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Roundup of selected state health developments, fourth-quarter 2020

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In this article

To wrap up 2020, states clarified employer reporting obligations, attempted to rein in prescription drug costs, and moved forward with state health plan initiatives, including updates to employer healthcare expenditures and changes to individual health plan options. Insurance laws and regulations addressed COVID-19 vaccine coverage, surprise medical bills, insulin cost sharing, mental health parity and telemedicine. States also updated or expanded paid and unpaid leave laws in the fourth quarter. Other benefit-related activity focused on employee status, pretax transportation fringe benefits, privacy and long-term care.

Reporting

The broad range of state reporting requirements for employers took on new urgency at the end of 2020 as health plan sponsors geared up for submitting 2020 coverage reports in states that have imposed their own individual mandates. California, Massachusetts, New Jersey, Rhode Island and Washington, DC, require their residents to maintain a minimum level of health coverage and require plan sponsors to submit coverage reports. Reporting obligations for 2020 coverage in California and Rhode Island begin in 2021.

Scope of state health plan reporting laws

Group health plan sponsors' state reporting obligations have grown over the past few years. While ERISA continues to preempt certain state regulation of private employers' group health plans, some state reporting requirements for group health plan sponsors have moved forward. Four states —

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California, New Jersey, Rhode Island and Vermont — along with Washington, DC, have imposed individual health coverage mandates, and most require employer reporting on coverage. Group health plan sponsors also face other state reporting requirements, sometimes in conjunction with a covered-lives surcharge or employment-related health benefit. For a review of key state reporting mandates for group health plan sponsors, see States increase group health plan reporting obligation (Nov. 17, 2020).

Massachusetts

Employers with six or more Massachusetts employees had to complete and submit the state's Health Insurance Responsibility Disclosure (HIRD) form by Dec. 15 via MassTaxConnect. The reporting obligation applies even if an employer doesn't offer health coverage. Employers report on any comprehensive medical coverage offered to Massachusetts employees for the upcoming plan year, but do not report on stand-alone dental or vision plans. For each federal employer identification number (FEIN) and each health plan that has variable benefits or rates, employers complete a separate health plan entry. Additional details and contact information are explained on the state's website.

New Jersey

New Jersey's updated individual health coverage reporting webpage for 2021 confirms reports are due to the state Division of Taxation by March 31 and to each covered employee by March 2. For the 2020 coverage year, the state will accept NJ-1095 forms, fully completed federal 1095-B and 1095-C forms, and/or 1095-C forms with parts I and III completed. The filing requirement is not limited to businesses that withhold New Jersey payroll taxes, but extends to out-of-state employers that provide health insurance to New Jersey residents.

Rhode Island

The Rhode Island Division of Taxation (DOT) posted a final regulation on the state's health insurance mandate. The rule details what information employers and other applicable entities must send to DOT and to employees showing, in part, the dates individuals had minimum essential coverage (MEC) for the previous calendar year. Rhode Island defines MEC the same as the federal law (26 USC § 5000A(f)) in effect on Dec. 15, 2017. The state reporting deadline is typically Jan. 31. For 2020 coverage reports due in 2021, DOT has extended the state deadline to March 2 for individual notices and to March 31 for DOT reports.

Reports to DOT must include the name, address and taxpayer identification number (TIN) of the primary insured; the TIN of each other individual covered under the policy; and their dates of MEC during the calendar year. Notice to the employee must include the same information. The DOT will accept IRS 1095-A, 1095-B and 1095-C returns if they contain the same information described in Internal Revenue Code (IRC) Section 6055 as of Dec. 15, 2017. Employers whose insurers must file don't have to submit a duplicate report.

FAQs (Pub. 2020-04) clarify these reporting requirements. The DOT's health coverage mandate website links a portal where applicable entities will be able to upload files.

Drugs

A landmark US Supreme Court ruling allowing Arkansas to regulate pharmacy benefit managers (PBMs) could have broad implications for state initiatives on drug pricing and drug plan management going forward. States are also exploring other avenues for reducing drug costs. California will look into partnering with manufacturers and others to purchase generic drugs. Florida is pushing ahead on its plan to import drugs from Canada.

Arkansas

ERISA doesn't preempt an Arkansas law (Ark. Code Ann. § 17–92–507, 2015 Act 900) that regulates how PBMs reimburse pharmacies, the US Supreme Court has unanimously ruled, upholding an Arkansas law (*Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540 (U.S. Dec. 10, 2020)). The decision has implications for other states' PBM laws, although some go beyond pharmacy reimbursement. Plan sponsors will need to work with PBMs to determine to what extent, if any, a particular state's PBM standards may apply to a self-insured plan. For more, see Supreme Court upholds Arkansas law regulating PBMs (Dec. 10, 2020).

California

A new state law (2020 Ch. 207, SB 852) requires the California Health and Human Services Agency (CHHSA) to procure generic prescription drugs by entering partnership contracts or purchasing agreements with a payer, state governmental agency, group purchasing organization, nonprofit organization or other entity. The goal of the legislation is to increase competition, lower prescription drug prices and address shortages in the generics market. The resulting savings should extend to public and private purchasers, taxpayers, and consumers, increasing patient access to affordable drugs.

CHHSA must gather stakeholder input and consider relevant legal, market, policy, regulatory factors, and specified costs when setting the price of the generic drug. By July 1, 2022, CHHSA must send the legislature a report describing the status of all drugs the agency decides to target under this law and analyzing resulting impact on competition, cost, and access to targeted drugs. By July 1, 2023, the agency must report to lawmakers on the feasibility of directly manufacturing generic drugs — including at least one form of insulin — and selling generic drugs at a fair price. This report must include an analysis of possible governance structures for manufacturing functions, such as chartering a private organization, a public-private partnership or a public board of directors.

Florida

Gov. Ron DeSantis announced that Florida has officially submitted its proposal to the US Department of Health and Human Services (HHS) for the state's Canadian Prescription Drug Importation Program.

In 2019, Florida enacted legislation (Ch. 2019-99, HB 19) to import drugs for consumers served by public payers, including state agencies and the state's Medicaid program. In August 2019, state regulators submitted a concept paper to HHS outlining the state's vision for the importation program. If approved, the state will contract with a vendor to manage all aspects of the program and to ensure Canadian suppliers and eligible importers comply with all federal and state law requirements. Eligible importers would be limited to wholesalers and pharmacists that are dispensing prescription drugs to consumers served by certain state and federal government programs.

Final federal importation rules effective Nov. 30, 2020, allow states, tribes, or, in certain circumstances, pharmacists or wholesale distributors to import certain prescription drugs from Canada. The Pharmaceutical Research and Manufacturers of America (PhRMA) has filed complaint in federal court seeking to overturn the HHS rule, claiming it poses additional risks to public health and safety. The Biden administration has been granted an extension to March 30, 2021, to respond to the suit.

State and local coverage initiatives

A few state and local health coverage initiatives garnered attention in the fourth quarter of 2020. San Francisco posted updates for employers' required 2021 health expenditures. Georgia received federal approval to drop off the federally facilitated health insurance exchange, though the move faces a legal challenge. Washington initiated its version of a public option for state residents.

California — San Francisco

San Francisco's Health Care Security Ordinance (HCSO) requires most employers spend a minimum amount on the healthcare for each hour worked by employees, subject to certain exemptions. To meet the 2021 exemption threshold, managerial, supervisory and confidential employees must earn more than $107,991 annually (or $51.92 per hour), the San Francisco Office of Labor Standards and Enforcement (OLSE) has announced.

OLSE also released a 2021 Health Care Security Ordinance Poster. Employers must place this poster, printed on 8.5" x 14" paper, at each job site or workplace in a location where employees can easily read it. For employees working remotely, however, employers may provide the poster electronically.

Georgia

In November 2020, the federal Centers for Medicare and Medicaid Services (CMS) announced approval of Georgia's innovative waiver plan under Affordable Care Act (ACA) Section 1332. Under 2019

legislation (Act 4, SB 106), the waiver plan calls for the state to implement a reinsurance program starting in 2022. In plan year 2023, the state will transition its individual health insurance exchange from the federally facilitated Healthcare.gov to a private-sector platform called the Georgia Access Model. Under the model, residents will shop for, compare and enroll in available plans through private-sector partners, including web brokers, health insurance companies, and traditional agents and brokers.

A lawsuit is challenging the waiver approval in federal court. The complaint claims the Georgia Access Model will drastically underperform the ACA and therefore violates the statutory guardrails for obtaining a waiver (*Planned Parenthood SE, Inc. v. Azar*, No. 1:21-cv-00117 (D.D.C. Jan. 14, 2021)).

Earlier in 2020, the state also received approval of a partial Medicaid expansion to residents at or below the federal poverty level who are subject to certain work requirements. The Medicaid waiver approval is effective from Oct. 15, 2020, through Sept. 30, 2025. Beneficiaries enrolled in the demonstration who are employed will have to enroll in employer-sponsored insurance (ESI) if it is cost-efficient for the state. Beneficiaries enrolled in ESI will receive premium and cost-sharing assistance through Georgia's health insurance premium program. The state won't provide wraparound services, so beneficiaries enrolled in ESI will have a benefit package limited to services covered by the ESI plan.

Washington

The Washington Health Care Authority announced that it had contracted with five health insurance carriers to offer the newly created Cascade Care public option plans in 19 counties. The state's Health Benefit Exchange (HBE) offered the plans through open enrollment held from Nov. 1, 2020, through Jan. 15, 2021. With some counties having more than one public option carrier, HBE developed standard plan designs to be offered across carriers.

The program was authorized under 2019 legislation (Ch. 264, SB 5526) calling for an option that includes plans that reduce deductibles, provide predictable cost sharing and encourage value-based choice. The carriers are BridgeSpan (one county), Community Health Network of Washington (nine counties), Coordinated Care (one county), LifeWise (three counties) and UnitedHealthcare (10 counties).

Insurance regulation

California insurance regulators posted guidance on COVID-19-related issues. Three more states — Maine, Michigan and Virginia — enacted surprise medical billing laws to protect consumers insured in the state, while other states continued existing efforts to end surprise medical bills. The federal restrictions on surprise medical billing enacted with 2021 appropriations legislation (Pub. L. No. 116-260) are expected to take effect in 2022 and appear to wrap around existing state insurance laws. Vermont and Washington joined the growing list of states curbing consumer cost sharing for insulin. Washington also announced new laws on telemedicine, mental health parity, PBMs and claim processes.

California

The California Department of Managed Health Care (DMHC) issued guidance reminding health plans that enrollees must receive all qualified, approved COVID-19 vaccines without cost sharing, regardless of whether an in-network or out-of-network provider administers the vaccine. In All Plan Letter 20-039, DMHC noted that the federal government covers the cost of the COVID-19 vaccines themselves. However, health plans must cover the cost to administer qualifying vaccines to enrollees. California also posted a consumer information page and guidelines for COVID-19 vaccination describing how the state will operationalize its COVID-19 vaccination program.

Maine

Recent Maine medical surprise-billing rules implement legislation (2020 Ch. 668) establishing an independent resolution (IDR) process for carriers and providers in the state to resolve out-of-network surprise bills. The program is open to participation by self-insured ERISA plans that annually file a notice with state regulators. Participating self-insured employers must amend the plan, agree to comply with the carrier regulations and submit to binding arbitration overseen by the state. Plan sponsors may contact their third-party administrators (TPAs) or administrative services carriers to opt in to the program. Payment for the IDR service will be the responsibility of the nonprevailing party or split between parties if neither party entirely prevails.

The law, first enacted in 2017 and later amended, bans balance billing by out-of-network providers beyond the applicable cost sharing for a covered service or procedure performed by a network provider at a network facility or for a service or procedure previously authorized by the plan. However, the law permits balance billing if an individual elects to receive healthcare services from an out-of-network provider when a network provider is available.

The rules set out requirements for participating IDR entities, parameters for out-of-network provider payments and IDR processes. IDR also will be open to individuals without insurance and those enrolled in self-insured ERISA plans that don't opt into the state's process. The rule applies to IDR requests for services rendered on and after Oct. 1, 2020.

Michigan

A new Michigan surprise billing law (2020 Act 234, HB 4459) prohibits out-of-network healthcare providers from balance billing insured patients for covered emergency services. The ban extends to nonemergency services at an in-network facility if the patient is unable to request a participating provider, hasn't received the required disclosures or receives the service within 72 hours after receiving a healthcare service in the hospital's emergency room. Patients are responsible for in-network cost sharing.

Healthcare providers and insurers have 60-day deadlines to bill and pay for the service. The payment for an out-of-network provider's services, excluding patient cost sharing, must be the greater of the mean negotiated rate for the area or 150% of the Medicare rate. Exceptions for complications must be considered. Beginning July 1, 2021, providers who believe the payment amount was incorrectly calculated may request a review by state regulators.

Companion 2020 legislation details nonparticipating provider disclosure obligations (Act 235, HB 4460) and provider enforcement (Acts 232 and 233, HBs 4990 and 4991). Effective Oct. 22, 2020, the laws apply to Michigan healthcare providers, health insurers, HMOs and self-insured governmental plans. They don't apply to or include self-insured ERISA plans.

Vermont

Vermont legislation (2020 Act 154, HB 969) requires health insurers and PBMs to limit a plan participant's total out-of-pocket cost for prescription insulin to a maximum of $100 per 30-day supply, regardless of the amount, type or number of insulin medications prescribed. The $100 monthly out-of-pocket spending limit on for prescription insulin applies regardless of whether the participant has met the health plan's deductible. The limit will take effect on Jan. 1, 2022, and apply to plans issued or renewed on or after that date, but not later than Jan. 1, 2023.

Virginia

Effective Jan. 1, 2021, a Virginia surprise billing law (2020 Ch. 1080, HB 1251) bans providers from balance billing for emergency services or nonemergency out-of-network surgical or ancillary services performed 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," less any cost sharing, 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.

The law allows self-funded plans to participate in the program as an "elective group" if the plan sponsor agrees to comply with all provisions of the law, including arbitration. To opt into the balance billing program, the elective group health plan sponsor or TPA must complete Elective Group Health Plans Opt-in Form and email it to the Bureau of Insurance at BBVA@scc.virginia.gov at least 30 days before the effective date. The effective date must be either Jan. 1 or the first day of the plan year.

While participants in an elective group won't see surprise bills, whether plan sponsors will see a cost increase will depend on how they determine the allowable charge for OON claims. Plan sponsors opting in will need to comply with state regulations related to the law. Few additional details are available.

Washington

Washington's Office of the Insurance Commissioner has issued its 2021 Plan Year Mandated Health Benefits Report identifying any new mandates that would affect the state's essential health benefits (EHBs) costs. None of the health insurance laws passed in 2020 established new benefit mandates that would impact EHBs. The health insurance laws enacted and generally effective Jan. 1:

- Require health carriers to reimburse providers for healthcare services provided through telemedicine at the same rate as services provided in person (Ch. 92, SB 5385)
- Establish health carrier requirements for prior-authorization standards and utilization reviews for certain benefits, including Eastern medicine and physical, occupational, speech, and hearing therapies (Ch. 193, SB 5887)
- Require health plans that cover insulin for diabetes treatment to cap total cost sharing at $100 per 30-day supply (Ch. 245, SB 6087)
- Align the state's mental health coverage law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and Section 1557 of the ACA (Ch. 228, HB 2338)
- Limit the maximum a PBM or insurer may require an enrollee to pay at the point of sale for a covered prescription medication to the lesser of the applicable cost sharing or the drug's cost if purchased without using a health plan (Ch. 116, HB 2464)
- Restrict the use of prior-authorization requirements for withdrawal management and inpatient or residential treatment of substance use disorders (Ch. 345, HB 2642)

Leave laws

State paid and unpaid leave laws continue to expand. An October 2020 National Conference of State Legislatures (NCSL) report provides an overview of state efforts. Since then, Colorado voters approved a paid family and medical leave (PFML) program. Hawaii expanded unpaid, job-protected leave to care for more family members. Maine finalized rules for its accrued leave law now in effect. Massachusetts kicked off its PFML program benefits. New Jersey and Rhode Island updated amounts for their disability/paid family leave programs. New York clarified paid sick leave requirements. Local governments updated and expanded COVID-19-related leave.

NCSL report

In the absence of a national policy, some states have enacted their own paid leave laws, and many more are considering similar moves, according to an NCSL report. Employee leave benefits generally fall into four categories: parental, family care, medical and sick leave. NCSL reviews the background of paid leave laws and state activity. The report also addresses business, employment, and other considerations and provides additional research.

Colorado

Colorado must launch a paid family and medical leave insurance (PFMLI) program, with contributions beginning in 2023 and benefits available in 2024. The ballot measure (Proposition 118) approved by voters is similar in many respects to a bill (SB 19-188) considered by state lawmakers in 2019. The PFMLI program will provide partial wage replacement for 12–16 weeks of leave, depending on the circumstances. Employees will be able to take paid leave for many of the same reasons permitted under the federal Family and Medical Leave Act (FMLA). The program also will extend paid leave so victims of domestic violence, sexual assault or stalking can handle related issues. For an overview of the new law, see Colorado voters approve paid family and medical leave law (Nov. 10, 2020).

Hawaii

A new law (2020 Act 40, HB 2148) extends the Hawaii Family Leave Law (HFLL) to include care for an employee's grandchildren. The legislation also clarifies that a sibling includes an employee's biological, step-, adopted or foster sibling. Effective July 1, 2020, employers must provide Hawaii employees up to four weeks of unpaid, job-protected family leave each calendar year to care for a child, spouse, reciprocal beneficiary, sibling, grandchild or parent who has a serious health condition. Employees may also use HFLL leave to bond with a new child, but not for their own serious health condition.

The law applies to employers with at least 100 employees for each workday during each of 20 or more calendar weeks in the current or preceding calendar year. Eligibility extends to employees who work at least six consecutive months for an employer, including a full-time, part-time, temporary, casual, on-call or intermittent worker. Because the Hawaii law doesn't fully align with the federal FMLA, Hawaii employees may be entitled to state leave in addition to leave taken under FMLA.

Maine

Final regulations and FAQs on Maine's earned paid leave law clarify key provisions on coverage, eligibility, accrual, notice, pay rates and interaction with existing leave plans. The law (ME Rev. Stat. tit. 26, § 637), enacted in 2019, allows Maine workers to accrue one hour of paid leave for every 40 worked, up to 40 total hours per year, to use for any reason after 120 days of employment. The measure applies

starting Jan. 1, 2021, and preempts any similar local laws in the state. For an overview of the law's provisions, see Maine's earned paid leave begins accruing Jan. 1, 2021 (Nov. 12, 2020).

Massachusetts

Massachusetts' paid family and medical leave (PFML) benefits became available for the first time on Jan. 1, 2021. Employees may now take up to 12 weeks to bond with a new child or handle a military exigency. The law also lets employees take up to 20 weeks to address their own serious health conditions and up to 26 weeks to care for a covered servicemember. Beginning July 1, 2021, eligible employees will be able to take up to 12 weeks to care for a family member with a serious health condition. A cap will limit any employee's total PFML to 26 weeks in a 52-week period. All employers must display an updated poster at their worksite.

Weekly benefits are calculated using the employee's and the state's average weekly wages. Covered individuals can use the DFML calculator to estimate available benefits. The maximum weekly benefit for 2021 will be $850 per week. For employers with 25 or more employees, the combined employer and employee contribution in 2021 will continue to be 0.75% of an employee's wages up to the Social Security income limit — $142,800 in 2021.

Recently released FAQs clarify that an employee can't "top off" PFML benefits by using accrued paid time off from their employer. However, an employer with a private plan exemption may allow their employees to supplement their private plan benefit amount with accrued paid leave.

The FAQs also note that private disability policies purchased separately by the employee, including through voluntary employee benefits, don't cause the employee to have a reduction in PFML benefits.

New Jersey

New Jersey posted its 2021 contribution and benefit rates for temporary disability insurance (TDI) and family leave insurance (FLI) beginning in 2021. New Jersey is one of several states plus Washington, DC, that provide partial wage replacement benefits for employees' medical/disability and/or family/parental leave.

The 2021 taxable wage base is $138,200, up from $134,900 in 2020, for both TDI and FLI. The 2021 employee contribution rate is 0.47% of wages up to the taxable wage base for TDI and 0.28% for FLI, for a combined employee contribution of 0.75%. The 2021 maximum weekly benefit for TDI or FLI beginning in 2021 is $903, up from $881 in 2020.

New York

New York's paid sick leave FAQs and website clarify accruals, usage, eligibility, front-loading, leave coordination and more. All private-sector workers in the state are covered by the new sick and safe leave

law (NY Lab. Law § 196-B), including hourly, salaried, temporary and seasonal employees. As of Sept. 30, 2020, employers with five or more employees must allow their employees to accrue one hour of paid sick and safe leave for every hour worked. Smaller businesses with a net income of $1 million or less must provide unpaid sick and safe leave to employees. Employees could start using accrued leave in January 2021.

Maximum accruals vary by employer size. The FAQs note that to determine size, the employer should count the total number of employees across all New York locations. Employees who telecommute are covered by the law for the hours when they are physically working in New York, even if the employer is physically located outside New York.

Rhode Island

The Rhode Island Department of Labor and Training has announced the 2021 rates for its temporary disability insurance and temporary caregiver insurance (TDI/TCI) program. The 2021 taxable wage base will be $74,000, up from $72,300 in 2020. The 2021 employee contribution will remain at 1.3% of wages up to the taxable wage base. Rhode Island updates its weekly benefit amount each July. The maximum weekly benefit is $887 for benefit years beginning on or after July 1, 2020 until a new rate is announced in July 2021. The state's updated quick reference sheet includes additional detail.

COVID-19

To alleviate some of the economic strain on employees unable to work due to COVID-19, some state and local authorities implemented new paid leave requirements. Other jurisdictions are modifying existing leave laws or benefit programs to accommodate employees' needs during the pandemic. Jurisdictions making fourth-quarter 2020 updates to COVID-19-related paid leave requirements include Sacramento County, which closely mirror the Sacramento ordinance and some updates to Michigan's mandate. A number of jurisdictions have also updated their mandates for 2021. For a comprehensive review of the mandates, see States, cities tackle COVID-19 paid leave (Feb. 1, 2021).

Other benefit-related activity

As 2020 wound down, states grappled with benefit-related issues beyond healthcare and leave laws. California voters weighed in on employee status and privacy rights. Los Angeles and Massachusetts updated guidance on pretax transportation fringe benefits. Washington will soon move ahead with a state-sponsored long-term care program.

California — employee status

After the passage of ballot measure Proposition 22 by California voters, app-based transportation (ride-sharing) and delivery drivers are classified as independent contractors instead of employees. Companies

like Uber, Lyft and DoorDash are now exempt from a 2019 law (2019 Ch. 296, AB 5) that codified an "ABC" test to determine if workers are employees and entitled to state labor protections and benefits. For more information, see California: App-based drivers are contractors — not employees.

California — privacy rights

Voter-approved Proposition 24, the California Privacy Rights Act of 2020 (CPRA), will modify the consumer privacy protections already in place under the California Consumer Privacy Act (CCPA).

The CCPA gives California consumers the right to know what personal information businesses collect, where the information comes from, for what purposes it's used and how it's shared. Consumers also have the right to stop or limit the collection, use, sharing or selling of their information. Beginning Jan. 1, 2023, the CPRA provides consumers the right to restrict use of sensitive personal information, correct data and opt out of advertisers using precise geolocation. Revised standards on covered businesses potentially reduce the number of businesses subject to the CCPA. Last, but not least, the CPRA also requires immediately establishing a California Privacy Protection Agency to implement and enforce the law.

The law extends the exemption for personal Information about a company's applicants or employees that is collected and used for employment purposes or benefits administration until Dec. 31, 2022. For more on the CCPA, see the state's dedicated website.

California — Los Angeles transit

Beginning in January 2021, the Los Angeles County Metropolitan Transportation Authority (LACMTA) plans to implement an employer pretax commuter benefits ordinance authorized by 2018 California legislation (CA Gov. Code § 65080.9). The law allows LACMTA to require employers with 50 or more full-time employees at a worksite in the LACMTA operating area to offer the benefit. Employers have until 2022 to comply before penalties apply.

The law requires employers in Los Angeles County with a total of 50 to 249 employees (full-time and part-time) at a single worksite in the county to offer a pretax commuter tax benefit that complies with IRC § 132(f) to every full-time employee at that worksite. The LA benefit can be used to pay for vanpooling, transit, and parking at park-and-ride and transit lots. Employers that have worksites subject to a city transportation ordinance or that offer an equitable commuter benefit may be exempt from the ordinance. Employers with more than 249 employees at a worksite should comply with South Coast Air Quality Management District rule.

Massachusetts — transit

Massachusetts guidance (TIR 20-16) sets limits for parking and transit benefits for taxable years beginning in 2021. The excludable state monthly tax limit will be $275 for employer-provided parking and $145 for combined transit pass and commuter highway vehicle transportation benefits. This differs from the federal monthly limits of $270 for each.

Massachusetts tax law (MA Gen. Laws ch. 62 §1) generally follows the federal tax code in effect on Jan. 1, 2005, with targeted updates. As a result, most federal tax changes enacted since 2005 — including the change to IRC § 132(f) — don't flow through to state income tax. The state didn't update its tax code to mirror the federal change allowing the same exclusion amount for both transit categories. Employers with Massachusetts employees receiving mass transit and/or commuter vehicle benefits must include any amount exceeding $145 per month as income at the state level.

Washington — long-term care

Washington will launch a state-run, long-term services and supports trust program in 2025, under 2019 legislation (Ch. 363, HB 1087). Starting Jan. 1, 2022, employers in the state will have to collect 0.58% of wages through payroll deduction and remit these employee premium contributions to the state. Employees with other long-term care insurance can waive participation. For an overview of this development, see Washington state to establish employee-funded long-term care (Oct. 29, 2020).

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- States increase group health plan reporting obligations (Nov. 20, 2020)
- Maine's earned paid leave begins accruing Jan. 1, 2021 (Nov. 12, 2020)
- Colorado voters approve paid family and medical leave law (Nov. 10, 2020)
- California: App-based drivers are contractors — not employees (Nov. 5, 2020)
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- Mercer supports national paid leave standard in comments to DOL (Sept. 15, 2020)

- New Hampshire targets Rx costs, joins other states to add insulin cap (Sept. 2, 2020)
- San Francisco posts 2021 health care expenditure rates (Aug. 31, 2020)
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- 2020 state paid family and medical leave contributions and benefits (Feb. 14, 2020)
- Massachusetts employers' health coverage reports due by Dec. 15 (Nov. 13, 2019)
- Accrued paid leave mandates expand state sick leave law totals (July 1, 2019)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)
- California's data privacy law appears not to reach HIPAA-covered group health plans but other impacts unclear (April 8, 2019)

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