Maryland
DEPARTMENT OF LABOR

DIVISION OF FAMILY AND MEDICAL
LEAVE INSURANCE (FAMLI)
1100 N. Eutaw Street
Baltimore, MD 21201

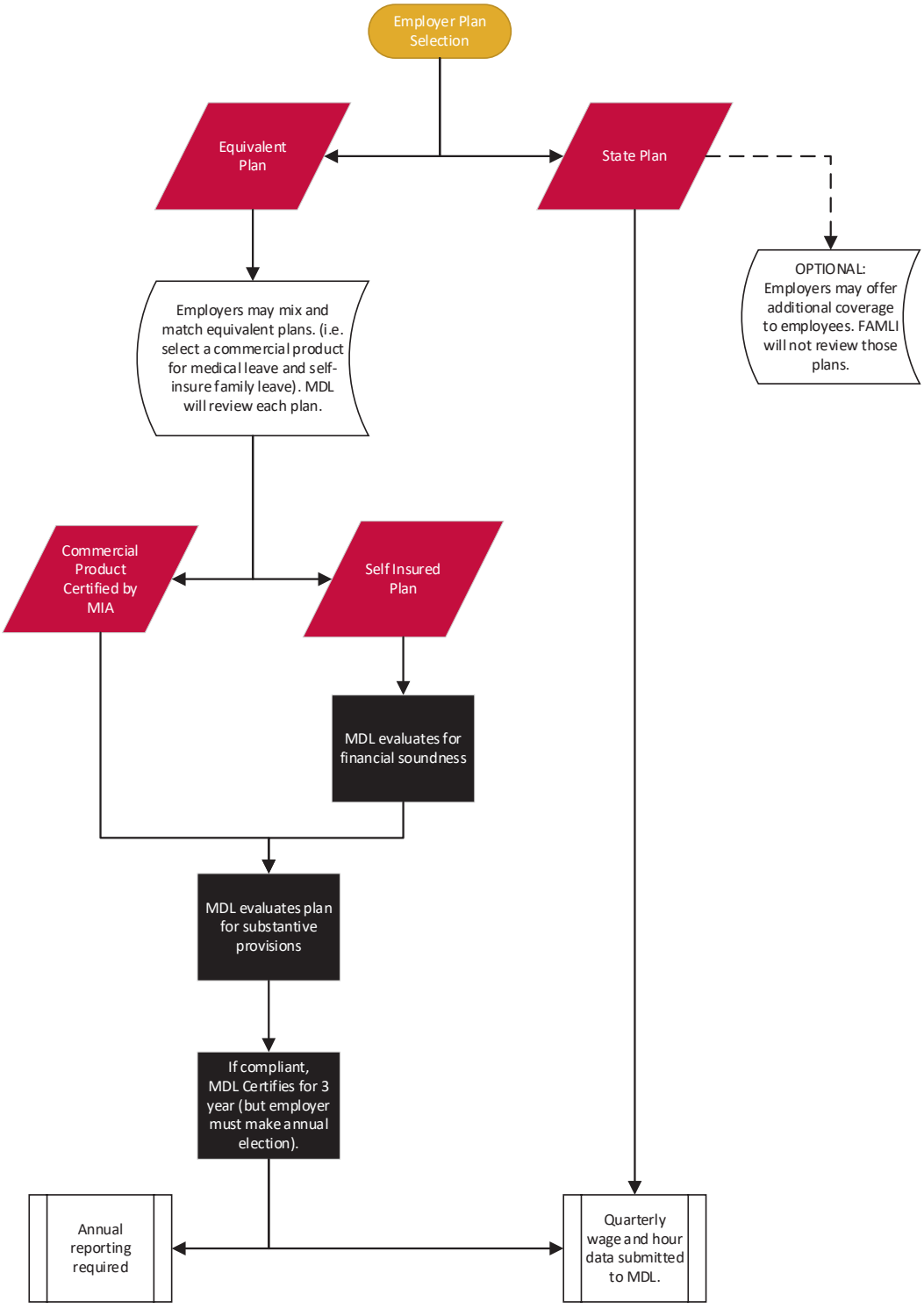
Informal Regulatory Stakeholder Engagement Process
Phase I
Discussion Document – Equivalent Private Insurance Plans

The Time to Care Act of 2022 provides that employers can elect to offer private plans (Equivalent Private Insurance Plans (EPIPs)) in lieu of contributing premiums to the state fund. Before drafting any proposed regulations on EPIPs, the Division seeks feedback from stakeholders on the 5 questions presented on the following pages.

Comments can be submitted by offering oral remarks at the June 15th informal regulatory stakeholder meeting and/or by submitting written comments via email to FAMLI.policy@maryland.gov.

1. **What should be the process for an employer to elect FAMLI coverage under a qualified Equivalent Private Insurance Plan?**

One option is described in this diagram:



2. **What might be the criteria for self-insured Equivalent Private Insurance Plans to qualify for coverage?**

Examples of requirements are as follows:

Mechanisms for ensuring plan solvency among employers who choose to provide a self-insured Equivalent Private Insurance Plan may include requirements to provide a surety bond, put funds in escrow, or meet other financial requirements to provide assurances of access to sufficient funds to cover the costs of insured events.

One way of calculating financial solvency would be to base the amount of required secured funds on the amount of expected future benefits as determined by a calculation of expected benefits to be paid over four calendar quarters. A similar method is in use in Massachusetts.

Such a formula could be expressed as:

[# of employees] x [the actuarially calculated event-specific utilization rate] x [12 weeks] x [the maximum benefit amount]

Based on the state's current actuarial projections, this generic formula could be further refined as:

For medical-only self-insured plans:

# of employees x .05 x 12 weeks x $1000

For family-only self-insured plans:

# of employees x .02 x 12 weeks x $1000

For combined-event self-insured plans:

# of employees x .07 x 12 weeks x $1000

There may be a minimum number of employees for the purposes of the calculation of secured funds, such as 50. This means any employer with fewer than 50 employees may be rounded up to 50 for the purposes of calculating the required amount of secured funds. However, an employer of any size may be permitted to elect to self-insure and meet the specified requirements. The number of employees for any employer would be rounded up to an interval such as the nearest 50. Therefore, under the example formulas provided above, the amount of secured funds for reference would be:

Number of employees	Medical self-insured	Family self-insured	Combined self-insured
1-50	$30,000	$12,000	$42,000
51-100	$60,000	$24,000	$84,000
451-500	$300,000	$120,000	$420,000
951-1000	$600,000	$240,000	$840,000
9951-10000	$6,000,000	$2,400,000	$8,400,000

The dollar amounts represent the amount of funds that would have to be demonstrated as secured for a self-insured Equivalent Private Insurance Plan to qualify for FAMLI coverage.

Note: The "number of employees" column is for reference only and does not represent the complete breakdown of employee-number increments. The increment would be an amount such as 50. This means the number of employees for any employer would be rounded up to the nearest 50 for the purposes of determining the amount of required secured funds.

3. What substantive provisions might an Equivalent Private Insurance Plan have to meet to qualify?

Examples of the substantive provisions that an Equivalent Private Insurance Plan would need to include in order to qualify as substantively providing the same rights and benefits under the state plan include :

1. COVERAGE: Must provide benefits to all covered individuals employed by the employer whose work is localized in Maryland. Benefits must be paid to anyone who has 680 hours for any work localized in Maryland in the base period.
2. LEAVE PURPOSES: Allowing family and medical leave insurance benefits to be taken for all purposes specified in the State Plan.
3. DURATION OF LEAVE: Allow covered employees to take family leave or medical leave in a benefit year for periods of time equal to or longer than the duration of leave provided under the State Plan.
4. BENEFIT AMOUNT: The benefit calculation must result in a benefit that is equal to or greater to what the benefit would be if the employee was in the State Plan.
5. NEW EMPLOYEES: If you have less than 680 hours of services, the benefit amount is the higher of the benefit amount that would be based on wages with that employer or the regular base period for the State Plan.
6. INTERMITTENT LEAVE: Allow leave to be taken in increments or nonconsecutive periods as provided under the State Plan;
7. NO CONDITIONS OR RESTRICTIONS: Impose no additional conditions or restrictions on the use of leave beyond those explicitly authorized by the State Plan.
8. EMPLOYEE CONTRIBUTION AMOUNT: The rate at which employee contributions are set cannot exceed the rate set for employee contributions under the State Plan;
9. CONTRIBUTION START DATE: Self-insured plans may begin collecting employee contributions on the date State contribution collection begins. Commercially insured products cannot begin collection until the policy effective date.
10. NON-COMMINGLED FUNDS: Ensure employee contributions that are received or retained under an equivalent plan are used solely for equivalent plan expenses, are not considered part of an employer's assets for any purpose, and for self-insured plans are held separately from all other employer funds.
11. DECISION REQUIREMENTS: Provide for decisions on benefit claims, to be in writing, either in hard copy or electronically if the employee has opted for electronic notification. Decisions on benefit claim approvals must include the amount of leave approved, reason for any leave denied, the weekly benefit amount, and a statement indicating how the employee may contact the Department to request the eligible employee's average weekly wage amount if the employee believes the benefit amount may be incorrect. Denial decisions must include the reason(s) for denial of benefits. All decisions must include an explanation of an employee's right to request a reconsideration and the process by which a reconsideration is requested.

12. RECONSIDERATION: Provide a reconsideration process to review any benefit decisions when requested by an employee that also requires the employer or administrator to issue a written decision. The employee must have at least 30 calendar days from the date of the written decision to request a reconsideration with the employer or administrator, if applicable, or as soon as practicable if there is good cause for the delay beyond the 30 calendar days as defined in the State Plan. The employer or administrator has 10 business days from the date the reconsideration is received, or as soon as practicable if there is good cause as described in the State Plan, to resolve the reconsideration and for the employer or administrator to issue a written reconsideration determination letter along with an explanation of the Department's appeal process as provided by the Department if a reconsideration is denied; the individual evaluating the reconsideration must be a different person than the individual who made the initial determination. The Department will accept appeals from reconsiderations using the appeals process outlined in the State Plan.
13. TIMEFRAME FOR APPROVALS: Provide that the equivalent plan employer or administrator must make all reasonable efforts to make a decision on whether to allow the claim within 10 business days of receiving it. Once approved, the employer or administrator must issue the first payment of any benefits to an employee within 5 business days after approving the claim or the start of leave, whichever is later. Subsequent benefit payments must be provided no less frequently than every 2 weeks. If the benefit is being paid through the employer's regular payroll system, the benefit may be paid according to the existing paycheck schedule as long as the first benefit is included in the first regularly scheduled pay date after the approval.
14. EMPLOYEE NOTICE: Ensure written notices using the Department's template, are provided at the same times as provided under the State Plan to all employees, at the time of hire and each time the policy or procedure changes, in the language that the employer typically uses to communicate with the employee.
15. NO OFFSET FOR SIMULTANEOUS EMPLOYMENT: Employers must pay based on the benefit calculation for your employment arrangement; Employers cannot reduce any other benefits received from simultaneous employment with a different employer.
16. And other requirements developed during the regulatory process.

4. **What might be the reporting requirements to MDL that an Equivalent Private Insurance Plan would have to comply with?**

The reporting requirements may include data elements such as:

1. Number of claims for benefits both in total and by leave type
2. Number of claims broken down by
    - Jurisdiction
    - Race and ethnicity
    - Gender
    - Zip code
    - Age
3. Number of claims for benefits approved both in total and each leave type
4. Number of claims approved by
    - Jurisdiction
    - Race and ethnicity
    - Gender
    - Zip code
    - Age
5. The number of claims for benefits denied both in total and by leave type
6. Number of claims denied by
    - Jurisdiction
    - Race and ethnicity
    - Gender
    - Zip code
    - Age
7. Number and status of reconsiderations
8. Average time from submission of completed application to approval
9. Contribution rate for employees
10. Total amount collected
11. Total amount disbursed
12. Fund balance *(if self-insured)*

5. **What rules might there be governing an employer's election to move from coverage under an Equivalent Private Insurance Plan to the State Plan or vice versa? What would the process be?**

Examples of rules governing the modification of election status may include the following:

Elections of coverage between EPIPs and the State Plan (SP) may be restricted to time periods that may be called "open enrollment periods" and could run for a period of time such as January through March every year.

There may be a standard plan election period that could run for a period of time such as one year beginning on July 1 and running through June 30. During this period, employers may be required to maintain coverage under the plan (either an EPIP or the State Plan) they chose during the last open enrollment period. Changing coverage elections between an EPIP and the SP during this period could result in assessments such as those described in the chart on the next page.

There may be a standard EPIP certification period that could run for a period of time such as three years beginning on July 1 of every year and running through June 30 three years later. During this three-year period, the plan could be certified as being "qualified" for the purposes of FAMLI, and during this period MDL may not request additional evidence of qualified status. There may be exceptions such as in the case of extraordinary audits for cause, complaints made by covered employees, or evidence that an EPIP no longer meets the FAMLI qualification criteria. Every three years, EPIPs may be required to recertify in order to maintain their "qualified" status.

SPECIAL IMPLEMENTATION RULES - There may be special rules for the FAMLI ramp-up and implementation period starting in 2024. For example, the first election plan period and EPIP certification period could run through some extended end date, such as June 30, 2029. The first election plan period for FAMLI would therefore be for an extended period of time compared with the standard one-year election plan period. The period extending from 2024 through June 30, 2029 would represent an initial plan election period extending three-and-one-half years after benefits are first paid in January 2026. Employers who drop coverage under an elected Equivalent Private Insurance Plan and choose to enter the State Plan prior to June 30, 2029 might be subject to an assessment such as one outlined in the chart on the next page. Any employee contributions in the possession of the employer who elected to establish a self-insured EPIP may have to be remitted to the Department if the employer drops coverage under the self-insured EPIP before June 30, 2029. However, it is possible that employers who initially elected coverage under the State Plan during the initial election plan period might still be allowed to drop coverage under the State Plan and enter a qualified EPIP during an open enrollment period before June 30, 2029. The normal three-year EPIP certification period may also be extended during the implementation period through some date such as June 30, 2029.

BEGINNING IN 2029 – The special implementation rules might be thought of as phasing out in 2029. Employers who elect to offer an Equivalent Private Insurance Plan in 2029 and after would follow the standard rules such as a one-year election period and a three-year EPIP certification period. Once the Department approves an EPIP as qualified, the plan may be certified for a length of time such as three years. Every year within the 3-year certification period, employers may be allowed to change their election of whether to maintain coverage under their EPIP or participate in the State Plan. Employers who join the State Plan, either voluntarily or involuntarily, outside of an open enrollment period could

be subject to an assessment as described in the chart. In addition, any employee contributions in the possession of the employer may have to be remitted to MDL.

(See chart.)