COMPLIANCE EDGE

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

ELEVENTH CIRCUIT ALLOWS ERISA CLAIM FOR MONETARY RELIEF BASED ON LIFE PLAN ENROLLMENT ERRORS

On June 28, 2022, in *Gimeno v. NCHMD, Inc., et al.*, the US Court of Appeals for the Eleventh Circuit held that an employer could be liable for the value of supplemental life insurance benefits that would have been available absent the employer's plan enrollment errors.

The plaintiff in this case, Raniero Gimeno, sued his late spouse Justin Polga's employer, NCHMD, Inc., for mishandling Polga's supplemental life insurance enrollment. As part of the initial hiring process, NCHMD's HR staff helped Polga complete enrollment paperwork for life insurance benefits. Polga elected to pay for $350,000 in supplemental life insurance coverage, for which the plan required an evidence of insurability (EOI) form. But Polga never received the EOI form from NCHMD HR, nor was he notified the form was necessary. Nonetheless, for three years, NCHMD deducted premiums for $350,000 in supplemental coverage from Polga's paychecks. NCHMD also provided Polga a corresponding benefits summary confirming $350,000 supplemental coverage on top of $150,000 employer-paid coverage.

After Polga's passing, Gimeno filed a claim for benefits with the plan's life insurance company. The supplemental benefits were denied based on Polga's failure to submit an EOI form. Gimeno sued NCHMD and its parent company NCH Healthcare alleging they breached their plan administrator fiduciary duties by failing to adequately notify his spouse about the EOI form and providing incorrect coverage information. Gimeno demanded compensation, arguing these breaches of fiduciary duty prevented his spouse from becoming eligible for the supplemental benefits.

First, the court found that both defendants were life plan fiduciaries. While NCH Healthcare was named as plan administrator in the plan documents, NCHMD conducted sufficient enrollment functions to make it a plan fiduciary.

Specifically, NCHMD acted as a plan fiduciary by providing Polga with enrollment paperwork, guiding him in completing it, notifying him when proof of dependent eligibility was missing, providing a benefits summary confirming $500,000 in life insurance coverage, and deducting corresponding premiums from his paycheck.

As to remedy, Gimeno conceded that since Polga never provided the EOI form, no supplemental benefits were payable under the terms of the life plan. Thus, there was no claim against the plan for the court to consider. But as to Gimeno's claims against NCHMD and NCH Healthcare, the Eleventh Circuit found that, in certain circumstances, plan fiduciaries can be sued independently from the plan for equitable relief under ERISA. Appropriate equitable relief would be monetary compensation equal to the insurance benefits lost due to the defendants' alleged breach of fiduciary duty. The Eleventh Circuit sent the case back to the lower court to determine whether NCHMD and NCH Healthcare breached their fiduciary duties with respect to Polga's enrollment process.

The *Gimeno* case serves as another illustration of how mistakes in administering group life plans create substantial liability for employers. The Eleventh Circuit's ruling here is not unique. Rather, it aligns with every other circuit court that has addressed the issue and found ERISA can provide monetary relief for breaches of fiduciary duties even when there is no claim for benefits under the terms of the plan. Depending on which plan functions an employer controls, it may be unknowingly acting as a fiduciary with liability for plan administration errors. ERISA plan sponsors should always take great care to adequately communicate enrollment requirements and ensure premiums are only collected on verified active coverage.

US SUPREME COURT OVERTURNS ROE V. WADE

On June 24, 2022, the Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization*. The *Dobbs* case involves a Mississippi law that would effectively ban most abortions in the state after 15 weeks of pregnancy. Although the law made exceptions for medical emergencies, it did not make exceptions for rape or incest. The lower courts found that the law was inconsistent with both *Roe v. Wade* and *Planned Parenthood v. Casey* and kept the state from enforcing it. The state appealed to the Supreme Court. The Court upheld that law, overturning both *Roe* and *Casey* in the process.

The decision also returned the right to legislate abortions to the states. Several states have already deemed abortion illegal under state law and several more are likely to do so as a result of this decision. Employers are also left to grapple with how this development affects their group health plans, and how they provide their employees with access to abortion care without violating the law.

Employers with either fully insured or self-insured group health plans will be affected by this case. If the applicable state law is an insurance regulation, fully insured group health plans would be directly subject to such laws. Accordingly, if a state law restricts abortion coverage, a policy issued by a carrier licensed in the state could not provide abortion coverage nor likely

reimburse the travel costs for a participant to obtain an abortion in a state permitting the procedure.

By contrast, self-insured plans are not designed to be subject to state insurance laws due to ERISA preemption. However, keep in mind that abortion prohibitions or restrictions that affect group health plans often are not drafted as state insurance laws. Rather, many may be found in the states' criminal and health and safety codes, and it is anticipated that some states will aggressively enforce such abortion prohibitions. So, employers should engage counsel to navigate the myriad of state laws that may apply. Of course, further state laws are anticipated, so employers will need to work with their counsel to continually monitor abortion-related regulations and enforcement actions in the states within which they operate.

US SUPREME COURT RULES PLAN'S OUTPATIENT DIALYSIS COVERAGE LIMITS DO NOT VIOLATE MEDICARE SECONDARY PAYER STATUTE

On June 21, 2022, the U.S. Supreme Court ruled, in *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc.*, that a group health plan limiting outpatient kidney dialysis treatment to out-of-network benefits did not violate the Medicare Secondary Payer (MSP) rules.

As a reminder, the MSP rules prohibit an employer (with 20 or more employees) from taking into account an employee's (or spouse's) eligibility for Medicare. They must be treated in terms of group health plan benefits and eligibility the same as any other eligible participant. The plan cannot incentivize or force an eligible employee to decline the group health plan in favor of making Medicare primary. Regarding end-stage renal disease (ESRD), a plan cannot impose higher premiums or fewer benefits for those participants with ESRD. The ESRD rules apply to employers of all sizes and only for the first 30 months of the individual's ESRD-based Medicare eligibility.

In this case, kidney dialysis treatment provider DaVita sued the self-insured group health plan sponsored by Marietta Memorial Hospital. DaVita argued that by limiting dialysis services to out-of-network benefits, the plan was providing disparate treatment to ESRD patients. After two lower courts issued conflicting opinions, the Supreme Court reviewed and ruled that such practice is not a violation of MSP rules. The Court acknowledged that dialysis treatment serves primarily those with ESRD; however, the limitation applies regardless of whether the participant has ESRD. Thus, the limitation is not targeted at those with ESRD and applies equally to those who do not.

The MSP rules can be complicated and costly for employers who violate them with group health plan designs. While this case has confirmed that the specific practice of limiting dialysis treatment to out-of-network benefits is permissible, any other plan designs based on Medicare eligibility should be closely reviewed with outside legal counsel.

SEVENTH CIRCUIT REMINDS EMPLOYERS: DON'T DISCOURAGE FMLA LEAVE

On June 1, 2022, the US Court of Appeals for the Seventh Circuit held in *Zicarrelli v. Dart et al.* that an employee's FMLA rights may be violated without an actual denial of leave — simply interfering with an employee's attempt to exercise those rights can violate the law.

Plaintiff Salvatore Zicarrelli worked for the Cook County Sheriff's Office for over 27 years. During that time, he periodically took FMLA leave. In September 2016, he called the Sheriff's Office FMLA manager to discuss taking more FMLA leave. According to Mr. Zicarrelli, when he asked to take FMLA leave, the FMLA manager responded by saying "don't take any more FMLA. If you do so, you will be disciplined." Though the contents of this conversation are hotly disputed, Mr. Zicarrelli retired from the Sheriff's Office soon thereafter, a decision that he claims was based on the conversation.

Mr. Zicarrelli then sued his former employer, alleging violations of FMLA and discrimination under the ADEA, the ADA, and Title VII of the Civil Rights Act. The lower district court ruled in favor of the Sheriff's Office on all claims. Specifically, the district court denied the FMLA interference claim because there was no denial of FMLA benefits. Mr. Zicarrelli appealed to the Seventh Circuit, but only as to his FMLA claims.

The Seventh Circuit ruled that threatening to discipline an employee for seeking FMLA leave to which the employee is entitled clearly qualifies as an unlawful interference with FMLA rights. In reaching this ruling, the Court found no ambiguity in the statute or regulations nor any conflicting interpretations among its sister circuit courts. First, the Court parsed the relevant section of the statute, which makes it unlawful for a covered employer to "interfere with, restrain, or deny" an eligible employee's attempt to exercise FMLA rights. The Court zeroed in on the disjunctive phrasing (i.e., "or" not "and"), which signified that *interfere with* can stand alone as unlawful without an actual denial of FMLA leave. Second, the inclusion of "*attempt to* exercise" within the Act's description of protected rights suggests that actual denial is not necessary. Third, the Court found that interpreting FMLA to allow employers to actively discourage the use of FMLA rights if no unlawful denial occurs would significantly diminish the rights granted. While FMLA was designed to accommodate employer's legitimate interests, the Court found no legitimate interest in impeding access to FMLA benefits through intimidation, deception or concealment. Finally, the Court looked to DOL regulations, which state that interfering with an employee's exercise of FMLA rights includes discouraging an employee from using such leave.

Having found Mr. Zicarrelli's FMLA interference claim legally viable, the Seventh Circuit sent the case back down to the lower court for a jury to decide whether to believe Mr. Zicarrelli's or the FMLA manager's version of the leave conversation in dispute.

The *Zicarrelli* case serves as a good reminder to employers to not discourage eligible employees from taking FMLA leave. Doing so is a clear violation of FMLA-protected rights. Supervisors, managers or other agents designated by employers to handle FMLA requests must be trained to not interfere with an employee's right to seek FMLA leave. Beginning with an

employee's initial inquiry, communications regarding leave should be documented in a way that prevents any misunderstanding between employer and employee. Similarly, written leave policies must be carefully drafted to not include any terms that could be interpreted as discouragement or limitation on eligible FMLA leave.

SIXTH CIRCUIT UPHOLDS PLAN REIMBURSEMENT RIGHTS

On May 23, 2022, in *Zahuranec v. Cigna Healthcare, Inc., et al.*, the Sixth Circuit Court of Appeals affirmed a district court decision that upheld a self-funded plan's subrogation and reimbursement rights.

The plaintiff-appellant, Lisa Zahuranec, was a plan participant who suffered serious complications after undergoing bariatric surgery. The plan approved and paid for the surgery, although it did not meet medical necessity criteria. Zahuranec received a settlement from a medical malpractice suit brought against the physicians who performed the surgery. She then brought ERISA claims against Cigna in an effort to avoid reimbursing the plan from her settlement proceeds. (Cigna, the claims administrator, had sought to enforce the plan's subrogation and reimbursement provisions.)

In Zahuranec's first ERISA claim, she sought enforcement of the plan terms. She asserted that the surgery was not a "benefit" under the plan because it did not meet medical necessity criteria. Therefore, the procedure was not subject to the plan's subrogation and reimbursement provisions. Next, in her ERISA breach of fiduciary duty claims, she argued that Cigna made a material representation that the procedure was medically necessary by approving the surgery. Finally, she brought an equitable estoppel claim, seeking to estop Cigna from seeking subrogation.

The Sixth Circuit rejected all these arguments and affirmed the district court's decision to dismiss all claims. In the court's view, the plan had the right to seek subrogation and reimbursement because Zahuranec had received payment for a covered expense (as defined by the plan terms) that had been paid as a plan benefit. Additionally, Cigna did not breach a fiduciary duty by deciding the plan would pay for the surgery; this determination was a coverage decision that the plan language made clear was neither a recommendation nor guideline for treatment. Finally, Zahuranec's equitable estoppel claim failed. Here, the court noted that she had not demonstrated the element of detrimental reliance on Cigna's promise that the surgery was medically necessary since the surgery was paid for by the plan.

The case reinforces a plan's right to pursue subrogation and reimbursement rights, as specified in the plan language, for benefits paid by the plan. It also serves as a reminder that plans should pay attention to what benefits are payable under plan terms.

HHS ISSUES GUIDANCE TO PHARMACIES ON ENSURING ACCESS TO REPRODUCTIVE HEALTHCARE SERVICES

Recently, HHS' Office for Civil Rights (OCR) released Guidance to Nation's Retail Pharmacies, reminding them of several civil rights laws that impact the pharmacies' ability to provide reproductive healthcare services.

The guidance points out that maternal deaths have increased over the last twenty years, particularly among Black and Native American women. OCR asserts that the recent *Dobbs* decision will increase the inequities and disparities for women. OCR is responsible for protecting the rights of women and pregnant people and making sure that their access to healthcare (including reproductive healthcare) is free from discrimination. Pharmacies supply medications and related services that are a part of a woman's reproductive healthcare, so the guidance touches on the federal laws that outline pharmacies' nondiscrimination obligations.

First, the guidance touches on Section 1557 of the Affordable Care Act, which prohibits recipients of federal assistance from excluding an individual from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex and disability, among other bases, in their health programs and activities. Similarly, Section 504 of the federal Rehabilitation Act prohibits recipients of federal assistance from discriminating in all programs and activities on the basis of disability. The guidance concludes that these statutes prohibit pharmacies that receive federal assistance (including Medicare and Medicaid payments) from discriminating against customers, such as supplying medications, making determinations regarding the suitability of a prescribed medication for a patient, or advising patients about medications and how to take them. In addition, pregnancy discrimination (including potential pregnancy, current pregnancy and medical conditions related to pregnancy) is a form of sex discrimination protected by federal civil rights law. Forms of pregnancy discrimination include denying medication.

Finally, the guidance mentions the Church Amendments, civil rights law that prohibits employment-related discrimination against healthcare professionals because they either provided or assisted in the provision of abortion or sterilization services or because they refused to do so. OCR does not provide blanket guidance concerning these laws but considers potential violations on a case-by-case basis.

Employers with plans that include prescription drug services should be aware of this guidance.

BIDEN ADMINISTRATION RELEASES EXECUTIVE ORDER ON PROTECTING ACCESS TO REPRODUCTIVE HEALTHCARE SERVICES

On July 8, 2022, President Biden issued an Executive Order in response to the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*. In the order, the President stated that his administration continues to support a woman's rights to make reproductive

healthcare decisions and will protect and defend those rights. To demonstrate that policy, the order gives specific directions to several agencies.

Specifically, the Secretary of HHS is ordered to submit a report to the President within 30 days detailing potential actions which would expand access to abortion care, including medication. HHS shall also develop a public education and awareness initiative related to access to reproductive health services.

HHS is also tasked with providing guidance under HIPAA regarding the protection of health information related to reproductive healthcare services. HHS has already issued some guidance on this issue.

The Attorney General and the Secretary of Homeland Security shall consider and identify actions to ensure the safety of patients and healthcare providers and protect the security of clinics (including mobile clinics), pharmacies and other entities providing, dispensing, or delivering reproductive and related healthcare services.

The order does not require any action from employers. It may be helpful to employers considering measures to support employees and their reproductive-related healthcare services. This is a fast-changing area of law. Employers should consult with counsel for specific guidance.

HHS ISSUES GUIDANCE ON PROTECTING PATIENT PRIVACY RELATED TO REPRODUCTIVE HEALTHCARE

On June 29, 2022, the Office of Civil Rights (OCR) issued guidance on the HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Healthcare concerning the disclosure of private health information (PHI) by covered entities pursuant to state law or a request by law enforcement. HHS also provided guidance for Protecting the Privacy and Security of Your Health Information When Using Your Personal Cell Phone or Tablet.

The OCR guidance states that covered entities, such as health plans, healthcare clearinghouses, and most healthcare providers, as well as business associates that handle PHI on behalf of covered entities, can only disclose a person's PHI without their consent if the HIPAA privacy rule expressly permits or requires it. The guidance points out that the privacy rule permits but does not require covered entities to disclose PHI pertaining to reproductive healthcare if the disclosure is required by another law and the disclosure complies with the requirements of the other law. Even this circumstance is limited to a "mandate[s] contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law," and only to extent necessary to comply with that law.

In the example provided in the guidance, an individual goes to a hospital emergency department while experiencing complications related to a miscarriage during the tenth week of pregnancy. A hospital workforce member suspects the individual of having taken medication to end their pregnancy. State or other law prohibits abortion after six weeks of pregnancy but does not require the hospital to report individuals to law enforcement. Where state law does not expressly

require such reporting, the privacy rule would not permit a disclosure to law enforcement under the "required by law" permission. Therefore, such a disclosure would be impermissible and constitute a breach of unsecured PHI requiring notification to HHS and the individual affected.

Similarly, the privacy rule permits but does not require covered entities to disclose PHI pertaining to reproductive healthcare for law enforcement purposes if the request is made pursuant to process and as otherwise required by law. Examples include such legal processes as a court order, court-ordered warrant, a subpoena or a summons. This does not allow a covered entity to voluntarily disclose PHI regarding reproductive health to law enforcement, either on the covered entity's initiative or if requested by law enforcement (in the absence of a legal process like the examples above).

The OCR guidance notes that the privacy rule permits but does not require covered entities to disclose PHI when doing so would prevent a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person or persons who are reasonably able to prevent or lessen the threat. However, the guidance points out that some PHI pertaining to reproductive healthcare is not considered by some healthcare professional ethical standards to rise to the level of a serious and imminent threat to the health or safety of a person or the public.

HHS also provided guidance on protecting PHI on a personal phone or tablet. The guidance points out that PHI stored on a personal phone or tablet is not protected by the privacy rule. However, information stored on those devices can be used by apps to collect that information, which can then be sold or used without a person's permission. The guidance provides several suggestions for eliminating or reducing that risk, such as turning off location services and enabling privacy settings in personal devices that prohibit apps from using data without the owner's permission.

Employers should be aware of this guidance, particularly those whose plans are self-insured.

DEPARTMENTS ISSUE LETTER ON CONTRACEPTIVE COVERAGE REQUIREMENTS

On June 27, 2022, Secretaries Xavier Becerra, Marty Walsh and Janet L. Yellen of the U.S. Departments of Health and Human Services, Labor, and Treasury (the departments) issued an Open Letter to Plans and Issuers on Access to Contraceptive Coverage addressing obligations under the Affordable Care Act (ACA) to cover contraceptive services at no cost. Though these coverage requirements have been in place for more than a decade, the departments noted persistent and troubling reports of noncompliance. Declaring it "more important than ever to ensure access to contraceptive coverage without cost-sharing, as afforded by the ACA," the departments expressed an expectation for industry commitment to promptly correct all areas of potential non-compliance.

Specifically, the ACA requires coverage of the full range of contraceptive products approved, cleared, or granted by the FDA and determined appropriate by an individual's medical provider. Coverage must include the clinical services, including patient education and counseling, needed

for the provision of the contraceptive product or service, and items that are integral to the delivery of the recommended preventive service, regardless of how such items or services are billed. While reasonable medical management techniques are allowed, they must be applied through an easily accessible, transparent, and expedient exceptions process that defers to the attending provider's recommendation. For example, a plan may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. However, the plan must accommodate individuals for whom the generic drug would be medically inappropriate, as determined by the attending provider. In such circumstances, accommodation would mean waiving the otherwise applicable cost-sharing for the brand version. The process to obtain an exception must not be unduly burdensome on the individual or their provider (i.e., not require an appeal). Note that these guidelines are not new; rather, they repeat guidance from the departments issued in several previous FAQs.

Employers should ensure their group health plans comply with the ACA's contraceptive services coverage requirements, including a review of medical management techniques and exceptions processes.

HHS ISSUES GUIDANCE ON AUDIO-ONLY TELEHEALTH AND HIPAA COMPLIANCE

On June 13, 2022, the Office of Civil Rights (OCR) updated its website with Audio-only Guidance related to telehealth and HIPAA Privacy and Security Rules. The OCR stated the guidance was in direct response to Executive Order 14058, which was issued in December 2021 and ordered the federal government agencies to design and deliver services in a more equitable and effective manner, especially for those who have been historically underserved. The guidance notes that telehealth that includes video may be difficult for certain populations to access because of various factors, including financial resources, limited English proficiency, disability, internet access, availability of sufficient broadband and cell coverage in the geographic area.

In March 2020, the OCR issued a notification and guidance related to the use of telehealth services during the COVID-19 public health emergency. Importantly, this new guidance will apply in situations where those rules do not and will remain in effect even after the public health emergency is declared to be over.

The HIPAA Privacy rules specifically provide for telehealth services, including audio-only services. Covered entities, including healthcare providers and health plans, must take steps to verify the identity of the individual. There are no prescribed methods of identification. Covered entities must apply reasonable safeguards to protect the privacy of protected health information (PHI) and avoid incidental uses or disclosures of PHI. Examples include not using speakerphones, using a lowered voice and providing the services in a private setting.

Regarding the HIPAA Security rules, a traditional landline telephone is not considered electronic communication. Thus, the rules would not apply to such communication. However, if the covered entity uses voice over internet protocol (VoIP), a cell phone, Wi-Fi, a smartphone

application or technology to transcribe or record the communication, the HIPAA Security rules would apply. In that case, the covered entity must identify, assess and address the potential risks and vulnerabilities (such as the transmission being intercepted by an unauthorized third party) and whether the communication method is encrypted.

If the telecommunications service provider (TSP) is only a conduit for the communication and does not create, receive or maintain any PHI from the session, no business associate agreement is required. An example would be a cell phone or internet provider if the session is conducted with a cell phone over Wi-Fi. However, if the TSP maintains the PHI after the session, an agreement would be required. An example would be a smart phone application that records the session and stores it in the cloud.

No action is required of employer plan sponsors as a result of the new guidance. However, it is welcome news for plans with underserved populations, as those participants may be able to better access health services due to the updated rules.

IRS REVISES OPTIONAL STANDARD MILEAGE RATES

On June 9, 2022, the IRS released IRS Announcement 2022-13, in which the agency increased the optional standard mileage rate for computing the deductible costs of operating an automobile for business to 62.5 cents per mile. The optional standard mileage rate for medical and moving expenses is increased to 22 cents per mile. These increases are effective starting on July 1, 2022 and were increased in part due to higher fuel costs. Taxpayers may use the optional standard mileage rates to calculate the deductible costs of operating an automobile for business, medical and moving purposes in lieu of tracking actual costs. These rates are also used by many businesses as benchmarks for reimbursing employees for mileage.

Employers who use these rates as benchmarks should be aware of and account for this increase.

DEPARTMENTS RELEASE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS CHECKLIST

On June 3, 2022, the IRS, DOL and HHS (the “departments”) released a Federal Independent Dispute Resolution (IDR) Process Checklist of requirements for group health plans and insurers. The checklist was designed to help plans and insurers understand their obligations when processing claims for items and services covered by the No Surprises Act (NSA) balance billing protections.

The NSA provisions protect participants from surprise bills for out-of-network (OON) emergency and air ambulance services and certain OON services received at in-network (INN) facilities. Participant cost-sharing for covered items and services is limited to the INN cost-sharing amount. The plan or insurer must address the remainder of the bill with the provider. If the parties cannot agree on the OON payment amount after a 30-day negotiation period, the federal IDR process can be initiated.

According to the departments, the checklist addresses common questions and complaints received by the No Surprises Help Desk. First, the guidance emphasizes that a plan or insurer must process claims within a 30-calendar-day timeframe after receiving an OON bill for covered items and services and make an initial payment or send a notice of payment denial. The 30-calendar-day period begins on the date the plan or insurer receives the information necessary to decide the claim. The initial payment should be an amount that the plan or insurer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan, prior to the beginning of any open negotiation period or initiation of the federal IDR process.

Second, the checklist outlines the information that a plan or insurer must provide in writing to a provider with each initial payment or notice of payment denial. Such items include the qualifying payment amount, which is the median contracted rate for the item or service for the geographic region, if participant cost-sharing was based on this amount. The plan or insurer must also provide the phone and email address for the appropriate contact person or office, in the event the provider wishes to initiate a 30-day open negotiation period to determine the total payment amount.

Third, the guidance explains that the 30-day open negotiation period can be initiated by one party providing the standard open negotiation notice to the other party. In such an event, the open negotiation period begins on the day that the initiating party sends the notice. An extension of the negotiation period can be requested in certain extenuating circumstances.

Finally, the guidance details the information that must be included if a party initiates the federal IDR process. The process must be initiated within four business days after the close of the open negotiation period by submission of a Notice of IDR Initiation to the other party and to the departments.

Group health plan sponsors and their service providers may want to review this practical checklist to ensure compliance with the federal IDR process requirements.

DOL PROVIDES CLARITY ON FMLA AND MENTAL HEALTH-RELATED LEAVES

On May 25, 2022, the Department of Labor's (DOL) Wage and Hour Division released Fact Sheet #280: Mental Health Conditions and the FMLA and series of FAQs on Mental Health and the FMLA. The new guidance does not change existing law. Rather, it serves to emphasize that mental health conditions should not be treated any differently than physical health conditions in FMLA administration.

Under FMLA, eligible employees working for covered employers may take job- and benefits-protected unpaid leave for their own serious mental or physical health condition, or to care for a spouse, child, or parent's serious mental or physical health condition. A serious mental health condition is one that requires either: 1) inpatient care in a hospital or treatment center; 2) continuing treatment by a healthcare provider for an incapacitating condition lasting more than

three consecutive days; or 3) treatment at least twice a year for a chronic condition that causes occasional periods of incapacitation. Employers may require a healthcare provider's certification supporting FMLA leave but cannot require a diagnosis.

The Fact Sheet provides the following examples of FMLA leaves that may be taken for the employee's own mental health condition or as caregiver leave for certain family members:

- Leave for the employee's mental health condition.
  Example: *Karen is occasionally unable to work due to severe anxiety. She sees a doctor monthly to manage her symptoms. Karen uses FMLA leave to take time off when she is unable to work unexpectedly due to her condition and when she has a regularly scheduled appointment to see her doctor during her work shift.*

- Caregiver leave for family member (spouse, child or parent) with a mental health condition.
  Example: *Wyatt uses one day of FMLA leave to travel to an inpatient facility and attend an after-care meeting for his fifteen-year-old son who has completed a 60-day inpatient drug rehabilitation treatment program.*

- Caregiver leave for disabled adult child with a mental health condition.
  Example: *Anastasia uses FMLA leave to care for her daughter, Alex. Alex is 24 years old and was recently released from several days of inpatient treatment for a mental health condition. She is unable to work or go to school and needs help with cooking, cleaning, shopping, and other daily activities as a result of the condition.*

- Military caregiver leave for mental health conditions.
  Example: *Gordon's spouse began to have symptoms of PTSD three years after she was honorably discharged from military service overseas. Gordon uses FMLA leave for two weeks to transport his spouse to and from outpatient treatment at a Veteran's Administration hospital and to assist her with day-to-day needs while she is incapacitated.*

The FAQs elaborated on these examples. Specifically, as to caregiver leave for a disabled adult child with a mental health condition, "disability" is defined by the ADA; that is, a mental or physical condition that substantially limits one or more major life activity, such as working. The FAQs further note that caregiver leave includes participating in a spouse's, child's, or parent's treatment program in addition to providing physical and psychological care.

The Fact Sheet and FAQs stress two final points related to FMLA administration. First, employers must maintain employee medical (including mental health) records confidential and separate from routine personnel files. However, an employee's manager may be informed of the employee's need for leave and any work duty restrictions or accommodations. Second, employers must not discourage leave by threatening to disclose an employee's or family member's mental health condition or otherwise interfere with an employee exercising their FMLA rights.

Again, this latest DOL guidance does not change existing FMLA rules in any way. It simply reiterates that mental health conditions should be treated no differently than physical health conditions in administering FMLA leaves.

FREQUENTLY ASKED QUESTIONS

FAQ: Who is responsible for sending life plan conversion notices when an employee goes on leave or terminates employment?

Typically, group life insurance coverage ends when active employment ends. But there is often a right to convert group coverage to an individual policy built into the plan. Conversion rights and the process of converting a group life plan to an individual policy are controlled by the specific plan terms. Note that some state laws require that carriers and/or employers provide certain conversion rights and notices to employees. A carrier agreement may require employers to assist with this. It may come as a surprise that required notices are not always handled by the carrier, sometimes leaving the employer legally responsible. Employers sponsoring group life insurance plans should take care to understand applicable conversion terms and their administrative obligations.

First, employers need to know who is responsible for distributing conversion notices and when and how those notices should be sent. In addition to the plan documents, the carrier agreement may address this. Conversion notice responsibilities will vary by carrier. When notice responsibility falls on the employer, it is best practice to keep documentation of mailing and delivery of conversion notices (e.g., first-class mail return receipt requested). As to what documentation needs to be provided to satisfy notice, employers should look to the plan terms. When an employee's employment terminates, the SPD, plan document, and any leave policies that address conversion rights should be provided.

Second, even where the carrier is responsible for providing conversion notices, employers should have consistent procedures to respond to conversion information requests from employees. Steps should be taken to ensure conversion rights are clearly, completely, accurately and timely communicated to employees. A description of conversion rights with reference to applicable plan terms should be included with any leave policies, leave communications and offboarding materials. Anyone designated to respond to life coverage inquiries must be trained in when and how a group plan can be converted to an individual policy. This includes whether coverage continues during leave and when coverage otherwise terminates, including deadlines to convert. Importantly, an employer's response to inquiries should not be limited to answering precise questions because employees may not know which specific questions to ask. Meaning, there should be no potentially harmful omissions.

While most employers are very familiar with COBRA and state continuation rights and notice requirements when group health plan coverage ends, compliance obligations related to group life plan coverage are often overlooked. Without ensuring proper procedures are in place to

provide notices and respond to coverage inquiries, employers may find themselves liable for claims under lapsed group coverage that was deprived of adequate conversion notice. Two such cases are *Chelf v. Prudential, et al.* and *Estate of Foster v. Am. Marine Servs. Group Benefit Plan, et al.*

FAQ: Is there guidance concerning a recent requirement that health plans must disclose certain rate and billing information on a public website?

New transparency requirements include a mandate that health plans and health insurance issuers must disclose, on a public website, information regarding in-network rates and out-of-network allowed amounts and billed charges for covered items and services in two separate machine-readable files (MRFs).

The regulations define MRFs as files presented in a digital format that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost (such as JSON). Based on language in the final regulations, there is an expectation that researchers, legislators, regulators and application developers will compile the information into reports, studies and internet tools, so that it can more readily be used for price comparison purposes. In other words, the information provided may not be immediately understandable by the average layperson, but others may take that data and present it in ways that the average layperson can understand.

The requirement to publicly post the MRFs applies to the group health plan level. The plan sponsor must be sure that the files are on a site available to the general public, meaning not just employees, but regulators, industry groups, application developers, etc. Additionally, the files must be accessible and free of charge without having to establish a user account, password or other credentials, and without having to submit any personal identifying information such as a name, email address or telephone number. Beyond those requirements, the regulations state the sponsor has discretion as to the exact location on the public website, since they are in the best position to determine where the files will be most easily accessible by the intended users.

The regulations allow an insured plan to enter into a written agreement with the insurer to assume liability for the disclosures. Under such an agreement, the carrier would provide the required information and assume responsibility for maintaining and updating it as required under the regulations. Note that the regulations allow either a group health plan or an issuer to enter into an agreement with a third party (such as a TPA) to provide and maintain the required information; however, the responsibility remains with the group health plan or the issuer if the third party fails to perform.

FAQ: We are considering offering fertility benefits. Are there any special compliance considerations?

Employers are increasingly choosing to offer fertility benefits to employees. However, it is important to ensure that such a benefit offering is properly structured.

To the extent the fertility benefits program provides medical care, it would generally be considered a group health plan and thus subject to the ACA, ERISA, COBRA and other laws. "Medical care" for this purpose is broadly defined to include amounts paid for "the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Under the ACA, group health plans are subject to specific requirements (e.g., coverage of preventive services without cost-sharing). ERISA imposes fiduciary obligations, claims review procedures, plan document and Form 5500 filing requirements. COBRA requires continuation of medical coverage for a minimum of eighteen months following certain losses of eligibility.

A stand-alone program typically cannot satisfy these group health plan requirements independently. Accordingly, perhaps the simplest way to offer fertility benefits is to amend/expand the coverage provided directly under the group major medical plan, which is already satisfying ACA, ERISA, COBRA and other requirements. This approach would be coordinated with the insurer or stop-loss carrier.

Alternatively, the fertility benefits could be offered through an integrated HRA, made available to only those employees enrolled in the employer's major medical plan (or confirmed to be enrolled in another group medical plan, such as a spouse's, although this adds administrative complexities). The employer could determine the types of fertility expenses and dollar amounts of the HRA reimbursements.

Generally, to be eligible for tax-free HRA reimbursement, the expense must be for medical care (as defined by Code §213(d)) for the employee or their spouse or dependent (but not a surrogate). Infertility expenses eligible for tax-free HRA reimbursement may include procedures such as IVF (including temporary storage of eggs or sperm) to overcome an inability to have children. However, expenses related to the long-term storage (typically greater than one year) of eggs and sperm would not qualify. Furthermore, medical expenses must be for services incurred during the coverage period and not just prepayment for such services. Please see IRS Publication 502, "Fertility Enhancement".

If the employer offers an HSA-qualified HDHP, the fertility HRA would need to be designed as a post-deductible HRA to preserve the employees' HSA eligibility. The HRA could not pay any benefits until the HDHP annual statutory minimum deductible ($1,400 self-only/$2,800 family in 2022) was satisfied.

The HRA would need to satisfy applicable compliance requirements. As a self-funded plan, these obligations would include, but not be limited to, Section 105 nondiscrimination testing and the PCORI fee filing and Form 720 reporting (although simplified reporting may apply).

Additionally, the employer should recognize that a fertility benefit vendor typically receives protected health information from covered entities (e.g., healthcare providers and/or the health plan) that are directly subject to regulation under the HIPAA Privacy Rule. So, a business associate agreement should be in place between the vendor and the covered entity.

Finally, given all the compliance considerations, it is always advisable for an employer to review the fertility benefits offering, structure and any related contracts with their counsel to ensure all legal requirements are satisfied.

STATE UPDATES

ALABAMA

Governor Signs Adoption Promotion Act into Law

Governor Ivey signed Senate Bill 31, the Adoption Promotion Act, into law. The act, which takes effect July 1, 2022, allows eligible employees to take up to 12 weeks of parental leave to care for and bond with a newborn or newly placed adopted child.

The act applies to covered employers and eligible employees under the FMLA. Accordingly, employers who employ 50 or more employees within 75 miles must comply. Employees are eligible after having been employed by the employer for at least 12 months and having worked 1250 hours in the 12 consecutive months prior to using the leave.

The leave must be taken within the first 12 months of the birth or placement of the child. Employees are expected to provide at least 30 days advance notice prior to taking the leave unless the leave is unforeseeable (in which case, notice should be provided as soon as practicable). Intermittent leave is permitted if agreed upon by the employer and employee.

Additionally, if the employer provides paid leave for birth and care of a child, the employer must provide equivalent paid leave for adoption for a period of two weeks or the duration of the employer's paid leave, whichever is less. If both adoptive parents work for the same employer, the employer is only required to provide paid leave to one employee.

Employers must consider requests for additional family leave due to the adoption of an ill or disabled child on the same basis as they would for the birth of a biological child to an employee. However, employers are not required to provide leave beyond the employee's FMLA entitlement.

Employers and their human resources staff should be aware of the new law and update their leave policies and procedures accordingly.

COLORADO

State Issues Guidance for Paid Sick Law

On June 24, 2022, the Department of Labor and Employment issued guidance for the state's Healthy Families and Workplaces Act (the Act). The Interpretive Notice and Formal Opinion (INFO) #68 guidance focuses on how sick pay accrues and leave taken for public health emergencies.

Starting in 2021, the Act requires employers to provide employees one hour of paid sick leave for every 30 hours worked, up to 48 hours per year, and unused hours can carry forward into the next year. The guidance states that any unused hours carried over into a subsequent year can be counted against the 48 hour/year total in that year. This also means that if the employee carried over 48 hours from the previous year, then they do not earn any additional sick leave in the current year.

The Act also provides for public health emergency leave for use when leave is associated with a public health emergency, such as the COVID-19 pandemic. This leave supplements the paid sick leave under the Act with up to 80 hours. The paid leave already accrued as of the date the public health leave is requested will count towards the public health leave. For instance, if an employee requests public health leave due to COVID-19, and they have 10 hours of paid sick leave accrued as of the date of their request, the employer must add 70 more hours of supplemental leave. The employee can use the public health leave granted in this way before they use their accrued sick leave.

Employers in the state or with employees in the state should be aware of this guidance.

CONNECTICUT

FMLA Proposed Regulations in Review as Notice Requirements Take Effect July 1

Proposed amendments to the Connecticut FMLA (CT FMLA) are expected to be reviewed and approved soon by the state's Legislative Regulation Review Committee. Additionally, new notice requirements become effective July 1, 2022.

In 2019, the state passed two laws that resulted in the Connecticut Paid Family and Medical Leave (CT PFML) program. The first law expanded employee eligibility and other provisions of the existing FMLA program. The second law provided eligible employees with income replacement for up to 12 weeks of leave, funded through employee payroll deductions that commenced in 2021. The paid leave program is overseen by the state's Paid Leave Authority.

Accordingly, the proposed regulations amend provisions of the prior CT FMLA regulations to incorporate the changes enacted in 2019 that took effect on January 1, 2022. The regulations also address several other outstanding issues. Among other items, the changes affect the definition of a covered employer, when an employee becomes eligible for leave, individuals for whom an employee can take leave to care for and the related documentation requirements, the amount of leave employees are entitled to, and the process for alleging a violation.

Additionally, each employer is required to provide written notice to each employee at the time of hire and annually thereafter: 1) of the entitlement to CT FMLA and the terms under which such leave may be used, 2) of the opportunity to file a claim for compensation under the program, 3) that retaliation by the employer against the employee for requesting or using such leave is prohibited, and 4) that the employee has a right to file a complaint with the Labor Commissioner for any violation. Fortunately, a model notice is available to satisfy the requirement, which takes effect July 1, 2022. Under the proposed regulations, an employer must also notify an employee

of their eligibility to take CT FMLA leave no later than five business days after receiving a request to take such leave or learning that the employee is taking leave for a qualifying reason.

Employers should comply with the notice requirements and be aware of the proposed regulations, which are expected to be approved soon without major changes. Employers should consult with employment law counsel for further information and to ensure their leave policies reflect the regulatory updates.

GEORGIA

Commissioner Issues Directive on Self-Funded Plans Opting in to State Surprise Billing Law

On July 1, 2022, the Insurance and Safety Fire Commissioner (the Commissioner) issued Directive 22-EX-5 regarding self-funded healthcare plans electing to participate in the Surprise Billing Consumer Protection Act (the Act).

The Act (originally HB 888) was signed into law on July 16, 2020, and was designed to stop surprise billing to patients receiving out-of-network care for emergency services and non-emergency services at in-network facilities provided without patient consent. For covered items and services, an out-of-network provider may bill a patient only for the cost-sharing amount (e.g., deductible, coinsurance, copayment, etc.) that the patient is responsible for under the terms of his or her plan or policy. The Act specifies a formula to determine the amount the plan or insurer is required to pay the out-of-network provider and establishes an arbitration process for out-of-network providers who believe they should be entitled to additional funds. Subsequently, the Act was amended by SB 566 to clarify that a medical or traumatic condition, sickness, or injury includes a mental health condition or substance use disorder and that emergency medical services include post-stabilization services.

Generally, the Act applies to fully insured plans. However, on April 29, 2021, HB 234 was signed into law, allowing self-funded healthcare plans operating in Georgia to elect to participate in the Act. Directive 22-EX-5 provides the form and instructions for an electing self-funded healthcare plan to notify the Commissioner of its decision. Note that most non-electing self-funded plans would otherwise be subject to the federal No Surprises Act surprise billing prohibitions for plan years beginning on or after January 1, 2022. Electing plans may still be subject to the federal provisions for any items and services covered by the NSA that are not covered by the Act.

Self-funded employers should be aware of this bulletin and may want to consult with their counsel and service providers for further information and guidance.

ILLINOIS

Governor Signs Series of Bills Mandating Coverage of Certain Services

Governor Pritzker signed a series of bills into law mandating health insurers in the state provide certain coverage for the following services:

- SB2969 (signed June 15, 2022): medically necessary continuous glucose monitors for individuals with Type 1 or Type 2 diabetes, effective January 1, 2023
- HB5318 (signed June 10, 2022): annual prostate cancer screening and medically necessary follow-up testing without imposing a deductible, coinsurance, copayment or any other cost-sharing, effective January 1, 2024
- HB4430 (signed June 10, 2022): HIV pre- and post-exposure prophylaxis drugs (PrEP and PEP) when dispensed by a pharmacist and at no less than 85% of the rate when provided by a physician, effective January 1, 2023
- HB4349 (signed May 13, 2022): medically necessary treatment of cranial facial anomalies, effective January 1, 2024
- HB5254 (signed May 13, 2022): medically necessary hormone therapy to treat menopause induced by a hysterectomy, effective January 1, 2024
- HB5585 (signed May 13, 2022): access to home health services for the duration of medically necessary care, effective January 1, 2024
- SB3819 (signed May 13, 2022): community-based pediatric palliative care and hospice care, effective January 1, 2024
- HB4271 (signed May 6, 2022): medically necessary breast reduction surgery, effective January 1, 2024

These provisions will apply to policies amended, delivered, issued or renewed in Illinois on or after the respective effective dates. Employers sponsoring health plans issued in Illinois should be aware of these developments and contact their carrier for further information.

State Expands Qualifying Losses Under Bereavement Leave Law

On June 9, 2022, Governor Pritzker signed the Illinois Family Bereavement Leave Act (FBLA) SB 3120 into law, expanding unpaid bereavement leave for Illinois employees to cover additional family member losses, pregnancy losses and failed adoptions. The FBLA amends the existing Child Bereavement Leave Act, which requires employers with at least 50 employees to provide up to 10 days of unpaid leave to parents and guardians after the loss of a child. Specifically, the FBLA expands the scope of family member losses covered by FBLA, requiring employers to provide leave to employees grieving the death of a spouse, domestic partner, sibling, parent, mother-in-law, father-in-law, grandchild, grandparent or stepparent. Covered losses will further include failed surrogacy agreements, unsuccessful reproductive procedures and other diagnoses or events impacting pregnancy and fertility.

Employee eligibility requirements for unpaid bereavement leave under Illinois's FBLA mirror federal FMLA eligibility requirements. The law permits – but does not require – employers to require reasonable documentation of qualifying loss. For the loss of a family member, that may include a death certificate or published obituary. However, as to pregnancy, fertility, surrogacy and adoption losses, employers are prohibited from requiring the employee to identify the

particular qualifying leave event. For these events, if the employer chooses to require documentation, the Illinois Department of Labor will provide a suitable form to be completed by an appropriate healthcare practitioner.

The FBLA becomes effective January 1, 2023. Illinois employers should review their bereavement leave policies with legal counsel and amend as appropriate to ensure compliance.

Illinois Governor Signs Health Insurance Consumer Protection Bills

On May 26, 2022, Gov. Pritzker signed two bills into law to increase health insurance protections and access for Illinois consumers, building on existing protections under the federal No Surprises Act.

First, HB 4703 (effective July 1, 2022) grants the Illinois Department of Insurance (IL DOI) additional authority to assist consumers who were billed at out-of-network rates after receiving care they believed was in-network, a billing practice prohibited by the No Surprises Act. Employers sponsoring health plans in Illinois should verify their carriers are complying with these requirements and are aware of the additional state enforcement authority.

Second, SB 3910 (effective January 1, 2023) requires health, prescription drug, and dental plan member ID cards to identify the regulatory entity that holds authority over the plan, whether the plan is fully insured or self-insured, and include any applicable deductibles or out-of-pocket maximums and plan contact information. This bill grants the IL DOI authority to enforce similar ID card transparency requirements embedded in the federal No Surprises Act. Employers sponsoring fully insured health, prescription drug, and dental plans in Illinois should verify their carriers are preparing to issue cards meeting the new requirements, many of which mirror the No Surprises Act.

MARYLAND

Coverage for Prescription Drugs to Treat Diabetes, HIV and AIDS

On May 29, 2022, HB 970 was enacted. Effective January 1, 2023, the new statute prohibits health insurers from imposing a prior authorization requirement for prescription drugs used as post-exposure prophylaxis for the prevention of HIV, if the drug is prescribed in accordance with CDC guidelines. This prohibition will apply to group health insurance policies issued in the state and which provide coverage for prescription drugs. Employer plan sponsors should verify with their insurer that the appropriate changes are made to the policy and documents.

On May 16, 2022, Gov. Hogan signed HB 1397 into law. Effective for policies issued on or after January 1, 2023, the new law prohibits insurers from imposing a copayment or coinsurance greater than $30 for a 30-day supply of insulin drugs or $150 for a 30-day supply of a prescription drug to treat diabetes, HIV or AIDS. The requirements apply to group health insurance policies issued in the state and which provide coverage for prescription drugs.

Employer plan sponsors should verify with their insurer that the appropriate changes are made to the policy and documents.

MINNESOTA

City of Bloomington Passes Earned Sick and Safe Leave Ordinance

On June 13, 2022, the Bloomington City Council adopted Ordinance 2022-31. Bloomington's ordinance requires employers to provide certain amounts of sick and safe leave to employees working at least 80 hours per year in the city. Specifically, the law requires private employers with at least five employees to provide employees with one hour of paid leave for every 30 hours on the job, for up to 48 leave hours a year. Smaller employers are required to provide the same amounts of unpaid leave. The law applies to an employer regardless of whether the employer is physically located in Bloomington. Employers are only required to allow an employee to carry over 80 hours of leave into the following year. Once the law goes into effect, employees may use accrued leave after 90 calendar days of employment.

Accrued sick and safe time may be used for any of the following reasons:

1. The employee's mental or physical illness; injury; health condition; need for medical diagnosis; care, including prenatal care; treatment of a mental or physical illness, injury or health condition; or need for preventive medical or healthcare.
2. The care of a family member with a mental or physical illness, injury or health condition who needs medical diagnosis; care, including prenatal care; treatment of a mental or physical illness, injury or health condition; or preventive medical or healthcare; or the death of a family member.
3. An absence due to domestic abuse, sexual assault or stalking of the employee or employee's family member for any of the following reasons:

    A. Seeking medical attention or psychological or other counseling services related to physical or psychological injury or disability caused by domestic abuse, sexual assault or stalking.

    B. Obtaining services from a victim services organization.

    C. Seeking relocation due to domestic abuse, sexual assault or stalking.

    D. Seeking legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from domestic abuse, sexual assault or stalking.
4. The closure of the employee's place of business by order of a public official to limit exposure to an infectious agent, biological toxin, hazardous material or other public health emergency.

5. To accommodate the employee's need to care for a family member whose school or place of care has been closed by order of a public official to limit exposure to an infectious agent, biological toxin, hazardous material or other public health emergency.
6. To accommodate the employee's need to care for a family member whose school or place of care has been closed due to inclement weather, loss of power, loss of heating, loss of water or other unexpected closure.

An employer may require reasonable documentation verifying the need for leave if the employee's absence is longer than three consecutive days; the employee's leave is for reasons in 1, 2 or 3A above; and the employer provides health insurance benefits to the employee.

Employers must notify employees that they are entitled to sick and safe time, the amount thereof and the terms of its use under the law. Prior to July 1, 2023, the City of Bloomington's Attorney's Office will provide a sample notice to conspicuously post and include in employee handbooks. Employers must also keep records documenting hours worked as well as leave accrued and used.

At this point, employers should be mindful of upcoming compliance requirements and expect interpretative guidance from the City Attorney's Office. Employers with employees in Bloomington should work with legal counsel to incorporate the new ordinance requirements into their overall leave policy.

NEW MEXICO

State Publishes Regulations and Guidance for New Paid Sick Law

On June 21, 2022, the Department of Workforce Solutions issued Final Regulations for the state's Healthy Workplaces Act, effective on July 1, 2022. The department also released a series of New Mexico Paid Sick Leave FAQs. Employees covered by the law (including temporary and seasonal workers) can accrue one hour of leave for every 30 hours worked (the FAQs point out that these are hours actually worked, so vacation time does not count), which they can use for sick time, safe time (e.g., reasons relating to domestic abuse or assault), or other reasons for themselves or for family members. Under the Act, employers can provide a higher accrual rate, or they can provide their workers with 64 hours of leave upfront on January 1 of each year. Employers are not allowed to require employees to take other leave before taking this leave, even if the leave is for a reason covered by the Act.

The FAQs state that the Act applies to employees performing work in the state, regardless of whether the employer is based in the state or elsewhere. However, the Act does not apply to work performed on tribal land. The department does not provide definite answers regarding remote workers, other than to say that remote workers working in the state are likely covered, unless they work for employers based outside the state and their services are not provided in the state. Those remote workers who work outside the state are not covered, even if their employers are based in the state. The department considers these questions to be heavily dependent on the facts and circumstances.

Although the Act does not cap the number of hours an employee can accrue, employers are not required to allow employees to use more than 64 hours of this leave per twelve-month period. The FAQs clarify that paid leave provided by employers before July 1, 2022, does not count toward employers' obligation to provide leave under the Act. If employers want to frontload hours in 2022, then they must provide 64 hours of leave on July 1, 2022. Note also that the new regulations cap hours that can be carried over to no more than 64 hours.

Regulations require employers to give written or electronic notice to an employee at the commencement of employment of the employee's rights to earned sick leave; the manner in which sick leave is accrued and calculated; the terms of use of earned sick leave as guaranteed by the Healthy Workplaces Act; that retaliation against employees for using sick leave is prohibited; the employee's right to file a complaint with the division if earned sick leave accrual or use is denied or if the employee is retaliated against; and all means of enforcing the Healthy Workplaces Act. This notice must be in English, Spanish, and any other language spoken by 10% or more of the employer's workforce. Employers are also required to display a poster with this information in a place where employees can see it.

Note that an employer can have a more generous leave policy than that required under the Healthy Workplaces Act (the Act); however, according to the FAQs, that policy must provide at least the same accrual rate as the Act and ensure the hours accrued can be used at a minimum for the same purposes and under the same terms and conditions as provided for by the Act.

Employers in the state or with employees in the state should be aware of this law, the regulations and the guidance.

OREGON

Paid Leave Oregon Announced 2023 Contribution Amount

The Oregon Employment Department has recently announced in a Paid Leave Bulletin Announcement that the contribution rate for the state's paid family and medical leave program (a.k.a., "Paid Leave Oregon") will be at 1% when contributions begin in 2023.

As a reminder, starting January 1, 2023, employees in Oregon will contribute 60% through payroll withholding, and employers will contribute 40% of the combined contribution rate of 1% of employee wages up to the annual maximum of $132,900. Employers with fewer than 25 employees are not required to contribute. Further, employers have the option to pay some or all of their employees' portion.

Similar to other states' paid family and medical leave programs, Paid Leave Oregon will provide paid time off for qualified reasons, including the birth or adoption of a child, employees' own serious illness or injury, taking care of a seriously ill family member, and safe leave for up to 12 weeks for all combined covered leave reasons in a benefit year.

Employers with at least one employee working in Oregon should be aware of the 2023 contribution amount and start communicating with their payroll vendor and internal payroll department to prepare for the Paid Leave Oregon contributions and other requirements.

SOUTH CAROLINA

Transitional Relief Extended for Grandmothered Plans

On June 8, 2022, the Department of Insurance issued Bulletin Number 2022-02 to announce an extension of transitional relief for certain non-grandfathered individual and small group policies known as "grandmothered" policies. The bulletin follows the recent CMS extension of the federal nonenforcement policy concerning specific ACA compliance requirements for these plans.

On November 14, 2013, CMS announced a transitional policy with respect to the healthcare reform mandates for coverage in the individual and small group markets. This nonenforcement policy provided relief from certain market reforms, including prohibitions of coverage exclusions based on pre-existing conditions and requirements to cover essential health benefits and limit annual out-of-pocket spending.

Under the policy, state authorities could permit health insurance issuers to continue coverage that would otherwise have been cancelled for failure to comply with the ACA requirements. The Department of Insurance has historically allowed insurers the option to continue such coverage. Bulletin 2022-02 represents the most recent extension of this policy and applies to renewals for plan or policy years beginning on or after October 1, 2022, and will remain in effect until CMS announces that all such coverage must come into compliance with the specified requirements.

Accordingly, small employers who are currently covered by such grandmothered policies issued in the state should be aware of the bulletin. These employers should work with their advisors and insurers regarding possible renewal of the coverage.

VERMONT

Crime Victim Leave Law Revised

Vermont's crime victim leave law, HB 477, requires employers to provide unpaid job protected leave for eligible employees to attend a deposition or court processing related to a criminal processing when an employee is an alleged victim. Employees who have been continuously employed for at least six months for an average of at least 20 hours per week and who are the victims of crimes are eligible to take the leave. The eligible employees are allowed to use accrued sick, vacation, and other paid time off leave during the crime victim leave.

Additionally, employers with Vermont employee(s) are required to post a written notice regarding an employee's right to crime victim leave. The Crime Victims Rights poster can be retrieved from the following state's site, Vermont Department of Labor.

The revised legislation (HB 477) expands the current crime victim leave to include relief from stalking or abuse. The term "alleged victim" also includes a family member.

Employers who have an employee(s) in Vermont should be aware of this added new change.

WASHINGTON

WA Paid Family and Medical Leave Updated Providers' Certification Forms

The Employment Security Department has updated the Washington Paid Family and Medical Leave Documents and Forms including certification of a serious health condition forms. With new updated certification forms, employees can complete a medical certification form with their healthcare provider by the type of leave they are taking.

The available new forms are as follows:

- Certification form (pregnancy and birth)
- Certification form (family leave)
- Certification form (medical leave)

Additionally, employers subject to the WA PFML program should verify whether their wage report status for the first quarter has a credit or balance on their employer accounts. To check their wage report status, employers can log in and view their "Wage Submission History."

Employers with at least one employee in Washington State should be familiar with the new certification forms.