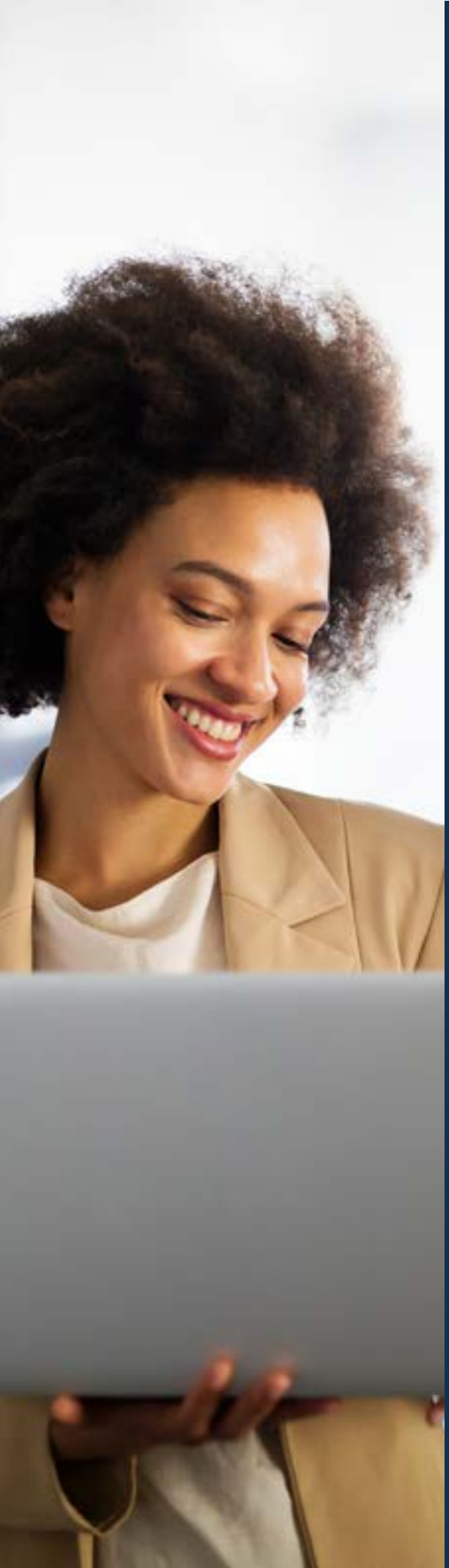

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New York Paid Family Leave 2024 Contributions and Benefits

Issued date: 09/27/23

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2024, will be set at **0.373%** of weekly wages.

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the *annualized* New York State Average Weekly Wage ("NYAWW"). For 2024:

- NYAWW in effect will be **$1,718.15**, an increase of 1.8% from the 2023 NYAWW of $1,688.19. The *annualized* NYAWW is **$89,343.80**.
- The maximum annual employee contribution will be **$333.25** ($399.43 in 2023).

The PFL benefit is **67%** of an employee's Average Weekly Wage (up to the NYAWW) payable for **12 weeks**. For 2024:

- The maximum weekly PFL benefit will be **$1,151.16** ($1,131.08 in 2023).
- The maximum annual PFL benefit payable for 12 weeks will be **$13,813.92** ($13,572.96 in 2023).

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a *52-consecutive week period* is limited to 26 weeks.

- If an employee begins continuous leave in 2023 and the leave extends into the 2024, the benefit is based on the rate in effect on the first day of leave (i.e., in 2023) and is not recalculated at the 2024 rate.

- If an employee begins intermittent leave in 2023 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2024 and the benefit is calculated at the 2024 rate.

Employer Action

Employers should prepare for the 2024 New York PFL contribution and benefit changes that begin in January. PFL coverage will typically be added as a rider on an employer's existing disability insurance policy, although benefits can be provided through a self-funded plan approved by the New York Workers' Compensation Board.

Massachusetts Paid Family Leave 2024 Contributions and Benefits

Issued date: 10/10/23

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2024. The DFML has also published the FY2023 Annual Report for the PFML program.

Contributions

The 2024 contribution rate on eligible wages will be 0.88% (adjusted up from the 2023 rate of 0.63%). Individual contributions are capped by the Social Security income limit. The 2024 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2023 limit which is currently set at $160,200.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2024:

- Medical Leave Contribution: 0.70% of eligible wages allocated as follows:
  - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
  - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).

- Family Leave Contributions: 0.18% of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2024 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- The portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- The portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2024:

- The MAAWW will be $1,796.72, an increase of 1.8% from the 2023 MAAWW of $1,765.34.
- The maximum weekly PFML benefit will be $1,144.90, an increase of 1.3% from the maximum weekly benefit of $1,129.82 in 2023.

Fiscal Year 2023 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2023.

Employer Action

Employers should prepare for the 2024 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2024. Updated workplace posters and notifications for the 2024 contribution rates and benefit amounts will be available to employers on the PFML website soon.

Illinois Enacts the Transportation Benefits Program Act

Issued date: 10/11/23

Illinois signed into law the Transportation Benefits Program Act [Public Act 103-0291] (the "Act") on July 28, 2023. Set to take effect January 1, 2024, the Act requires certain covered employers in Illinois to allow covered employees the option to exclude from taxable wages the employee's commuting costs for the purchase of a transit pass to use public transit or for the purchase of qualified parking, up to the maximum amount permitted under federal law.

Covered Employers

A covered employer under the Act is one that meets all the following requirements:

- Employs 50 or more full-time employees (works at least thirty-five hours per week and receives compensation on a full-time basis;
- The 50 or more full-time employees are employed at an address that is within one of the specified geographic areas; and,
- That location is within 1 mile of a fixed-route transit service run by the Regional Transportation Authority (RTA).

The physical address must be within 1 mile of a fixed-route transit service in one of the following areas:

- Addison Township
- Algonquin Township
- Aurora Township
- Avon Township
- Batavia Township
- Benton Township
- Bloomingdale Township
- Cook County
- Deerfield Township
- Downers Grove Township
- Dundee Township
- DuPage Township
- Elgin Township
- Frankfort Township in Will County
- Geneva Township
- Grant Township in Lake County
- Homer Township
- Joliet Township
- Libertyville Township
- Lisle Township
- Lockport Township
- McHenry Township
- Milton Township
- Naperville Township
- New Lenox Township
- Nunda Township
- Plainfield Township
- Shields Township
- St. Charles Township
- Troy Township
- Vernon Township
- Warren Township in Lake County
- Waukegan Township
- West Deerfield Township
- Wheatland Township in Will County
- Winfield Township
- York Township
- Zion Township

Covered Employees

A full-time employee working at a location meeting the above-referenced criteria is covered by the Act and must be allowed to payroll deduct contributions towards a transit pass. While an employer may choose to extend such a program to employees at all locations, the Act only applies to those locations that employ 50 or more covered employees. The employee must be eligible to participate in the transit program beginning the employee's first full pay period following 120 days of employment.

Employer Action

It is unclear whether the 120-day employment period before a covered employee must be able to participate in a qualified transit program will begin accruing after the law takes effect January 1st, 2024, or if employment leading up to the effective date will also be counted for this purpose. As such, conservative covered employers may wish to ensure a program is in effect for January 1st, 2024. Compliant programs are offered by the CTA and the RTA, as well as many third-party vendors.

Reminder: Massachusetts HIRD Reporting Due December 15, 2023

Issued date: 10/17/23

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure (HIRD) form through the MassTaxConnect (MTC) web portal. The HIRD reporting will be available to be filed starting November 15th and **must be completed by December 15th.**

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer **with six or more employees in Massachusetts** to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form.

- An individual is your employee if you, as the employer, included such individual in your quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- If you are an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is your employee if they are hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: https://www.mass.gov/info-details/masshealth-premium-assistance-pa.

Court Vacates Drug Manufacturer Coupon Cost-Sharing Rule

Issued date: 10/19/23

On September 29, 2023, the District Court for the District of Columbia vacated a Department of Health and Human Services ("HHS") rule that permitted (but did not require) group health plans and health insurance carriers to count manufacturer coupons toward the plan's cost-sharing.

As a result, HHS has been directed to reconsider the rules based on the Court's decision.

Background

Some drug manufacturers offer financial support (e.g., a coupon) to patients to help pay for certain prescription drugs.

Prior to the issuance of guidance, there were questions as to whether these coupons (and other reimbursements) apply to the participant's cost-sharing under the terms of the plan. For example, suppose the standard cost for a particular drug is $1,000, but the manufacturer provides a coupon for $600. The unsettled question has been whether the participant should receive credit towards the plan's out-of-pocket maximum ("OOPM") for the $400 that the participant actually paid for the drug, or the drug's actual cost of $1,000.

In 2019, HHS issued a final rule that clarified plans do not have to count the value of drug manufacturer coupons towards a participant's out-of-pocket calculations if a medically appropriate generic drug is available. Though not specifically stated, the language in the rule suggested that if a medically appropriate generic drug is not available, plans would need to count these coupons when calculating a participant's cost-sharing. This interpretation raised a conflict for qualified high deductible health plans ("HDHPs") that are compatible with health savings accounts ("HSAs"), because crediting the

coupon towards the deductible may be considered non-HDHP coverage that disqualifies a participant from being eligible to make or receive HSA contributions.

Subsequently, the Departments of Labor ("DOL"), the Treasury, and HHS (collectively, "the Departments") issued FAQ Part 40. The Departments recognized the HDHP/HSA conflict and announced they would not initiate enforcement action if a group health plan excludes the value of drug manufacturers' coupons from the OOPM calculation, even where there is no medically appropriate generic equivalent available. This non-enforcement position remained in effect until further guidance was issued.

In May 2020, HHS published the Notice of Benefit and Payment Parameters 2021 ("NBPP 2021"), a final rule that included a clarification on how drug manufacturer support, including coupons, may accrue towards the OOPM. Under the clarified policy, health insurance carriers and group health plans were permitted, but not required, to count any form of financial support offered by drug manufacturers to enrollees for specific prescription drugs toward the deductible and annual out-of-pocket maximums, to the extent consistent with state law.

It should be noted that with this permissive language, HDHP participants could retain HSA eligibility if drug manufacturer coupons were not credited toward the HDHP minimum statutory deductible.

Court Decision

Three advocacy groups, along with three individuals, challenged the NBPP 2021 drug manufacturer support rule in a lawsuit. The plaintiffs argued that:

- the rule conflicts with both the Affordable Care Act's ("ACA") statutory definition of "cost-sharing" and the pre-existing regulatory definition of that term, and

- the rule is arbitrary and capricious for a variety of reasons, including that the same statutory and regulatory language is defined in two conflicting ways.

The Court agreed with the plaintiffs, setting aside the NBPP 2021 drug manufacturer support rule based on both its contradictory reading of the same statutory and regulatory language, and the fact that the agencies have yet to offer a definitive interpretation of the term "cost-sharing" as applied to manufacturer assistance.

The Court directed HHS to reconsider the NBPP 2021 rule in a manner consistent with the Court's decision.

New PCOR Fee Announced

Issued date: 10/20/23

On October 18, 2023, the IRS released Notice 2023-70, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2023, and before October 1, 2024, is $3.22.

The PCOR filing deadline is July 31, 2024, for all self-funded medical plans (including level-funded) and some HRAs for plan years (including short plan years) ending in 2023. Carriers are responsible for paying the fee for insured policies.

PCOR Fee due by July 31, 2024:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2023	$3.00/covered life/year
February 28, 2023	$3.00/covered life/year
March 31, 2023	$3.00/covered life/year
April 30, 2023	$3.00/covered life/year
May 31, 2023	$3.00/covered life/year
June 30, 2023	$3.00/covered life/year
July 31, 2023	$3.00/covered life/year
August 31, 2023	$3.00/covered life/year
September 30, 2023	$3.00/covered life/year
October 31, 2023	**$3.22/covered life/year**

November 30, 2023	**$3.22/covered life/year**
December 31, 2023	**$3.22/covered life/year**

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in mid-2024 of the fee and additional information for filing and paying the PCOR fee with the IRS.

It should be noted that we have seen increased enforcement activity from the IRS around missing PCOR fees.Specifically, the IRS is issuing CP161 notices to employers who appear to have missed a prior year PCOR fee filing, requesting payment (including interest and penalties).

HHS Penalties Increase for 2023

Issued date: 10/23/23

The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "Inflation Adjustment Act") directs federal agencies to adjust the civil monetary penalties for inflation. On October 6, 2023, the Department of Health and Human Services ("HHS") issued final rules adjusting civil monetary penalties for inflation.

The adjusted penalties are applicable to penalties assessed on or after October 6, 2023 (assuming the violation occurred on or after November 2, 2015, when the Inflation Adjustment Act was enacted).

Updated Penalties

The following chart contains the updated penalties applicable to group health plans:

Description	2022 Penalty (Prior)	2023 Penalty (New)
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$174 per violation $43,678 annual cap	$187 per violation $47,061 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision without knowledge	$127 min. $63,973 max. $1,919,173 annual cap	$137 min. $68,928 max. $2,067,813 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision with reasonable cause and not due to willful neglect	$1,280 min. $63,973 max. $1,919,173 annual cap	$1,379 min. $68,928 max. $2,067,813 annual cap

February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$12,794 min. $63,973 max. $1,919,173 annual cap	$13,785 min. $68,928 max. $2,067,813 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$63,973 min. $1,919,173 max. $1,919,173 annual cap	$68,928 min. $2,067,813 max. $2,067,813 annual cap
Failure to provide the Summary of Benefits and Coverage ("SBC")	$1,264	$1,362
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$10,360	$11,162
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the plan was primary payer to Medicare	$1,325	$1,428

Employer Action

Covered entities (health care plans, health care clearinghouses and health care providers) must ensure proper application and compliance with HIPAA's Privacy and Security Rules.

Employers should avoid using incentives to discourage Medicare/Medicaid eligible employees from enrolling in the employer's health plan.

Employers should be aware of the SBC disclosure requirement and ensure employees receive SBCs in a timely fashion (e.g., in connection with open enrollment).

Final 2023 ACA Reporting Instructions and Forms Issued

Issued date: 10/31/23

The IRS released final instructions and forms for calendar year 2023 ACA reporting, including Forms 1094-C, 1095-C, 1094-B, and 1095-B. As a reminder, it is important to ensure the forms are filed accurately and timely with both the IRS and as distributed to employees, as good faith relief from penalties is no longer available.

Forms 1094-C/1095-C

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

The calendar year 2023 Form 1095-C must be furnished to full-time employees and other individuals by **Friday, March 1, 2024**. This deadline usually falls on March 2, except in a leap year when the date is March 1. The Form 1094-C and all Forms 1095-C must be filed with the IRS electronically by **Monday, April 1, 2024**.

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2023 in preparation to complete, furnish and file these forms for 2023.

Forms 1094-B/1095-B

Employers that are not ALEs and offer self-funded group health plan coverage (including level-funded plans) must furnish and file forms regarding minimum essential coverage. Specifically, as the provider of the self-funded plan, the employer reports to the IRS and all covered individuals (e.g., employees, COBRA qualified beneficiaries, spouses, dependents) the coverage they had during the calendar year. To meet this requirement, employers use Forms 1094-B and 1095-B.

The calendar year 2023 Form 1095-B must be furnished to covered individuals by **Friday, March 1, 2024**. The Form 1094-B and all Forms 1095-B must be filed with the IRS electronically by **Monday, April 1, 2024**. Very few employers will be able to file by paper with the IRS, as set forth below. If eligible, paper filing is due by February 28, 2024.

Employers should coordinate with payroll or other reporting vendors to assist in this process.

What's New

While there are no significant changes to the 2023 forms, most employers will be required to file the forms electronically with the IRS. In addition, the penalties for failures have increased.

Electronic Filing Required (10+ Forms)

Employers required to file 10 or more information returns (e.g., Forms W-2, 1094-C, 1095-C, 1094-B, 1095-B) during the year must file these forms electronically on or after January 1, 2024. Previously, the IRS allowed employers filing fewer than 250 returns to file hard-copy (paper) forms.

The IRS also encourages employers filing fewer than 10 returns to consider electronic filing.

2023 Penalties

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. Good faith relief is no longer available. However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2023, the following penalties may apply:

- Failure to file a correct return is $310/statement (total calendar year penalty not to exceed $3,783,000).
- Failure to furnish a correct statement is $310/statement (total calendar year penalty not to exceed $3,783,000).

It should be noted that an employer that fails to both file and furnish a correct statement is subject to a combined penalty of $620/statement with a maximum penalty of $7,566,000.

Employer Action

It is important to identify vendors, like payroll or other reporting administrators, to assist in this process especially as most employers will be required to file forms electronically with the IRS. A health plan carrier typically does not prepare this reporting.

ALEs should begin preparing and ensure that Form 1095-C is furnished to full-time employees and other individuals by **March 1, 2024**. Form 1094-C and all Forms 1095-C should be electronically filed with the IRS by **April 1, 2024**.

Employers that are not ALEs but offer self-funded group health plan coverage should ensure a process is in place for furnishing and filings Forms 1094-B and 1095-B. Form 1095-B must be furnished to covered individuals by **March 1, 2024**, and all forms 1095-B along with Form 1094-B must be electronically filed with the IRS by **April 1, 2024**.

Employers should be certain the statements are complete and accurate since good faith relief is no longer available.

Employers may have additional reporting obligations for employees residing in states with an individual mandate (California, Massachusetts, New Jersey, Rhode Island, Vermont, Washington D.C.). Ensure vendors will assist with state reporting obligations.

Minnesota's New Leave Laws

Issued date: 11/01/23

On May 25, 2023, Minnesota became the 12th state to provide paid family and medical leave ("PFML"). Starting January 1, 2026, eligible employees will be able to apply for up to 20 weeks of paid leave with the Minnesota Department of Employment and Economic Development ("DEED").

In addition, beginning January 1, 2024, most employees that work within Minnesota will become eligible for a new paid sick leave benefit under the Minnesota Earned Sick and Safe Time Leave Law ("ESST"). ESST will supplant the prior Minnesota paid leave law, which allowed an employee the option to use their own personal sick leave benefits for related purposes and will sunset effective December 31, 2023.

Minnesota Paid Family and Medical Leave Law

Covered Employers

Any employer with at least one employee working within Minnesota must provide PFML. This includes most private and public employers such as school districts and city/county public entities. Self-employed individuals and independent contractors may opt into the program. Seasonal hospitality employees (i.e., those that work less than 150 hours per year) are not eligible for PFML benefits.

Eligible Employees

Eligible employees have work and wage requirements. Eligible employees are those persons that either:

- Work at least 50% of their time within Minnesota;

- Do some of their work in Minnesota and reside within Minnesota for at least 50% of the calendar year; or
- Neither work or reside in Minnesota but the place where their work is directed from is located in Minnesota.

In addition, Minnesota employees must earn at least $3,500 in wages (from a single employer or multiple employers) within a period of 12 consecutive months prior to applying for paid leave.

Types of Leaves

The law classifies eligible leave into two categories (i) family leave, and (ii) other leave, with each providing up to 12 weeks of leave in a benefit period, although an employee may take up to 20 weeks of combined leave in a 12-month benefit period. The qualifying leave events are:

Family leave:

- Serious health condition for the employee.
- Pregnancy and parental leave, including bonding with a new biological, adopted or foster child.
- Care of family member's or military member's serious health condition.

Other leave:

- To care for self or family member's domestic assault, sexual assault, and/or stalking (includes legal assistance and household relocation).
- Qualifying exigencies, such as imminent departure of family member to active military duty.

To be eligible, the qualifying event must have an expected duration of at least seven days (except for bonding with a new child) and will be considered to be taken consecutively unless the event is identified as intermittent on the PFML application.

PFML defines "family member" as the employee's:

- spouse, domestic partner, child (including in loco parentis, legal guardian, and "de facto" parent), parent/legal guardian, sibling, grandparent (including spouse's grandparent), grandchild, son/daughter-in-law; and
- an individual who has a relationship with the applicant that creates an expectation and reliance that the applicant cares for the individual, whether or not the applicant and the individual reside together.

Additional guidance will be necessary on how to properly test or confirm the existence of such a relationship. Presumably, this broad definition incorporates leave for such persons as domestic partners, which is something that FMLA does not cover.

Contributions and Benefits

Starting mid-2024, covered employers will commence submitting wage detail reports to DEED. These reports will outline the quarterly wages paid to PFML eligible employee and their hours worked.

In 2025, employers will be required to provide notices to employees that outline the PFML, including eligibility requirements and how to request leave. DEED will provide language for these notices closer to their distribution deadline.

Starting January 1, 2026, employers will contribute 0.7% of employee wages, although employers can opt to pay the entire amount or elect to have employees pay up to 50% of the required premiums.

The PFML benefit is based upon a percentage of the employee's wages and the state's average weekly wage. Workers can expect to receive:

- 90% of their weekly wages that are less than or equal to 50% of the stage's average weekly wage);
- 66% of their weekly wages that is greater than 50% of the state's average weekly wage but less than 100% of the state average weekly wage; or
- 55% of their weekly wages that is more than 100% of the state average weekly wages.

An employer cannot require that the employee use their accrued PTO, sick and/or vacation time at the same time as PFML or instead of PFML Employees can however choose to use their accrued paid time off ("PTO"), sick and/or vacation time instead of the PFML and the PFML protections will still be in effect for the individual. An employer can choose to provide supplemental benefit payments to compensate employees to their normal compensation amounts.

Starting July 1, 2025, employers will be able to substitute state-approved private plans instead of participating in the state program. Additional guidance on the process will be forthcoming but private plans are expected to include a surety bond.

Notice Requirements and Retaliation Prohibition

Employers are required to post a notice in the workplace about the PFML in both English and the primary language of 5 or more employees. Employers are also required to provide newly hired employees with written notice on their expected PFML benefit amount and instructions on how to apply for the benefits. DEED is expected to produce a template for employers.

Employees are required to provide notice to the employer at least 30 days in advance of their intent to apply for a foreseeable leave or as soon as practicable for an unforeseeable leave. The employer can still require the employee to follow their normal call-in/reporting procedures if they do not unnecessarily interfere with the employee's ability to apply for the leave.

Employers are prohibited from retaliating against employees for utilizing their paid leave. Employees that were hired at least 90 days prior to using their leave have the right to be reinstated with their employer into either their same job or an equivalent job. Similar to FMLA, employees retain access to their health insurance while on paid leave.

Minnesota's Earned Sick and Safe Time Leave

As mentioned above, beginning January 1, 2024, most employees that work within Minnesota will become eligible for a new paid sick leave benefit under the ESST. It should be noted that the cities of Bloomington, Duluth, Minneapolis, and St. Paul already have their own paid leave laws that are like ESST. If there is an overlap between an existing paid leave law and ESST, the more protective law is required to apply.

Covered Employers and Employees

Any employer with employees that work within Minnesota is subject to ESST.

Most employees that work at least 80 hours in a year in Minnesota will be eligible for this paid sick leave benefit. However, ESST does provide eligibility exceptions for some persons, such as:

- Independent contractors,
- Federal employees,
- Individuals employed by an air carrier, such as flight deck and cabin crew members, and
- Building and construction employees that are represented by a trade labor organization or union that has submitted a valid waiver of the requirements due to similar paid leave already present in their existing collective bargaining agreement.

Staffing agencies are responsible for providing ESST to their leased employees, not the employer that has contracted for their services.

An employee that is rehired within 180 days of termination must regain their ESST accrued but unpaid balance that existed prior to their departure unless the ESST accrued but unpaid hours were paid to them upon their termination. Employees that are terminated due to a merger and acquisition will retain their accrued but unpaid ESST balance if they are hired by the new owners within 30 days of the ownership change.

Leave Benefit

Starting January 1, 2024, for every 30 hours that an eligible employee works, including overtime hours if the employee is eligible for such time, they earn an hour of paid sick leave, up to 48 hours per year. Any unused and accrued benefits must be carried over into the next year up to an 80-hour maximum. An employer may choose to be more generous than the law requires and allow for additional time to accrue but they cannot choose an amount lesser than what ESST provides.

An employer can also choose to frontload the 48 hours per year instead of having employees accrue the amounts over time. Therefore, the employee would immediately have access to their entire ESST benefit as of the first day of the specified year. If an employer uses the frontload option, the carryover requirement does not apply but an employer may choose to pay out any unused amounts.

Lastly, an employer can choose a different benefit method (e.g., accrual or frontload) for their part-time employees compared to their full-time employees.

Reasons for Leave

Eligible employees will be able to request the paid leave benefit for the following reasons:

- Their own or a family member’s mental or physical illness, treatment or preventive care need;

- Their own or a family members domestic abuse, sexual assault or stalking;
- Workplace closure due to weather or public emergency, including closure of a family member's school or care facility for the same reasons;
- Health authority or professional's determination that the employee or their family member is at risk of infecting others with a communicable disease.

The term "family member" under the Law includes the following persons:

- Child (biological, foster child, adult child, legal ward, of whom employee is legal guardian or in loco parentis);
- Spouse or registered domestic partner;
- Sibling, step sibling or foster sibling;
- Biological, adoptive or faster parent, stepparent or person who was loco parentis for employee when they were a minor child;
- Grandchild, foster grandchild or step grandchild;
- Grandparent or step grandparent;
- Child of a sibling of the employee (e.g., employee's niece/nephew);
- Sibling of the employee's parents (e.g., employee's aunt/uncle);
- Child-in-law or sibling-in-law;
- Any other family members listed above of an employee's spouse or registered domestic partner;
- Any other individual related by blood or whose close association with the employee is equivalent to a family relationship; and
- One person designated on an annual basis by the employee.

Notice and Disclosure Requirements

At the end of each payroll period, employers must provide a tally to each employee of the ESST hours that they have accrued, currently available, and those used. This information must be reported in the employees' earnings statements.

By January 1, 2024, employers must provide their existing employees with notice of their ESST rights and benefits. This notice will be due to new hires at the start of their employment. The notice must be made available in English and other language if the employee's primary language is not English. The employer must also include this notice in their employee handbook if the employer provides one to employees.

Employer Action

PFML

Employers should begin to determine if they have employees that will be eligible for this future leave benefit. Creating a process to track eligibility would be prudent and to develop a process to provide the required written notice to new hires.

Employers may want to review their existing leave policies and handbooks to see if there is any potential overlap with the new requirements. This may be especially important for multi-state employers that have attempted to create uniform leave policies to satisfy the different leave laws in these jurisdictions.

DEED is currently drafting frequently asked questions and additional guidance for employers and employees. Employers may want to sign up for their newsletters to keep up with the most recent updates.

ESST

Employers should take the following steps now:

- Update their existing payroll systems with the ability to calculate ESST time as it is accrued and used. Further, the system should be updated so that payroll stubs provide an ongoing balance for employees of what ESST time is earned, used and still available.

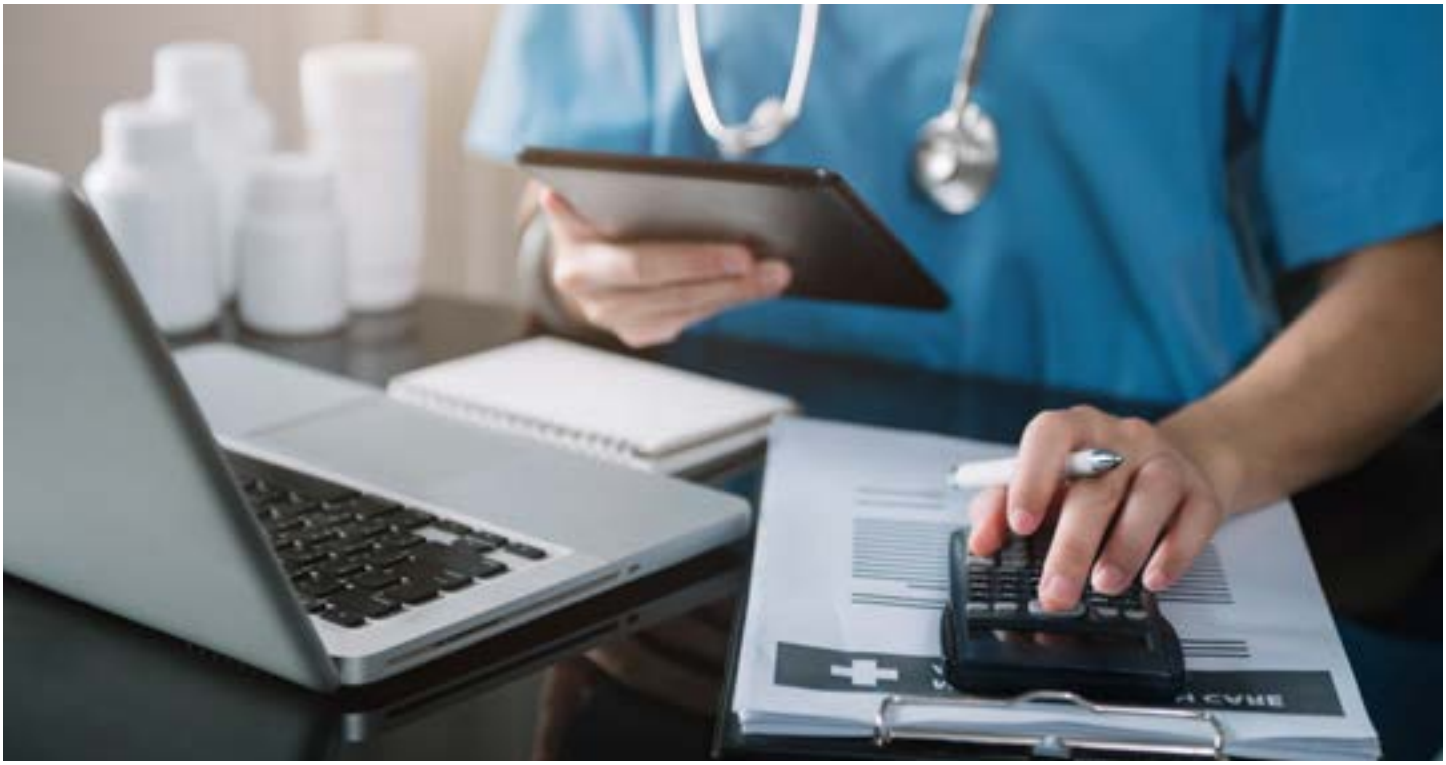
- Develop rehire and termination processes to track the termination reason and the amount of time that has lapsed since the date of termination and rehire. It may be prudent to incorporate information on the status of their ESST benefits (e.g., either returned to them or ineligible for return) in correspondence to the rehired employee.

- For employees that work in Minneapolis and are subject to the Minneapolis Wage Theft Prevention Ordinance, include ESST benefits in their pre-hire notices for new hires and any compensation change notices for existing employees.

- Modify handbooks to incorporate the required ESST language. Distribute the required notice to new hires and existing employees.

- Update existing leave policies to see if they are already sufficient to cover ESST requirements or if additional benefits must be provided. Identify any type of concurrent leaves that may apply with ESST (e.g., Family Medical Leave Act (“FMLA”) and ESST).

- Educate managers on the ESST requirements and the proper process for employees to request such leave.



New Guidance on the No Surprises Act and IDR Process

Issued date: 11/03/23

On October 6, 2023, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") issued updated guidance in response to court decisions that vacated some of the regulations governing the independent dispute resolution ("IDR") process under the No Surprises Act ("NSA").

The Departments issued FAQ Part 62 which modifies prior guidance on:

- the proper methodology to determine the qualifying payment amount ("QPA"); and
- plan or issuer disclosure requirements of the initial payment or notice of denial of payment to out-of-network ("OON") air ambulance service providers.

Additionally, it was announced that the federal IDR portal has reopened for the initiation of new single disputes.

Background

The NSA, enacted as part of the Consolidated Appropriations Act, 2021, and subsequent guidance generally limit OON cost sharing and prohibit balance billing when participants in a group medical plan receive (1) emergency services from an OON healthcare provider, (2) non-emergency services from an OON healthcare provider at an in-network medical facility, or (3) OON air ambulance services.

Unless a state law or the All-Payer Model Agreement applies, a participant's cost-sharing and how much the plan will pay to the provider for these services is generally based on the lesser of the provider's billed charge or a QPA. The QPA is the

median of the contracted rates for a particular item or service plus an inflation adjustment; the rules for calculating the QPA are complicated.

The federal IDR process may be used when the provider receives an initial payment (or denial notice) from the group health plan for NSA-eligible items or services, and the plan and provider do not agree on a payment amount through an open negotiation process. There are provisions for batching items and services, which allow multiple qualified items and services for IDR disputes to be considered jointly as a single determination by the IDR entity.

Court Decisions

The IDR rules were challenged in multiple courts on various grounds. In these cases, the courts vacated portions of the IDR guidance, including (1) those dealing with batching claims, (2) those related to the methodology for calculating QPAs, and (3) certain provisions pertaining to air ambulance disputes, including the timeframe for sending an initial payment or notice of denial of payment to the provider.In response to these rulings, HHS temporarily suspended all federal IDR process operations effective August 25, 2023, in order to make changes necessary to comply with the Court's opinions and orders.

As of September 21, 2023, the federal IDR process was open to single and bundled disputes initiated on or before August 3, 2023 (but not batched disputes). The IDR portal has remained unavailable for all new disputes.

Recent Developments

On October 6, 2023, the Departments issued additional guidance in response to the Court's decisions, as summarized below.

FAQ About Consolidated Appropriations Act, 2021, Implementation Part 62

Methodology to Determine QPA and Enforcement Discretion

The Departments disagree with the court's decision to vacate some of the provisions of the methodology for calculating QPAs, and plan to appeal. However, in the meantime, they maintain that plans and issuers must determine the QPA in a good faith and reasonable interpretation of the remaining portions of the guidance. This is because the court's decision did not create a standardized QPA process for issuers and plans to follow for NSA compliance.

Because this lack of certainty may create additional compliance complications for plans and issuers, the Departments will exercise enforcement discretion until May 1, 2024 (the first day of the calendar month that is 6 months after the issuance of these FAQs) for an entity that uses a QPA calculated in accordance with the methodology guidance in effect immediately prior to the court's decision for purposes of:

- patient cost sharing;
- providing required disclosures with an initial payment or notice of denial of payment; and
- providing required disclosures and submissions pursuant to the federal IDR process.

HHS will extend this enforcement discretion to providers, facilities, or providers of air ambulance services that bill or hold liable a participant, beneficiary or enrollee for a cost-sharing amount based on a QPA determined using the methodology that was before the court's decision. HHS also encourages states that enforce these NSA provisions to adopt a similar

enforcement approach regarding QPAs.

Certified IDR entities can continue to rely on alternative non-prohibited information and factors to decide which party's offer best represents an appropriate value for the item or service at issue.

Disclosures to OON Air Ambulance Providers

Plans and issuers are still required to determine whether OON air ambulance services are covered and provide an initial payment or notice of denial of payment within 30 calendar days of receipt of the bill for the ambulance services.

Plans and issuers subject to ERISA are also reminded to follow the ERISA claims procedure regulation and the ACA internal claims and appeal regulations, which include the option to request additional information from the claimant if necessary to complete the claim's processing. If a plan or issuer is unable to determine coverage within the 30-calendar-day timeframe, a notice of benefit denial due to an adverse benefit determination should be provided, disclosing that the denial was due to insufficient information.

The Departments reiterate that an adverse benefit determination due to insufficient information does not allow OON providers of air ambulance services to balance bill a participant, beneficiary, or enrollee. Instead, such providers will need to resubmit or appeal a claim to the plan or issuer, since balance billing would violate the NSA.

No Surprises Act (NSA) Independent Dispute Resolution (IDR) Partial Reopening of Dispute Initiation Frequently Asked Questions (FAQs)

As of October 6, 2023, the Departments reopened the federal IDR portal for the initiation of most new single disputes, including single disputes involving bundled payment arrangements.

However, the federal IDR portal still remains temporarily unavailable for:

- new disputes involving air ambulance services, and
- batched disputes (regardless of whether new or previously initiated).

The Departments say they are working quickly to issue updated guidance and make system changes that would allow the federal IDR portal to become available for these items. Updates will be provided to the public at www.cms.gov/nosurprises as they become available.

Employer Action

For fully insured group medical plans, the insurance carrier or HMO is responsible for complying with the final rules.

For self-funded group medical plans, the third-party administrator ("TPA") should be handling compliance with the final rules, although employers or other plan sponsor are ultimately liable for any noncompliance. Employers should work with their TPAs to make sure they are processing claims in accordance with this latest guidance. Importantly, claims that go through the IDR process will likely experience further delays, given the opening/closing/reopening of the process and the various changes required to the system. Employers with self-funded plans will want to discuss this issue with their TPAs and stop loss carriers to ensure sufficient coverage for claims that are caught up in delays related to the IDR process.

New York City Amends Earned Safe and Sick Time

Issued date: 11/01/23

The New York City Department of Consumer and Worker Protection published a final rule amending the regulations governing NYC's Earned Safe and Sick Time Act ("ESSTA"). These changes provide guidance to clarify and update various ESSTA provisions. The final rule became effective on October 15, 2023.

Background

The New York City Earned Sick Time Act, now known as the ESSTA, took effect on April 1, 2014 and required covered employers to provide eligible employees with paid time off to care for themselves or a qualifying family member. The ESSTA has been amended several times, which amendments included adding "safe" time as a covered absence, and aligning the ESSTA with the New York State Paid Sick Leave Law. In October 2022, proposed amendments were published, but left employers with limited formal guidance regarding the new law. The amended rule takes effect on October 15, 2023.

Highlights of the Final ESSTA Rule

- Employer size which is used to determine the accrual and amount of ESSTA leave available is based on the number of full-time and part-time employees ***nationwide*** and not on those employed in New York City ("NYC"). This should not have a material impact on NYC employers as the statewide paid sick leave requirement already determines employer size based on the total national workforce.

- Employees who "regularly perform or are expected to regularly perform work in NYC during a calendar year" will be entitled to ESSTA leave.

- Accrual of ESSTA hours will be based on all hours an employee physically works within NYC. When an employee works less than 30 hours per week (accrual standard to earn an hour of leave), employers must allow for fractional safe and sick time accruals that may be rounded to the nearest five minutes, one-tenth of an hour, or one-quarter of an hour.

- Employees who exclusively work remotely for a NYC employer will not be entitled to such leave.

- A definition of "foreseeable leave," has been incorporated in the rules stating that "a need is foreseeable when the employee is aware of the need to use safe/sick time seven days or more before such use."

- Employers must have a written policy that outlines the procedures and notification process employees may take to request any foreseeable need for leave. In addition, the policy must now include a statement that the employer "will not ask the employee to provide details about the medical condition that led the employee to use sick time, or the personal situation that led the employee to use safe time, and that any information the employer receives about the employee's use of safe/sick time will be kept confidential and not disclosed with anyone without the employee's written permission or as required by law."

- Employers must reimburse an employee for any fees incurred in obtaining necessary documentation from a health care provider to substantiate the request for leave.

- The new rules expand enforcement by "reasonable inference" when as "a matter of official or unofficial policy or practice, [the employer] does not provide or refuses to allow the use of accrued safe/sick time in violation of the Administrative Code". Specifically, if an employer fails to maintain or distribute a written safe/sick time policy, fails to maintain adequate records of employees' accrued safe/sick time use and balances, or when there is additional evidence that an employer maintains a policy or practice of not providing or refusing to allow the use of accrued safe/sick time, penalties shall
  be imposed.

Employer Action

New York City employers, with their counsel, should review and update their NYC safe and sick time policies and procedures to ensure compliance with these latest rules.

Massachusetts Paid Family Leave 2024 Contributions and Benefits and Updates

Issued date: 11/06/23

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced changes to the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2024. The DFML has also published the FY2023 Annual Report for the PFML program.

In addition, recent legislative changes to the PFML program will allow employees to supplement (or "top off") their weekly PFML benefit amount with accrued paid leave under an employer policy or collective bargaining agreement. The changes take effect for claims filed on or after November 1, 2023.

Contributions

The 2024 contribution rate on eligible wages will be **0.88%** (adjusted up from the 2023 rate of 0.63%). Individual contributions are capped by the Social Security income limit. The 2024 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2023 limit which is currently set at $160,200.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2024:

- **Medical Leave Contribution:** 0.70% of eligible wages allocated as follows:

    - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
    - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).
- **Family Leave Contributions:** 0.18% of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical leave or family portions of the benefit. The employee's 2024 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- The portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- The portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2024:

- The MAAWW will be $1,796.72, an increase of 1.8% from the 2023 MAAWW of $1,765.34.
- The maximum weekly PFML benefit will be $1,149.90, an increase of 1.3% from the maximum weekly benefit of $1,129.82 in 2023.

FY2023 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2023. The annual report can be found at https://www.mass.gov/doc/fy2023-dfml-annual-report/download

Topping Off

Topping off allows employees on PFML to supplement their weekly PFML benefit with their accrued vacation pay, sick pay, or other paid leave, up to the employee's Individual Average Weekly Wage ("IAWW"). The state provides the following example: An employee's IAWW = $2,000 and they have an approved PFML application that pays $1,100 per week. The employee may top off that amount with PTO up to $900, if available.

As a reminder, under the state program, an employee's IAWW is calculated by the DFML from the amount an employee earned in the last four completed calendar quarters before the start of the employee's benefit year. The IAWW is the average amount the employee earned per week in the two quarters when the employee earned the most money (or the one quarter with the most money if the employee only worked in two or fewer quarters).

Employer Responsibilities under the State Program

Prior to these changes, employees were only allowed to top-off benefits under an approved private plan; employees who received PFML benefits through the state program were not allowed to use accrued paid leave during any leave period in which the employee was receiving PFML benefits from the state. Employers will now be responsible for monitoring and ensuring that the combined weekly sum of employer-provided paid leave benefits and PFML benefits does not exceed an employee's IAWW. Employers do not need to report top off amounts to the DFML.

Employers with a registered Leave Administrator can determine an employee's weekly PFML benefit rate and their IAWW by accessing the employee's PFML Approval Notice. The DFML stresses that employers who do not have a registered Leave Administrator will not be able to access this information. Employers must have a registered Leave Administrator on file with DFML.

Employer Responsibilities under a Private Plan Exemption

Prior to these changes, employers who administered an approved private plan could allow their employees to top off their PFML benefits with accrued paid leave. Under the new rules, employers with a private plan exemption must allow for top offs.

Employer Action

Employers should prepare for the 2024 PFML contribution and benefit increases by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2024. Updated workplace posters and notifications for the 2024 contribution rates and benefit amounts will be available to employers on the PFML website soon.

Employers should also review the guidance and resources released by the DFML and should review and update their PFML policies and procedures to comply with these recent changes effective November 1, 2023.

2024 Cost of Living Adjustments

Issued date: 11/10/23

The IRS has released cost of living adjustments for 2024 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2024, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $3,050 to $3,200.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health FSA, subject to inflation for plan years beginning after December 31, 2013.

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins in 2024 that can be carried over to the following plan year is $640 (up from $610 in 2023).

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a static maximum of $500 to 20% of the currently indexed heath FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2024, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $300 to $315.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increased from $150,000 to $155,000 for 2024.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). *Prop. Treas. Reg. 1.125-7(a)(9).*

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2024 increased from $215,000 to $220,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. *Prop. Treas. Reg. 1.125-7(a)(10).*

Non-Grandfathered Plan Out-of-Pocket Cost-Sharing Limits

As previously reported, the 2024 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $9,450 for self-only coverage and $18,900 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2024, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $6,150 ($12,450 for family coverage), which increased from $5,850/$11,800 in 2023.

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2024, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,100 (increased from $1,950 in 2023).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts (HSAs) for 2024 were provided by the IRS in *Rev. Proc. 2023-23.*

Annual contribution limitation

For calendar year 2024, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $4,150; the limitation on deductions for an individual with family coverage under a high deductible health plan is $8,300.

High deductible health plan

For calendar year 2024, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,600 for self-only coverage or $3,200 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $8,050 for self-only coverage or $16,100 for family coverage.It should be noted that for family HDHP coverage, an individual embedded deductible cannot be less than $3,200.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, 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 qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code Section 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Delaware Publishes Rules on Paid Family and Medical Leave

Issued date: 11/10/23

As previously reported, the Healthy Delaware Families Act ("HDFA") was signed into law on May 10, 2022. On July 11, 2023, the Delaware Department of Labor ("DDOL") released the first set of anticipated rules implementing the HDFA. While payroll contributions will not go into effect until 2025 and benefits do not begin until 2026, there are several upcoming deadlines for employers to be aware of, and decisions that need to be made prior to January 1, 2024.

Specifically, plans should be aware of the following deadlines:

- October 1, 2023 – January 1, 2024: Grandfathered paid time off plan applications available through online portal.
- January 1, 2024: Must notify the Division of Paid Leave of intent to temporarily reduce parental leave from 12 weeks to 6 weeks.
- December 1, 2024: Must notify employees of intent to temporarily reduce parental leave from 12 weeks to 6 weeks.
- September 1, 2024 – December 1, 2024: Private plan opt-out form available through online portal.

Below you will find a summary of the rules.

Background

The HDFA requires Delaware employers to provide paid family and medical leave to eligible employees. The program is funded through employer and employee contributions and will provide eligible employees with 80% of their average weekly

wages earned during the 12-months prior to their application for benefits, up to a maximum benefit of $900 per week. Employees are permitted to take paid leave for:

- *Parental Leave*. Due to the birth, adoption, or placement through foster care of a child or for caring for the child during the first year after the birth, adoption, or placement of the child.
- *Family Caregiving Leave.* Caring for a family member with a serious health condition.
- *Medical Leave*. Due to their own serious medical condition.
- *Qualified exigencies*. Due to time off needed for qualified issues arising from military deployment.

Covered employers are permitted to apply to the state for an exemption from the contribution requirements when offering a private plan, provided the plan benefits are at least as generous as those required by the statute.

Employer and employee contributions are scheduled to begin January 1, 2025, with benefit payments beginning January 1, 2026.

Regulations

The DDOL released the first in what's expected to be multiple rounds of regulations clarifying various requirements under the HDFA. This first set of regulations clarifies requirements as follows:

Covered Employers and Employees

The HDFA requires that to be eligible for paid leave, employees must have been:

- Employed for at least 12 months by the employer from whom leave is being requested;
- Worked a minimum of 1,250 hours over the 12-month period prior to the request; and
- Worked at least 60% of their work hours at a worksite in Delaware (determined quarterly).

The type of paid benefits that a covered employer must provide is determined based on employer size:

- Employers with 25 or more Delaware employees must provide all paid family and medical leave benefits.
- Employers with 10-24 Delaware employees are only required to comply with the parental leave requirements.

An employer meets the employee threshold determination based on the preceding 12-month period and once this determination has been made, they are subject to the requirements of the applicable classification for a subsequent 12-month period. If the employer's classification changes, they must provide notice to employees that gain or lose paid leave benefits due to the change in classification within 30 days of the change.

Benefit Amount

The amount of an employee's benefit will be 80% of their average weekly wage calculated as the average gross weekly wages for the 52-week period prior to their claim submission. If the employee is salaried, it is determined based on the employee's gross wages divided by 52 weeks.

Employees must receive at least a minimum paid leave benefit of $100 per week but no more than $900 per week.

Duration of Leave

Employees are eligible for:

- Parental leave: 12 weeks in the applicable year.
- Medical, family caregiving, or qualified exigencies leave: 6 weeks in any 24-month period.

Employers with 10-24 Delaware employees may temporarily reduce the amount of parental leave available from 12 weeks to 6 weeks for claims submitted prior to January 1, 2031. To do so, employers must notify the Division of Paid Leave ("Division") by January 1, 2024, and must notify their employees in writing by December 1, 2024.

Payroll Contributions

If a covered employer chooses to participate in the public plan, contributions must be paid at least quarterly to the Division and will be assessed against wages paid on or after January 1, 2025 (the date that payroll contributions begin). For 2025 and 2026, the contribution rates, as a percentage of an employee's FICA wages, are as follows:

- Parental Leave: 0.32%
- Medical Leave: 0.40%
- Family Caregiving and Qualified Exigency Leave: 0.08%

Payroll contributions will begin the first day of the pay period after an employee is hired and for an employer who rises above an employee threshold, will begin the first day of the payroll period after the employer rises above the threshold.

The HDFA defaults to a 50/50 split of the contributions between the employer and employee, however an employer can choose to pay more than 50% (but not less than 50%) of the required contribution. Notice of such a variation from the default split must be given to employees and to the Division through its online portal.

No contributions are required when an employee is on HDFA leave.

Notice Requirements

When an application for leave is received, an employer, insurance carrier, or third-party administrator has 5 business days to approve or deny the application. An employer must provide the employee with written notice of the claim's approval or denial. If approved, the notice must include:

- the amount of the benefit payment;
- the party to whom the benefit payment is being made;
- the party that the payment was sent to;
- the address of the party that the payment was sent to; and
- the date that benefit payments begin and their expected end date.

If the claim is denied, the notice must explain the reason for the denial and that the employee has a right to appeal the decision including instructions on how to file an appeal.

Coordination with Other Leave Programs

The Division has deferred issuing rules concerning coordination with other leave programs (e.g., FMLA, short and long-term disability, etc.) for future rulemaking.

Private Plans

Covered employers may offer a private plan by purchasing an approved insured plan or by self-insuring the leave benefits.

If opting for an insured private plan, an employer must notify the Division through its online portal of the decision to opt out of the public plan by indicating their intention to purchase an approved insured plan.

Similarly, if an employer wishes to opt-out of the public plan and use a self-insured plan, they must notify the Division of their intent to opt-out. To maintain a self-insured plan, there must be 100 covered individuals at all times and provide the Division with a surety bond. For a self-insured plan to be approved, the benefits offered must meet the requirements of the HDFA. Note that if a self-insured plan falls below 100 covered individuals, they will be decertified at renewal and required to enroll in the public plan.Additionally, the employer will be required to pay to the fund the amount that would have been due under the public plan for the previous 12 months.

For both the insured and self-insured private plan option and for 2025 only, the opt-out form will be available on the Division's online portal from September 1, 2024 through December 1, 2024. For subsequent years, an employer can opt-out of the public plan or renew their insured or self-insured plan from October 1 through December 1 of the applicable year.

Grandfathered Plans

If a covered employer had a voluntary paid time off plan in place prior to May 10, 2022, that is considered "comparable" to the public plan, it can apply for an exemption from the public plan to continue its paid time off plan through December 31, 2029. A "comparable plan" will be deemed to exist if:

- the 3 main benefit components (benefit percentage, maximum benefit, and benefit duration) are within 10% of the equivalent public plan components;
- it provides coverage for birth, adoption, and fostering a child (and provides benefits regardless of the parent's gender or marital status); and

- employees covered under the existing plan cannot be required to contribute more to the existing plan than they would under the public plan.

In addition, an employer must submit a sworn affidavit to the Division through their online portal that the plan was in writing and had been available to all employees as of May 10, 2022. A copy of the paid time off plan must be submitted with the application as well. Any grandfathered plan cannot be altered unless the change is to improve the benefits under the plan.

Applications to grandfather an existing paid time off plan can be submitted through the Division's online portal from October 1, 2023, through January 1, 2024.

Employer Action

Employers will need to determine whether they are considered a covered employer and which employee threshold applies. Employers with 10-24 covered employees will need to determine whether they intend to temporarily reduce the parental leave benefit from 12 weeks to 6 weeks and submit notice to the Division.

If a covered employer wishes to opt-out of the public plan by using an insured plan, self-insured plan, or grandfathered plan, the employer should be prepared to submit a notice of opt-out or application of grandfathering by the applicable deadlines.

California Requires Employers to Provide More Paid Sick Leave

Issued date: 11/15/23

California has enacted a new law that requires employers to make changes to their mandatory paid sick leave programs effective January 1, 2024, including the following:

- California employees may use up to 40 hours (or five days) of accrued paid sick leave in a year, which is an increase from 24 hours (or three days) per year.
- The total accrued paid sick leave for a California employee may be limited to 80 hours (or ten days), which is an increase from 48 hours (or six days).
- New employees in California are generally required to have accrued no less than 40 hours (or five days) of paid sick leave by the 200th calendar day of employment, if the employer does not use the standard accrual method of one hour of paid sick leave for each 30 hours worked.

Below you will find highlights of the new law.

Background

California's mandatory paid sick leave law, known as the "Healthy Workplaces, Healthy Families Act of 2014," applies to employers that employ an individual who works in California for at least 30 days in a year for the same employer, regardless of the employer size or the location of the employer's principal place of business.

Under current state law, employees performing services in California are generally entitled to accrue at least one hour of paid sick leave for every 30 hours worked. Employees may begin using accrued paid sick leave on their 90th day of employment.

An employer may limit an employee's use of paid sick leave in a year to 24 hours or three days. Under the accrual method, accrued but unused paid sick leave must carry over to the next calendar year; however, the employer may limit the overall amount of paid sick leave that an employee may accrue to 48 hours or six days.

Alternatively, instead of tracking accruals and carryovers, an employer may choose to credit employees with the full 24 hours or three days of paid sick leave in a lump sum at the beginning of each year.

Changes to the Mandatory Paid Sick Leave in California

Area	Current Law	Requirements Effective January 1, 2024
Use	An employer may limit an employee's use of paid sick leave accruals to 24 hours per year (or three days)	An employer may limit an employee's use of paid sick leave accruals to 40 hours per year (or five days)
Carryover and accruals	Accruals must be carried over from year to year, but an employer may cap accruals at 48 hours (or six days)	Accruals must be carried over from year to year, but an employer may cap accruals at 80 hours (or ten days)
Alternative lump sum method	As an alternative to tracking accruals and carryovers, an employer may instead grant employees a lump sum of not less than 24 hours (or three days) of paid sick leave accruals at the beginning of each year of employment, calendar year, or 12-month period. In the case of a new employee, an employer may instead grant a lump sum of not less than 24 hours (or three days) of paid sick leave accruals upon completion of the 120th calendar day of employment	As an alternative to tracking accruals and carryovers, an employer may instead grant employees a lump sum of not less than 40 hours (or five days) of paid sick leave accruals at the beginning of each year of employment, calendar year, or 12-month period. In the case of a new employee, an employer may instead grant a lump sum of not less than 24 hours (or three days) of paid sick leave accruals upon completion of the 120th calendar day of employment, AND not less than 40 hours (or five days) of paid sick leave accruals upon completion of the 200th calendar day of employment
Alternative accrual method	An employer may use a different accrual method (other than one hour of paid sick leave for every 30 hours worked), as long as the accrual is on a regular basis so that the employee accrues not less than 24 hours (or three days) of paid sick leave by the 120th calendar day of employment or in a calendar year or in a 12-month period.	An employer may use a different accrual method (other than one hour of paid sick leave for every 30 hours worked), as long as the accrual is on a regular basis so that the employee accrues not less than 24 hours (or three days) of paid sick leave by the 120th calendar day of employment or in a calendar year or in a 12-month period AND not less than 40 hours (or five days) of paid sick leave by the 200th calendar day of employment or in a calendar year or in a 12-month period.

Existing paid sick leave or paid time off policy	An employer with an existing paid sick leave or paid time off (PTO) policy does not have to provide additional paid sick leave, as long as the program meets the accrual, usage, carryover, and reinstatement requirements of California law, **AND** provides at least 24 hours (or three days) of annual paid sick leave within the first nine months of employment	An employer with an existing paid sick leave or paid time off (PTO) policy does not have to provide additional paid sick leave, as long as the program meets the accrual, usage, carryover, and reinstatement requirements of California law, **AND** provides at least 40 hours (or five days) of annual paid sick leave within the first six months of employment

The new California law also extends certain employment law protections under the paid sick leave law to employees covered by a valid collective bargaining agreement, and exempts certain railroad employees from the mandatory paid sick leave law.

Employer Action

Employers have a relatively short time (until January 1, 2024) to make appropriate changes to their paid sick leave or PTO policy for California employees to comply with the requirements of the new law. Employers should work with their employment-law attorney or resource to understand and implement the details of these new rules.

Employers will need to update their payroll systems to correctly track and report employees' paid sick leave accruals.

In addition, employers should consider how to educate and communicate their paid sick leave policy to human resources personnel, managers, and employees. For example, employers may need to update their employee handbook for this purpose.

Life Insurance Carriers Agree to Claim Reforms in DOL Settlements

Issued date: 11/20/23

Two recent settlement agreements between the Department of Labor ("DOL") and group life insurance carriers highlight the potential liabilities for carriers and employers if life insurance claims are denied due to missing evidence of insurability ("EOI") even though employee premiums were collected for the coverage.

Background

Many employers provide basic life insurance coverage to their employees at no cost. Basic life insurance is usually "guaranteed issue" up to a certain amount, which means the employee is covered without having to provide an EOI as proof of good health.

Employees can often purchase additional life insurance coverage for themselves and/or their dependents and pay for the coverage with payroll deductions. However, this supplemental coverage is generally conditioned upon the carrier receiving and approving an EOI submitted by the insured individual. Some employers assist with the administration of the supplemental coverage by collecting the employees' EOIs and premiums for the insurer.

DOL Investigations

Regional offices of the DOL's Employee Benefits Security Administration ("EBSA") conducted investigations into the administration of life insurance plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA").

As a result, the DOL found that several life insurance carriers, including the Prudential Insurance Company of America ("Prudential") and United of Omaha Life Insurance Company ("United"), had a pattern of denying supplemental coverage

claims due to missing EOIs, despite having continually accepted employee premiums for the coverage. In many cases, the employers had assumed the duties of collecting the EOIs and premiums for the insurer. The premiums were forwarded, but the EOIs were never collected. Neither the employer nor the insurer informed the participants that the required EOIs were missing and that the failure to provide the information could result in denial of their claims. Unfortunately, the beneficiaries or the employee became aware of the deficiency only after the insured individual passed away and the life insurance claim was denied.

For example, according to the DOL, Prudential had denied more than 200 supplemental coverage claims due to missing EOIs from 2017 to 2020, despite having collected premiums for this supplemental coverage – in some cases back to at least 2004.

Although the DOL has not pursued actions against the participating employers, the agency believes that the insurer and the employers jointly have ERISA fiduciary responsibility for these arrangements. Specifically, the DOL determined that failing to properly administer a plan, including a failure to collect required documentation, confirm eligibility, or provide proper and timely notice to applicants of their eligibility, can result in a breach of fiduciary duty by both entities.

Settlement Agreements

Both Prudential and United entered into settlement agreements with the DOL earlier this year to resolve these issues without litigation. The settlement agreements are similar, but not identical.

Under the agreements, the carriers agreed to implement new procedures for handling supplemental coverage claims when EOIs are missing:

- Claims received within ninety (90) days of the first premium payment can be denied due to a missing EOI. The insurer must provide a denial notice indicating that the denial is due to the missing form and return all premiums to the employee or the beneficiary that it has received to date for the coverage.

- Claims received after ninety (90) days of the first premium payment will not be denied due to a missing EOI.

- If an enrolled employee or dependent is still alive, and the carrier discovers that the required EOI is missing, it can request the missing information if the inquiry is made within one year of the receipt of the first premium payment for supplemental coverage. The carrier cannot request or make its coverage decision on any information other than the applicant's health status as of the date the first premium payment for coverage was received. If eligibility for coverage is ultimately denied, the insurer must return all collected premiums to the employee.

The carriers also agreed to notify existing and new group life insurance policyholders (e.g., employers) that if the policyholder collects premiums from an employee for coverage that requires EOI without first confirming that the carrier has approved the EOI, the policyholder may be liable for the benefit.

Both carriers have advised the DOL that they are voluntarily reprocessing previously denied claims to provide benefits for claims denied based solely on a missing EOI; Prudential back to June 2019, and United back to February 2018.

Employer Action

Because employers could be liable for an ERISA breach of fiduciary duty if they assist in the administration of these supplemental life insurance coverages, employers should:

- Confirm the employee or dependent's coverage status before submitting any premiums to the carrier. If the employer collects premiums from the employee before a determination is made, the employer should have a set time period (e.g., 60 days) from the date of the receipt of the first payment until confirmation of coverage with the insurer. If the insurer fails to comply with this timeline, the employer would then return the premiums to the employee with notice that the carrier failed to confirm coverage and encourage the employee to communicate with the carrier.

- Create a process to confirm with the carrier on a regular basis (e.g., quarterly) which employee coverages are in effect. This will help stop premium collection from employees whose coverage has lapsed, as well as provide an opportunity for the carrier to request required information from the employees, such as missing EOIs.

Employers that outsource their EOI administration should confirm their vendors' processes in light of the DOL settlement agreements. As open enrollment season has begun, now is a good time to review existing practices.

New Chicago Paid Leave Ordinance Takes Effect Soon

Issued date: 12/01/23

On November 9, 2023, Chicago passed a new Paid Leave and Paid Sick Leave Ordinance that takes effect on December 31, 2023. This new ordinance replaces the current ordinance in effect. Under the new ordinance, every 12-month accrual period, Covered Employees will be able to accrue:

- 40 hours of Paid Sick Leave
- 40 hours of Paid Leave usable for any purpose

The ordinance applies to all employers with employees in Illinois. Covered Employees are employees who, within any two-week period, perform two hours or more of work while physically present within the geographic boundaries of Chicago ("the City"). The 40 hours of Paid Leave usable for any purpose is similar to the Illinois Paid Leave for All Workers Act which takes effect January 1, 2024.

Accruing and Using Leave

Covered Employees will accrue one hour of Paid Sick Leave and one hour of Paid Leave for every 35 hours worked. The ordinance requires that the time accrued be in whole-hour increments and no fractions. Exempt or non-hourly employees accrue time based upon the presumption that they work 40 hours per work week unless their regular work week schedule is less than 40 hours. If the work week is less than 40 hours, then the accrual is based upon the hours of the employee's regular work week. Nothing in the ordinance impacts an employer's policy that is more generous.

In lieu of calculating accruals, employers can front-load the 40 hours of Sick Leave and 40 hours of Paid Leave. If the full hours of Paid Leave are front-loaded at the beginning of the 12-month accrual period, then any unused time does not

carry over to the next period. However, if the employer implements policies or denies access to the Paid Leave hours that prevents the employee from having meaningful access, then those denied hours must carry over. Front-loading the Paid Sick Leave never eliminates the employer's obligation to carry over up to 80 hours of unused Paid Sick Leave from one accrual period to the next.

If the employer has an unlimited paid time off policy and this policy is available immediately on an employee's first date of employment or at the beginning of each 12-month accrual period, the employer does not need to track any unused time to carry over. Additionally, employers with these policies may not require preapproval for the paid time off. An unlimited paid time off policy does not exempt an employer from paying out 40 hours of paid time off minus the hours used in the 12-month accrual period after a termination, resignation, retirement, separation, or transfer outside geographic limits of the City (see discussion below).

The ordinance requires that if a Covered Employee has accrued Paid Sick Leave prior to January 1, 2024, and the employer's current policy does not comply with the new ordinance, the Covered Employee is entitled to roll over Paid Sick Leave from one 12-month accrual period to the next.

Covered Employees can begin using Paid Sick Leave by the 30th day of employment (or 30 days from the effective date of the ordinance) and Paid Leave by the 90th day of employment. An employer cannot set a policy with greater restrictions as to when employees can begin using leave. However, an employer can set minimum hour requirements as long as those requirements do not exceed four hours for Paid Leave or two hours for Paid Sick Leave per day.

Requesting Leave and Requirements and Restrictions on Leave

Paid Leave may be used for any reason and an employer cannot require the employee to provide a reason for the leave or request document or proof in support of the leave. An employer may require an employee to provide reasonable notice of Paid Leave, but not to exceed seven days' notice prior to the leave and may require reasonable preapproval to maintain continuity of operations for the employer.

An employee can use Paid Sick Leave for:

- When the employee is sick, injured or receiving professional or diagnostic care;
- When a family member is sick, injured, ordered to quarantine or receiving professional or diagnostic care;
- When the employee or a family member is a victim of domestic violence;
- When the employee's place of business is closed due to a public health emergency or an employee's family member's school or place of care has been closed;
- When an employee is following an order issued by the Mayor, Governor, Chicago Department of Public Health or a treating healthcare provider to remain at home or quarantine.

Employers may require notice, up to seven days in advance, if the Paid Sick Leave is foreseeable. Otherwise, employers may require notice as soon as possible on the day the employee intends to use the Sick Leave. However, any requirement for advance notice will be waived if the employee is unable to provide notice due to being unconscious or otherwise medically incapacitated. If there is an absence of more than three consecutive days with the use of Paid Sick Leave, then the employer may require reasonable documentation or certification that the leave was used for a permitted purpose.

The employee, not the employer, gets to choose which documentation to provide if requested or required by the employer. An employer cannot require more than one document per incident. Additionally, the employer cannot delay the use of the Paid Sick Leave or the employee's wages until the employer receives certification or documentation.

Noteworthy is that the ordinance requires that any unused Paid Sick Leave and Paid Leave be "…retained by the Covered Employee if the Employer sells, transfers, or otherwise assigns the business to another Employer and the Employee continues to work in the City."

Upon a termination, resignation, retirement or other separation from the employer, the employer must pay the monetary equivalent for all unused, accrued Paid Leave as part of the employee's final compensation. There is limited relief from this requirement for small and medium sized employers:

- **Small employers (50 or fewer Covered Employees)** are not required to pay out Paid Leave when there is a termination, resignation, retirement, or separation or if the employee ceases to meet the definition of a Covered Employee.

- **Medium employers (51 to 100 Covered Employees)**, the maximum of 16 hours of Paid Leave will be paid out until December 31, 2024, unless the medium employer sets a higher limit. On or after January 1, 2025, medium employers will be required to pay out the monetary equivalent of all unused and accrued Paid Leave.

The ordinance does not require that any Paid Sick Leave be paid out upon an employee's termination, resignation, retirement, or other separation from the employer unless the terms of an applicable collective bargaining agreement specify otherwise.

Employer Action

Given the approaching deadline, employers should:

- Assess current paid time off and sick leave policies to determine compliance with the new ordinance;

- Determine if any hours accrued need to be carried over;

- Review and update any postings and pay stub notification requirements;

- Update handbooks as necessary; and

- Train staff regarding new requirements and updated policies.

While further guidance is expected from the City, affected employers should work with their employment counsel or other advisors to comply with these new requirements.

House Passes Health Care Transparency Law

Issued date: 12/15/23

The U.S. House of Representatives voted 320-71 to pass the Lower Costs, More Transparency Act ("the Act") on December 11, 2023. The legislation aims to lower health care costs by increasing transparency in the market. The Act includes changes that would impact employers sponsoring group health plans.

For group health plans, the bill:

- Codifies the current transparency in coverage regulations (related to posting machine-readable files ("MRF") and making certain cost information available) into statute with some changes (e.g., specific timing to post the MRF – 10th day of such month). This provision, if enacted, would apply to the first plan year on or after January 1, 2026.

- Requires Pharmacy Benefit Managers ("PBMs") to provide semi-annual reporting to a group health plan that includes detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. PBMs who fail to comply may face penalties of $10,000/day. If enacted as is, it would apply to the first plan year on or after a date that is 2 years after the date of enactment.

- Enhances transparency requirements to ensure health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan. Penalties for noncompliance may be assessed against TPAs and PBMs of $10,000/day. If enacted as is, it would apply effective for the first plan year on or after the date of enactment.

- Amends ERISA 408(b)(2) compensation disclosure requirements to directly include PBMs and TPAs as service providers that must disclose their compensation. If enacted as is, it would apply to contracts entered into on or after January 1, 2025.

- Prohibits gag clauses in pharmacy contracts that would restrict a pharmacy from disclosing to a covered participant or beneficiary cost information related to a drug. The effective date of this provision is unclear.

While the House was successful in passing this bipartisan legislation, it is unlikely the Senate will consider or pass this bill as a standalone piece of legislation. However, the House and Senate will need to pass government funding bills in early 2024 and it is possible that components of this legislation could make it into one of those spending bills that are ultimately enacted into law. We will continue to monitor developments.

Chicago Paid Leave Ordinance Amended and Delayed

Issued date: 12/28/23

On December 13, 2023, the Chicago City Council voted to delay the Paid Leave and Paid Sick and Safe Leave Ordinance ("Paid Leave"), which was enacted on November 9, 2023, and was originally to take effect on December 31, 2023. The Ordinance will now take effect on July 1, 2024.

Changes to the Ordinance

In addition to the delay in effective date, the Council modified the Ordinance in other aspects. Importantly, the definition of a covered employee was amended. The amended ordinance defines a Covered Employee as an individual who works at least 80 hours for an employer within any 120-day period while physically present within the geographic boundaries of the City of Chicago. Previously, the Covered Employee only had to work at least two hours within any particular two-week period. The amended ordinance clarifies that once that threshold is met, that individual will remain a Covered Employee for their entire employment.

While the underlying notice requirements were not modified, employers must now provide their time off policy in writing to each of their Covered Employees in that employee's primary language.

Additionally, regardless of whether an employee meets the definition of a Covered Employee, if their regular work duties occur within the geographical boundaries of the City, then the employer must comply with all recordkeeping requirements for that employee as explained below.

The partial payout period for medium-sized employers has been postponed until July 1, 2025. Previously, medium-sized employers needed to pay out a maximum of 16 hours of Paid Leave until December 31, 2024, and then, effective January 1, 2025, were required to pay out all accrued, unused Paid Leave.

The last modification was adding a prerequisite to the private cause of action for an employee to sue an employer. The prerequisites are explained in more detail below and are set to expire on July 1, 2026.

Record Retention and Private Cause of Action

Every employer must maintain records for at least five years containing the following information for each employee:

- Name and address
- Hours worked
- Pay rate
- Wage agreement
- Number of paid time off hours earned each year
- Date on which paid time off hours were taken and paid
- Any other records or documents necessary to demonstrate compliance with this law

A Covered Employee can sue an employer in a civil action if the Covered Employee is not allowed to obtain or use benefits as entitled under the Ordinance. The Covered Employee can seek damages equal to three times the full amount of any leave denied or lost by reason of the alleged violation as well as any interest and reasonable attorney's fees. Until July 1, 2026, before bringing a civil action the Covered Employee can only bring a suit if: (1) an alleged violation occurs and (2) the payday for the next regular payroll period or 16 days after the alleged violation occurred passes, whichever is the shorter period.

Employer Action

In addition to the recommended action steps in our prior guidance, employers should also:

- Identify if the change in definition for covered employee has any impact on which employees that PLSSPL must be provided. Some employers may find that the modified definition decreases the number of covered employees that are subject to this law.
- Update their recordkeeping and payroll systems to adjust to the new effective date in July.
- Access resources that will allow for translation of the employer's written policy in the employee's primary language. If there are existing resources, it may be prudent to inquire if they already have a template or boilerplate policy that the employer can easily modify, if necessary.
- Assess current paid time off and sick leave policies to determine compliance with the new ordinance;
- Determine if any hours accrued need to be carried over;
- Review and update any postings and pay stub notification requirements;
- Update handbooks as necessary; and
- Train staff regarding new requirements and updated policies.

While further guidance is expected from the City, affected employers should work with their employment counsel or other advisors to comply with these new requirements.

REMINDER: Upcoming Deadline to Apply for 2024 Colorado FAMLI Private Plan

Issued date: 10/24/23

As previously announced, Colorado will commence paid family medical leave for eligible employees starting January 1, 2024. The deadline for employers who wish to establish a private plan effective January 1, 2024 is fast approaching on October 31, 2023.

More information follows.

Background

Since January 1, 2023, covered employers have registered with the Colorado Paid Family and Medical Leave program ("FAMLI") and provided quarterly wage reports and employer and employee contributions.

Employers can choose to either participate in the state sponsored FAMLI program or initiate their own private plan. Private plan options are both fully insured via carriers or self-funded by holding the employer and employee contribution in a separate account that is backed by a surety bond.

Private Plan Option

Any type of private plan must be approved by FAMLI. FAMLI has provided list of approved plans offered by fully insured carriers which can be found at: https://famli.colorado.gov/employers/private-plans. Other carrier and self-funded plans have until October 31, 2023, to submit an application for approval for their private plan if they want to have it in effect as of January 1, 2024. Employers will use My FAMLI+ Employer at: https://famli.colorado.gov/employers/my-famli-employer to submit their applications which will include proof of purchase documentation.

Upon approval of the employer's private plan, FAMLI will refund any contributions that they have received to the employer based upon the employer's preference on how they would like to receive the refund (ACH credit or paper check). For those employees that no longer work for the employer but did contribute to FAMLI, FAMLI will forward those refunds to the employees directly. While employers do not need to do anything to initiate the refund, they may proactively request the refund by calling FAMLI at 1-866-CO-FAMLI (1-866-263-2654).

Once the private plan is approved, employers have 30 days to send written notice to employees of their decision to use a private plan instead of the state program. The notice can be provided electronically, in person, or via mail. Subsequent new hires will receive the notice immediately upon hire. Additional information is available at: https://famli.colorado.gov/employers.

Recently, FAMLI issued several proposed guidance documents for the public and held a public hearing on October 17, 2023. Once the guidance is finalized, additional information will be provided, especially as the guidance relates to the administration of private plans and other key elements of the FAMLI program.

Updates to Maryland's Paid Family and Medical Leave Requirement

Issued date: 12/01/23

As previously reported, Maryland passed the Time to Care Act of 2022 ("the Act"), which mandates that covered employers provide paid family and medical leave to their employees in Maryland. On May 3, 2023, Governor Wes Moore signed SB 828, amending the Act. The Legislature's notable modifications include a delay in implementation as well as providing clarification on how the Act will coordinate state benefits with existing federal Family and Medical Leave Act ("FMLA") requirements and employer paid time off.

Separately, on September 29, 2023, the Maryland Department of Labor ("DOL") announced the initial contribution rate for the Family and Medical Leave Insurance State Plan.

Legislative Changes and Updates

- Employers participating in the State Plan will begin making payroll contributions starting on October 1, 2024 (a delay of one year from the original date). Similarly delayed one year, benefits payments will begin on January 1, 2026.
- Where an employee is eligible for leave under both federal FMLA and under the Act, the DOL can consider the use of FMLA to offset the duration of available leave under the Act where:
    - An employer designates a period of leave taken by an employee as FMLA leave and it is also eligible under the Act;
    - The employer provides the employee notice that the leave is eligible under the Act; and
    - The employee does not apply for benefits under the Act.
- Contrary to the language in the original Act, the amendments now prohibit an employer from requiring an employee to use up all available vacation, sick, or other employer-provided paid leave prior to applying for (or while receiving) benefits under the Act.
- On September 29, 2023, the DOL announced the initial contribution rate for the Act would be a rate of 0.90% of covered wages and will be divided equally between employees and employers with more than 15 workers. The contribution rate will be split evenly between employers and employees, each paying a 0.45% share.

This contribution rate will continue through at least June 20, 2026.

Employer Action

Employers should

- 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, employers will need to apply for approval from the DOL to offer an alternative plan. Guidance on this process is expected in the future.
- Provide written notice to all covered employees of their rights and duties under the Act.
- Ensure that payroll is prepared to begin contributions on October 1, 2024.
- Future regulations are expected and employers should continue to await their release.

Oklahoma PBM Law Preempted by ERISA

Issued date: 10/11/23

The 10th Circuit Court of Appeals ruled in favor of ERISA preemption in *Pharmaceutical Care Management Association ("PCMA") v. Mulready*, finding that Oklahoma's Patient's Right to Pharmacy Choice Act ("the Act") regulating pharmacy benefit managers ("PBMs") is preempted by ERISA. This decision reversed the lower court's finding that the Act was not preempted.

Briefly, the court considered the Act's following requirements in its analysis of ERISA preemption:

- Network Restrictions:
    - Access Standards. A PBM must comply with network access standards and may not use mail-order pharmacies to meet these standards.
    - Discount Prohibition. An individual's choice of in-network provider may include a retail pharmacy or a mail-order pharmacy. A PBM may not restrict such choice and may not require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy.
    - AWP Prohibition. A PBM cannot deny a provider the opportunity to participate in any pharmacy network at preferred participation status if the provider is willing to accept the terms and conditions that the PBM has established for other providers as a condition of preferred network participation status.
- Probation Prohibition. A PBM may not deny, limit, or terminate a provider's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy.

Finding in favor of ERISA preemption, the court held that:

- The network restrictions effectively abolish the two-tiered network structure, eliminate any reason for plans to employ mail-order or specialty pharmacies, and oblige PBMs to embrace every pharmacy into the network. These limits are state law mandated benefit structures which are not permitted under ERISA.
- The probation prohibition acts like a network restriction, dictating which pharmacies must be included in a plan's PBM network. An ERISA plan that chooses to hire a PBM is limited by state statute to using PBM networks of a certain structure – one that would include a pharmacist on probation. Such a state restriction is also preempted by ERISA.

The court distinguished its ruling from the U.S. Supreme Court's decision finding an Arkansas PBM law was not preempted by ERISA as the law regulated cost (reimbursement-rate regulation). The court found that the Oklahoma law goes further than Arkansas's PBM law in it regulates aspects of plan administration and design and therefore has an impermissible connection with ERISA plans.

> "Unlike Arkansas's reimbursement-rate regulations, Oklahoma's network restrictions do more than increase costs. They home in on PBM pharmacy networks—the structures through which plan beneficiaries access their drug benefits. And they impede PBMs from offering plans some of the most fundamental network designs, such as

preferred pharmacies, mail-order pharmacies, and specialty pharmacies. In sum, PCMA is not resisting the Act's imposing higher costs, but Oklahoma's attempting to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration."

Mulready, the insurance commissioner of Oklahoma, has already expressed his intent to appeal the 10th Circuit ruling and indicates that enforcement of the Act will continue to the maximum ability of state law. Most likely the Supreme Court will be asked to weigh in on this issue.

Employer Action

For now, employers should carefully monitor developments in the state PBM space. Federal courts may take a closer look at the state PBM laws for areas of overreach consistent with the 10th Circuit ruling. Ultimately, the U.S. Supreme Court may be asked to weigh in again on the intersect between state PBM regulations and ERISA preemption.

Oregon Expands Domestic Partner Registration Eligibility

Issued date: 10/13/23

Currently, Oregon registered domestic partnership is limited to same sex couples. Effective January 1, 2024, Oregon will allow opposite sex couples to register their domestic partnership. Employers that sponsor fully insured plans[1] that cover registered domestic partners of employees may have more employees enrolling a registered domestic partner in the group health plan.

Background

Under Oregon law, domestic partners who are registered with the state's domestic partner registry are generally afforded the same rights, protections, and benefits as are granted to spouses.[2]

Fully insured group health plans in Oregon as well as non-ERISA plans sponsored by state and local government employers that cover spouses of Oregon employees are required to provide coverage to registered domestic partners.

Self-funded plans covered by ERISA are not required to provide coverage for registered domestic partners. However, an employer sponsoring a self-funded plan may voluntarily choose to extend coverage to domestic partners, whether they are registered or based on the plan's domestic partner eligibility criteria.

Under Oregon law, in order to register a domestic partnership, a couple must file a notarized Declaration of Oregon Registered Domestic Partnership form with an Oregon county clerk. The form attests that the couple meets certain criteria at the time of filing. Until December 31, 2023, one requirement is that the couple are both members of the same sex.[3]

HB 2032

On April 6, 2023, Oregon Governor Tina Kotek signed HB 2032 amending Oregon law to expand eligibility for Oregon Registered Domestic Partnerships.[4] This new law eliminates the requirement that both domestic partners be of the same sex in order to register their domestic partnership. This change is effective January 1, 2024; opposite sex couples must wait until that date to file the required declaration form with a county clerk.

Employer Next Steps

Employers with fully insured plans in Oregon must treat registered domestic partners on the same basis as spouses in the group health plan. This will extend to opposite sex couples who register under the expanded definition.

Employers with Oregon employees should review the eligibility terms in their plan documents, summary plan descriptions, employee handbook, open enrollment material, and other communications to see if there is a domestic partner definition that needs to be updated. No change to the term "registered domestic partner" is necessary, but any listing of the criteria to register a domestic partnership in Oregon will need to reflect the eligibility of opposite sex couples effective January 1, 2024.

Employers sponsoring a self-funded plan that has voluntarily extended coverage to domestic partners, and whose domestic partner eligibility allows same sex couples only, may consider amending the criteria to reflect the upcoming change in the eligibility for an Oregon registered domestic partnership.

Additionally, newly registered domestic partners would become eligible for coverage under a fully insured group health plan and would likely qualify for mid-year enrollment on the group health plan. However, the tax treatment of the employee cost for this coverage is subject to different rules at the state and federal level. Employers will want to confirm that their payroll tax reporting and cafeteria plan deductions comply with these tax rules.

As noted above, the requirement to cover registered domestic partners applies to all state and local governmental plans that are not covered by ERISA.

RESOURCES

- Oregon State Legislature website for HB 2032, https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/HB2032

- Oregon Registered Domestic Partnership Website, https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/dp.aspx

[1]The requirement to cover registered domestic partners applies to state and local governmental plans that are not ERISA covered.
[2]ORS 106.340
https://oregon.public.law/statutes/ors_106.340#:~:text=Any%20privilege%2C%20immunity%2C%20right%20or,granted%20on%20equivalent%20terms%2C%20substantive
[3]Couples must meet the following requirements to file for Oregon Registered Domestic Partner status:
1. the couple must be 18 years of age or older,
2. one partner must be a resident of Oregon,
3. neither partner can presently be in a marriage or a legally recognized registered domestic partnership; and
4. (a) Until December 31, 2023 – both partners must be of the same sex (b) on or after January 1, 2024 partners may be of any sex.
https://www.oregon.gov/oha/ph/birthdeathcertificates/registervitalrecords/pages/dp.aspx

[4]https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2032/Enrolled

Paid Leave Oregon Benefit and Contribution Amount Adjustments

Issued date: 12/21/23

December 21, 2023 Update: The Social Security wage cap has been released for 2024. The "Contribution Limit" section below includes several updates to reflect this and additional related information.

As previously reported in August 2021, leave and benefits under Paid Leave Oregon ("PLO") will become available on September 3, 2023. Recently, the Oregon Employment Department ("ED") announced the adjusted weekly wage replacement benefit amounts based on the State Average Weekly Wage. Additionally, the Oregon Legislature modified PLO to align the wage cap for employee contributions with the social security wage limit.

Background

PLO took effect January 1, 2023 and will begin providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits.

Wage Replacement

On June 1, 2023, ED announced the weekly benefit amounts for PLO effective July 1, 2023, through June 30, 2024. The minimum and maximum weekly benefit amounts are adjusted annually based on the Oregon State Average Weekly Wage set by ED. The State Average Weekly Wage ("SAWW") increased to $1,269.69 from $1,224.82. The minimum weekly benefit under PLO is 5% of the SAWW and the maximum is 120% of the SAWW.

	Minimum weekly benefit amount	Maximum weekly benefit amount
July 1, 2023 – June 30, 2024	$63.48	$1,523.63

Contribution Limit

The total contribution amount of 1% of eligible wages is split between employees and employers. Employees pay 60% and employers pay 40%. For example, $1,000 in wages would equal $10 in premiums paid to PLO of which, the employee would pay $6, and the employer would pay $4.

Employers that do not sponsor approved equivalent plans are required to deduct PLO premiums from employee paychecks and remit those premiums to the Paid Family and Medical Leave Insurance Fund. ED annually sets the maximum wage limit from which employers deduct premiums. Initially, the wage limit was set at $132,900. Recently Oregon enacted SB 913 which aligned the PLO wage cap with the Social Security wage cap beginning January 1, 2024. The Social Security cap has been announced for 2024 and is set at $168,600. ED is required to announce the adjusted contribution limit by November of each year for the following calendar year.

Paid Leave Oregon Website

The PLO website provides extensive information for employers including program information, employer resources, printable forms, employee contribution calculators, and FAQs. Employers can also access program guidebooks, checklists, and guidance and tools related to administering equivalent plans.

Employer Action

Employers should plan to update their 2024 employee payroll deductions to the adjusted amount starting for payroll dates on or after January 1, 2024.

Washington Decreases 2024 Paid Family and Medical Leave Premium

Issued date: 11/09/23

The Washington Employment Security Department ("ESD") announced a decrease in the premium rate for Washington Paid Family and Medical Leave ("WA PFML"). The premium rate will decrease to 0.74% of employee wages, down from the current 0.8%. The decrease is effective for the first quarter of 2024 and should be reflected in contributions and reporting for all pay dates on or after January 1, 2024.

Background

Effective January 1, 2020, all employers with at least one (1) employee performing services in Washington must provide paid family and medical leave through the state insurance fund or an approved voluntary plan. WA PFML benefits are funded by premiums paid by employers and employees. Premiums are funded by employee and employer contributions based on employee wages up to the social security cap ($168,600 in 2024). Employers are also required to report employee wages and hours when premiums are remitted to ESD.

2024 Premium Changes

Effective for payrolls on or after January 1, 2024:

- The premium amount is decreasing to 0.74% of employee wages.
- The wages subject to premiums are increasing to $168,600 to reflect the higher social security wage cap for 2024.
- The employer portion of the premium is increasing to 28.57% and the employee portion is decreasing to 71.43%.

Employers with fewer than 50 employees are not required to pay the employer portion.

Example of annual premium amount for an employee earning $75,000 in 2023 and 2024:

- Total annual premium in **2023**: $75,000 x 0.8% = **$600**
  Employee cost: $436.56
  Employer cost: $163.44
- Total annual premium in **2024**: $75,000 x 0.74% = **$555**
  Employee cost: $396.44
  Employer cost: $158.56

Employer Action

Employers should confirm their payroll systems are prepared to deduct the new lower rates from employee paychecks beginning January 1, 2024. Employers are prohibited from deducting more than the maximum allowable employee portion of the premium from wages paid in a pay period.

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