2022: Second Quarter

Compliance Digest

Compliance Bulletins Released April-June

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This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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HHS Extends Public Health Emergency until July 15, 2022

Published: April 20, 2022

On April 12, 2022, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency, effective April 16, 2022. This will once again extend the Public Health Emergency period for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period. HHS issued a Public Health Emergency beginning January 27, 2020. This Emergency Period is now set to expire July 15, 2022 (unless further extended or shortened by HHS).

Outbreak Period. The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, or 2) 60 days after the announced end of the COVID-19 National Emergency.

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

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

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

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

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs

without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network.

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

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

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

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

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

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

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

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

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

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

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

Note: There is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Employer Action

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

Proposed Regulations to Fix ACA's Affordability "Family Glitch"

Published: May 3, 2022

The Treasury Department and the Internal Revenue Service ("IRS") recently proposed regulations that would expand the availability of premium tax credits in the Marketplace. For purposes of eligibility for a premium tax credit, the proposed rule provides that:

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

If finalized in their current form, the proposed rules are expected to take effect in the 2023 tax year.

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

Background

Under the current rules, individuals are not eligible for premium tax credits in the Marketplace if they are offered employer-sponsored group health plan coverage that is "affordable" and provides minimum value. For this purpose, employer-sponsored coverage is considered "affordable" if an employee is not required to pay more than 9.5% of household income for self-only coverage (9.61% for 2022 - the applicable percentage for 2023 has not yet been announced). If this is the case, then the coverage is considered affordable for both the employee and the employee's family members, regardless of how much the employee must pay to cover those family members. This is known as the "family glitch."

An employer-sponsored plan provides minimum value if the plan's share of the total allowed cost of benefits provided is at least 60%. Under current rules, as long as self-only coverage offered by an employer provides minimum value to an employee, then coverage offered to the employee's family members is also considered to provide minimum value.

Proposed Rule

Affordability

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

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

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

Minimum Value

The proposed rule would also amend the premium tax credit eligibility rules related to minimum value. An employer-sponsored plan would be considered to provide minimum value for family members if the plan's share of the total allowed costs of benefits provided to family members is at least 60%, and the plan includes substantial coverage of inpatient hospital services and physician services.

Employer Action

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

However, should the rule take effect as currently written, employers may see employees more closely evaluate options for family members in the Marketplace. Employees may find Marketplace coverage more cost effective than the employer plan and move their family members off the group health plan coverage.

Further, it is possible the Form 1095-C will be revised with new offers of coverage codes, since the IRS will need to understand whether affordable and minimum value offers of coverage were made to family members who otherwise may obtain a premium tax credit in the Marketplace.

2023 Inflation Adjusted Amounts for HSAs

Published: May 10, 2022

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying high deductible health plans ("HDHPs") effective for calendar year 2023, and the maximum amount that may be made newly available for excepted benefit health reimbursement arrangements ("HRAs"). All limits have increased from the 2022 amounts, some significantly.

For the Bulletin, see Rev. Proc. 2022-24, April 29, 2021, https://www.irs.gov/pub/irs-drop/rp-22-24.pdf.

Annual Contribution Limitation

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

High Deductible Health Plan

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

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

Catch-up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Excepted Benefit HRA Adjustment

For plan years beginning in 2023, the maximum amount for an excepted benefit HRA that may be made newly available for the plan year is $1,950.

July 1 Deadline Approaching for Machine-Readable Files

Published: May 26, 2022

On October 29, 2020, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") finalized proposed rules regarding transparency requirements for non-grandfathered group health plans. The Transparency in Coverage ("TiC") rules initially required disclosures of pricing and cost-sharing under plans to first take effect beginning January 1, 2022. On August 20, 2021, the Departments issued an FAQ that delayed the TiC requirement to publish certain machine-readable files ("MRFs") on a public website.

Briefly, the TiC rules require public disclosure, via MRFs, of the following information:

1. In-network provider rates for covered items and services; and

2. Out-of-network allowed amounts and billed charges for covered items and services.

A third required MRF disclosing negotiated rates and historical net prices for covered prescription drugs is currently delayed pending future guidance.

Employers sponsoring non-grandfathered insured and self-funded plans should be prepared to comply with the MRF disclosure requirements, as follows:

- For plan years that begin between January 1, 2022, and July 1, 2022, the files must be posted by July 1, 2022.

- For plan years that begin after July 1, 2022, the information must be posted in the month the plan year begins.

- Going forward, the information must be updated monthly and clearly indicate the date the files were most recently updated.

Who is Responsible for Compliance?

Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. If the carrier fails to provide full or timely information, the carrier (not the plan/employer) is liable.

Similar relief is not available to self-funded group health plans. While a self-funded health plan may contract with a third party (like the third-party administrator or "TPA") to provide the required disclosure, the plan is ultimately responsible.

Good Faith Compliance – Safe Harbor

A plan or carrier will not fail to comply with these requirements when, acting in good faith and with reasonable diligence:

- an error or omission in the required disclosure is made, provided the information is corrected as soon as practicable.

- the internet website hosting the MRF files is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable.

Further, when information must be obtained from a third party, the plan or carrier will not fail to comply with this requirement because it relied in good faith on the information provided by the third party, unless it is known (or reasonably should have known) the information is incomplete or inaccurate.

What is the Disclosure Requirement?

MRFs will typically contain vast amounts of data such that they will be quite large. They will be in a machine-readable language such that the data will not be easy to interpret or search, and few, if any, plan sponsors will be able to meet the disclosure requirements on their own. Thus, carriers and TPAs are assisting plan sponsors in complying with these requirements by hosting the files and posting them on public servers or websites they will maintain.

This disclosure requirement is unique in that it must be made to the public as opposed to most disclosure requirements that are limited to plan participants. As such, posting the information or a link to the information on a company's intranet or behind a password protected page will not be sufficient disclosure.

A conservative reading of the requirements suggests a plan sponsor should post a link to the MRFs on its public-facing website even if the carrier or TPA is doing the same on behalf of the plan.

> **Example.** ABC Company sponsors a self-funded medical plan. Green TPA provides ABC Company with a Uniform Resource Locator ("URL," briefly, a website address) where MRFs for the plan will be posted publicly and updated. ABC Company adds the URL
> link to their public-facing company website.

If a plan has multiple carriers or TPAs, multiple links may be necessary.

Several carriers and TPAs are taking this position, though further guidance would be welcome.
For example, UnitedHealthcare takes the following position: "The regulation requires self-funded customers accessing the UnitedHealthcare public MRF website to add the URL to their own public website." See Transparency in Coverage – External Frequently Asked Questions (May 5, 2022), page 15.

Direct Provider Contracting and Alternative Payment Models

For certain self-funded plans, one approach to controlling the cost of care involves plan sponsors directly contracting with providers or facilities to provide services to plan participants for discounted amounts. This is often in addition to the more prevalent commercial approach whereby a plan rents an established network from an insurance carrier or TPA. If the plan's TPA is not adjudicating claims for these unique agreements, the TPA may not have access to the required information to meet the TiC MRFs requirements. Plans should be proactive in coordinating with all applicable vendors and service providers to ensure accurate data is posted by the applicable deadline.

Further, the Departments recently issued FAQ 53 that addresses the compliance challenge for plans that have an alternative payment model and may not always provide a certain dollar amount for services and items before they are provided. Specifically, the plan may have negotiated rates with providers based upon a "percentage of billed charges" which would only ensure an accurate dollar amount after the services or item has been provided. As the rule's purpose is to provide transparency in advance of the cost of these services, this alternative payment arrangement posed compliance challenges.

In response, the Departments have provided a safe harbor for arrangements that do not permit plans to accurately determine dollar amounts for contracted items and services in advance of their provision. The safe harbor allows plans to:

- report a percentage number instead of a dollar amount for contractual arrangements where the plan or carrier pay the in-network provider a percentage of billed charges; and

- disclose an open text field for outlining formulas, variable methods, or other information necessary to understand the arrangement when a percentage or dollar amount is not possible.

The Departments caveated that the safe harbor does not exist for arrangements where it still is possible to sufficiently disclose a dollar amount.

Employer Action

Employers sponsoring non-grandfathered fully insured group health plans should obtain written assurances that the carrier will be responsible for posting the MRFs. Employers with fully insured plans may post a link to the MRFs from the carrier on their public website. Coordinate with IT resources to ensure that a link to the MRFs is posted timely.

Employers sponsoring self-funded non-grandfathered group health plans should:

- Reach out to TPAs (or other vendors) to ensure that they will assist in creating and posting the MRFs on behalf of the plan. It appears that most national carriers acting as TPAs on self-funded business have indicated they will support creating and posting this information.

- Add a link to the MRF URL to the employer's public-facing website. Coordinate with IT resources to ensure that a link to the MRFs is posted timely.

2022 PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 1, 2022

The Patient-Centered Outcomes Research (PCOR) fee filing deadline is August 1, 2022, for all self-funded medical plans and HRAs for plan years ending in 2021. The IRS issued Notice 2022-04 announcing the adjusted fee amount for this year.

The plan years and associated amounts are as follows:

Plan Year END Date	Amount of PCOR Fee	Payment and Filing Date
January 31, 2021	$2.66/covered life/year	August 1, 2022
February 28, 2021	$2.66/covered life/year	August 1, 2022
March 31, 2021	$2.66/covered life/year	August 1, 2022
April 30, 2021	$2.66/covered life/year	August 1, 2022
May 31, 2021	$2.66/covered life/year	August 1, 2022
June 30, 2021	$2.66/covered life/year	August 1, 2022
July 31, 2021	$2.66/covered life/year	August 1, 2022
August 31, 2021	$2.66/covered life/year	August 1, 2022
September 30, 2021	$2.66/covered life/year	August 1, 2022
October 31, 2021	$2.79/covered life/year	August 1, 2022
November 30, 2021	$2.79/covered life/year	August 1, 2022
December 31, 2021	$2.79/covered life/year	August 1, 2022

Employers with self-funded health plans ending in 2021 should use the 2nd quarter Form 720 to file and pay the PCOR fee by August 1, 2022. The information is reported in Part II.

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

For additional information, please visit the following IRS sites:

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

Mental Health Conditions Can Trigger FMLA

Published: June 21, 2022

In May 2022, the Wage and Hour Division of the U.S. Department of Labor released Fact Sheet #280 related to mental health conditions and the Family and Medical Leave Act ("FMLA").

As background, among the qualifying reasons that a person may qualify for FMLA leave are:

- To care for a spouse, son, daughter, or parent who has a serious health condition; and
- Because of a serious health condition that makesthe employee unable to perform the functions of his or her position.

A **serious health condition** is defined as an illness, injury, impairment, or physical or mental condition that involves (1) inpatient care in a hospital, hospice or residential medical care facility or (2) continuing treatment by a health care provider.

The fact sheet clarifies that a serious mental health condition that requires inpatient care includes an overnight stay in a hospital or other medical care facility, such as, for example, a treatment center for addiction or eating disorders.

In addition, the fact sheet notes that a serious mental health condition that requires continuing treatment by a health care provider includes:

- Conditions that incapacitate an individual for more than three consecutive days and require ongoing medical treatment by a health care provider, including a psychiatrist, clinical psychologist, or clinical social worker; and
- Chronic conditions (e.g., anxiety, depression, or dissociative disorders) that cause occasional periods when an individual is incapacitated and require treatment by a health care provider at least twice a year.

In the fact sheet, examples are provided outlining situations that can trigger FMLA (or military caregiver leave):

- The employee's own serious mental health condition
- A family member's serious mental health condition
- An adult child (unable to care for him/herself) with a serious mental health condition
- A military family member's serious mental health condition

Employer Action

Employers should ensure that they comply with applicable state and federal laws, including FMLA. Additionally, employers should make sure they appropriately determine whether a particular mental health condition of an employee or dependent rises to the level of a serious health condition warranting FMLA.

Philadelphia Re-Enacts Emergency Paid Sick Leave Benefits

Published: June 23, 2022

On March 9, 2022, the Philadelphia City Mayor signed into law an ordinance amending the city's existing public health emergency leave requiring covered employers to provide continuing paid COVID-19 leave through December 31, 2023.
The law became effective on March 9 and is the third iteration of the COVID-19 paid leave mandate.

Background

On September 17, 2020, Philadelphia passed the Public Health Emergency Leave Bill (the "COVID-19 Leave"), which provided paid "public health emergency leave" to individuals who work within the geographic boundaries of Philadelphia. The COVID-19 Leave expanded paid sick leave benefits to individuals who were not otherwise covered by the Families First Coronavirus Response Act. The COVID-19 Leave expired on December 31, 2020 and was expanded on March 29, 2021. On March 9, 2022, an ordinance was signed into law requiring covered employers to provide continuing leave through December 31, 2023 (the "2022 COVID-19 Leave"). While there are a few differences from the COVID-19 Leave, the most notable difference in this iteration is the amount of leave that must be provided by employers

Overview

Under the 2022 COVID-19 Leave, eligible employees are entitled to paid "public health emergency leave." Eligible employees may use this leave for situations when they are unable to work due to one or more of the following:

- A determination from a public official, health care provider or employer that the employee would jeopardize the health of others because of exposure to COVID-19, or he or she is showing symptoms, regardless of whether he or she was diagnosed with or tested positive for COVID-19
- Caring for a family member in a similar situation
- Isolating due to diagnosis of, or testing positive for COVID-19, or isolation due to having symptoms, or to seek or obtain diagnosis
- Caring for a family member who is isolating due to diagnosis of, or testing positive for COVID-19, or isolation due to having symptoms, or to seek or obtain diagnosis
- Caring for a child whose school was closed due to COVID-19
- An employee's need to be vaccinated, including a booster
- An employee's need to recover from a vaccination side effect

Covered Employers and Eligible Employees

The 2022 COVID-19 Leave applies to employers with 25 or more employees (previously the leave only applied to employers with 50 or more employees). To be a covered employee, an employee must have worked for a covered employer for 90 or more days and:

- Works for an employer within Philadelphia;
- Normally works for that employer within the city of Philadelphia but is currently teleworking from any other location due to COVID-19; or
- Works for that employer from multiple locations or from mobile locations, as long as 51% or more of the employee's time is spent working within the city of Philadelphia.

Amount of Leave

Under the 2022 COVID-19 Leave, employers are required to provide less leave than before. Employers must provide the following amounts of paid leave:

- Employees who work 40 or more hours per week are entitled to 40 hours of leave, unless the employer designates more (previously this was 80 hours)
- Employees who work less than 40 hours per week are entitled to leave in an amount equal to the time the employee is otherwise scheduled to work, or actually works, on average in a 7-day period, whichever is greater, unless the employer designates more
- Employees whose weekly schedule varies are entitled to the average number of daily hours the employee was scheduled over the past 90 days of work, including hours where the employee to ok leave of any type, multiplied by 7.

Rate of Pay

Employers must provide paid leave at the covered employee's regular rate of pay, with the same benefits (including health care benefits) as the employee normally receives from the employer.

Notice Requirements

Employers must provide employees with notice of the need for leave as practicable and as soon as feasible, but only when the need for the leave is foreseeable. Philadelphia's Department of Labor published a model notice satisfying these requirements that can be found at https://www.phila.gov/media/20220315165758/2022-COVID-19-Pandemic-Paid-Sick-Leave-NOTICE-POSTER-ENG.pdf. The notice must be conspicuously displayed in the workplace or, if the employer does not have a physical workplace or an employee teleworks, the notice must be provided through electronic communication or a conspicuous posting in the web-based platform. The notice must also be included in any employee handbook.

Employees are entitled to job restoration to the same position held when the 2022 COVID Leave began. Employers can request an employee submit a self-certified statement stating that leave was taken for a covered reason under the 2022 COVID-19 Leave. Employers cannot require employees to find a replacement to cover their leave, nor can they retaliate against employees who use or request leave.

Coordination with Other Paid Leave

The 2022 COVID-19 Leave is in addition to all other paid leave an employer provides and cannot be reduced by the amount of any paid leave an employee has previously received. Employees may not be required to use other paid leave available before using the 2022 COVID-19 Leave unless state or federal law requires otherwise. In certain situations, as set forth below, employers can use pre-existing benefits to satisfy COVID-19 leave requirements:

- Where employees complete the majority of their work through telework, employers are not required to change existing policies or provide an additional paid leave if the existing policies provide teleworking employees with at least 80 hours of paid leave in 2022 and employees can use such paid leave for the same purposes and under all of the same conditions as set forth under the Ordinance.

- Where an employer's existing leave policy provides 120 hours or more of paid time off in 2022, whether or not such leave is specifically designated as sick leave, if such leave can be used for the same purposes and under all of the same conditions as the 2022 COVID-19 Leave. Additionally, a provision that differs from the previous version of leave provides that, for employers that operate on a 7.5-hour workday and consider an employee working 37.5 hours a week to be a full-time employee, the amount of leave required to qualify for this exemption is 112.5 hours.

- Where federal or state laws require employees to provide paid leave or paid sick time related to COVID-19, employers may substitute leave under the federal or state law to the extent they coincide and the relevant federal or state law permits such concurrent use of paid leave.

- Where an employer has adopted a policy which provides its employees with additional paid time specifically for use for COVID-19, employers may substitute leave under such employer policy for the 2022 COVID-19 Leave to the extent they coincide.

Employer Action

Employers with employees performing service in Philadelphia should work with labor and employment counsel to review their leave policies and procedures to ensure that they are compliant with the 2022 COVID-19 Leave.

Delaware Enacts New Paid Family and Medical Leave Requirement

Published: June 28, 2022

On May 10, 2022, Governor John Carney signed the “Healthy Delaware Families Act” (“the Act”) into law, making Delaware the eleventh state to offer paid family leave in the country.

Overview

- The new paid leave requirements are applicable to any employer that employs 10 or more employees in Delaware.
- The Act establishes three categories of leave including: parental leave; medical leave; and family caregiving leave.
- Employers with 10-24 employees are only subject to the parental leave provisions. Employers with 25 or more employees are subject to all leave provisions. Employers with fewer than 10 employees are not obligated to participate in the leave program, although an employer can opt-in for a 3-year participation period.
- Benefits will be funded by employer and employee contributions. The contribution percentages have been established by the Act for years 2025 and 2026, with the state’s Department of Labor setting the contributions annually beginning in 2027.
- Contributions are scheduled to begin January 1, 2025, while benefit applications will commence January 1, 2026.

Employee Eligibility

To be eligible for, and receive benefits from the program, employees must have been employed for at least 12 months by the employer from whom leave is being requested and have worked a minimum of 1,250 hours over the 12-month period prior to requesting benefits.

The employee must also primarily work at a site located in Delaware. If the employee reports to work at a location outside of Delaware, the employer has discretion to classify that employee as eligible for participation in the state's leave program. Employees employed by the state whose work is classified as "Casual Seasonal" are ineligible to participate in the program.

Reasons for Leave

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth, adoption or after the placement of the child through foster care or for adoption;
- To care for a family member with a serious health condition;
- To provide leave to the employee due to a serious health condition that results in the employee being unable to perform the functions of their position or
- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee

Benefit Amount and Duration

The program will pay 80% of the covered individual's average weekly wages during the 12-month period prior to their application. For 2026 and 2027, the benefit payments will be capped at a maximum of $900 per week and indexed for inflation thereafter. The minimum weekly benefit cannot be less than $100, unless the employee's average weekly wages are less than $100 per week. In those instances, the employee's benefit will be their full weekly wage.

If the leave is intermittent or partial, benefits will be prorated but are not payable if less than one workday of covered leave is taken by the employee.

Benefits for eligible employees under the Act are capped as follows:

- Parental leave: up to 12 weeks in an application year.
- Medical and family caregiving leave: The maximum aggregate number of weeks available is 6 weeks in any 24-month period.
- Once every 24-month period for all leave except parental leave.
- If two parents are entitled to leave and work for the same employer, the employer is allowed to aggregate the number of weeks of leave to which they are both entitled to a total of 12 weeks during a 12-month period.

Contribution Rates

For 2025 and 2026, the contribution rates as a percentage of an employee's wages will be as follows:

- Parental Leave: 0.32%
- Medical Leave: 0.40%
- Family Caregiving Leave: 0.08%

An employer may deduct from the wages of each employee up to 50% of the contribution required, however, the employer at its own election can pay some or all of the employee's share of the contribution. Beginning in 2027, the contribution rates will be adjusted annually.

Employee Benefit Application

Employees who apply for benefits must provide written certification which includes the following information:

- The date when the serious health condition commenced;

- Information related to the condition provided by a healthcare provider;
- Duration of the condition; and
- A statement that they are unable to perform their job duties, or if the employee is looking to take family caregiving leave, a statement that the leave is to care for a family member who has a serious health condition.

Employer Private Plan Substitution

If the employer already has a paid leave program that provides medical, family caregiving and parental leave benefits, and that program is subsequently approved by the state, the employer will not have to remit contributions to fund the state's leave program. Employers must submit applications for approval to the state by January 1, 2024. To be approved, the employer's leave program must meet the Act's requirements and cannot impose additional conditions or restrictions beyond those permitted by the law.

If the employer's private plan does not cover all three leave types (for example, the policy only covers medical leave), the employer is permitted to participate in the state's paid leave program by remitting contributions for those leave benefits not covered by their private plan.

Employee Notice Requirements

If the need for use of leave is foreseeable, an employer may require the employee to give at least 30 days' written notice before taking leave. If the leave is unforeseeable, notice to the employer from the employee will be due as soon as practicable.

Leave covered by this Act may also qualify as leave under the FMLA and must run concurrently with FMLA leave. Employers are permitted to require that payments made under this leave program are coordinated with payments made to the employee under a separate leave policy (e.g., employer's private plan or a collective bargaining agreement). Employers can require employees to use their unused paid time off before they can take leave covered by this Act. However, eligible employees cannot collect more than 100% of their regular wages from leave programs.

Employer Responsibilities

An employer must provide written notice to each employee of their rights under this Act at the time of the employee's hire, whenever an employee requests covered leave, or the employer has reason to believe an employee's leave is due to a qualifying event.

The notice must contain:

- The procedure an employee must utilize to file their claim;
- The amount of family and medical leave benefits;
- The employee's rights to leave benefits and job protection, as well as protection from discriminatory and retaliatory actions of their employer for requesting and/or using leave benefits, and to file a complaint for alleged Act violations; and

- Whether leave benefits are available to the employee through the state or the employer's approved private plan.

An employer must:

- Continue any health benefits that a covered employee is enrolled during any leave taken under the Act.
- Protect and restore an employee to their position (or an equivalent) prior to taking eligible leave.

If the employee is entitled to greater benefits under a collective bargaining agreement or prior employer policy, the employer is obligated to follow those policies and cannot utilize the Act as a reason to reduce

Employer Action

Employers should:

- Await published regulations from the Delaware Department of Labor and review and examine their existing paid leave policies (and their employee handbook) to determine whether they can utilize these policies to satisfy, or supplement, their requirements under the Act.
- Apply for approval with the Delaware Department of Labor by January 1, 2024, if seeking to substitute an existing leave or private insurance policy.
- Provide written notice to all covered employees of their rights and duties under the Act.

Maryland Enacts New Paid Family and Medical Leave Requirement

On April 11, 2022, the Maryland State Legislature voted to override Governor Larry Hogan's veto of SB 275, known as the Time to Care Act of 2022 ("the Act"). The Legislature's vote to override the Governor's veto made Maryland the tenth state to offer paid family leave in the country.

Overview

- The new paid leave requirements are applicable to any employer that employs at least one individual in Maryland. The Act does not specify whether this number is limited to employees in Maryland or inclusive of all employees of an employer, regardless of residence or workplace. Employers with more than 15 total employees are required to pay into the state benefit fund.

- The benefits will be funded primarily by employer and employee contributions. The amount of the employee payroll tax has not yet been determined; however, the Maryland Department of Labor will determine an appropriate tax rate in the future.

- The payroll tax provisions of the Act are scheduled to begin on October 1, 2023, while benefits applications are scheduled to begin January 1, 2025.

- The Maryland Department of Labor is required to issue regulations by June 1, 2023.

Employee Eligibility

In order to be eligible for, and receive benefits from, the program, employees must have worked at least 680 hours over the twelve-month period preceding the date on which the leave is set to begin. There is no distinction between full-time and part-time employees.

Employees may be eligible for paid family leave for the following reasons:

- To care for a child during the first year after the child's birth or after the placement of the child through foster care, kinship care, or adoption;

- To care for a family member with a serious health condition;

- To provide leave to the employee due to a serious health condition that results in the employee being unable to perform the functions of their position;

- To care for a service member who is the employee's next of kin; or

- The employee has a qualifying exigency arising out of the deployment of a service member who is a family member of the employee.

Benefit Amount and Duration

The program will replace up to 90% of weekly wages for an employer's lowest-paid eligible employees, with a lower percentage of wages replaced for those who earn higher incomes. Benefit payments will be capped at a maximum of $1,000 per week. The maximum benefit amount is indexed for inflation.

Benefit payments will be calculated based on the employee's average weekly wage over the last 680 hours that the individual was paid divided by the number of weeks worked. If the leave is intermittent or partial, a different formula for how to calculate the payment owed to the employee will be utilized.

Eligible employees may receive benefit payments for up to 12 weeks in an application year. An employee may be eligible for an additional 12 weeks of paid leave if, for example, the employee is ordered to bed rest by their attending physician prior to delivery of their child.

Employee Benefit Application

Employees who apply for benefits must provide written certification which includes the following information:

- The date when the serious health condition for the employee, their family member or service member began;
- Facts related to the condition provided by the licensed healthcare provider;
- Probable duration of the condition; and
- A statement that they are unable to perform their job duties.

Additional information will be requested when the leave is to care for a family member or due to deployment for a family member.

Leave Substitution

A covered employer may satisfy their requirements under the Act through other employer-provided leave, private insurance, or a combination of both. The substituted employer provided leave or insurance policy must pay benefits and offer terms (including eligibility, rights, and protections) equal to or exceeding those required by the Act. A private employer plan must be filed with the Maryland Department of Labor for approval.

Employee Notice Requirements

If the need for use of leave is foreseeable, an employer may require the employee to give at least 30 days' written notice before taking leave. If the leave is unforeseeable, notice to the employer from the employee will be due as soon as practicable.

If the leave requested by the eligible employee is to be taken on an intermittent leave basis, the employee must make a reasonable effort to schedule the leave in a manner that does not unduly disrupt the operations of the employer and provide reasonable prior notice of the reason why the intermittent leave is necessary. Intermittent leave cannot be taken in increments of less than 4 hours.

In all leave circumstances, the Act requires that eligible employees exhaust all employer-provided leave that is offered outside of the leave provided by the Act prior to making an application for benefits to the program.

Employer Responsibilities

An employer must provide written notice to each employee of their rights under this Act at the time of the employee's hire and then annually thereafter.

The notice must contain:

- The procedure an employee must utilize to file their claim;
- Advise the employee of their responsibility to provide proper notice prior to commencing leave and associated penalties for failure to do so;
- Note the employee's rights to job protection and to file a complaint for alleged Act violations; and
- A description of prohibited activities, penalties and complaint procedures under the Act.

If an employee requests leave under the Act, or the employer knows that the employee is on leave for an eligible reason, the employer will notify the employee of their eligibility to take leave within 5 business days.

An employer must:

- Continue any health benefits that a covered employee is enrolled during any leave taken under the Act.
- Protect and restore an employee to their position (or an equivalent) prior to taking eligible leave.

If the employee is entitled to greater benefits under a collective bargaining agreement or prior employer policy, the employer is still obligated to follow those policies and cannot utilize the Act as a reason to reduce the employees' rights under those leave policies.

Employer Action

Employers should:

- Await published regulations from the Maryland Department of Labor, expected in June 2023.
- Review and examine their existing paid leave policies (and their employee handbook) to determine whether they will want to utilize these policies to satisfy, or supplement, their requirements under the Act.
- Contemplate whether to participate in the state program or offer a private program (e.g., substitute existing leave or purchase a private insurance policy). Note, employer will need to apply for approval from the state's Department of Labor to offer an alternative plan. Guidance on this process is expected.
- Provide written notice to all covered employees of their rights and duties under the Act.

Oklahoma's Abortion Prohibitions and Their Impact on Health Plans

Similar to the Texas Heartbeat Act, Oklahoma's SB 1503 bans abortion after about six weeks of gestation except in the case of medical emergency. It was signed into law on May 3, 2022.

On May 25, 2022, another bill (HB 4327) which bans abortion at the time of fertilization with exceptions for medical emergencies or if the pregnancy was a result of rape, sexual assault, or incest reported to law enforcement was signed into law.

Both bills are effective immediately upon enactment and allow civilians to file lawsuits against people performing or facilitating access to abortion care. They also attempt to strip Oklahoma's state courts from any jurisdiction to consider whether the law violates state constitutional protections.

These bills are two of the three major abortion bans in Oklahoma passed in a little over a month. The other bill is SB 612 which was signed into law on April 12, 2022 and makes it illegal to perform or attempt to perform an abortion except to save the life of a pregnant woman in a medical emergency. A person convicted of performing or attempting to perform an abortion is guilty of a felony punishable by a fine not to exceed $100,000.00 and/or by confinement in the custody of the Department of Corrections for a term not to exceed ten years.

Civil Penalties

Both SB 1503 and HB 4327 allow any person to bring a civil action against any person who:

1. Performs or induces an abortion in violation of their terms;

2. Knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise, if the abortion is performed or induced in violation of their terms, regardless of whether the person knew or should have known that the abortion would be performed or induced in violation of their terms; or

3. Intends to engage in the conduct described by (1) or (2) above.

If a claimant prevails, the court will award:

1. Injunctive relief sufficient to prevent the defendant from violating these laws or engaging in acts that aid or abet violations of these laws;

2. Statutory damages in an amount of not less than $10,000 for each prohibited abortion that the defendant performed or induced;

3. Nominal and compensatory damages if the plaintiff has suffered harm from the defendant's conduct, including but not limited to loss of consortium and emotional distress; and

4. Court costs and attorney fees.

The statute of limitations is six years.

Importantly, in the context of employee benefits, an employer whose plan covers abortion could be held liable. The laws could also potentially affect employees at clinics, anyone who provides transportation for a patient to an abortion provider, those who donate funds for an abortion, and friends or family members who provide information to a patient about where to get an abortion.

While ERISA generally preempts any state law (other than a criminal law) that relates to employee benefit plans, it will be interesting to see whether challenges to preemption arise in this context.

Employer Action

Oklahoma employers with self-funded plans covering abortion should decide whether they want to continue to do so.

Employers should watch for further developments.

Connecticut Publishes Model Notice under CTFMLA and CTPL

As previously reported, the Connecticut Family Medical Leave Act ("CTFMLA") and the Connecticut Paid Leave Act ("CTPL") require employers to notify employees of certain rights under the Acts. The Connecticut Department of Labor ("CTDOL") and the Connecticut Paid Leave Authority ("CTPLA") have recently published a model notice for employers to provide employees which serves as a combined notice of eligibility and rights and responsibilities. The notice requirement is effective July 1, 2022. The notice may be found at: https://portal.ct.gov/-/media/DOLUI/NEW-53122-Prototype-of-Employers-Written-Notice-to-Employees-of-Rights-under-CTFMLA-and-CTPL.pdf.

Background

Beginning July 1, 2022, employers are required to provide written notice to each of their employees:

- Describing job-protected leave provided under CTFMLA;
- The opportunity to apply for income-replacement benefits from the CTPLA;
- The retaliation protections provided by the CTFMLA; and
- The employee's right to file a complaint with the Labor Commissioner.

Employer Notification

Under the Acts, employers are required to provide written notice at the time of hiring and annually thereafter. According to proposed amended CTFMLA regulations that have not been finalized, the notification can be satisfied by including the notice or policy in employee handbooks or other written guidance to employees concerning employee benefits or leave rights, if written materials exist, or by distributing a copy of the notice or policy to each new employee upon hiring. The proposed regulations and the CTDOL inform that employers may create their own forms or policies (as opposed to using the model combined notice) so long as they contain the information required by the regulations. The proposed regulations also inform distribution of the notice or policy may be accomplished electronically.

Employer Action

Employers should work with employment and labor counsel to review their leave policies and procedures to ensure they are compliant with the written notice requirement effective July 1, 2022. In addition, employers should monitor the CTDOL and CTPLA's websites for additional guidance and regulations.

Updates to Washington's Paid Family and Medical Leave Program

Governor Inslee signed into law legislation (2SSB 5649) that updates and modifies Washington's Paid Family and Medical Leave program ("WA PFML").

Notable modifications are as follows:

- Family leave for death of qualified family members. Allows family leave to be taken by an employee during the seven calendar days following the death of a family member for whom the employee:

  – would have qualified for medical leave for the birth of their child; or

  – would have qualified for family leave to bond with their child.

- Postnatal leave as medical leave unless employee chooses otherwise. Specifies that leave taken by certain employees in the first 6 weeks after giving birth must be medical leave unless the employee chooses to use family leave. A certification of serious health condition form is not required for paid leave benefits used in the postnatal period.

- Collective bargaining exception expires. Sunsets the collective bargaining agreement exception on December 31, 2023.

- ESD to post employers with approved voluntary plans. Requires the state's Employment Security Department ("ESD") to publish a list of employers with approved voluntary plans on its website.

- ESD will likely issue further guidance on these changes.

Washington State Lowers PAL Assessment Again

On May 25, 2022, the Washington Health Care Authority ("HCA") approved a reduction in the PAL assessment amount for fiscal year 2023. The WAPAL Fund announced a lower monthly assessment amount of $0.06 (reduced from the current $0.07) per covered life effective for payments due on November 15, 2022.

Background

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021. Washington's HCA is responsible for enforcement of this provision.

The 2022 WAPAL Fund monthly assessment rate was previously set at $0.13 per covered life and was reduced to $0.07 per covered life for payments due February 15, 2022. The assessment amount is based on the number of covered lives each month. The WAPAL Fund Advisory Council reviewed the fiscal operations of the WAPAL Fund and determined that the rate could be reduced.

The PAL Assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provides health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services.

The next reporting and payment deadline is August 15, 2022, for the months of April, May, and June 2022. The payment rate for payments due on August 15, 2022 is $0.07 per covered life.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at:

- The current rate of $0.07 for the payment due August 15, 2022 and
- The lower rate of $0.06 for the payment due on November 15, 2022.

A third-party administrator ("TPA") may be assisting with this process. Employers that make a payment at the higher rate should watch for a refund of excess funds from KidsVax. If not refunded within 30 days of payment, employers are directed to notify KidsVax.

Carriers are responsible for the payment for fully insured group health plans. No employer action is necessary.

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