Families First Coronavirus Response Act (FFCRA)

The news continues to come fast and furious.

"On Tuesday, March 24, the Department of Labor (DOL) announced that the effective date of the leaves available through the Families First Coronavirus Response Act (FFCRA) will be **April 1, 2020.**

Based on the language in the bill, the effective date was widely believed to be April 2.

Resources just released this afternoon:

Fact Sheets:

- Families First Coronavirus Response Act: Employee Paid Leave Rights
- Families First Coronavirus Response Act: Employer Paid Leave Requirements

Questions and Answers:

- Families First Coronavirus Response Act: Questions and Answers
- COVID-19 and the Fair Labor Standards Act: Questions and Answers
- COVID-19 and the Family and Medical Leave Act: Questions and Answers

Posters

- Employee Rights: Paid Sick Leave and Expanded Family and Medical Leave under The Families First Coronavirus Response Act (FFCRA)
- Federal Employee Rights: Paid Sick Leave and Expanded Family and Medical Leave under The Families First Coronavirus Response Act (FFCRA)
- Families First Coronavirus Response Act Notice – Frequently Asked Questions

Field Assistance Bulletin

- Field Assistance Bulletin 2020-1: Temporary Non-Enforcement Period Applicable to the Families First Coronavirus Response Act (FFCRA)

Wage and Hour Division Response to COVID-19

Today, Law.com published "Top 10 Employee Benefits Issues in a Slowing Economy" (You have to register to read the article, but it is free)

This article identifies some of the top employee benefits issues for employers to be aware of in this ever-changing environment.

1. HIPAA and Other Privacy Issues: Sharing COVID-19 Information
2. Tax-qualified Retirement Plans: Partial Plan Termination
3. Participant 401(k) Loans and Hardship Distributions
4. Termination of Employment: Tax-qualified and Non-Qualified Plan Distributions
5. Health and Welfare Premiums During Leave
6. Short-Term Disability Considerations
7. Loss of Medical Coverage: COBRA Notice Requirements
8. Life Insurance—Conversion Notice

9. Use of Flexible Spending Account (FSA) Funds
10. Equity Incentive Plans

Hat tip to DailyInsuranceReport.com for making us aware of the article.

We received the following message from Dr. Jennifer Christian, an occupational medicine expert. Shared as both an FYI and also some important information if you work with health care providers.

"More than 1,000 people listened yesterday's ACOEM Covid19 webinar featuring two occ docs, Dr. Leo Guo from National University of Taiwan, and Dr. Francesco Violante who is with a major institution in Bologna, Italy which is adjacent to the Lombardy region where the CoVid19epidemic has swamped the healthcare system. The day before, the Amer Coll of Cardiology had hosted a Covid19 webinar that featured five doctors from various parts of China.

Many topics were covered in a brief period of time, most of which were not a surprise. The three specific points below really perked up my ears / made me think. If you're rushed, skip to #3.

POINT 1. If you are in the little occ med department in a large institution, Italy's Dr. Violente briefly mentioned something you might find helpful. All of the other specialty departments in the hospital were told to designate a single physician to serve as their designated point person for occ med – to pay attention to monitoring and managing the safety and health of the HCWs in that specialty area. And I presume, to liaise with Dr. V. who is coordinating/ communicating among those specialty department designees and with top leaders. (I think I heard this correctly.)

POINT 2. Dr. Violente also said he wanted to explain why some hospitals (including his) are being converted to dedicated CoVid19 hospitals – he felt he had to tell us HOW patients are dying in order to do that. He said the patients who become critically ill and die do so VERY RAPIDLY – typically four days from infection to symptoms, and four days from initial symptoms to death. The strategy to create dedicated hospitals (or to consolidate infectious areas into separate within hospitals as I heard in another Italian account) arose because they recognized the need to:

(1) increase separation between CoVid19 and NON-CoVid19 treatment areas in order to reduce cross-contamination and protect vulnerable patients with other conditions as well as the HCWs caring for them;

(2) concentrate critical (and scarce) respiratory care resources (oxygen, ventilators, ECMO) in one place to maximize their immediate availability (community resource allocation). Those who are in the critical phase of the illness progress very rapidly.

POINT 3. After listening to the ACOEM webinar (and the ACC one before it), I realized that there is a DUAL purpose in protecting HCWs in a pandemic situation.

1. Protect each INDIVIDUAL HCW's health and well-being.

2. Conserve / maximize the AVAILABILITY of the healthcare workforce so there are enough HCWs to meet the future needs of the people for care. This is a larger scale and immediate social purpose, and may require thinking about things a bit differently. Specifically, it may mean treating some healthcare workers differently from others.

HCWs are NEEDED now and will be needed even more in the next few weeks and months as the demand for CoVid19 care explodes here in the US – and continues for a many month period. Dr. Violente commented that “you will lose more and more HCWs over time” and stop caring for patients because they must be quaratined (after being exposed or infected), or become symptomatic and too sick to work, or even die. (14 physicians have already died in Italy.) While the HCW workforce is being depleted, the seriously and critically ill patient population will be continuing to grow – creating a potentially desperate situation. During the pandemic, the population will continue to develop acute healthcare needs for other reasons – trauma, cardiac, maternity, other infections, etc. etc. And after the pandemic ends, there will be a backlog of unmet needs that were postponed during the crisis. As a country, we simply can’t afford to waste any HCWs. We must CONSERVE them – and do everything we can to enable them to keep contributing.

So, it looks to me like the planners among us should come up with strategies (location sensitive ones) for how to assure the maximum CONTINUING AVAILABILITY of the HCW workforce – including the HCWs most likely to contract a severe form of the illness and become disabled for a long time, require ICU /ventilator care, or die and thus be lost forever. In other words, focus on intelligently maximizing the utility of your HCW workforce. Luckily, that means KEEP THEM WELL. Dr. Violente, the Italian speaker, kept emphasizing how important it is to know whether HCW’s are infected, and to isolate them from the healthy ones. Going a step beyond that, we may need to find ways to allow HCWs to safely keep contributing even while infected or after testing positive -- as long as they feel well enough to help.

Dr. V. said they are assigning HCWs who have vulnerabilities to work in areas of the hospital that are NOT devoted to CoVid19. By vulnerabilities, he mentioned chronic conditions, but did not mention age. (A day earlier, when I listened to 5 Chinese physician speakers in the American College of Cardiology’s webinar on CoVid, they said their hospitals are using younger doctors to treat CoVid19 patients and are in fact PROHIBITING physicians over the age of 60 from being “on the frontline” with CoVid19 (on the wards, particularly in ICU) – due to the risk of age itself. Here is a link to Part #3 of that ACC webinar, which begins with the Chinese doctors talking about this issue.)

Dr. Guo (from Taiwan) said they are seriously considering allowing HCW who want to work but have tested positive and asymptomatic/functional to continue working – but ONLY to care for sick CoVid19 patients – since the patients are already infected. This is now under active consideration. Dr. Guo said many physicians view this option positively BUT they are hesitating due to concerns about possibility re-infecting patients. This concern is based on the ONE reported case of a recovering patient who first tested negative and then positive. The main question: Was that negative test a false negative?

In another part of the webinar, Dr. Guo talked about the extremely high false negative rate of nasal swabs – 30% in a first test, 9% in a second test, and 3% in a third test. He said this is thought to be due to the virus’ lower rate of adherence to the pharyngeal mucosa (and its higher rate of adherence to ACE receptors in the lung, which is why sputum testing is much more accurate)."