Sixth Circuit Expands FMLA Leave Rights to Siblings

By: Abby Blankenship

In *Chapman v. Brentlinger Enterprises*, the U.S. Court of Appeals for the Sixth Circuit (the "Sixth Circuit") expanded the scope of family relationships covered under the Family and Medical Leave Act ("FMLA"), ruling that employees may be eligible for leave to care for a seriously ill sibling.

Background

As a general rule, the FMLA provides eligible employees with unpaid, job-protected leave for the following reasons: (i) their own serious health condition; (ii) to care for a seriously ill or injured spouse, child, or parent; (iii) for the birth, adoption, or placement of a child; or (iv) to deal with "exigencies" related to their spouse's military deployment. The FMLA also includes a limited exception when an employee assumes a parental role ("in loco parentis") for someone who is not their legal child.

Facts

Celestia Chapman ("Chapman") was employed as a finance manager at Brentlinger Enterprises, d/b/a Midwestern Auto Group ("MAG"), a luxury car dealership. While employed at MAG, Chapman began to care for her terminally ill sister, who was battling non-Hodgkin lymphoma and lived in another state. Chapman provided financial support for her sister, including paying part of her bills and purchasing groceries for her. She also performed daily caregiving tasks for her sister, such as cooking, cleaning, hand-feeding, and general housekeeping, as well as administering medications, driving her sister to medical appointments, and tending to her bed sores.

After Chapman exhausted her paid time off while caring for her sister, MAG allowed her to take a brief, unpaid, non-FMLA leave at its discretion, though the length of this leave was unclear. On her last paid day off, Chapman requested FMLA leave, but MAG denied her request, stating that the FMLA did not provide leave to care for an adult sibling. Although MAG declined her request for FMLA leave, it approved a modified schedule with reduced hours for her. However, Chapman did not report for work as scheduled, and MAG subsequently terminated her employment. Chapman then filed a lawsuit against MAG, claiming FMLA interference and retaliation. The district court ruled in favor of MAG, agreeing that the FMLA did not cover leave to care for an adult sibling.

The Sixth Circuit's Decision

After an appeal of the district court's decision, the Sixth Circuit considered whether Chapman could be eligible for FMLA leave based on an "in loco parentis" relationship with adult sibling. The Sixth Circuit reversed the district court's summary judgment in favor of MAG, ruling that the district court erred in concluding that an in loco parentis relationship could not exist between adult siblings.

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The Sixth Circuit acknowledged Chapman's argument that, since she cared for her sister in a manner similar to how a parent cares for a child, she was acting in loco parentis to her sister. The Sixth Circuit noted that "the statutory text does not tell us whether the FMLA recognizes in loco parentis relationships under these circumstances." As a result, the Sixth Circuit looked to the common law definition of in loco parentis, which refers to a person "who has put himself in a situation of a lawful parent by assuming the obligations incident to the parental relation without going through the formalities necessary a to legal adoption." Additionally, the Sixth Circuit noted that the "touchstone of this inquiry is intention."

The Sixth Circuit outlined several factors to evaluate "whether a person intended to assume parental status over another adult." The factors evaluated by the Sixth Circuit include whether the person:

1. Is in close physical proximity to the adult in question;
2. Assumes responsibility for supporting them;
3. Exercises control or has rights over them; and
4. Shares a close emotional or familial bond with them, akin to that of an adult child.

Based on this guidance, the Sixth Circuit remanded the case to the district court to reconsider whether Chapman and her sister had a relationship that was parental in nature.

Key Takeaways for Employers

Although currently limited to the states covered by the Sixth Circuit – Kentucky, Michigan, Ohio and Tennessee – this case highlights the need for employers to carefully evaluate FMLA leave requests, especially when dealing with nontraditional caregiving situations.

As a best practice, employers should:

1. Thoroughly review the facts and circumstances surrounding each FMLA request before denying leave; and
2. Ensure that all FMLA requests are well-documented, and that communication with employees regarding leave requests is clear and consistent.

Second Trump Administration in The Health and Welfare Space: What's to Come

By: Kate Belyayeva

In the first month of the second Trump presidency, the administration has focused on several executive orders and policy changes that may have significant implications for employer health and welfare plans. In a sweeping overhaul of federal policies, these changes target healthcare coverage, diversity initiatives, and federal funding which have the potential of sparking legal challenges with some changes already subject to criticism. Notably, executive orders do not directly change the law—instead, they are a mechanism to direct federal agencies, such as the Departments of Labor, Treasury, and Health and Human Services ("HHS, collectively, the "Agencies"), to promulgate regulations and issue guidance in line with the executive orders. Nevertheless, employers should familiarize themselves with the content of the executive orders to grasp an idea of what lies ahead.

Gender-Affirming Care

Late last month, President Trump signed an executive order titled "Protecting Children from Medical and Surgical Mutilation." This order directs federal agencies to cease funding, support, and assistance to federal insurance programs, including TRICARE and Medicaid, and federally funded institutions, such as hospitals and universities, that provide gender-affirming care. This order has already faced legal challenges from human rights groups, but it is too early to tell its final fate.

Moreover, the second Trump administration issued an executive order titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," which speaks on issues involving biological sex and gender identity. Specifically, the order calls for recognition of only two sexes—male and female—which are not considered to be changeable. For example, the term "sex" means "an individual's immutable biological classification as either male or female" and expressly excludes the concept of gender identity.

In one section of the order, which is titled "Recognizing Women Are Biologically Distinct From Men", the Trump Administration urges HHS to provide guidance that expands on the order's new definition. All federal employees are instructed to use the order's definition in interpreting or applying federal law. Furthermore, it is prohibited to use federal funds to promote gender ideology. The order also repeals several Biden administration orders, including, but not limited to, orders titled "Preventing and Combatting Discrimination on the Basis of Gender Identity or Sexual Orientation" and "Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals."

While the gender-related orders do not immediately impact existing protections, the orders signal that changes are around the corner. For example, while the orders do not expressly require HHS to amend the existing Section 1557 rule against discrimination based on gender and gender identity, there is a much greater likelihood that such amendment is upcoming. As

such, employers offering health plans that include coverage for gender-affirming care may have to eventually reevaluate their policies. However, employers should also consider state laws and non-discrimination policies to ensure they align on all fronts, federally and statewide.

Affordable Care Act

The Trump administration has revoked a few Biden-era executive orders titled "Continuing to Strengthen Americans' Access to Affordable Quality Health Coverage," "Strengthening Medicare and the Affordable Care Act," and "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage." Among other things, the revoked orders lengthened the enrollment period for the Affordable Care Act ("ACA") and reduced premium subsidies to help more individuals afford ACA coverage. Effectively, the executive order revoking the aforementioned Biden orders seeks to restrict the ACA, with potential implications for the scope of Medicare and Medicaid.

Other Changes

The following changes are also of note:

- (1) The Trump administration rescinded the fixed indemnity notice requirement;
- (2) Biden's executive order titled "Lowering Prescription Drug Costs for Americans" was rescinded;
- (3) Although not by hand of the Trump administration directly, the Agencies have withdrawn proposed regulations regarding over-the-counter contraceptive coverage last month; and
- (4) The Trump administration issued a temporary regulatory freeze pending review.

Conclusion

As noted above, Trump's initial orders will have very little immediate impact, which gives employers some breathing room to get their affairs in order to ensure compliance. At the same time, given the conflicting praise and criticism from various stakeholders, it is hard to predict which initiatives will be able to withstand scrutiny. We will monitor the developments and provide updates in the future.

Tri-Agency FAQ Provides Updated Guidance Regarding Compliance with the Gag Clause Prohibition

By: John Collier

On January 14, 2024, the Departments of Labor, Health and Human Services, and the Office of Personnel Management (the "Departments") jointly released the FAQs About Consolidated Appropriations Act, 2021 Implementation Part 69 (the "FAQs"). The FAQs provide valuable guidance with respect to compliance with the gag clause prohibition.

Background

The gag clause prohibition, introduced under the Consolidated Appropriations Act of 2021 (the "CAA"), is designed to eliminate contractual barriers that inhibit transparency within the health care and insurance industries. Specifically, group health plans and health insurance issuers are prohibited from entering into agreements with health care providers, third-party administrators (TPAs), or other service providers that restrict the plan or issuer from:

- (1) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;
- (2) electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage consistent with applicable privacy regulations, upon request; or
- (3) sharing such information or data described in (1) and (2), or directing such data be shared, with a business associate consistent with applicable privacy regulations.

In addition to these restrictions, plans and insurers are required to submit an annual Gag Clause Prohibition Compliance Attestation ("GCPCA") to the Departments by December 31 of each year, affirming their compliance with these provisions.

The FAQs

The FAQs provide much-needed clarity on several aspects of the gag clause prohibition, particularly regarding its application to complex contractual relationships and data access protocols.

1. Application to Downstream Contracts.

First, the FAQs make clear that, if a plan contracts with a TPA that in turn contracts with provider/network entities, the TPA's contracts with those downstream entities are also subject to the gag clause prohibition and may not from contain clauses restricting disclosure. The Departments view such arrangements as indirect restrictions that violate the gag clause prohibition.

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1. Provider Discretion Over De-Identified Data.

Second, the FAQs provide that an agreement contains a prohibited gag clause if it allows disclosure of de-identified data based on the discretion of a provider or TPA.

2. Restrictions on Data Access.

Third, the FAQs provide that a limitation on the scope, scale, or frequency of electronic access to de-identified claims and encounter information or data is considered a prohibited gag clause.

3. Attestation Despite Non-Compliance

Finally, the FAQs clarify that if a plan is unable to remove a provision that violates the gag clause prohibition, it must still submit the GCPCA. This requirement applies not only to direct agreements between the plan and issuer but also to downstream agreements between a provider and another entity. Upon identifying a non-compliant provision, the plan should attest to the non-compliance and provide details about the prohibited gag clause in the "Additional Information" section of the attestation.

Employer Takeaways

The updated guidance provided in the FAQs has important compliance implications for employers and plan sponsors. To ensure adherence to the gag clause prohibition and mitigate risk, employers should take the following steps:

1. Review and Update Contracts

Employers should conduct a thorough review of all contracts with TPAs, network providers, and other service vendors. Special attention should be given to identifying and removing any prohibited gag clauses, including those in downstream agreements between TPAs and providers or network entities.

2. Ensure Unrestricted Data Access

Employers should confirm that providers and TPAs are not imposing any limitations on the scope, scale, or frequency of electronic access to de-identified claims and encounter data. Any contractual language that allows providers discretion over data disclosure or restricts data sharing with business associates should be amended to align with the gag clause prohibition.

3. Prepare for the GCPCA Submission

Employers and plan sponsors must submit the GCPCA to the Departments by December 31 of each year. Even if prohibited gag clauses are identified and cannot be immediately removed, the attestation must still be submitted. In such cases, plans should indicate non-compliance and provide details on the prohibited clauses and efforts being made to address them in the "Additional Information" section of the attestation.

4. Implement Ongoing Compliance Monitoring

Given the evolving regulatory landscape, employers should establish regular compliance checks and contract audits. This will help ensure that gag clause prohibition requirements are continuously met and that new agreements do not inadvertently introduce prohibited provisions.

Compliance Corner: An Overview of Form 5500

By: Abby Blankenship

If your company offers an employee benefit plan under the Employee Retirement Income Security Act ("ERISA"), you are likely required to file Form 5500. Form 5500 is an annual report that contains information about a company's benefits, including welfare benefit plans (including medical, dental, life insurance and disability benefits), retirement plans, fully-insured plans, and self-funded plans. In this month's Compliance Corner, we cover the essentials of Form 5500, including who is required to file, the filing deadline, and the potential penalties for failing to file.

Who is Required to File Form 5500?

As a general rule, plans with 100 or more participants at the beginning of a plan year must file Form 5500 with the Department of Labor ("DOL"). Additionally, any plan funded through a trust—regardless of the number of participants—must also file Form 5500. Welfare plans with fewer than 100 participants that are either unfunded or insured (i.e., do not hold assets in trust) are typically exempt from filing. This exemption also applies to government entities and church plans.

For the purposes of Form 5500 filing, "plan participants" include all eligible employees, regardless of whether they have enrolled, as well as others who receive benefits from the plan, such as former employees (retirees or those who have separated from the company) and beneficiaries of deceased employees.

What is the Deadline to File Form 5500?

Form 5500 is due on the last day of the seventh month following the end of the plan year. For example, for a calendar-year plan, the deadline is July 31 (or the following business day if July 31 falls on a weekend). Employers can file Form 5558 on or before the Form 5500 deadline to request an extension of up to 2 ½ months. Employers granted an extension must file Form 5500 by the extension deadline to avoid penalties. Additionally, any penalties incurred are retroactive to the original Form 5500 due date if the extended deadline is missed.

What Information is Included in Form 5500?

Form 5500 includes the main form, along with various schedules and attachments that provide additional details. While the required schedules depend on the specifics of your employee

benefit plan, the form covers a range of topics, including:

- The plan's start date;
- The number of plan participants;
- Information about the plan sponsor and administrator; and
- Details regarding the plan's funding and benefits provided.

Additionally, a separate Form 5500 must be filed for each plan that meets the filing requirements. Employers may choose to "wrap" multiple benefit plans together for the purpose of filing Form 5500. However, it is essential for employers to have proper documentation that confirms the benefits are covered under a single plan. If the necessary "wrap plan" documentation is not provided, individual filings will be required for each plan.

What are the Penalties for Failure to File Form 5500?

Employers who file Form 5500 late could face penalties from both the Internal Revenue Service ("IRS") and the DOL. The IRS penalty for late filing of a Form 5500 is $250 per day, up to a maximum of $150,000. The DOL penalty for late filing can run up to $2,529 per day, with no maximum. However, these penalties can be reduced by participating in the Delinquent Filer Voluntary Compliance Program (DFVCP).

In an effort to encourage plan administrators to file overdue Form 5500s, the DFVCP provides administrators with the opportunity to pay reduced civil penalties for voluntarily complying with the annual reporting requirements. The DOL offers an online DFVCP penalty calculator to assist administrators in determining the applicable payment needed to participate in the program.

Conclusion

Filing Form 5500 is an essential part of maintaining compliance with regulations for employee benefit plans under ERISA. Since late filings can result in significant penalties from both the IRS and the DOL, it is important to understand the filing requirements and deadlines to avoid costly penalties.

STAY IN THE KNOW...

- DOL, HHS, and IRS have jointly released their 2024 report to Congress, outlining efforts to enforce the Mental Health Parity and Addiction Equity Act (MHPAEA). In the report, DOL highlighted six main areas that continue to comprise the "vast majority" of Non-Quantitative Treatment Limitations (NQTLs) subject to review. These areas include: (1) prior authorization for inpatient services; (2) concurrent care review for outpatient services; (3) provider network admission standards and reimbursement rates; (4) out-of-network reimbursement rates and methods for determining usual, customary, and reasonable charges; (5) exclusions of treatments for mental health and substance use disorders; and (6) standards for mental health and substance use disorder provider networks.

- The Internal Revenue Service released the 2025 cost-of-living adjustments for various benefit programs. Employers are advised to review their benefit plans to ensure they align with these new limits.

- Last month, the Centers for Medicare & Medicaid Services ("CMS") released the Draft CY 2026 Part D Redesign Program Instructions, proposing an update to the simplified determination methodology for assessing whether prescription drug coverage qualifies as creditable coverage for the 2026 plan year. Under the proposed methodology, prescription drug coverage will be deemed creditable if it provides reasonable coverage for brand-name and generic prescription drugs and biological products, ensures reasonable access to retail pharmacies, and is designed to pay on average at least 72% of participants' prescription drug expenses. This revision aligns the simplified determination methodology with the actuarial value of the defined standard Medicare Part D benefit. Employers and plan sponsors should evaluate how these changes may impact their prescription drug coverage determinations for the 2026 plan year.

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