



Important Employment and HR Considerations for Employers

Fall Session- 2024



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EXPERTISE

- ERISA/Benefits matters
- State & Federal employment issues
- State Equal Rights Division
- EEOC matters
- DOL audits

Marquette University
Law School



30 years of law
experience

AFFILIATIONS

- Wisconsin Bar Association- member
- Admitted to practice before U.S. Tax Court and Eastern District of Wisconsin.
- Director, Vice President, Treasurer & Co-founder of the Wisconsin Youth Basketball League, Inc.
- Founder of Whitnall Youth Basketball Club, Inc.
- Previous Board of Directors and Member of the Executive Committee for Racine County Economic Development Corporation
- Previous Board of Directors of Racine Zoological Society.
- Prior Audit Committee Member for Neighborhood Housing Services of Southeast Wisconsin, Inc.

Legal Disclaimers

All comments today are intended to be educational in nature. They are not intended to be legal advice.

Be advised: as there is pending litigation on some of these topics, the law will continue to evolve.

Agenda

- 1. FTC Non-Compete Update**
- 2. AI Update**
- 3. DOT Overtime Update**
- 4. Mental Health Parity Update**
- 5. Medicare Notices Update**
- 6. HIPAA Update**
- 7. ACA Update**
- 8. FMLA Case Updates**
- 9. COBRA Coverage Issues**
- 10. Miscellaneous**

Non-Competes Live Another Day

FTC proposed rule struck down.

FTC Issued A Non-Compete Ban

April 23, 2024

- The Federal Trade Commission issued a final rule to promote competition by banning noncompete agreements nationwide.
- This resulted in a flood of litigation in several courts.



FTC Issued A Non-Compete Ban

August 20, 2024

A Texas federal district court struck down the rule which means it cannot take effect nor be enforced for the foreseeable future. The court held the FTC exceeded its authority and that the rule was “arbitrary and capricious.”



FTC Non-Compete Ban Struck Down

Takeaways

- The battle is over, but the war still rages.
- The FTC has indicated it will appeal the decision.
- Expect then the loser of that appeal to appeal to the Supreme Court.
- We still have that pathetic nuisance called the NLRB examining noncompete agreements also.
- Do NOT forget that some states bar noncompete agreements already.



AI Update

Verify all information obtained- mistakes are prevalent

AI #1

Can you have employees in Wisconsin punch in and punch out during breaks?

In Wisconsin, the Fair Labor Standards Act (FLSA) does not require employers to provide breaks, but if they do, breaks of less than 20 minutes must be paid. However, meal periods of 30 minutes or more can be unpaid as long as the employee is completely relieved of duties during this time. Regarding employees punching in and out during breaks, it is generally permissible under Wisconsin law, provided that it is clearly outlined in your company policy and communicated to the employees. This practice can help ensure accurate timekeeping and compliance with wage and hour laws.



AI #1

Your answer said breaks of 20 minutes or less must be paid but your next paragraph said they can punch out and not be paid. It can't be both. What is the correct answer?

You are correct, and I appreciate your attention to detail. Let's clarify this:

Under the Fair Labor Standards Act (FLSA) and Wisconsin state law, breaks of 20 minutes or less must indeed be paid.

Employees should not be asked to punch out for these short breaks, as they are considered compensable work time.

For meal periods of 30 minutes or more, employees can be required to punch out, provided they are completely relieved of all duties during this time. These meal periods do not need to be paid if the employee is not working.

So, the correct policy should be:

1.Breaks of 20 minutes or less: Employees remain punched in, and these breaks are paid.

2.Meal periods of 30 minutes or more: Employees punch out, and these periods are unpaid, assuming they are completely relieved of duties.



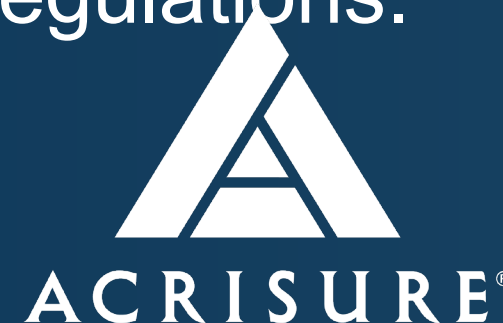
AI #2

For the Medicare Part D letters, do we need to use the 2025 simple determination on the 2024 plans? OR do we continue to use the 2024 determination and move to 2025 determination next year for the 2025 benefit plan year?

When it comes to Medicare Part D creditable coverage disclosure letters, you should use the determination based on the current plan year. Therefore, for the 2024 plans, you should use the 2024 determination. You will move to the 2025 determination next year for the 2025 benefit plan year.

Here's a step-by-step approach to ensure compliance:

- 1. 2024 Plan Year:** Use the 2024 determination to assess whether the prescription drug coverage is creditable or non-creditable.
- 2. Disclosure Letters:** Send out the Medicare Part D creditable coverage disclosure letters to Medicare-eligible individuals by October 15, 2024, using the 2024 determination.
- 3. 2025 Plan Year:** Next year, reassess the prescription drug coverage using the 2025 determination for the 2025 benefit plan year.
- 4. Annual Notification:** Ensure that you notify participants each year using the appropriate determination for the respective plan year to remain compliant with CMS regulations.



AI #2

But for reporting the October 15, 2024 creditable coverage notices to CMS, are we not reporting on the 2025 plan year?

You are right; for the October 15, 2024, creditable coverage notices to CMS, you are indeed reporting on the upcoming 2025 plan year. Here's how it works:

1. 2024 Plan Year Determination: Use the 2024 determination to assess whether the current year's prescription drug coverage is creditable or non-creditable.

2. October 15, 2024 Notices: These notices are based on the coverage for the 2025 plan year. Therefore, you should use the 2025 determination to assess the creditable coverage status for the 2025 benefit plan year.

So, while the letters sent to participants in 2024 are based on the 2025 determinations, you are simultaneously using the 2024 determination for any mid-year assessments or disclosures relevant to the 2024 plan year.

To summarize:

For October 15, 2024 Notices to CMS: Use the 2025 plan year determination.

For ongoing 2024 Plan Year: Use the 2024 determination.

This dual approach ensures compliance with CMS guidelines and keeps your assessments up-to-date with the correct plan year determinations.



AI #2

Why does your former answer differ from your latter answer? In the former answer you said the Oct. 15, 2024 notices are based using the 2024 determination while the latter answer says the Oct. 15, 2024 notices are based on a 2025 determination?

I apologize for any confusion caused by my previous responses. Let me clarify the correct approach:

For the **October 15, 2024** creditable coverage notices to CMS, you should indeed be using the **2025 plan year** determination. The notices sent out on October 15 of each year are intended to inform Medicare-eligible individuals about the status of their coverage for the upcoming plan year, which in this case is 2025.

Here's a corrected summary:

- 1. 2024 Plan Year Determination:** Use the 2024 determination to assess whether the current year's prescription drug coverage is creditable or non-creditable.
 - 2. October 15, 2024 Notices:** These notices are meant for the 2025 plan year. Therefore, you should use the 2025 determination to assess the creditable coverage status for the 2025 benefit plan year.
- So, for the October 15, 2024, notices, you should use the 2025 determination to ensure compliance with CMS requirements. I appreciate your attention to detail and hope this clears up any confusion.



DOL Overtime Regulations Remain Intact

The Litigation Continues!!

Litigation Is Winding Down

It is looking like the rule may stay in place.

- Over the summer, a Texas court ruled the new DOL OT laws do not apply to Texas companies, but the judge did not extend the injunction beyond the state of Texas.
- On Sept. 11th, the U.S. Court of Appeals for the 5th Circuit held (along with 4 other circuit courts of appeal) that the DOL has authority to impose a minimum salary requirement for application of the exemption.
- Caveat: This was a decision on the prior 2019 rule which increased the OT wages, not the new rule!!



Litigation Is Winding Down

It is looking like the rule may stay in place.

- **It does remain to be seen if the 2024 final rule “further increasing” the salary level in two stages if valid.**
- While the Fifth Circuit’s decision did not foreclose the DOL’s right to impose a minimum salary requirement, it leaves open the question whether the DOL could set a floor so high that it effectively, and impermissibly, negates the duties test. As the appeals court explained, “If the proxy characteristic frequently yields different results than the characteristic Congress initially chose, then use of the proxy is not so much defining and delimiting the original statutory terms as replacing them.”

Litigation Is Winding Down

It is looking like the rule may stay in place.

- A bigger issue is the lack of time.
 - The first increase already went through.
 - The second increase is only 3 months away.
 - They just finished litigating the 2019 changes!!

What are you going to do? Cuts in pay after the fact will create major issues.



DOL Revised Final Overtime Rule

Expected to impact 4 million workers

Under the prior and current overtime rule, employees must meet three requirements to be classified as exempt from overtime under the FLSA's exemption for executive, administrative, and professional employees.

- Employees must:
 - Meet a “duties test”;
 - Be paid on a salary basis; and
 - Previously be paid at least \$684 per week (\$35,568 annually).



DOL Revised Final Overtime Rule

- The rule incorporates two increases: The first step increased the salary threshold for exempt employees from \$684 per week (\$35,568 annually) to \$844 per week (\$43,888 annually) effective July 1, 2024.
- The second increase goes from \$844 per week (\$43,888 annually) to \$1,128 per week (\$58,656) or more per year as of January 1, 2025.



DOL Revised Final Overtime Rule

Limited Exceptions for Certain Employees

There are limited exceptions to the requirements of the general three-part overtime exemption test.

- Employees may be exempt under the highly compensated employee exemption if they satisfy a shortened version of the duties test.
- Certain designated types of employees such as doctors, lawyers, and teachers may be classified as exempt even if they don't meet the salary level test.



DOL Revised Overtime Rule

The rule has a provision for automatic increases to the overtime salary threshold amounts every three years based on then current wage data starting July 1, 2027.



DOL Revised Overtime Rule

- The rule also increases significantly the total annual compensation requirement for highly compensated employees from \$107,432 to \$132,964 on July 1 and then to \$151,164 on January 1, 2025

The regulations contain a special rule for “highly compensated” employees who are paid total annual compensation of \$107,432 or more. A highly compensated employee is deemed exempt under Section 13(a)(1) if:

1. The employee’s primary duty includes performing office or non-manual work; and
2. The employee customarily and regularly performs at least one of the exempt duties or responsibilities of an exempt executive, administrative or professional employee.

Thus, for example, an employee may qualify as an exempt highly compensated executive if the employee customarily and regularly directs the work of two or more other employees, even though the employee does not meet all of the other requirements in the standard test for exemption as an executive.



DOL Revised Final Overtime Rule

Steps to take

- Assess current pay practices and become familiar with the exemptions currently utilized to claim exempt status for salaried-exempt employees within the organization;
- Identify exempt employees who fall below the proposed required salary level and HCE salary level increases and determine which employees could be reclassified as non-exempt to comply with the new overtime rule;

DOL Revised Final Overtime Rule

Steps to take- cont'd

- Analyze employees affected by the changes and determine whether classifying their jobs as non-exempt and eligible for overtime is an acceptable alternative or whether the implementation of strategies for those employees to maintain their exempt status is required;
- Assess the potential negative impact on morale for those employees changed from salaried-exempt to hourly non-exempt;



DOL Revised Final Overtime Rule

Steps to take- cont'd

- Prepare a communication plan if employee pay changes will occur so that discussion of the changes will be a smooth transition; and
- Be prepared to train both managers and newly non-exempt employees on the differences that exist between exempt and non-exempt employees. Distinctions include different pay practices and potentially different benefits.

DOL Revised Final Overtime Rule

Bonus Make-Up Option

- One clarification- payments must be made quarterly, not annually. So $\frac{1}{4}$ of each bonus each quarter.
- Employers can count non-discretionary bonuses and incentive payments (such as commissions) towards the 10% of the standard salary level.



DOL Revised Final Overtime Rule

Bonus Make-Up Option Summary

- Up to 10% of salary.
- Quarterly payments.
- Catch-up payment. If the combined salary and bonuses do not meet the minimum threshold by the end of a quarter, employers have one pay period to make a catch-up payment.



DOL Revised Final Overtime Rule

Commission Employees- it varies but it's not favorable!!

- Exempt v non-exempt. First you need to determine whether your commission employees are exempt or non-exempt under the FLSA.

- IF exempt, their earnings must average 1.5 times the federal minimum wage for any workweek in which OT is worked. If non-exempt, they get paid OT regardless and there is no threshold to reach.



DOL Revised Final Overtime Rule

Commission Employees- it varies but it's not favorable!!

It is suggested that if an exempt commission employee cannot reach the minimum salary requirements, that they be reclassified as non-exempt and be entitled to OT for hours worked in excess of 40 hours. If you do not want to reclassify, you will need to pay the minimum base salary PLUS their commissions which means they fare much better. Again, they get the base salary PLUS commissions. I'd either reclassify as non-exempt OR restructure their pay eliminating commissions (at least for those who are right around the minimum levels). For those way above the minimum, since you must pay the minimum weekly salary plus commissions, I'd reduce to commission schedule taking this into effect.



Mental Health Parity Update

Bad news as the revised rules
are now final.

Final Rules Are Published

1. On September 9th, the DOL issued final rules on Mental Health Parity (MHP).
2. Some rules take effect 1/1/25 and the rest are effective 1/1/26.
3. The rules simply make things more confusing, costly and frustrating for employers.
4. Expect Mental Health Parity audits to increase quite a bit.
5. MHP applies to those companies with 50 or more employees.



MHP- Top Changes To The Status Quo

1. The NQTL (nonquantitative treatment limitation) Analysis is much more complex.

The final rule expands this analysis and describes specific types of information that must be included in each element of the analysis, with one element that requires plan-specific, detailed analysis.

The takeaway is that these enhanced requirements now make it impossible for a plan sponsor to complete this task on its own.



MHP- Top Changes To The Status Quo

2. Plans May Need to Expand Their Mental Health Provider Networks.

The final rule includes requirements related to network composition standards, such as requirements for provider admission to a network.

Plans are expected to take action to address any material differences in access and to document any actions taken to mitigate the material differences.



MHP- Top Changes To The Status Quo

3. Plans May Need to Cover More Mental Health Resources.

The final rule includes a new “meaningful benefits” standard, which requires that if a plan provides any benefits, it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical/surgical benefits are provided.

This means your plan may need to expand the scope of covered services in these areas or start covering services in additional classifications.



MHP- Top Changes To The Status Quo

4. Plan Fiduciary Certification is Required.

The final rule requires the plan fiduciaries to review the analysis and certify in writing that they engaged in a prudent process to select one or more providers to conduct the NQTL analysis and to prepare a written report.

Who wants to be a fiduciary, lol??



MHP- Top Changes To The Status Quo

5. Response Timeframes Have Narrowed.

Copies of the analysis must be provided:

30 days- upon participant request.

10 business days- upon DOL request.

10 more business days if DOL finds the initial request inadequate.

45 days to respond to a DOL initial determination of noncompliance.

7 days to notify participants after a final determination of noncompliance.



MHP- What Should The Employer Do?

Fully insured should confirm the insurer's obligation to comply with MHPAEA (Mental Health Parity and Addiction Equity Act) via written agreement. This should be available since insurers are subject to the MHPAEA's comparative analysis requirements.

Self-insureds must make sure their TPA agreements address responsibility for MHPAEA compliance. If the TPA refuses to provide this service, the plan will need to engage legal counsel or a qualified vendor.



MHP- There Is “Some” Good News

“For group health plans and group health insurance coverage, the final rules generally apply for plan years beginning on or after January 1, 2025. **However, the provisions implementing the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, required use of outcomes data, and certain related comparative analysis requirements apply for plan years beginning on or after January 1, 2026.** For individual health insurance coverage, the final rules apply for policy years beginning on or after January 1, 2026.”



MHP- There Is “Some” Good News

Also, the DOL has indicated that there will be updated guidance and compliance assistance materials. Don't hold your breath waiting for this!

There is always the hope of litigation!!!



Medicare Part D Notice Updates

Changes May Occur

Why Is This A Bigger Deal Now?

1. In 2022, Congress made significant changes to the Medicare Part D prescription program.
2. The biggest change takes effect for 2025 where the out-of-pocket cap will be reduced to \$2,000.
3. Collectively, all the changes increase the “richness” of the Part D standard benefit, setting a higher minimum standard for an employer’s pharmacy coverage to be considered “creditable”.
4. Having creditable coverage allows an individual to delay signing up for Medicare Part D coverage without a penalty.



What Does This Mean?

1. Notices are due on October 15.
2. IF your plan was borderline creditable for 2024, it will likely be considered non-creditable for the 2025 plan year.
3. Plan sponsors do not have to provide creditable plans; they simply must inform those plan participants if that is the case.



What Does This Mean?

5. Individuals who lose employer-sponsored creditable coverage have a special enrollment window to enroll in Part D without penalties. Penalties for failure to enroll continue to accrue.
6. To be safe, distribute notices to all participants on the plan. You may not know about an older spouse or a spouse or dependent who is disabled on Medicare.



Determination of Creditable Coverage.

There are two sanctioned methods to determine whether coverage is creditable for purposes of Medicare Part D — a simplified determination method and an actuarial determination method. Most employer plan sponsors can use the simplified determination method. Details from the Centers for Medicare and Medicaid Services (CMS), the federal agency governing Medicare, on the simplified determination method can be found on the CMS website by [clicking here](#).



Determination of Creditable Coverage.

Below is a concise summary of the simplified determination method to deem a prescription drug coverage benefit creditable:

1. The plan provides coverage for brand and generic prescriptions;
2. The plan provides reasonable access to retail providers;
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
4. The plan satisfies at least one of the following:
 - The coverage has no annual benefit maximum or maximum annual benefit payable by the plan of at least \$25,000;
 - The coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 annually per Medicare-eligible individual; or
 - For employers that have integrated prescription drug and health coverage, the **integrated plan** has no more than a \$250 deductible per year, has no annual benefit maximum or a maximum annual benefit of at least \$25,000, and has no less than a \$1,000,000 lifetime combined benefit maximum.



Determination of Creditable Coverage.

An **integrated plan** is a plan where the prescription drug benefit is combined with other coverage offered by the employer, such as medical, and the plan contains all of the following plan provisions:

- . A combined plan year deductible for all benefits under the plan;
- . A combined annual benefit maximum for all benefits under the plan; and
- . A combined lifetime benefit maximum for all benefits under the plan.

Employers participating in the [Retiree Drug Subsidy \(RDS\) program](#) cannot use the simplified determination method and must use the actuarial determination method. This requires an attestation by a qualified actuary, using generally accepted actuarial principles in accordance with CMS actuarial guidelines.

For employers offering multiple plan options (for example: a PPO, an HDHP, and/or an HMO), the creditable coverage status must be determined separately for each plan option.



EXAMPLE:

Example

Jane loses creditable prescription drug coverage as of January 1, 2025 (the first day of the 2025 plan year) and fails to enroll in Part D by March 1, 2025 (the end of their special enrollment period). Jane elects to enroll in Part D coverage during Medicare's 2026 annual enrollment period for a 1/1/2026 effective date. Since Jane has a 12-month gap in creditable coverage, their monthly base premium amount may permanently increase by as much as 12%.

Here is a sample calculation (for illustrative purposes, this assumes the 2024 base premium rate):

$.12 \text{ (12\% penalty)} \times \$34.70 \text{ (2024 base beneficiary premium)} = \4.164

$\$4.164 \text{ rounded to the nearest } \$0.10 = \$4.20$

$\$4.20 = \text{Jane's monthly late enrollment penalty for 2025 (the actual amount for 2025 and future years will depend on the base premium rate for that year).}$



HIPAA Update

Changes in effect for 1/1/25

HIPAA Privacy Rules Amended

1. In April, the Dept of Health and Human Services (HHS) issued new regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that impose new restrictions on the use and disclosure of reproductive health care by covered entities, include employer-sponsored health plans.
2. There are two relevant deadlines: December 23, 2024 and February 16, 2026.



HIPAA Privacy Rules Amended

3. Covered entities (health plans amongst others) and business associates must comply with the new requirements by December 23, 2024, but they have until February 16, 2026, to update their Notice of Privacy Practices.
4. Reproductive healthcare includes female (contraception, preconception screening, counseling, pregnancy screening, miscarriage management, fertility and infertility diagnosis, menopause, etc.) and male (vasectomies and erectile dysfunction) matters.



What Does The Final Rule Do?

- 1) Prohibits the use of PHI against people for providing or obtaining lawful reproductive healthcare.
- 2) Prohibits covered entities and business associates from using or disclosing PHI for either of the following non-health care purposes:
 - a) to conduct a criminal, civil or administrative investigation into or impose similar liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided; and
 - b) the identification of any person for the purpose of conducting such an investigation or imposing such liability.



What Does The Final Rule Do?

- 3) Requires you to obtain a signed statement in certain situations before using or disclosing PHI related to reproductive healthcare.
- 4) Requires the distribution of a revised Notice of Privacy Practices.

Steps To Take

- 1) Update HIPAA policies and procedures.
- 2) Update BAAs.
- 3) Train your workforce on the new rules – employees are the most common cause of healthcare data breaches.
- 4) Keep up with state (and neighboring state) laws related to reproductive healthcare. Some of the prohibitions under the new law apply only when PHI at issue involves lawful reproductive healthcare.
- 5) Prepare required statements or attestations. See here:
<https://www.hhs.gov/sites/default/files/model-attestation.pdf>



ACA Updates

ACA Penalties Have Decreased!

- 1) They aren't reduced by much but when is the last time our govt reduced a fine?
- 2) It is more important than ever before that you don't make mistakes. "Good faith" reliance no longer applies. All mistakes are now penalties.
- 3) Paper filings no longer permitted.



ACA Penalties Have Decreased!

An ALE is generally an employer that averages 50 or more full-time equivalent (“FTE”) employees during the prior calendar year. Only employers who are ALEs are subject to the employer mandate. Except for employers not in existence in the previous calendar year who reasonably expect to employ 50 or more FTEs in their first year, ALE status is always based on the prior calendar year rather than the employer’s plan year.



ACA Penalties Have Decreased!

The (a) penalty is triggered when an “Applicable Large Employer” or “ALE” does not offer coverage to at least 95% of its full-time employees and at least one full-time employee receives a Premium Tax Credit (“PTC”) or subsidy to purchase individual coverage through an ACA public exchange.

The (b) penalty applies for each month when an ALE offers coverage that is either unaffordable or does not meet minimum value requirements, or does not offer coverage to a full-time employee, and that employee receives a PTC to purchase individual coverage through an exchange.



ACA Penalties Have Decreased!

- 1) The (a) penalty for 2025 is \$2,900, down from \$2,970. The penalty though is the total # of FTEs less 30.
- 2) The (b) penalty for 2025 is \$4,350, down from \$4,460. The penalty is per person who receives a subsidiary.



The Affordability % Has Increased!

The affordability percentage for self only coverage increases to 9.02% for 2025; an increase from 8.39% in 2024.



But The Affordability % Has Increased!

Impact:

Employers can increase employee contributions as long as they remain under the 9.02% affordability percentage for self only coverage.



Federal Poverty Level Limit Set

Employers offering a medical plan option in 2025 that provides minimum value and costs the employee no more than \$113.20 per month for employee-only coverage automatically satisfies ACA affordability.



FMLA Case Updates

Tanner V. Strkyer Corporation

As an employee of Stryker Corporation, Tanner was eligible for and requested FMLA leave for the birth of his child. The company approved that request and notified Tanner that his leave would not begin until his child was born. The company further notified Tanner that for any absences prior to the child's birth, Tanner would be required to use available sick or vacation days. Even though Tanner knew that the child's due date was expected to be around August 12, 2021, Tanner opted to be absent from work starting on July 30 so that he could pack and prepare for his trip to Connecticut where his girlfriend planned to have their baby. By August 13, Tanner had exhausted all of his accrued paid time off – although his child was not born until nearly one week later. Pursuant to the company's attendance policy, his days of absence after exhaustion of PTO were counted as "occurrences." Because such occurrences totaled the maximum number allowed under the attendance policy, and such maximum was reached prior to the birth of his child, Tanner was discharged due to excessive absenteeism.

Did the Company legally terminate Tanner?



Tanner V. Strkyer Corporation

Yes, here the Court held that an employee's absence while awaiting birth of his child was not covered by the FMLA.

Based on the plain reading of the FMLA, the Court found no language which defined leave to include pre-birth absences. In fact, the FMLA discusses measuring FMLA from the "beginning date of such birth."



Tanner V. Strkyer Corporation

Other issues:

1. He can't cite complications since he's not the one pregnant.
2. He couldn't use it to care for mom even if mom had pre-birth complications because they were NOT married. He can't say he has to care for his girlfriend's pre-birth FMLA health issues because she is not a spouse (yet).
3. This wasn't an adoption which permits pre-birth leave under the FMLA.



Perez v. Barrick Goldstrike Mines, Inc.

An underground miner claimed he was injured at work, and obtained a doctor's note requesting five days off to recover. The employer, based on the medical note, granted the leave. Once the initial leave expired, the doctor indicated the employee needed an additional two weeks off due to ongoing pain. The employer again approved the leave.

Subsequently, the employer learned information raising questions about whether the employee had a serious health condition. The employer investigated the employee's accident, and found no evidence the accident had occurred. Moreover, a coworker told management that, before the incident, the employee had stated that he planned to fake an injury so he could take time off to work on his rental properties. Based on this evidence, the employer hired an investigator to look into the matter, and received video evidence showing that the employee was not suffering from a serious health condition. The employer terminated the employee's employment as a result.

Can the Company terminate legally?



Perez v. Barrick Goldstrike Mines, Inc.

Yes, here the Court held that an employer may, in certain circumstances, rely on nonmedical evidence in contesting an employee's right to FMLA leave.

Based on the plain reading of the FMLA, the Court found the word "may" indicated the FMLA allows, but does not require, a second opinion.



Shipton v. Baltimore Gas & Electric Co.

An employee in August 2017 requested and was granted intermittent FMLA leave based on a health provider certification that he was diabetic and experienced episodes of hypoglycemia.

Several months later, in May 2018, the employee took intermittent FMLA leave for neuropathy, which was also related to his diabetes. But because his existing FMLA certification established leave only for his diabetes-related hypoglycemia (and not for neuropathy), the employer requested additional medical documentation.

The additional medical documentation, however, stated that the employee had not experienced hypoglycemia for over two years. Based on the conflicting medical documentation, including the August 2017 request for intermittent FMLA based on hypoglycemia and the May 2018 medical documentation stating that the employee had not suffered from hypoglycemia since at least May 2016, the employer suspected that the employee was not taking FMLA leave for an approved purpose. The employer subsequently terminated his employment.

Can the Company terminate legally?



Shipton v. Baltimore Gas & Electric Co.

Yes, here the Court held that where an employer has a legitimate basis for believing an employee committed misconduct related to the use of FMLA leave, it may take disciplinary action, up to and including termination.



Shipton v. Baltimore Gas & Electric Co.

Takeaway:

1. Investigate when you have a legitimate basis to believe there has been misconduct related to FMLA use.

Legitimate bases for suspected misuse include conflicting medical documentation, the employee's failure to communicate properly about unscheduled absences, and plausible statements by the employee and co-workers. The investigation into the FMLA misuse may include fact-finding interviews with the employee and co-workers, and additional requests for medical documentation.

Wrong Way To Investigate FMLA Fraud

The plaintiff worked as an attorney for the defendant. According to the plaintiff, he needed to care for his mother who suffered from degenerative joint and bone diseases. So, he requested FMLA leave to care for her, and the defendant provided the plaintiff with FMLA paperwork for the mother's doctor to complete.



Wrong Way to Investigate FMLA Fraud

He completed most of the form, including the section his mother's physician was supposed to fill out. Then, at a doctor's appointment for his mother, the plaintiffs gave the form to his mother's nurse. The nurse "left the room with the form—presumably to discuss the certification with [the doctor]—then returned to the room and signed it" on behalf of the doctor. The plaintiff then returned the completed form to the defendant.

The plaintiff further alleged that upon reviewing the form, HR became suspicious. However, rather than contact the plaintiff directly to discuss its concerns, HR called the doctor's office to verify who completed the form. The doctor's office confirmed that "no one in the office—including the doctor and RN—filled out the form" and "[t]he doctor did not authorize anyone to fill it out or sign it on her behalf." So, the defendant fired the plaintiff.

Wrong Way to Investigate FMLA Fraud

The plaintiff sued claiming FMLA forbids an employer from calling a physician to inquire about authenticity of FMLA paperwork. The court AGREED.

“The employer shall advise an employee whether the employer finds a certification incomplete or insufficient, and shall state in writing what additional information is necessary to make the certification complete and sufficient”



Wrong Way to Investigate FMLA Fraud

The regulations state that “[i]f an employee submits a complete and sufficient certification signed by the health care provider, the employer may not request additional information from the health care provider.” But, an “employer may contact the health care provider for purposes of clarification and authentication of the medical certification...*after* the employer has given the employee an opportunity to cure any deficiencies...”



COBRA Coverage Issues

COBRA Early Termination

Q12: Can continuation coverage be terminated early for any reason?

A group health plan may terminate coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

If COBRA coverage is terminated early for nonpayment, that person generally won't be able to get a Marketplace plan outside of the open enrollment period.



COBRA Reduction In Hours

It does NOT always result in an offer of COBRA. It depends on whether the ACA applies to you, what measurement period you are using and how long the employee has been with you.



COBRA Reduction In Hours

New employee: It won't matter whether ACA applies or not and you can offer COBRA.

For a new hire who has only worked for 6 months, the stability period considerations under the ACA might not apply in the same way as they do for an employee who has already completed a full measurement period.

Initial Measurement Period: For new hires, employers often use an initial measurement period to determine whether the new employee qualifies as a full-time employee based on their hours of service.

Initial Stability Period: If the new hire is deemed full-time based on the initial measurement period, they would then enter an initial stability period during which they must be offered health insurance benefits, regardless of variations in hours worked during this stability period.

Since your new hire has only worked for 6 months, they are still within their initial measurement or administrative period, depending on your company's specific policies. If they haven't yet been determined to be full-time, they might not yet be in a stability period that guarantees continued benefits.



COBRA Reduction In Hours

Existing employee: If you don't have to follow the ACA (less than 50 FTEs the prior year), you can immediately offer COBRA.



COBRA Reduction In Hours

Existing employee: If you follow the ACA, use the lookback measurement period and offer COBRA, you can be subject to either of the two ACA penalties.

“An employee in a stability period generally continues to receive health insurance benefits even if they are not completing any hours of service, provided they were previously determined to be a full-time employee during the associated measurement period.

Under the Affordable Care Act (ACA), the stability period is designed to provide a consistent period during which the employee's eligibility for health insurance benefits is maintained, regardless of variations in their hours of service.”



COBRA Reduction In Hours

Existing employee: If you follow the ACA and offer COBRA, you can be subject to either of the two ACA penalties.

There could be exceptions such as using the monthly measurement period, a termination of employment or the employee declining to continue to make health insurance payments given the limited income he/she is now earning.



Leaves of Absence

Somewhat related to the prior discussion, a LOA is not a COBRA matter. If you are going to offer COBRA, make sure it is due to a reduction in hours (subject to the ACA rules), not a LOA.

Why? Most plans, if not all, allow for continued eligibility under the health plan while on an approved LOA of 12 weeks or less (some go out even longer).



Retroactive Cancellation of COBRA?

An employer can retroactively cancel coverage if no COBRA payments are ever made and if the initial notices were timely provided.

A plan may either (a) continue coverage during a payment grace period and then retroactively cancel it for nonpayment; or (b) if the plan allows retroactive reinstatement, cancel coverage and retroactively reinstate it upon payment of required premiums.⁶⁶ Claims incurred during a payment grace period need not be paid until COBRA coverage is elected and any required payment for coverage has been made.⁶⁷

29 CFR 2590.606-4(b)(4)

Reminder: No retroactive termination under the ACA for a non-COBRA matter.



Miscellaneous Updates

The Fun Never Ends!

Compliance Deadlines

September 30: MLR Rebates. Employers with fully insured health plans that receive rebates must distribute these funds. Penalty is \$100 per entity per day per individual affected by the violation.

October 15: Medicare Part D Notices. These notices must be distributed to health plan participants indicating whether plans are creditable.

December 31: Gag Clause Attestations. Must be filed with CMS electronically. \$100 penalty per day per entity per individual affected by the violation.

<https://hios.cms.gov/HIOS-GCPCA-UI>





Under the CAA, a gag clause is defined as:

1. Restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with HIPAA, GINA and ADA privacy regulations, including, on a per claim basis—

- Financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;
- Provider information, including name and clinical designation;
- Service codes; or
- Any other data element included in claim or encounter transactions; or

2. Restrictions on sharing information or data, or directing that such information or data be shared, with a business associate.

The gag clause provisions of the CAA (specifically Code section 9824, ERISA section 724, and PHSA §2799A-9(a)(1)), generally prohibit plans and carriers from entering into agreements with providers, TPAs, or other service providers that include such provisions.

Gag Clause Attestation

For self insured or level funded plans, the plan may need to enter into an agreement with the plan's service provider (TPA or PBM) where the service provider will attest on the plan's behalf by December 31st each year.

The plan is responsible for the Attestation and may have to do this itself. If the service provider fails to timely do this submission or does the Attestation incorrectly, the plan is still liable. Plans should ask their TPAs and networks to confirm that gag clauses have not been in their contracts.



New Fixed Indemnity Plan Notice

Employers who offer fixed indemnity coverage must provide clear and conspicuous notices to consumers explaining that fixed indemnity plans are not a substitute for comprehensive health insurance and probably do not meet the minimum essential coverage requirements under the ACA.

These are usually part of an employer's voluntary benefit package.



New Fixed Indemnity Plan Sample Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- + The payment you get isn't based on the size of your medical bill.
- + There might be a limit on how much this policy will pay each year.
- + This policy isn't a substitute for comprehensive health insurance.
- + Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

****minimum 14 pt font must be used.**



New Medicare Reporting Rule

CLARIFICATION: As our discussion went along, we ended up getting things right.

You report 1) individuals (employees, spouses and dependents) who are medicare eligible and who ARE enrolled on the Company plan, AND 2) individuals (employees, spouses and dependents) who are Medicare eligible but waived the Company health insurance. I realize you may not know all of this information, or the employee may not disclose this info but you have an obligation to at least request it.



New Medicare Reporting Rule

Group health plans must report coverage provided to Medicare beneficiaries within one year of the effective date of the coverage. Generally, the responsible reporting entity (RRE) is the insurer (for fully-insured plans), or the third party administrator (TPA, for self-funded plans). In the case of a group health plan that is self-insured and self-administered, the plan administrator or fiduciary would be the RRE. As part of this reporting, RREs are required to report the Medicare ID or social security number of every Medicare beneficiary covered under the group health plan.

These reporting obligations apply broadly to employer-sponsored group health plans, whether self-funded or fully insured, and whether covered by ERISA or exempt due to local government plan status. The reporting obligation does not apply to FSA plans, HSA plans in which Medicare beneficiaries may not make a contribution, or Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs).



New Medicare Reporting Rule- Penalty

While the RRE reporting obligations have been in place for some time, CMS recently finalized its rule specifying how and when it will calculate and impose civil money penalties (CMPs) when group health plan and non-group health plan RREs fail to meet their Medicare Secondary reporting obligations. Going forward, CMS plans to randomly sample 1,000 records per year to ensure that RREs are reporting all of the required data.

Penalties

A group health plan that fails to report information regarding a Medicare beneficiary or beneficiaries will be subject to a civil monetary penalty (a fine) of \$1,000/beneficiary/day that the information has not been reported.

Effective Date

The final rule becomes applicable on October 11, 2024. Penalties may be imposed beginning one year later, as of October 11, 2025.



New Medicare Reporting Rule- Action Plan

RREs should obtain Medicare ID numbers or SSNs from all Medicare-covered persons covered under the group health plan. Because Medicare is available to some persons under the age of 65, employers should ask participants in the plan to identify whether they are Medicare beneficiaries. Below are links to a letter and a model form that CMS has developed that RREs may use to obtain that information.

Letter: <https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/mandatory-insurer-reporting-for-group-health-plans/downloads/new-downloads/revisedcollectionssneins.pdf>

Model Form: <https://www.cms.gov/files/document/mmsea-111-mbi-ssn-collection-ghp-model-language.pdf>



Pay Transparency Laws

Salary ranges must now be posted for jobs in many states, including Illinois and Minnesota as of January 1, 2025.

If posting for remote workers, pay ranges are a must unless you expressly exclude candidates from all of the states that require a salary range.



QUESTIONS?

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