Roundup of selected state health developments, third-quarter 2020

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In this article

States scrambled in the third quarter of 2020 to address health coverage and quality, prescription drug costs, COVID-19 testing, paid and unpaid leave, and other benefit-related issues. California and Rhode Island drafted reporting regulations for health plans covering state residents, while other jurisdictions moved ahead with coverage initiatives that may affect even self-insured ERISA plans. Studies reviewed healthcare issues in the presidential election, state health system rankings and COVID-19's mental health impact by state. Assessments will soon begin for insured plans in New Jersey and will continue for New York insurers and self-insured plan sponsors. A number of states imposed new or clarified existing insurance coverage mandates, including COVID-19 testing and gender nondiscrimination issues. Employment laws related to employee classification and transit benefits also garnered attention.

Individual health coverage mandates

Two states — California and Rhode Island — where individual health coverage mandates took effect this year have proposed regulations for employer reports due in 2021. Both states require residents to carry minimum essential coverage (MEC) or face a state tax penalty.

California

Employers with group health plans covering California residents will have to file coverage reports with the state's Franchise Tax Board (FTB) and provide written statements to covered individuals beginning in 2021. FTB draft regulations define terms and affordability parameters for residents required to

maintain MEC. The draft rules also specify that applicable entities, such as health insurers and employer group health plan sponsors, must file MEC reports for a calendar year with FTB by March 31 of the following year. Final regulations may clarify whether the carrier for fully insured employer plans can satisfy this reporting requirement or both covered entities will have to report. Penalties for failure to file — $50 per covered individual — won't begin to accrue until May 31. Written statements to individuals are due every Jan. 31. When the penalty for individual statement noncompliance will begin to accrue is unclear.

Insurers and employers subject to coverage reporting under the federal Affordable Care Act (ACA) can use IRS Forms 1095 to satisfy the state requirements. Any entity filing at least 250 returns in a year with FTB must file electronically unless granted a waiver due to technology constraints or undue hardship. Smaller entities may opt to file either by paper or electronically. The rules define MEC (Cal. Health & Safety Code § 1345.5) largely the same as the federal law in effect Dec. 15, 2017. FTB held a Sept. 30 hearing to collect public input on the draft regulations.

Rhode Island

Proposed Rhode Island regulations on the state's individual health coverage mandate (RI Pub. Laws §§ 44-30-101 and -102) address reporting obligations for insurers, employer plan sponsors and other "applicable entities." The state follows the federal definition of MEC in effect Dec. 15, 2017. An employer or applicable entity that provides MEC to any Rhode Island resident must send reports to both the Division of Taxation (DOT) and covered individuals by Jan. 31 each year, starting in 2021.

The report to individuals must include the applicable entity's name, address and contact information. Each applicable entity must notify each covered individual, including dependents. Reports to the DOT must include name, address and taxpayer identification number of the primary insured and each other covered individual, as well as their MEC coverage dates. IRS Forms 1095 can be used to satisfy these requirements.

The proposed regulations don't indicate whether any state-specific form will be required or indicate how entities will file with the DOT — such as through a specified portal or other means. FAQs on the state's insurance exchange website don't address employer or carrier reporting obligations. Additional guidance may become available before year-end.

State and local healthcare initiatives

State and city leaders continue to look for ways to expand health coverage and improve quality through assorted local initiatives. San Francisco regulators have updated health coverage standards for employees of the city's contractors and set expenditure rates for 2021. Seattle's health coverage law for hotel workers has survived an initial court challenge and will move ahead with rates updated for 2021 as litigation continues

With unprecedented expansion of telehealth services during the COVID-19 outbreak, Colorado, Nevada, Oregon and Washington are collaborating to identify best practices that support telehealth services even after the pandemic ends. The state leaders see telehealth as a way for patients to connect with healthcare providers while mitigating virus exposure risks.

San Francisco, CA

HCAO standards. Effective Jan. 1, 2021, new minimum standards under the Health Care Accountability Ordinance (HCAO) raise certain cost-sharing limits, but largely remain the same as the 2020 requirements. San Francisco contractors and tenants (including those at the city's international airport and port) must offer minimum health benefits at no cost to covered employees under the HCAO, which differs from the Health Care Security Ordinance discussed below. The HCAO applies to employees who work at least 20 hours per week on a city contract or city property. Employees working on a San Francisco contract are covered, even if their contract work is done outside the city.

The 2021 in-network, out-of-pocket maximum will be $8,200, up from $7,800 in 2020. The in-network deductible will rise from $2,000 to $3,000 for medical and from $200 to $300 for prescription drugs. Primary care copayments can't exceed $50, up from $45.

HSCO expenditure. San Francisco has posted the 2021 expenditure rates required by the Health Care Security Ordinance (HCSO). The HCSO applies to all employers with a valid San Francisco business registration certificate that have at least 20 employees in any location and at least one working in the city. For employers with 100 or more employees, the 2021 HCE rate will rise to $3.18, up from $3.08 in 2020. For more detail on HCSO and employer obligations, see San Francisco posts 2021 health care expenditure rates.

Colorado, Nevada, Oregon and Washington

Governors from Colorado, Nevada, Oregon and Washington have announced a joint plan to promote telehealth services after the COVID-19 crisis. The group intends to work with federal agencies to support continued use and availability of telehealth, which has broadly expanded during the pandemic. The approaches will be state-driven but share specific principles: patient-centered equitable access; patient confidentiality; network adequacy; standards of care; reduction of fraud, waste, discriminatory barriers and abuse; patient choice; and provider reimbursement. The announcement didn't include any specific timeline or meeting schedules.

Seattle, WA

Seattle has announced its healthcare expenditure rates for 2021 under the city's hotel employees' medical care ordinance (Mun. Code Ch. 14.28), which took effect for some employers on July 1, 2020. The ordinance requires certain hotels and related industry employers to spend a minimum amount on

Seattle employees' healthcare or provide cash compensation directly to covered employees. Covered employers will need to adjust planned expenditure rates for 2021 as follows:

- $437 per month for an employee with no spouse, domestic partner or dependents
- $743 per month for an employee with only dependents
- $874 per month for an employee with only a spouse or domestic partner
- $1,310 per month for an employee with a spouse or domestic partner and one or more dependents

Earlier this year, a federal district court held that ERISA doesn't preempt the mandate (*ERISA Indus. Comm. v. Seattle*, No. C18-1188-TSZ (W.D. Wash. May 8, 2020)). The court found that Seattle's ordinance is nearly identical to the San Francisco HCSO, which survived a similar ERISA challenge (*Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 546 F.3d 639 (9th Cir. 2008)). The ERISA Industry Committee (ERIC) has appealed, arguing the Seattle mandate is distinct because of its "intricate employer-to-employee direct-payment regime (and accompanying administrative system)."

For more on the Seattle ordinance and ERISA litigation, see Seattle healthcare expenditure for hotels survives ERISA challenge.

Healthcare studies

As the 2020 presidential election nears, the Commonwealth Fund examines voters' views on healthcare issues. Another Commonwealth Fund report evaluates state healthcare systems. The Kaiser Family Foundation (KFF) has issued state-by-state fact sheets and a national summary reviewing the impact of COVID-19 on mental health.

Healthcare and the election

A September Commonwealth Fund poll asked likely voters in battleground states about the importance of a candidate's ability to address the public health needs and economic costs of COVID-19, protect health insurance coverage for people with preexisting health conditions, and lower healthcare costs. The poll found 40% of respondents ranked public health needs and economic costs of COVID-19 as the top concern; 29% chose insurance protections for people with preexisting health conditions; and 20% indicated lower healthcare costs is the top concern.

State health system performance

A state-by-state Commonwealth Fund report measures healthcare access, quality, outcomes and disparities. The 2020 Scorecard on State Health System Performance finds that Hawaii outpaces other states in its overall health ranking, with Massachusetts Minnesota, Iowa and Connecticut rounding out

the top five. Mississippi continues to rank at the bottom, with worsening access and affordability. Florida has made the greatest improvement, particularly in prevention and treatment. The report also notes insurance coverage gains associated with the ACA have stalled, and affordability and out-of-pocket costs are worsening.

Mental health and COVID-19

A KFF summary examines national and state-level data on mental health and substance abuse before and during the coronavirus pandemic. As shown in several accompanying fact sheets, the report finds that mental health outcomes, access and coverage vary substantially from state to state. The pandemic and resulting economic downturn have taken a toll on mental health, with more than 30% of US adults now reporting symptoms consistent with an anxiety and/or a depressive disorder.

States with the highest percentage of adults reporting symptoms of an anxiety or a depressive disorder are Louisiana (42.9%), Florida (41.5%), Oregon (41.3%), Nevada (39.1%) and Oklahoma (39.0%). Those with the lowest percentage are Wisconsin (27.2%), Minnesota (30.5%), Nebraska (30.6%), North Dakota (30.9%) and South Dakota (31.0%).

Drug prices

As prescription drug prices continue to rise, states have sought to hold manufacturers, pharmacy benefit managers and insurers responsible for limiting costs, as well as reporting and justifying price increases. A ruling in a lawsuit heard Oct. 6 by the US Supreme Court (*Rutledge v. Pharm. Care Mgmt.*) may clarify the extent to which states can exercise this authority. Ahead of that decision, which is expected by June 2021, Minnesota and New Hampshire have enacted drug price reporting obligations. In addition, New Hampshire has set a cost-sharing limit for insulin and moved ahead with plans to purchase prescription drugs from Canada.

Minnesota

Beginning Oct. 1, 2021, Minnesota-licensed prescription drug manufacturers must report any increase meeting certain thresholds in a drug's price — defined as its wholesale acquisition cost — within 60 days after the increase. Thresholds include an increase of $100 or more for a 30-day supply, a 10% increase for brand-name drugs over the past 12 months or 16% over the past 24 months, or a year-over-year increase of 50% or more for generics.

Under the new law (2020 Ch. 78, SB 1098), reports must detail manufacturers' costs and net profit, information on patent expiration, the price of any comparable drug in any in other countries, and any patient financial assistance, such as coupons and prepaid cards. Similarly detailed cost reports are due for new and newly acquired prescription drugs.

The Department of Health (DOH) will enforce the mandate and may impose penalties and fees for failure to timely and accurately file reports. DOH must annually provide the legislature starting Jan. 15, 2022, a summary report on the legislation's effectiveness in enhancing prescription drug price transparency, cost management and other findings.

New Hampshire

A comprehensive New Hampshire law (2020 Ch. 13, HB 1280) sets a cost-sharing limit for insulin, requires coverage for certain drugs, establishes a prescription drug affordability board to set pricing targets for public sector plans, creates a "competitive prescription drug marketplace" and authorizes a wholesale importation program to purchase prescription drugs from Canada, subject to federal approval. New Hampshire joins nine other states to limit insulin cost sharing and at least three other states planning drug importation programs. For more detail, see New Hampshire targets Rx costs, joins other states to add insulin cap.

Health plan assessments

In 2021, employers with insured health plans issued in New Jersey may see insurers pass along a premium excise tax enacted to support the state's reinsurance program. New York has again extended its Health Care Reform Act (HCRA) assessments and surcharges for insurers and self-insured health plan sponsors to support indigent care and graduate medical expenses.

New Jersey

Beginning Jan. 1, 2021, a New Jersey law (2020 Ch. 61, AB 4389) will impose a 2.5% excise tax on health insurance premiums, replacing the ACA assessment repealed by Congress. The fee closely mirrors the repealed ACA tax in the policies impacted: The charge will apply to net written premiums of fully insured health plans, HMOs, and certain dental and vision plans, but not to premiums for small-group or excepted-benefit plans. The fee does not apply to self-funded plans or stop-loss policies.

Gov. Phil Murphy said the health insurer assessment (HIA) will help fund a subsidy program for New Jersey residents with annual incomes up to 400% of the federal poverty level. The fee will also help pay for a state reinsurance program to address high-cost claims and lower premium costs in the individual market. While the assessment won't directly affect employers, plan sponsors that purchase group health policies in New Jersey may see a cost increase if insurers pass along the charge.

New York

New York's budget (2020 Ch. 56, SB 7506, Part Y) extends the HCRA program for three more years, through 2023. Surcharge rates remain unchanged. The HCRA requires healthcare payers, such as self-insured employers and health insurers, to subsidize indigent care and state healthcare initiatives through

surcharges on hospital care and certain laboratory services provided in the state (NY Pub. Health Law § 2807-T). In addition, payers that cover New York residents must pay a covered-lives assessment to fund graduate medical education (New York Pub. Health Law § 2807-S).

Health insurance mandates, billing reforms

A mix of insurance laws will take effect in 2021. California has fortified its regulatory authority over certain ACA provisions. Colorado has enacted pre- and post-HIV-exposure drug obligations for pharmacists and insurers. Georgia and Virginia have adopted surprise healthcare billing restrictions. Illinois is actively enforcing mental health parity compliance in the state, while Massachusetts has affirmed its contraceptive law's requirements. Some states have imposed new or updated COVID-19 coverage requirements. Several states have clarified gender nondiscrimination provisions. These insurance laws don't apply to self-insured ERISA plans.

California

A California law (2020 Ch. 302, SB 406) adopts certain health plan requirements originally enacted as part of the federal ACA. Under the new law, health insurers and HMOs issuing plans in California can't impose annual or lifetime dollar limits on any essential health benefits, whether provided in or out of network. In addition, nongrandfathered health plans must cover 100% of the cost for certain preventive care. The California preventive coverage mandate substantially mirrors ACA requirements. The state law will protect individuals covered under California insured plans if pending litigation before the US Supreme Court leads to a decision striking down these ACA provisions.

Colorado

A new Colorado law (2020 Ch. 281, HB 20-1061) authorizes pharmacists to prescribe and dispense HIV prevention drugs and requires carriers to reimburse in-network pharmacists for the prescription and an adequate consulting or enhanced dispensing fee. The ACA requires nongrandfathered group health plans to cover preventive services with no cost sharing if they have received A or B recommendations from the US Preventive Services Taskforce (USPSTF). After a USPSTF recommendation issued in June 2019, coverage of HIV pre-exposure prophylaxis (PrEP) without cost sharing must begin by July 2020 (2021 for calendar-year plans). However, Colorado's law goes further for insured plans.

While the USPSTF calls for PrEP coverage, Colorado insurers must also cover *post*-exposure prophylaxis (PEP). In addition, insured plans can't require covered individuals to undergo step therapy or obtain prior authorization before receiving HIV drugs. The law also allows certain physician assistants and advanced practice nurses to prescribe these therapies. Pharmacists may prescribe and dispense these drugs after fulfilling specific requirements. Though the ACA requires first-dollar coverage for PrEP, Colorado doesn't mandate this for PEP. Regular cost sharing can apply.

Georgia

A new Georgia surprise-billing law (2020 Ch. 470, HB 888), effective Jan. 1, 2021, requires health plans in the state to pay for emergency services without prior authorization and prohibits retrospective denials for medically necessary services, even if obtained out of network. The law also prohibits healthcare providers and facilities from balance-billing patients for charges exceeding the plan's in-network cost sharing. Health plans' provider payments must include a notice indicating whether the plan is a self-insured ERISA plan exempt from state regulation, including the new law. The same provisions apply to covered nonemergency services provided by out-of-network providers, but an individual who chooses an out-of-network provider in writing doesn't qualify for protections.

Insurers must pay using verifiable contracted rates (median in-network rate in the geographic region, not including Medicare or Medicaid) or a higher amount. Providers that dispute the amount paid may initiate arbitration with the Department of insurance.

Illinois

Five Illinois insurers must pay $2 million in fines for violating the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and a similar state law (215 IL Comp. Stat. 5/370c.1), according to the state's Department of Insurance (DOI). Under the MHPAEA, group health plans that cover mental health conditions and substance use disorders must provide those benefits at the same level as medical and surgical benefits.

After performing market conduct examinations from 2015–2017, the DOI determined that CIGNA Healthcare of Illinois, CIGNA Health and Life Insurance Co., United Healthcare Insurance Co., Health Care Service Corp., and Celtic Insurance Co. violated multiple MHPAEA requirements. In particular, the insurance companies failed to use appropriate medical necessity guidelines, banned exceptions to prescription drug step-therapy requirements, required prior authorization for substance use disorder and behavioral health drugs, imposed step therapy for drugs used to treat depression, and failed to perform proper internal testing to confirm that all plans are in parity.

Massachusetts

A Massachusetts contraceptive coverage mandate applies to insured plans covering state residents and employees whose principal work location is in Massachusetts. Insurance Bulletin 2020-26 clarifies that the 2017 mandate (Ch. 120) requires first-dollar contraceptive coverage, including for female sterilization. The mandate largely mirrors the ACA's contraceptive coverage requirements for nongrandfathered plans.

While the state law provides certain exemptions for a church or qualified church-controlled organization, the Trump administration has attempted to expand exemptions to the federal mandate. The bulletin

confirms that health insurers licensed in Massachusetts must comply with the state's more stringent mandate.

Virginia

Beginning Jan. 1, 2021, a new Virginia law (2020 Ch. 1080, HB 1251) bans providers from balance-billing patients for emergency services or nonemergency surgical or ancillary services provided by an out-of-network provider at an in-network facility. A covered individual must pay the in-network cost sharing that would otherwise apply. The insurer must reimburse the provider "a commercially reasonable amount, based on payments for the same or similar services provided in a similar geographic area." Any disputes not resolved within certain time limits must go through arbitration. The measure establishes an arbitration framework that includes a timeline for proceedings, arbitrator selection, nondisclosure agreements and an appeals process.

COVID-19 coverage

COVID-19 continues to spread. While federal lawmakers have taken some steps to alleviate diagnostic testing costs, states like California and New York have imposed additional COVID-19 cost-sharing restrictions on insured plans. Michigan regulators have announced potential premium refunds or credits for plan sponsors with insured policies, since nonessential health and dental services were often unavailable due to the COVID-19 pandemic.

California

Emergency COVID-19 rules (Cal. Code Regs. tit. 28, § 1300.67.01) from California's Department of Managed Health Care (DMHC) expand the scope of diagnostic testing that managed care plans (generally HMOs) must cover during the governor's declared state of emergency due to COVID-19. As noted in the DMHC FAQs, the expanded requirements don't apply to self-insured, ERISA-covered group health plans. However, federal rules prohibit all health plans from limiting the number or frequency of COVID-19 tests or imposing utilization-management, prior-authorization or cost-sharing obligations on COVID-19 testing for enrollees with symptoms of or known or suspected exposure to the disease.

As of July 17, the California ban on utilization-management and prior-authorization requirements for COVID-19 tests extends to asymptomatic "essential workers" who have no known/suspected exposure to the virus. For more detail, see California expands COVID-19 test coverage for managed care plans.

Michigan

Plan sponsors with insured group health plans in Michigan could receive more than $20.4 million in adjustments, refunds or credits for health and dental insurance premiums, according to the Michigan Department of Insurance and Financial Services (DIFS). The adjustments follow DIFS Bulletin 2020-26-

INS, which "strongly encourages" health and dental insurers to provide appropriate premium refunds or credits consistent with specific guidelines for periods when nonessential health and dental services were unavailable due to the COVID-19 pandemic.

The bulletin requires detailed communications to inform policyholders about the refunds or credits, the manner in which they will be applied, and the timeframe during which the refund or credit will apply. The notices must include a description of how annual benefits will be addressed, such as well-baby visits, annual physicals, dental cleanings, mammograms and more.

New York

A pair of emergency regulations require insured health plans in New York to provide first-dollar coverage for COVID-19 diagnosis and testing and all telehealth care. Both rules took effect in early September and expire on Nov. 9, but can be readopted. The state website also includes health insurance COVID-19 FAQs for consumers.

One emergency rule bars New York insured health plans from imposing cost sharing — including copayments, coinsurance or deductibles — for in-network provider visits or laboratory tests to diagnose COVID-19 (NY Comp. Codes R. & Regs. tit. 11, § 52.16(p). Cost sharing may apply for any COVID-19 follow-up care or treatment, including an inpatient hospital admission. The state's testing coverage mandate goes beyond the federal law, which only requires no-cost coverage of testing for enrollees with symptoms of or known or suspected exposure to the disease.

The other emergency rule prohibits cost sharing for in-network services delivered via telehealth if the service would have been covered if delivered in person (NY Comp. Codes R. & Regs. tit. 11, § 52.16(q)). Insurers must notify in-network providers in writing that they should not collect any deductible, copayment or coinsurance for these services.

Gender nondiscrimination in insured plans

As gender nondiscrimination questions arise at the federal level, four states — Illinois, Michigan, New Hampshire and Wisconsin — have issued guidance clarifying state-law coverage obligations for insured plans. Two recent federal developments have spurred state regulators to clarify their stance: First, a decision by the US Supreme Court held that federal protections against workplace sex discrimination extend to gender identity and sexual orientation (*Bostock v. Clayton County*, 140 S. Ct. 1731 (2020)). Second, a revised federal rule under ACA Section 1557, issued in June, in part eliminates certain federal protections against discrimination in healthcare on the basis of gender identity provided by a previous iteration of the rule. Select portions of the revised final rule are currently on hold due to nationwide preliminary injunctions in ongoing litigation.

Illinois

Recent regulatory guidance clarifies the Illinois Human Rights Act's protections against discrimination based on an individual's sexual orientation or gender-related identity in the provision of healthcare services and health insurance. In addition, Illinois insurance regulations prohibit discrimination in health insurance coverage based on sexual orientation or actual or perceived gender identity, among other traits (IL Admin. Code tit. 50, §§ 2603.30 and 2603.35). Despite the revised ACA 1557 rule that removes these protections, the state law applies to insured Illinois plans.

Group and individual health insurance policies cannot contain exclusions that directly or indirectly discriminate, treat medical benefits for gender dysphoria differently than other covered medical conditions, charge a higher rate or deny a claim for coverage for the surgical treatments for gender dysphoria, or deny or limit coverage or a claim for services because the insured is transgender or is undergoing or has undergone gender transition. This nondiscrimination standard also applies to healthcare services that are ordinarily or exclusively available to individuals of one sex.

Michigan

Michigan Bulletin 2020-34-INS confirms a ban on discrimination based on sex, sexual orientation and gender identity in all statutes and rules administered by the Department of Insurance and Financial Services (DIFS), including health insurance laws and regulations. In an announcement, DIFS regulators explain that health insurance plans cannot deny access to covered services, medications, supplies or durable equipment; limit benefits; impose additional cost sharing or engage in discriminatory marketing practices because of an individual's sex, including gender identity and sexual orientation. The guidance follows *Bostock*.

New Hampshire

New Hampshire Bulletin INS 20-033-AB clarifies gender nondiscrimination requirements for insurers in the state. Despite the revised federal ACA 1557 rule, the bulletin notes that 2019 legislation (HB 608) that took effect in 2020 specifically bans discrimination based on gender identity. Insurers are prohibited from denying, excluding or limiting medically necessary services on the basis of an individual's gender identity. All covered services and supplies must be available to all covered individuals for whom a medical provider has determined those services or supplies are medically necessary.

Wisconsin

A Wisconsin insurance bulletin clarifies that nondiscrimination in health insurance coverage applies to therapeutic interventions, medical and surgical procedures, and prescription medications related to gender identity, including for transgender individuals or insured who have been diagnosed with gender dysphoria. Issued by the Office of the Commissioner of Insurance (OCI), the bulletin reasons that an

insured's gender identity is unrelated to the nature and degree of risk, and Wisconsin law (WI Stat. § 628.34(3)(a)) prohibits an insurer from "offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk."

The OCI notes that state law prohibits excluding, limiting or denying benefits to an insured individual on the basis of gender identity, and this prohibition extends to self-funded nonfederal government plans (WI Stat. § 632.746 (10)). In addition, denying benefits or coverage on the basis of gender identity is unlawful sex discrimination, as supported by the US Supreme Court decision in *Bostock*.

Leave

The COVID-19 pandemic has highlighted gaps in leave benefits, leading states, cities and counties to implement and expand paid and unpaid leave benefits for employees. While many paid leave mandates are specific to COVID-19 needs, some jurisdictions have enacted permanent changes. California has expanded its unpaid, job-protected leave provisions. Connecticut, Massachusetts and New York have updated and clarified paid family and medical leave requirements. New York City has amended its paid sick and safe leave law to better align with a recently enacted state law. Puerto Rico has expanded its maternity leave law for certain adoptive mothers.

COVID-19

To alleviate some of the economic strain on employees unable to work due to COVID-19, some state and local authorities have begun to implement new paid leave requirements. Other jurisdictions are modifying existing leave laws or benefit programs to accommodate employees' needs during the pandemic. Jurisdictions making third-quarter updates to COVID-19-related paid leave requirements include Sacramento, San Mateo County and Santa Rosa. Colorado also made changes to its pandemic paid leave requirements, while Philadelphia amended its paid sick leave ordinance providing public health emergency paid leave to employees not covered by the federal Families First Coronavirus Response Act's leave requirements. Additional COVID-19-related paid leave mandates have been enacted for employees of large employers in Sonoma County, for food production workers in Washington state and for workers of large employers in California. Oakland, CA, has posted FAQs about its supplemental paid leave requirements. For a comprehensive review of the mandates, see States, cities tackle COVID-19 paid leave.

California

Beginning Jan. 1, 2021, the California Family Rights Act (CFRA) will expand job-protected, unpaid leave to smaller employers, additional family members and more employees. The current CFRA is similar in most respects to the federal Family and Medical Leave Act (FMLA), and leave periods taken under the two laws for reasons other than pregnancy-related disability commonly run concurrently, limiting job-protected, unpaid leave to 12 weeks in a 52-week period.

The CFRA amendments (2020 Ch. 86, SB 1383) extend the law to employers with five or more employees — rather than employers with 50 or more employees (and 20 or more employees for new child bonding) — within 75 miles of the worksite. Family members with a serious health condition for whom the employee can take caregiver leave will include grandparents, grandchildren, siblings, registered domestic partners and their children, along with currently covered members — a spouse, child or parent. The expanded definition mirrors the family members covered by California's Paid Family Leave law.

The expanded CFRA also will apply to key employees, who were previously exempt, and provide leave for a military exigency. The amendment eliminates an employer's ability to limit leave to 12 weeks combined when both parents work for the same employer, so employers will need to grant eligible parents 12 weeks each to bond with a new child. The law's expansion may entitle some previously ineligible employees to CFRA leave or extend leave for situations that previously didn't apply. Because the CFRA no longer fully aligns with the FMLA, the changes could have provide some California employees with expanded job-protected leave rights.

Connecticut

Connecticut has begun preparing for the rollout of its Paid Family and Medical Leave Insurance (PFMLI) program (Public Act No. 19-25). Employee contributions start Jan. 1, 2021. Beginning in 2022, covered employees will be able to take up to 12 weeks of paid leave to deal with their own or a family member's serious health condition, donate an organ or bone marrow, bond with a new child, or handle a military exigency. Additional leave will be available for employees experiencing domestic violence or pregnancy-related complications.

The newly created PFMLI Authority will administer the program and has launched a new website. The agency has also issued a program overview, private plan options, guidance for carriers seeking to offer PFMLI coverage, key implementation dates, and a chart comparing elements of the Connecticut program to those offered in California, Massachusetts, New Jersey, New York, Oregon Rhode Island and Washington.

Massachusetts

Private PFML plans. Employers that offer Massachusetts-based employees a paid family and medical leave (PFML) private plan have upcoming renewal obligations. Self-insured employers had to file for renewals by Sept. 30 and submit revised surety bond amounts if previously approved plans were due to expire on that date. Employers offering insured private plans set to expire any time before 2021 can renew between Nov. 30 and the end of 2020. In addition, the Department of Family and Medical Leave (DFML) has updated PFML final regulations to clarify terms, private plan requirements and reimbursements to employers. DFML plans to publish more program information throughout the fall,

leading up to the Jan. 1 start of benefits. For more detail, see Massachusetts family/medical leave private plan renewal due soon.

PFML for telecommuters. A Massachusetts technical information release (TIR-20-10) clarifies state tax requirements — including taxes for PFML contributions — for employees working remotely due solely to the COVID-19 pandemic. To address the pandemic, some employers are imposing work-from-home requirements. Many affected employees live and work in neighboring states, raising concerns about which employees should pay the state's PFML contributions, since participation is based on work location.

Until the earlier of Dec. 31, 2020, or 90 days after the end of the Massachusetts state of emergency, employees telecommuting in a neighboring state solely due to COVID-19 won't be deemed to have altered their work location for tax and PFML contribution purposes. For more detail, see Massachusetts clarifies paid leave taxes for temporary telecommuters.

New York

New York will soon complete its four-year phase-in of paid family leave (PFL) benefits. For qualified leave beginning on or after Jan. 1, 2021, eligible employees will receive 67% of their average weekly wage up to the annually adjusted maximum, for up to 12 weeks. The annual maximum will rise to $971.67 in 2021, up from $840.70 this year.

In addition to the leave reasons permitted under the PFL law in prior years, a new law (2020 Ch. 25, SB 8091) allows qualified employees to use PFL in the event they — or their dependent minor child — are under an order to quarantine or isolate due to COVID-19. To address the costs associated with this additional coverage, regulators have added a COVID-19 risk adjustment to employee contributions in 2021.

Regulators have announced that the premium rate for PFL coverage beginning Jan. 1, 2021 will be 0.506%, plus a 0.005% risk adjustment for the COVID-19 claims, for a total of 0.511% of an employee's wages each pay period, up to an annual maximum employee contribution of $385.34. This reflects a significant increase over the 0.27% of pay (and $196.72 maximum) required in 2020. The state's website includes the updates and FAQs. For more on New York's and other states' PFL programs, see 2020 state paid family and medical leave contributions and benefits.

New York City

New York City has amended (Int. No. 2032-A) its Earned Sick and Safe Time (ESST) law, which took effect in 2014 and expanded in 2018 to allow safe leave. The amendments increase ESST accruals at larger employers; ease eligibility terms; require payroll statements giving an employee's EEST balance

and any ESST accrued and used in each pay period; strengthen nonretaliation provisions, enforcement and penalties; and make other clarifications.

Before the amendment, city employers had provide up to 40 hours of ESST per year (1 hour for every 30 hours worked) to employees who worked at least 80 hours per year in the city. The amendments align the accrual requirements with the new state paid sick leave law by requiring city employers with 100 or more employees to provide up to 56 hours of ESST per year.

The increased accrual requirement and extension to certain smaller employers will take effect Jan. 1, 2021. Other changes — like the removal of both the 80 workhours per year requirement for eligibility and the 120-day waiting period before use — took effect Sept. 30, 2020.

Employers must provide a notice of the amended ESST law to current employees by Oct. 30, 2020. The notice must also be posted in the workplace and provided to new hires. The Department of Consumer and Worker Protection is in the process of making the notice available in multiple languages and updating other materials.

Puerto Rico

Working mothers in Puerto Rico who adopt children aged six years or older will be entitled to five weeks of paid leave under a new law (Bill No. 2424 in Spanish) that took effect Aug. 8. Working women previously could only take adoption leave for children younger than five years who weren't enrolled in school. Working women adopting younger children now are entitled to eight weeks of paid leave, the same as birth mothers. The leave begins on the day the child is placed with family, even if the adoption is not finalized. Employees must give at least 30 days' notice of their intention to adopt a child and take leave and indicate their expected date of return to work.

Puerto Rico law (PR Laws Ann. tit. 29, § 467) mandates a maternity benefit payable at 100% of salary for eight weeks. The leave can begin up to four weeks before the mother's due date. The eight-week benefit must be paid as salary, not as an insured benefit. In addition, the employer must pay full amount at the beginning of the leave. The employer must extend 12 additional weeks of unpaid job-protected leave for any post-natal complications.

Gig work, commuter benefits

Certain state and local employment laws could affect employee benefits, including whether an employee is classified as an employee or independent contractor. Though a proposed Department of Labor (DOL) rule aims to simplify the distinction under the Fair Labor Standards Act, California has imposed stricter parameters. Pretax transit benefits have also received attention in New Jersey and Washington, DC.

California

A new California law (2020 Ch. 38, AB 2257) exempts more professions from the "ABC" strict independent contractor test. In 2019, the governor signed legislation (Ch. 296, AB 5) codifying the ABC test used by the state supreme court in *Dynamex Ops. W., Inc. v. Superior Court*, 416 P. 3d 1 (2018). Assemblywoman Laura Gonzalez, who authored both laws, says AB 2257 "makes a clear distinction between employer-employee relationships and professionals that run their own independent businesses" and is the "product of robust dialogue over the last year with workers and businesses from every part of the state." Exempt professionals, occupations and business relationships are instead governed by the multifactor test outlined by the California Supreme Court in *S.G. Borello & Sons, Inc. v. Dep't. of Indus. Relations*, 769 P. 2d 399 (1989).

New Jersey

New rules for New Jersey's pretax transportation fringe benefit law (2019 Ch. 38, SB 1567) outline the requirements, enforcement procedures and potential penalties. Since March 1, 2020, employers have to offer employees who work primarily in New Jersey an opportunity to participate in a transit or commuter offer a highway benefit program that qualifies for tax-free treatment under federal law (Internal Revenue Code (IRC) § 132(f)). Employers that receive a notice from state regulators have a 90-day cure period to demonstrate compliance before being assessed $100–$250 penalty. Additional penalties accrue for every 30 days of noncompliance beyond the cure period.

The statute itself appears to allow an "alternative means of commuting," including car and van pools, ferries, bicycling, telecommuting and walking, which may be used in conjunction with such strategies as flextime, staggered work hours, compressed workweeks and similar measures. The regulations don't address these options or other alternatives.

Washington, DC

Washington, DC, has amended its 2014 pretax transportation fringe benefit mandate to discourage employers from offering subsidized employee parking benefits. Under the earlier law, employers in the city had to offer employees a pretax transit fringe benefit other than parking that complies with IRC § 132(f).

The amendment (Act 23-305) requires employers that offer DC employees a paid or subsidized parking benefit to offer instead a "clean-air transportation fringe benefit" equal to the market value of the parking benefit in addition to the employee's normal compensation. The clean-air transportation benefit can take the form of a transit pass, commuter highway vehicle or reimbursement for bicycling costs. If an employee's estimated transportation costs are less than the market value of employer-provided parking, the employer must pay the difference as additional compensation and/or as an increased contribution to the employee's health coverage. Alternatively, the employer can take one of two approaches:

- Pay the District Department of Transportation a clean-air compliance fee of $100 per month for each employee offered parking benefits.
- Implement a "transportation demand management plan" that reduces the number of commuter trips employees make by car, including cars for hire, such as taxi, Uber or Lyft.

The amendment's effective date originally was tied the city budget reflecting the fiscal impact of the change. But that provision was repealed by the Aug. 31 passage of the 2021 budget bill, accelerating the effective date immediately after the 60-day congressional review period.

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