were "employees having similar seniority, status, and pay who are on furlough or leave of absence" to the officers on military leave and as such, these officers were entitled to the same rights and benefits as provided to employees on paid administrative leave.

The city appealed this decision to the Eleventh Circuit, arguing that the trial court should have found no USERRA violation since the four officers on unpaid leave were treated the same as other employees on unpaid leave for purposes of holiday pay and benefits accrual.

The Eleventh Circuit rejected the city's argument and affirmed the trial court's determination that the employees on paid administrative leave were the appropriate employee group to which the officers on military leave should have been compared. While the court acknowledged some ambiguity in the USERRA statutory language, it observed that the DOL's interpretation of that language – that status and pay relate to the position and compensation of active employees, not those of employees on leave – was permissible.

The court further noted that this interpretation was consistent with other Federal Circuit Court opinions that compensation itself is among the rights and benefits to be compared to those of other employees on leave as well as with the overall purpose of the statute itself, which is to provide protections to employees away on military leave.

USERRA is unusual among federal employment laws because it applies to all employers regardless of size. Employers with employees who have been or potentially may be called to active military service should regularly review their policies and procedures to ensure compliance with USERRA's rules. Employers should bear in mind that when conflicts of USERRA interpretation arise, courts are generally inclined to broadly interpret USERRA's protections in favor of employees in active military service.

CMS ISSUES GUIDANCE ON SUNSET OF MHPAEA OPT-OUT FOR SELF-FUNDED NON-FEDERAL GOVERNMENTAL PLANS

On June 7, 2023, CMS issued guidance on the sunset of MHPAEA opt-out provision for self-funded nonfederal governmental plans and related collective bargaining agreements (CBAs). The Consolidated Appropriations Act, 2023 (CAA 2023), signed into law on December 29, 2022, eliminated the annual opt-out provision from the MHPAEA previously available to self-funded state and local governmental group health plans. Specifically, new opt-out elections are not permitted and existing elections expiring on or after June 27, 2023, cannot be renewed.

Under CAA 2023, a limited exception was noted for certain collectively bargained plans. That is, a self-funded nonfederal governmental group health plan subject to multiple CBAs of varying lengths that had a MHPAEA opt-out election in effect on December 29, 2022, which expires on or after June 27, 2023, may extend the opt-out election until the expiration of the last CBA. The new CMS guidance provides specific instructions for plans to request the extension, including providing CMS with existing CBA details on the term and applicability to the group health plan

for which the extension is being sought. After receiving CMS approval, the plan must then submit a renewal opt-out election to extend the plan's existing opt-out.

Sponsors of collectively bargained and self-funded nonfederal governmental plans with existing MHPAEA opt-out elections should carefully review the CMS guidance and consult with legal counsel on application to their specific plan.

IRS ISSUES MEMO ON TAX TREATMENT OF FIXED INDEMNITY WELLNESS BENEFITS

The IRS recently published an IRS Office of Chief Counsel Memorandum regarding the tax treatment of an employer-funded insured fixed indemnity wellness policy. This guidance was issued in response to an internal request for guidance regarding a particular employer's benefit offerings.

Specifically, the memo addresses whether wellness payments under an employer-funded, fixed indemnity insurance policy (including where the premium for the coverage is paid by employee salary reduction through a §125 cafeteria plan) are includible in the gross income of the employee if the employee has no unreimbursed medical expenses related to the payment. Additionally, the memo discusses whether wellness indemnity benefits included in the employee's gross income are subject to employment taxes.

In this case, the employer offered employees fully insured major medical coverage, which provided coverage of preventive services without cost-sharing. Additionally, the employer offered employees the option to enroll in coverage under a fixed indemnity health insurance policy that was intended to supplement the employee's other coverage by providing wellness benefits. Employees who elected the fixed-indemnity coverage paid the monthly $1,200 premiums by salary reduction through a §125 cafeteria plan.

The fixed indemnity health insurance policy provided several types of benefits, including a payment of $1,000 per month if the employee participated in certain health or wellness activities (e.g., use of preventive care, such as vaccination). The policy also provided wellness counseling, nutrition counseling and telehealth benefits at no additional cost. Additionally, the policy provided a benefit for each day that the employee was hospitalized. The wellness benefits were paid by the insurer to the employer, which then paid the benefits via their payroll system to employees.

Upon analysis, the memo concludes that the wellness payments under such a fixed indemnity insurance policy funded by employee salary reductions are includible in the employee's gross income if the employee has no unreimbursed medical expenses related to the payments (either because the activity that triggers the payments does not cost the employee anything or because the cost of the activity is reimbursed by other coverage). The guidance explains that the § 105(b) tax exclusion for medical expenses is limited to amounts paid solely to reimburse expenses incurred for medical care and does not apply to amounts that the employee would be entitled to receive regardless of whether expenses for medical care are incurred. Additionally,

the memo confirms that because the wellness payments are not for medical expenses, the payments are treated as wages for employment tax purposes.

The memo applies only to the specific case and cannot be cited as a precedent. However, employers may find the memo helpful in understanding how the IRS interprets the tax laws as applied to this type of wellness benefit. For specific tax advice, employers should always consult with their tax or legal advisor.

FIFTH CIRCUIT AFFIRMS INSURER ABUSED DISCRETION IN DENYING CANCER THERAPY TREATMENT

On May 3, 2023, in *Salim v. Louisiana Health Service & Indemnity Company* (dba Blue Cross and Blue Shield of Louisiana, the United States Court of Appeals for the Fifth Circuit (the Fifth Circuit) affirmed a lower court ruling that Blue Cross abused its discretion when it denied the plaintiff coverage even when substantial evidence did not support that decision.

The plaintiff, Robert Salim, was a business owner who bought a health insurance plan from Blue Cross to cover himself and his employees. Blue Cross insured the plaintiff when he was diagnosed with throat cancer. The plaintiff sought coverage for proton therapy, but the treatment needed to be preauthorized before the insurer would pay for it. The entity tasked with preauthorizing the treatment denied it, stating that it was not medically necessary and citing outdated clinical guidelines in support of its decision. The plaintiff appealed this decision to Blue Cross. When the insurer (which had full discretionary authority to make determinations regarding benefits) denied that appeal, again based on the same outdated clinical guidelines used to deny the preauthorization, the plaintiff initiated a second-level appeal with Blue Cross by requesting that an independent medical organization review the denial.

In this second-level appeal, the plaintiff's doctor pointed out that the clinical guidelines Blue Cross relied on had been updated to now support the plaintiff's claim. Additionally, the doctor cited over a dozen evidence-based publications as support for his conclusion that proton therapy was medically necessary for the plaintiff's particular diagnosis. An independent reviewer handled the second-level appeal. The reviewer denied the appeal, concluding that more study was needed before determining whether proton therapy was the standard treatment option for this type of cancer and, in any event, the plaintiff did not meet the criteria that would make this treatment necessary.

The plaintiff took Blue Cross to court, alleging that the insurer abused its discretion when it determined that proton therapy was not medically necessary. The court ruled in favor of the plaintiff. Although the plan gives Blue Cross full discretionary authority to make determinations regarding benefits, the court determined that there was no substantial evidence to support the insurer's decision that the therapy was not medically necessary. Blue Cross appealed to the Fifth Circuit.

The Fifth Circuit agreed with the lower court. The Fifth Circuit noted that in ERISA cases, substantial evidence "is such relevant evidence as a reasonable mind might accept as adequate

to support a conclusion." Although this standard allows the insurer wide latitude in making determinations concerning benefits, its decisions cannot be arbitrary and capricious.

In this case, the entity that promulgated the guidelines that the insurer relied upon when making its determination had updated the guidelines to support proton therapy as medically necessary for the plaintiff's type of cancer. Although the second-level reviewer relied on additional sources to support its denial, the Fifth Circuit determined that these sources were not enough to outweigh the new guidelines. The Fifth Circuit concluded that Blue Cross abused its discretion by mischaracterizing the guidelines upon which it relied.

This case provides a cautionary tale for plans. Although plans can have broad discretionary authority to make determinations concerning benefits, the determination cannot be made in an arbitrary and capricious manner.

DOL ISSUES OPINION LETTER ON CALCULATING FMLA LEAVE USED DURING A HOLIDAY WEEK

On May 30, 2023, the DOL issued DOL Opinion Letter FMLA 2023-2-A that affirms its prior guidance regarding how to calculate the amount of FMLA leave entitlement when a workweek includes a holiday. "Workweek" is defined under the FMLA as the employee's normal schedule (hours/days per week) prior to the start of FMLA leave.

The opinion letter confirms that when a holiday falls during a week when an employee is taking a full workweek of FMLA leave and is not expected to work on the holiday, the entire week is counted as FMLA leave. For example, an employee who works Monday through Friday and takes leave for a week that includes a holiday would use one week of leave and not 4/5 of a week even though the employee used only four days of FMLA leave that week.

When an employee takes FMLA leave on an intermittent or reduced schedule during a week in which there is a holiday, the holiday generally does not count against the employee's FMLA leave entitlement if the employee would not be required to work on the holiday. In other words, where leave is taken in less than a full workweek, the actual workweek includes the day of the holiday. Accordingly, the fraction of the workweek of leave used would be the amount of FMLA leave taken (which would not include the holiday) divided by the total workweek (which would include the holiday). For example, an employee who normally works Monday through Friday takes leave for a week that includes a holiday on Monday and takes FMLA leave on Tuesday and works Wednesday through Friday. In this situation, the employee's FMLA leave allotment is calculated as 1/5 of the week instead of 1/4 of the week, which ensures that the employee's leave entitlement is protected and not reduced due to the holiday.

In summary, under the FMLA, the employee's normal workweek is the controlling factor for determining how much leave an employee is entitled to use when taking FMLA leave intermittently or on a reduced workweek schedule for specified family and medical reasons. If a holiday falls during an employee's workweek, and the employee works for part of the week and

uses FMLA leave for part of the week, the holiday does not count towards the FMLA leave entitlement calculation when the employee was not required to work on the holiday.

Employers who are subject to FMLA should review their current FMLA leave administration practice and leave policy to ensure that their employees' FMLA leave is calculated according to these rules and communicated with the employees clearly.

REMINDER: FORM 5500 FILING FOR CALENDAR YEAR PLANS DUE JULY 31

Applicable plan sponsors must file their Form 5500-series returns on the last day of the seventh month after their plan year ends. As a result, calendar-year plans generally must file by July 31. Plans may request a two-and-a-half-month extension to file by submitting Form 5558, Application for Extension of Time to File Certain Employee Plan Returns, by the plan's original due date.

The 2022 Form 5500 and instructions are accessible on the DOL website.

As a reminder, group health plans sponsored by a governmental or church entity aren't required to file a Form 5500, as those plans aren't subject to ERISA. Additionally, unfunded, insured, or a combination of unfunded and insured health plans with fewer than 100 participants on the first day of the plan year are also exempt from the filing.

REMINDER: PCORI FEE, FORM 720 FILING DUE JULY 31

The ACA imposed the PCORI fee on health plans to support clinical effectiveness research. The PCORI fee applies to plan years ending on or after October 1, 2012, and before October 1, 2029. The PCORI fee is generally due by July 31 of the calendar year following the close of the plan year.

PCORI fees are required to be reported annually on Form 720, Quarterly Federal Excise Tax Return, for the second quarter of the calendar year. Plan sponsors that are subject to PCORI fees but no other types of excise taxes should file Form 720 only for the second quarter.

The PCORI fee is generally assessed based on the number of employees, spouses and dependents covered by the plan. The fee for policy and plan years ending on or after October 1, 2021, but before October 1, 2022, remains at the applicable rate of $2.79, multiplied by the average number of lives covered under the plan. For plan years ending on or after October 1, 2022, but before October 1, 2023, the fee is increased to the applicable rate of $3.00, multiplied by the average number of lives covered under the plan.

The PCORI fee can be paid electronically or mailed to the IRS with the Form 720 using a Form 720-V payment voucher. The IRS recently published an updated Form 720 (Rev. June 2023) that reflects accurate PCORI fee rates in Part II, No. 133, for plan years ending on or after October 1, 2022, and before October 1, 2023. According to the IRS, the fee is tax-deductible as a business expense.

As a reminder, the insurer is responsible for filing and paying the fee for a fully insured plan. The employer plan sponsor is responsible for filing on a self-insured plan, including an HRA. A stand-alone dental or vision HRA would be excepted and would not be subject to the PCORI fee.

FREQUENTLY ASKED QUESTIONS

FAQ: Which benefit plans are covered by a HIPAA business associate agreement?

To review, the HIPAA privacy rule requires covered entities, which include group health plans and insurers, to enter a written agreement with a plan service provider before sharing protected health information (PHI) with them. PHI is any individually identifiable health information maintained or transmitted in any form or media, whether electronic, paper or oral. The written business associate agreement (BAA) is designed to ensure the plan service provider (i.e., business associate) will appropriately safeguard PHI and only use or disclose PHI for permissible purposes.

Importantly, the HIPAA privacy and security requirements, including the BAA, apply only to health plans and not to all welfare benefit plans. A health plan is an individual or group plan that provides (or pays the cost of) medical care.

Major medical plans, dental and vision plans, health FSAs and HRAs are health plans that must comply with the HIPAA privacy and security rules. There is no exception for governmental, church and retiree health plans.

By contrast, plans providing only certain incidental coverage for nonmedical benefits, such as accident-only, workers' compensation, disability income, or life insurance coverage, are exempt from the HIPAA privacy and security rules. Similarly, stop-loss coverage is typically not health insurance because it does not pay for medical care. Additionally, an ERISA-exempt HSA program is likely not considered to be a health plan subject to HIPAA's privacy and security requirements.

With a fixed indemnity (e.g., hospital indemnity) or specific illness (e.g., cancer insurance) policy, the particular coverage terms must be reviewed. Generally, coverage that pays a flat amount per day for hospitalization or illness without regard to medical services received is not considered to be a health plan. However, policies that provide reimbursement based on the medical care received likely are health plans subject to HIPAA privacy and security rules.

A wellness program included as part of the major medical plan or a stand-alone wellness program providing medical care (e.g., medical testing with individual results) would normally be required to comply with HIPAA's privacy and security requirements. The same would be true for an employee assistance plan that provides mental health coverage (since that is medical care).

Accordingly, employers should review their various benefits carefully and determine which are health plans subject to the HIPAA privacy and security rules. Insurers and health plans that will

be disclosing PHI to a plan service provider should enter a BAA with the service provider. Generally, the insurer would enter the BAA for a fully insured plan, and the employer/plan sponsor would enter the BAA on behalf of a self-insured plan.

However, if the benefit plan serviced is not a health plan, then a BAA would not be appropriate because the HIPAA privacy and security rules would not be implicated. Rather, for non-health plans that will be disclosing confidential data to a plan service provider, the parties could consider entering a nondisclosure or confidentiality agreement.

Of course, employers are always advised to consult with their legal counsel for specific advice and guidance regarding any contractual agreements (including BAAs and nondisclosure or confidentiality agreements).

FAQ: What information must be included in the COBRA election notice?

Although COBRA is not a new law, there are still mistakes that employer plan sponsors can make when administering their COBRA offering. Among the possible mistakes is failing to include the required content in the COBRA election notice. As a reminder, the following 14 items must be included in every COBRA election notice:

1. Contact information for the plan, including the plan name and the name, address and telephone number of the entity that administers COBRA on behalf of the plan.
2. The qualifying event that has triggered an offer of COBRA. Remember that COBRA is required to be provided due to an employee's termination of employment, reduction in hours, entitlement to Medicare, death, divorce or a dependent child's ceasing to be a dependent under the plan terms.
3. An identification of the qualified beneficiaries who are due an independent right to elect COBRA and the date that plan coverage will end if COBRA is not elected.
4. A statement indicating that all COBRA qualified beneficiaries have an independent right to elect COBRA coverage.
5. A provision explaining how to go about electing COBRA coverage, including the deadline by which COBRA must be elected.
6. A provision that lays out the consequences of failing to elect COBRA, including the failure's effect on future rights of qualified beneficiaries and information on how to revoke a waiver of the right to continuation coverage.
7. A description of the continuation coverage that will be provided if elected (i.e., the benefits that may be continued under COBRA).
8. The duration of COBRA coverage, including the maximum number of months that continuation is available if elected, the date COBRA would terminate and any situations that would cause the maximum COBRA coverage period to be shortened.

9. A description of situations where COBRA may be extended due to a second qualifying event.
10. A description of how qualified beneficiaries may provide notice of a second qualifying event or disability determination.
11. COBRA premium amounts for each qualified beneficiary.
12. Premium payment procedures, including due dates.
13. An explanation of the importance of keeping the plan administrator informed of qualified beneficiaries' address(es).
14. A statement indicating that more complete information about the right to continuation under COBRA may be found in the plan SPD.

Any COBRA election notice that does not include all the items above would be considered deficient and could subject the employer to a lawsuit by COBRA qualified beneficiaries and/or DOL investigation and penalties. Helpfully, the DOL provides a model notice that is available here.

Even if the employer utilizes a third party to administer COBRA, compliance with COBRA regulations is still ultimately the employer's responsibility. As such, employer plan sponsors who rely on a third party to provide the COBRA election notice should routinely ensure that the notice, as provided, includes all the elements required under the COBRA regulations.

STATE UPDATES

FLORIDA

New Laws Regulate Paid Family Leave Insurance and Pharmacy Benefits

Gov. DeSantis recently signed the following bills into law:

HB 721, as enacted, amends the insurance laws to specify standards for transacting paid family leave insurance in Florida. The state does not require employers to provide paid family leave, but HB 721 allows insurers to provide paid family leave coverage for an employer wishing to offer such leave.

Specifically, life insurers may transact paid family leave insurance as a policy or as a rider to a group disability income policy. Further, HB 721 specifies circumstances under which paid family leave insurance benefits may be provided, and it also requires paid family leave insurance policies or riders to include disclosures and coverage requirements, such as benefit periods, waiting periods, benefit amounts, offsets and the payment of benefits.

HB 721 took effect upon becoming law, and rules will soon be issued to implement the law's provisions.

SB 1550, which is now known as the state's Prescription Drug Reform Act (the "Act"), regulates the coverage of pharmacy benefits. The Act focuses on transparency, accountability and relationships within the outpatient pharmaceutical delivery system.

The Act creates a regulatory framework designed to address several important concerns regarding pharmacy benefit plans and pharmacy benefit managers (PBMs). PBMs operating in the state will be regulated as administrators under the Florida Insurance Code and required to comply with certain disclosure, financial reporting and contractual requirements.

Under the Act, contracts between PBMs and plans must require a PBM to reimburse a pharmacy using a pass-through model (meaning the full amount paid by the plan), thus prohibiting spread pricing unless the PBM passes along the entire amount of any difference to the plan. Additionally, any PBM-negotiated manufacturer rebate must be passed to the plan for offsetting defined cost-sharing and reducing premiums of covered persons. A PBM must also meet certain network adequacy requirements and provide a 60-day continuity-of-care period upon revising a formulary of covered prescription drugs during a plan year so that the covered drug continues to be provided to the covered patient at the same cost during the 60-day period.

The Act becomes effective July 1, 2023. The PBM contracting provisions apply to all contracts that are executed or amended after July 1, 2023, which apply to pharmacy benefits beginning on or after January 1, 2024. Rules will be issued to implement the Act's provisions.

Employers should be aware of the new laws and monitor for further guidance.

LOUISIANA

Governor Signs New Healthcare Bills into Law

Recently, Gov. Bel Edwards signed numerous healthcare bills into law.

Act 336 (previously HB 41) requires a health plan to pay for covered occupational therapy services provided via telehealth equivalent to the coverage and payment for the same service provided in person. Generally, the new law's provisions prohibit coverage maximums, cost-sharing, and other conditions relative to telehealth services that are inapplicable to in-person services.

Act 299 (previously HB 186), known as "The Medically Necessary Fertility Preservation Act," requires health plans to cover medically-necessary expenses for standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is a fertility impairment caused by surgery, chemotherapy, radiation or other medical treatment. Coverage for standard fertility preservation services includes costs associated with storing oocytes and sperm for certain periods. The plan cannot require preauthorization; however, certain cost-sharing and maximum benefit limitations are permitted.

Act 270 (previously HB 272), a health plan that provides benefits for maternity services must include coverage for maternity support services provided by a doula to pregnant and birthing women before, during and after childbirth. A doula is an individual who has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families.

The new law also requires health plans to provide up to two months of coverage for medically necessary pasteurized donor human milk as prescribed by an infant's pediatrician due to certain conditions.

Act 281 (previously HB 578) requires a health plan to include coverage for smoking cessation benefits for a minimum period of six months if a licensed physician recommends and certifies that the smoking cessation benefits may help the person to quit smoking. Smoking cessation benefits means smoking cessation treatments and services, including individual counseling, group counseling, nicotine patches, nicotine gum, nicotine lozenges, nicotine nasal spray, nicotine inhaler, and the medications bupropion and varenicline. The required coverage cannot be subject to annual deductibles, coinsurance, copayment, or any other out-of-pocket or cost-sharing expense provisions.

Act 324 (previously SB 104), a health plan must cover biomarker testing for purposes of the diagnosis, treatment, appropriate management or ongoing monitoring of an individual's disease or condition when such testing is supported by certain medical and scientific evidence. Biomarker testing is used in cancer treatment and involves the analysis of an individual's tissue, blood or other biospecimens for the presence of a gene mutation or other characteristic that can be evaluated to assess how an individual may respond to a particular course of therapy. The coverage can be subject to annual deductibles and cost-sharing.

Plans are not required to cover biomarker testing for screening purposes.

Generally, the above new laws apply to health policies and plans issued or delivered in the state on and after January 1, 2024. Additionally, any health policy or plan in effect prior to January 1, 2024, is required to conform to these new laws on or before the renewal date but no later than January 1, 2025.

Employers should be aware of these coverage updates and contact their carriers for further information.

MINNESOTA

State Protects Access to Preventive Healthcare Services

On May 24, 2023, Gov. Walz signed an omnibus bill, SF 2744, that includes provisions requiring health insurers regulated by the state to provide preventive services (as specified in the federal ACA) at no cost. The intent of this law is to preserve the preventive services provisions of the ACA in light of current litigation seeking to remove those provisions from federal law.

Employers with plans regulated by the state should be aware of this new law.

State Passes Paid Sick Leave Law

On May 24, 2023, Gov. Walz signed a bill providing paid sick and safe time leave to employees in the state. Under the new law, effective January 1, 2024, employees (including part-time and temporary employees) performing work for their employer in Minnesota for at least 80 hours in a year may accrue up to 48 hours of this leave per year (at a rate of a minimum of one hour of this leave for every 30 hours worked). Independent contractors are exempt.

Employees can take this leave for the following reasons:

- The employee's mental or physical illness, treatment or preventive care;
- A family member's mental or physical illness, treatment or preventive care;
- Absence due to domestic abuse, sexual assault or stalking of the employee or a family member;
- Closure of the employee's workplace due to weather or public emergency or closure of a family member's school or care facility due to weather or public emergency; and
- When determined by a health authority or healthcare professional that the employee or family member is at risk of infecting others with a communicable disease.

Employees may use earned sick and safe time for the following family members:

1. Child, including foster child, adult child, legal ward, child for whom the employee is legal guardian or child to whom the employee stands or stood in loco parentis (in place of a parent);
2. Spouse or registered domestic partner;
3. Sibling, stepsibling or foster sibling;
4. Biological, adoptive or foster parent, stepparent or a person who stood in loco parentis (in place of a parent) when the employee was a minor child;
5. Grandchild, foster grandchild or step-grandchild;
6. Grandparent or step-grandparent;
7. A child of a sibling of the employee;
8. A sibling of the parents of the employee;
9. A child-in-law or sibling-in-law;
10. Any of the family members listed above of an employee's spouse or registered domestic partner;
11. Any other individual related by blood or whose close association with the employee is the equivalent of a family relationship; and

12. Up to one individual annually designated by the employee.

In addition to granting this leave, employers are required to:

- Include the total number of earned sick and safe time hours accrued and available for use, as well as the total number of earned sick and safe time hours used, on earnings statements provided to employees at the end of each pay period; and
- Provide employees with a notice by January 1, 2024, or at the start of employment, whichever is later (the state's Department of Labor and Industry will prepare a uniform employee notice that employers can use). The notice should be in English and in an employee's primary language if that is not English, informing them about earned sick and safe time.
- Include a sick and safe time notice in the employee handbook if the employer has an employee handbook.

Although this law is statewide, it does not preempt city ordinances that provide similar leave. When Minnesota's statewide earned sick and safe time law goes into effect January 1, 2024, employers must follow the most protective law that applies to their employees. Earned sick and safe time local ordinances already exist in the cities of Bloomington, Duluth, Minneapolis and St. Paul, Minnesota. Employers must follow the applicable law that provides the greater protections to their employees.

Earned Sick and Safe Time Website; Earned Sick and Safe Time Fact Sheet

State Passes Family and Medical Leave Law

On May 25, 2023, Gov. Walz signed HF 2 (Family and Medical Leave Act), creating a statewide Paid Family and Medical Leave program. Under the program, Minnesota employees will be eligible for paid family and medical leave once they have earned more than $3500 within the state over the course of a year. These employees will be entitled to partial wage replacement for 12-20 weeks of leave in a 52-week period for medical leave, bonding or caring for a family member.

A fund maintained by the state will pay the partial wage replacement. Employers and employees will contribute to the fund in premiums of 0.7% of an employee's taxable wages. Employers may charge their employees a maximum of half this premium (or 0.35%) through a wage deduction. The program will start collecting these premiums on January 1, 2026, through an employer account system.

In order for an employee to receive this benefit, they must:

- Provide at least 30 days' notice if the event is foreseeable.
- Experience a qualifying event of at least seven calendar days. Qualifying events include caring for a family member with a serious health condition, bonding with a new baby or

child, or dealing with a serious health condition that prevents the employee from working.

- Apply to the Paid Family and Medical Leave program for the leave. The application must include a certification of the reason for the leave provided by a medical professional.

In addition to submitting the premiums to the program, employer obligations include:

- Starting in mid-2024, most Minnesota employers will be required to submit a wage detail report, which will detail the quarterly wages received and hours worked for each employee.
- Starting in late 2025, employers must notify their employees about the program. The Paid Family and Medical Leave program will provide language for this notification.
- Starting in January 2026, employers will also be required to submit any premium payments due.

Employers with employees in the state should be aware of this new program and monitor for future guidance and notices on the Paid Family and Medical Leave Program Website.

NEW MEXICO

Superintendent Reminds Managed Care Plans of Requirement for Reasonable Access to Out-of-Network Providers

On May 30, 2023, the Office of Superintendent of Insurance released Bulletin 2023-013 as a public reminder to New Mexico health insurance carriers that the state's Patient Protection Act (PPA) obligates managed healthcare plans to provide "reasonably accessible health care services that are available in a timely manner," including coverage of out-of-network services when "medically necessary covered services are not reasonably available through participating providers."

The bulletin indicates that the superintendent has knowledge of recent incidents where carriers are administratively denying coverage by out-of-network providers, contrary to the PPA's requirements, and makes clear that violations are subject to enforcement actions which include administrative penalties of up to $10,000 per violation, suspension of any certificate of authority or license issued under the Insurance Code, and private remedies available to both patients and providers.

Employers that offer managed healthcare plans in the state to their employees should be aware of this recent bulletin.

VIRGINIA

Organ and Bone Marrow Donor Unpaid Leave Law Effective July 1, 2023

On April 12, 2023, Gov. Youngkin signed SB 1086 into law, expanding unpaid leave for Virginia employees following an organ or blood marrow donation.

Beginning July 1, 2023, the law requires Virginia employers with 50 or more employees to provide eligible employees with up to 60 business days per 12-month period of unpaid leave for organ donation and up to 30 business days per 12-month period of unpaid leave for bone marrow donation. Employees are eligible if they have worked for the employer for at least 12 months and at least 1,250 hours during the previous 12 months. The leave is in addition to (not taken concurrently with) federal FMLA leave.

Employers are prohibited from treating eligible organ or bone marrow donation leave as a break in service for purposes of employee benefits, including salary adjustments, sick leave, vacation, PTO, or seniority. Specifically, employers must maintain the employee's health insurance coverage and pay any commission that becomes due based on work performed prior to the leave. Retaliatory action is prohibited. Additionally, upon return from leave, eligible employees are entitled to be restored to the same or equivalent position.

Virginia employers should review their leave policies with legal counsel and amend them as appropriate to ensure compliance.

WASHINGTON

Long-Term Care Program ("WA Cares Fund") Implementation Begins July 1, 2023

As a reminder, after an 18-month delay, WA Cares Fund premium collections from employee wages are set to begin on July 1, 2023. The WA Cares Fund is the state's new long-term care (LTC) program that will be funded through a payroll tax on employees. The premium amount for 2023 is 0.58% of gross wages with no maximum limit.

Employers do not contribute to the program but are responsible for reporting employee wages and hours and paying the premiums to the Employment Security Department on a quarterly basis using the same process they use to report Paid Family and Medical Leave premiums.

In addition to the delay of the premium tax collection start date, the benefits' availability for the LTC program has been delayed until July 1, 2026, from January 1, 2025.

Employers with employees working in Washington should be aware of the imminent implementation of the WA Cares Fund on July 1, 2023, communicate with employees, and coordinate with their payroll vendors as necessary to report and collect required premiums.

The state has released guidance for employers available here: Employers: 5 Things You Need to Know and Toolkits & Resources.