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2026: First Quarter

Compliance Digest

Compliance Bulletins Released January to March

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Pittsburgh Updates its Paid Sick Days Act Effective January 1, 2026

Issued date: 01/06/26

On December 9, 2025, the City of Pittsburgh released updated guidelines regarding the administration of the Pittsburgh Paid Sick Days Act (PSDA). The PSDA applies to most employers with at least one employee working within the City of Pittsburgh.

Effective January 1, 2026, the PSDA introduced several significant changes for employers.

Background

The PSDA became effective March 15, 2020. Before January 1, 2026, employees earned 1 hour of paid sick leave for every 35 hours worked in Pittsburgh. Employers with 15 or more employees were required to provide 40 hours per year. While employers with fewer than 15 employees were required to provide 24 hours per year, employers could use existing PTO or collective bargaining agreements (CBA) provisions if they met PSDA standards and allowed leave for the same purposes. The PSDA was amended in June 2025, with changes becoming effective January 1, 2026.

Updated Requirements Effective January 1, 2026

Revised guidelines were recently released which provide a few new obligations, as well as additional clarifications in connection with the June 2025 amendment. Employees will now accrue paid sick leave at a faster rate, and annual paid sick leave amounts have also increased. In addition, employers are now required to notify employees of their accrued sick leave balance and policies that impose restrictions like advance written notice, requiring employees to find their own replacement, or subjecting leave to employer approval will no longer comply with the PSDA. Below are highlights from the new guidance:

- **Accrual Rate:** Employees can now earn one hour of paid sick leave for every 30 hours worked (previously 35 hours).
- **Cap on Accrual Requirements (note that employers may allow higher amounts):**
    - Employers with 15 or more employees: 72 hours per year (previously 40 hours).

    - Employers with fewer than 15 employees: 48 hours per year (previously 24 hours).

- **Mandatory Notifications:** Employers must notify employees of accrued sick leave amounts, such as on pay stubs or via an accessible online system.

- **Policy Restrictions:** PTO or CBA policies requiring advance written notice, employee replacement, or employer approval do not comply with PSDA.

- **Recordkeeping:** Employers must retain records of hours worked, sick leave taken, and policies for two years.

- **Penalties:** Fines for notice and posting violations apply per instance of non-compliance.

Employer Action Steps

Employers should implement these changes as soon as possible and consider these action steps:

- Ensure PTO or sick leave policies meet new accrual rates and usage requirements. Remove restrictive provisions such as requiring replacements or advance written notice.

- Set up pay stub disclosures or online portals to show accrued sick leave balances. Employers will want to work with payroll administrators.

- Post updated notices and distribute revised policy documents. Notices are available here: www.pittsburghpa.gov/City-Government/Legal-Services/Office-of-Equal-Protection/Paid-Sick-Days-Act/Paid-Sick-Day-Act-Notice.

- Keep detailed records of hours worked, leave taken, and policies for at least two years.

- If operating in both Pittsburgh and Allegheny County, align policies to meet stricter Pittsburgh standards.

Medicare Part D
CMS Notification Reminder

Issued date: 01/13/26

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services ("CMS").

In order to provide this information, employers must access CMS's online reporting system at: www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/disclosure-form.

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the **beginning** date of each plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status of the prescription drug plan.

For example, an employer with a **calendar year plan** (January 1 – December 31, 2026) must complete this reporting **no later than March 1, 2026.**

Note: If there was a change in the creditable coverage status of a prescription drug plan offered by the employer (e.g., from creditable to non-creditable, or vice versa), notice should be provided to CMS within 30 days of the change. For example, if a change occurred in connection with the January 1, 2026 plan year, CMS should be notified by January 31, 2026.

Employer Action

- For **calendar year 2026 plans**, timely complete reporting with CMS. For **non-calendar year plans**, timely complete reporting with CMS following the start of your 2026 plan year.

- You will need to have the following information ready to include when you complete the CMS online reporting:
    - The creditable (or non-creditable) status of prescription drug coverage provided by all plan options available to employees.
    - The date that the annual creditable (or non-creditable) coverage notice was furnished to Part D eligible individuals. You may have included this notice with open enrollment materials or sent it following the start of the plan year.
    - An estimate of the number of Medicare Part D eligible individuals covered under the plan. This does not have to be an exact number.

State Health Coverage Reporting Requirements for CY 2025

Issued date: 01/14/26

Currently, five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia have enacted individual health insurance mandates with their own requirements for:

- Furnishing information regarding health insurance coverage to residents of the state, and
- Filing that information with certain state agencies.

These requirements and deadlines may (or may not) align with the federal requirements.

Reminder: under the Affordable Care Act ("ACA"), 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. An applicable large employer is defined as an employer that employed on average at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year.

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). 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 (Forms 1094-B and 1095-B).

Calendar year 2025 Forms 1095-C must be furnished by March 2, 2026, and filed electronically with the IRS by March 31, 2026.

Under the Paperwork Burden Reduction Act, employers (or carriers) may furnish the federal forms 1095-C (or 1095-B) upon request when:

- A timely, clear and accessible notice is provided to any individual (who would otherwise receive a Form 1095-C (or 1095-B)) informing them that they may request a copy of the applicable Form; and

- Upon request, the applicable Form is furnished by the later of January 31 or 30 days after the date of such request.

As described below, satisfying the federal requirements may not satisfy the applicable state obligations. It is important to ensure both federal and state requirements (as applicable) are met. The applicable states and District of Columbia have not adopted this federal relief. Employers (and carriers) should prepare to furnish Forms 1095-C (or 1095-B) to covered residents as they have in prior years (e.g., by mail).

The following chart summarizes important deadlines related to CY 2025 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2026. However, no penalty is imposed for failing to furnish by this deadline	March 31, 2026. No penalties will be assessed if filed by May 31, 2026
District of Columbia	March 2, 2026	April 30, 2026 (30 days after federal deadline)
Massachusetts	January 31, 2026	January 31, 2026
New Jersey	March 2, 2026	March 31, 2026
Rhode Island	March 2, 2026	March 31, 2026
Vermont	N/A	N/A

Note: The state reporting deadlines are subject to change if the states update their reporting information.

Important issues to consider regarding furnishing and filing state-level health coverage information are as follows:

- **State residents.** Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.

- **Forms.**

  - California, the District of Columbia, New Jersey, and Rhode Island use the federal Forms 1094/1095 (B, C) for the state's individual mandate reporting requirements.

  - Massachusetts requires MA Form 1099-HC to be furnished to Massachusetts residents and filed with the state by January 31. In addition, Massachusetts requires employers with at least 6 employees residing in Massachusetts to file the Health Insurance Responsibility Disclosure ("HIRD") form. The Massachusetts HIRD form is available starting November 15 of the filing year and must be completed by December 15 of the filing year.

- **Employers with fully insured plans.**

  - Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency.

  - The District of Columbia requires employers that sponsor a fully insured group health plan with at least 50 full-time employees, including at least one employee who is a resident of the District, to file information returns with the Office of Tax and Revenue ("OTR").

Note: A carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.

- **Employers with fully insured plans issued out-of-state.** Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.

    - For employers with fully insured plans that are written outside of a state with an individual mandate, if the carrier will not furnish the forms to state residents or file with the applicable state agency, the employer may be required to furnish and/or file the statements. This may require involvement with your payroll provider or other ACA reporting vendor to coordinate.

- **Employers with self-funded plans.** Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

    - For self-funded health plans (including level funded and ICHRA), if the TPA will not furnish the forms to state residents or file with the applicable state agency, the employer may be required to furnish and/or file the statements. This may require involvement with your payroll provider or other ACA reporting vendor to coordinate.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.

Washington Increases 2026 Paid Family and Medical Leave Premium

Issued date: 01/15/26

The Washington Employment Security Department ("ESD") announced an increase in the premium rate for Washington Paid Family and Medical Leave ("WA PFML"). The premium rate will increase to 1.13% of employee wages, up from the 2025 rate of 0.92%. The increase is effective for the first quarter of 2026 and should be reflected in contributions and reporting for all pay dates on or after January 1, 2026.

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 employer and employee contributions based on employee wages up to the social security cap ($184,500 in 2026). Employers are also required to report employee wages and hours when premiums are remitted to ESD.

2026 Premium Changes

Effective for payrolls on or after January 1, 2026:

- The premium amount is increasing to 1.13% of employee wages.
- The wages subject to premiums are increasing to $184,500 to reflect the higher social security wage cap for 2026.
- The employer portion of the premium is increasing slightly 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 of the premium.

Example of annual premium amount for an employee earning $75,000 in 2025 and 2026
Total annual premium in 2025: $75,000 x 0.92% = $690 • Employee cost: $493.49 • Employer cost: $196.51
Total annual premium in 2026: $75,000 x 1.13% = $847.50 • Employee cost: $605.37 • Employer cost: $242.13

Other 2026 WA PFML Changes

There are several changes to the WA PFML program for 2026, including:

- **Job protection.** Employers with 25 or more employees must provide job protection to employees taking WA PFML.
- **Benefits continuation.** If an employee qualifies for job protection under WA PFML, employers must maintain health insurance coverage as if they are still working. Employees can be asked to pay their share of the premium.
- **Minimum leave increments.** Minimum leave increment is reduced from eight (8) to four (4) hours.
- **Coordination with FMLA ("stacking").** Permits employers to count FMLA protected leave against an employee's WA PFML job restoration period. This provides a maximum period of job protection of 16 weeks (18 weeks in certain cases) in a 52-week period when an employee takes FMLA leave that is also eligible for WA PFML. Employers must provide notice if FMLA leave is counted against this period.

Employer Action

Employers should confirm their payroll systems are prepared to deduct the new higher rates from employee paychecks beginning January 1, 2026. Employers that fail to deduct the maximum allowable employee share from wages for a pay period are considered to have elected to pay that uncollected portion of the employee share for that pay period. This means that deductions in arrears to make up for missed employee contributions are prohibited.

Changes to Colorado Family Medical Leave Insurance for 2026

Issued date: 01/16/26

Two major changes to Colorado Family Medical Leave Insurance ("FAMLI") took effect January 1, 2026, including:

- Adding paid leave for newborn children hospitalized in a neonatal intensive care unit ("NICU"), and
- Reducing the FAMLI premium from 0.9% to 0.88% of wages for calendar year 2026.

Neonatal Care Leave ("NCL")

Effective January 1, 2026, parents of a newborn hospitalized in a neonatal intensive care unit are now able to take additional paid leave under FAMLI. While the child is admitted to the NICU, employees that are the parents of the infant (including biological, foster, adoptive or stepparents) and individuals acting in loco parentis to the infant are eligible for Neonatal Care Leave.

NCL is in addition to the existing 12 weeks of FAMLI leave related to newborn children, including bonding and care. Therefore, an employee may be eligible for up to 24 weeks of paid FAMLI leave (12 weeks for NICU and 12 weeks for bonding leave). Employees may be eligible for an additional four weeks of FAMLI leave if there are pregnancy or childbirth complications. NICU treatment or infant care that occurred prior to January 1, 2026, will not disqualify an employee from receiving NCL beginning January 1, 2026.

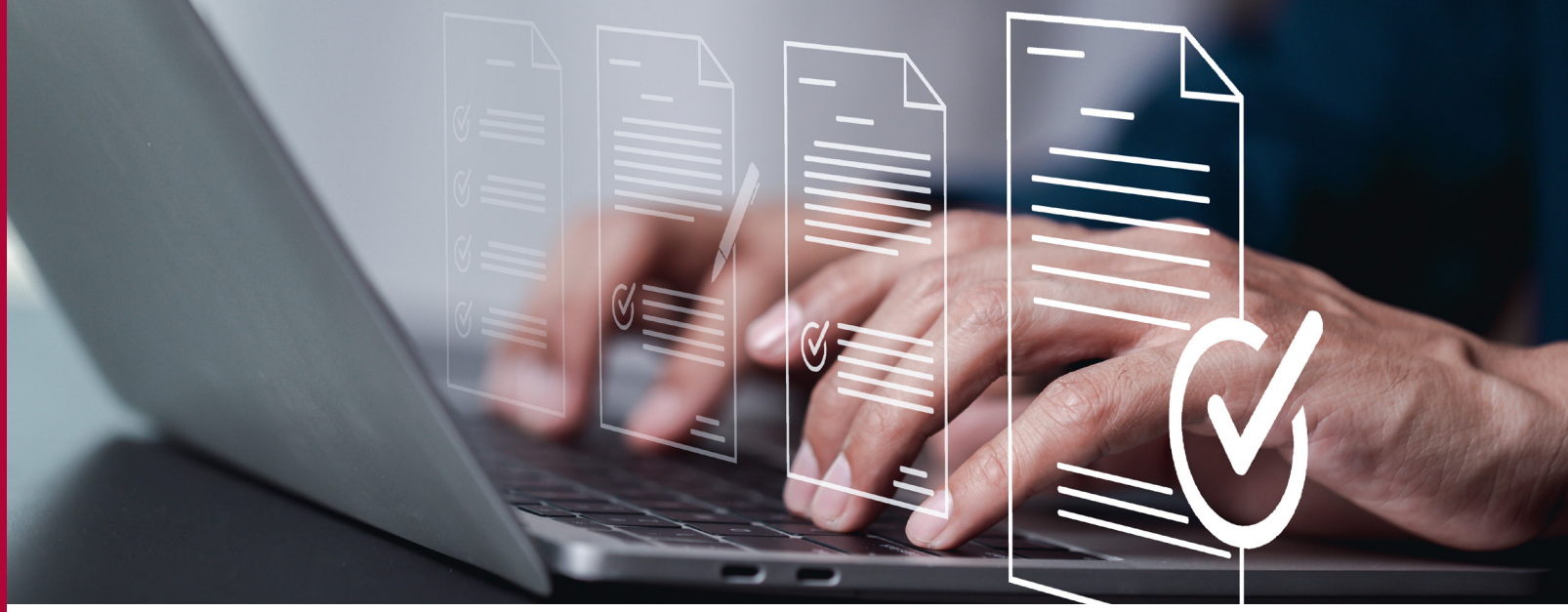
Adjustment of Premium Wages

FAMLI is funded by employer contributions and employee payroll deductions. The maximum amount that employees contribute is 50% of the required annual premium, although employers may elect to contribute all or a portion of the employee's share of the cost.

For calendar year 2025, the required premium contribution amount was 0.90%. The required premium contribution amount reduces to 0.88% for calendar year 2026. Premium amounts for all future calendar years are to be determined on or before September 1st of the preceding year by the director of Colorado's FAMLI Division.

Employer Action

Employers should update their leave policies and handbooks to include NCL as an option under FAMLI leave. Employers with private plans will also need to update their existing plans to incorporate coverage for NCL.



DOL Expands DFVC Program to Include Form M-1 Filings

Issued date: 01/20/26

The U.S. Department of Labor ("DOL") has expanded the Delinquent Filer Voluntary Compliance ("DFVC") Program to cover Multiple Employer Welfare Arrangements ("MEWAs") and Entities Claiming Exception ("ECEs") that have missed their M-1 filing requirements.

Background

The DFVC Program was designed by the DOL to encourage voluntary compliance with the annual reporting requirements under the Employee Retirement Income Security Act of 1974 ("ERISA"). The DFVC Program gives delinquent plan administrators a way to avoid potentially higher civil penalty assessments by satisfying the program's requirements and voluntarily paying a reduced penalty amount.

Previously, the DFVC Program applied to plan administrators filing overdue Form 5500s. Under the program, the maximum penalty amount for a Form 5500 for a given plan year is $750 for small plans (i.e., a plan with fewer than 100 participants at the beginning of the plan year) and $2,000 for large plans (i.e., a plan with 100 or more participants at the beginning of the plan year). If submitting more than one delinquent Form 5500 filing for the same large plan, the maximum penalty amount is $2,000 for each Form 5500, not to exceed $4,000 per plan.

The DFVC Program also provides reduced penalties for plan administrators filing annual reports for top hat plans and apprenticeship and training plans.

The relief under the DFVC Program is not available if the DOL has already notified the plan of its failure to file.

DFVC Program Expanded to Include Form M-1 Filings

Effective December 31, 2025, the DOL announced that the DFVC Program has been expanded to include delinquent Form M-1 filings.

Form M-1 is a required annual filing for:

- MEWAs that are group health plans (i.e., plan MEWAs);
- MEWAs that are not group health plans but provide benefits that consist of medical care (i.e., non-plan MEWAs), and;
- ECEs (i.e., an entity that claims it is not a MEWA because it is established or maintained pursuant to one or more collective bargaining agreements as determined by the Secretary).

Following a review of the DFVC Program, the DOL has expanded the penalty relief to plan MEWAs, non-plan MEWAs, and ECEs who are required to file the Form M-1. Administrators subject to the requirement who have missed the Form M-1 filing will now be permitted to file delinquent Form M-1 filings through the expanded program and voluntarily pay a maximum penalty of $750.

Without participating in the DFVC Program, the statutory penalty for failure to file Form M-1 is up to $1,992 per day (for 2025).

Other Updates to the DFVC Program

In addition, the DOL simplified and updated the process assessing the flat rate penalty of $750 for top hat plans and apprenticeship and training plans by providing a direct link for payment. Previously, these plans were directed to a DFVC payment calculator.

Employer Action

Administrators of MEWAs and ECEs should speak with their legal counsel to determine whether they have been compliant with Form M-1 filing requirements and consider utilizing the expanded DFVC Program if discovering any missed filings.

2026 Federal Poverty Guidelines Announced

Issued date: 01/21/26

The Department of Health & Human Services ("HHS") recently announced the 2026 federal poverty guidelines which, among other things, establish the federal poverty line ("FPL") affordability safe harbor for purposes of the Affordable Care Act ("ACA") employer mandate.

For plan years beginning February 1, 2026 or later, the 2026 FPL safe harbor is $132.46/month in the lower 48 states and DC, $165.58/month for Alaska, and $162.38/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect 6 months before the first day of the plan year for purposes of using the FPL affordability safe harbor. Plan years that begin on February 1, 2026, but before July 1, 2026, may use either the 2025 or 2026 guidelines to determine affordability under the FPL safe harbor

Note for Calendar Year Plans. Because the 2026 guidelines were announced after the start of the calendar year, plans with plan years beginning on January 1, 2026 use $129.89/month for the lower 48 states and DC ($162.26/month for Alaska and $149.31/month for Hawaii), which is 9.96% of the 2025 applicable federal poverty guidelines.

Background and FPL Safe Harbor

Large employers may be subject to the employer mandate penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees, and at least one full-time employee receives a subsidy in the Marketplace.

A large employer's offer of coverage will be considered "affordable" under the FPL safe harbor if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed - 9.96% for 2026) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2026 FPL Affordability Safe Harbor

For FPL affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The 2026 FPL is $15,960 for a single individual in every state (and Washington D.C.) except Alaska or Hawaii. Thus, if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value is $132.46 (9.96% of $15,960/12, rounded down) or less, the employer's offer of coverage meets the FPL affordability safe harbor for a plan year beginning February 1, 2026 or later in the lower 48 states and DC.

FPL Guidelines

The following are the 2026 HHS poverty guidelines:

2026 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/household	Poverty guideline
1	$15,960
2	$21,640
3	$27,320
4	$33,000
5	$38,680
6	$44,360
7	$50,040
8	$55,720
For families/households with more than 8 persons, add $5,680 for each additional person.	

2026 Poverty Guidelines for Alaska	
Persons in family/household	Poverty guideline
1	$19,950
2	$27,050
3	$34,150
4	$41,250
5	$48,350
6	$55,450
7	$62,550
8	$69,650
For families/households with more than 8 persons, add $7,100 for each additional person.	

2026 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty guideline
1	$18,360
2	$24,890
3	$31,420
4	$37,950
5	$44,480
6	$51,010
7	$57,540
8	$64,070
For families/households with more than 8 persons,add $6,530 for each additional person.	

Employer Action

- Employers subject to the Employer Mandate and intend on using the FPL safe harbor need to should review these numbers and adjust premiums accordingly or use a different safe harbor.
- Failure to use an any affordability safe harbor (W-2, Rate of Pay or FPL), ALEs must use mainland FPL to determine affordability ($132.46).

Notice of Privacy Practices Deadline Approaching

Issued date: 01/22/26

Plan sponsors of group health plans should be aware of an upcoming February 16, 2026, deadline to revise HIPAA Notices of Privacy Practices ("NPPs") to reflect changes required by a 2024 Final Rule ("Final Rule") regarding privacy practices for Part 2 records.

What is changing?

Covered entities, including group health plans, should revise their NPPs to reflect the additional privacy protections for Part 2 records.

Briefly, a Part 2 record refers to a medical record that has information about a person's substance use disorder ("SUD") where the record is made by a SUD treatment program. There may be instances where the group health plan receives or maintains Part 2 records. Under the Final Rule, covered entities must update their NPPs to reflect how such records are protected by the covered entity and limitations on their use and disclosure.

Notices should be updated and included in materials going forward and posted to the covered entity's website (if applicable). For example, if the employer sponsors a group health plan and maintains a website for group health plan information, the revised NPP should be posted there.

Is another mailing of the NPP needed?

Not necessarily.

When there is a material change in the NPP, a health plan that posts its notice on its website must post the revised notice on its website by the effective date of the change (February 16, 2026) and provide the revised notice in the next annual mailing to individuals covered by the plan.

If the notice is not posted on the plan's website, then the revised NPP or information about the material change and how to obtain the revised NPP should be furnished to the primary insured covered by the plan within 60 days of a material revision. The notice may be provided electronically if an individual has agreed to receive the notice in that manner.

Note. If a NPP was furnished in connection with open enrollment for 2026, it may have already been updated to comply with this requirement.

Is there a model notice?

The Department of Health and Human Services ("HHS") maintains model notices of privacy practices for group health plan covered entities. These model notices have not been updated for the changes related to Part 2 records. While it is expected that HHS will update their model versions, it's not clear whether it will be done by this compliance deadline.

Are there other changes required?

The 2024 Final Rule included additional protections for reproductive protected health information ("rPHI"). Among other things, this required updating the NPP to correspond to new protections for rPHI. However, as previously reported, a federal court vacated the provisions of the Final Rule relating to rPHI. Therefore, updates to the NPP to address rPHI are no longer required. If an NPP was updated to reflect this information, it should be revised accordingly.

Employer Action

- *For fully insured health plans,* the carrier is responsible for the NPP. No action is required by employers.
    - The group health plan should maintain a copy of the carrier's NPP and provide upon request.
- *For self-funded health plans* (including major medical, dental, health FSAs, and HRAs), the covered entity is the self-funded health plan. Employers sponsoring a self-funded health plan will want to ensure they have an updated NPP by the deadline.
    - A third-party administrator ("TPA") or administrative vendor may provide the NPP on behalf of the covered entity.

HHS Releases 2025 Civil Monetary Penalties in 2026

Issued date: 02/09/26

On January 26, 2026, 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 January 28, 2026, if the violation occurred on or after November 2, 2015.

Updated Penalties

The following chart contains penalties related to failures under HIPAA Privacy and Security, failures to provide summary of benefits and coverage, and Medicare Secondary Payer ("MSP") rules applicable to group health plans:

Description	2024 Penalty (Prior)	2025 Penalty (New)
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$193 per violation $48,586 annual cap	$198 per violation $49,848 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision without knowledge	$141 min. $71,162 max. $2,134,831 annual cap	$145 min. $73,011 max. $2,190,294 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision with reasonable cause and not to willful neglect	$1,424 min. $71,162 max. $2,134,831 annual cap	$1,461 min. $73,011 max. $2,190,294 annual cap

February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$14,232 min. $71,162 max. $2,134,831 annual cap	$14,602 min. $73,011 max. $2,190,294 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$71,162 min. $2,134,831 max. $2,134,831 annual cap	$73,011 min. $2,190,294 max. $2,190,294 annual cap
Failure to provide the Summary of Benefits and Coverage ("SBC")	$1,406 per day	$1,443 per day
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	$11,524	$11,823
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 GHP was primary payer to Medicare	$1,474	$1,512

Employer Action

- Covered entities (health 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).

Federal Funding Bill Adds New PBM Transparency Requirements

Issued date: 02/17/26

On February 3, 2026, the Consolidated Appropriations Act of 2026 ("CAA-26") was signed into law. While this legislation is primarily a funding bill for various departments of the United States government, it includes significant reforms impacting group health plans, both insured and self-insured, that provide pharmacy benefits.

Specific to group health plans, the legislation:

- Creates new pharmacy benefit manager ("PBM") transparency, reporting, and disclosure requirements.
- Requires full pass-through of rebates and other renumeration.
- Expands entities required to furnish ERISA Sec. 408(b)(2) compensation disclosures to include PBMs and third-party administrators ("TPAs").

The legislation is significant and will require rulemaking and other guidance for implementation. The Departments of the Treasury, Labor, and Health and Human Services will be responsible for enforcement and are directed to issue guidance within 18 months of enactment (by August 3, 2027).

Generally, unless otherwise noted, compliance with these requirements is effective for plan years beginning on or after August 3, 2028.

Note: Before this legislation was enacted, the Department of Labor ("DOL") issued a proposed rule requiring additional transparency of PBMs. This rule is currently in a comment period. It is unclear how the two will interact or whether the DOL will revisit this proposed rule in light of changes under CAA-26. Further guidance will be needed.

PBM transparency and reporting

Reporting

PBMs must provide specific reporting to self-insured large employer plans (employers who employed an average of at least 100 employees on business days during the preceding calendar year or plan year) every 6 months (or quarterly, if requested). Reports must be made available in plain language and in a machine-readable format. The reports must include very specific information on prescription drug benefits, including such things as:

- Drug-level claims data
- Pricing information (e.g., amount paid by the plan to PBM, amount PBM paid to pharmacies, spread pricing amounts, dispensing channel)
- Rebates, fees, and other renumeration, such as manufacturer rebates, administrative fees, prices concessions/discounts
- High-cost drug information
- Information on PBM affiliated pharmacies (percentage of prescriptions fulfilled by affiliates, steering practices and financial impact)

Fully insured large employer plans may opt-in to receive this detailed reporting on an annual basis.

In addition, all group health plans (regardless of size) will receive aggregated, high level summary information from the PBM. Briefly, it includes:

- Total prescription drug spending
- Rebates and prices concessions
- Overview of high-cost drugs
- Participant cost-sharing information
- PBM affiliate and network information

PBMs will also furnish plans and carriers a summary document for distribution to participants and beneficiaries upon their request.

Lastly, the statute requires a group health plan to furnish participants and beneficiaries with a written notice each plan year concerning the PBMs' requirement to submit these reports to group health plans.

Information that is provided by the PBM shall be done in a manner consistent with HIPAA Privacy and Security rules, including providing only summary health information.

Access to data

Under the legislation, a group health plan or an entity providing PBM services on behalf of such a plan cannot enter into a contract (including an extension or renewal) with an applicable entity unless the applicable entity agrees to:

- Not limit or delay the disclosure of information to the group health plan in a manner that would prevent the PBM from providing the required reporting (as described above); and

- Provide the PBM that is providing services on behalf of the group health plan the relevant information necessary to make the required reporting.

Generally, an "applicable entity" includes group purchasing organization, drug manufacturer, distributor, wholesaler, rebate aggregator (or other purchasing entity designed to aggregate rebates), or associated third party; a subsidiary, affiliate or subcontractor of the group health plan, carrier or PBM; or any other entity as designated by future regulations.

Enforcement

The statute includes significant penalties for non-compliance:

- $10,000/day for each day a plan administrator, carrier or entity providing PBM services on behalf of a group health plan does not comply with these requirements.

- Up to $100,000 may be imposed against a plan administrator or entity providing PBM services on behalf of a group health when they knowingly provide false information.

Penalties may be waived, or the period of time for compliance may be extended, for a particular requirement if the entity in violation has made a good-faith effort to comply.

Full rebate pass through and audit rights

For plans subject to ERISA, contracts or arrangements (or extensions or renewals) with PBMs and other entities must pass through 100% of rebates, fees, alternative discounts and other renumeration. These amounts must be remitted on a quarterly basis to the group health plan (or to the carrier in an insured arrangement) and no later than 90 days after the end of each quarter. Amounts should be fully disclosed and outlined to the health plan or insurance carrier.

The records of rebates, fees, alternative discounts, and other renumeration shall be made available for audit by the plan at least annually.

If the PBM fails to remit required payments to the plan, there is relief to protect responsible plan fiduciaries who are acting in good faith from penalties when:

- The plan fiduciary did not know that the covered service provider failed or would fail to make required remittances and reasonably believed that the covered service provider remitted such required amounts.

- Upon discovering the failure, the fiduciary requests in writing that the covered service provider remit such amounts.

- If the covered service provider fails to comply with this written request, the plan fiduciary notifies the DOL within 90 days of the service provider's failure.

ERISA Sec. 408(b)(2) Compensation disclosures

The CAA-26 amends ERISA's compensation disclosure rules to make PBMs and TPAs directly subject to these disclosure requirements. Specifically, TPAs and PBMs are considered "covered service providers" under ERISA 408(b)(2) and will be required to disclose direct and indirect compensation to the ERISA group health plan fiduciary.

Note. The statute did not include an effective date for this provision; therefore, it may be viewed as being effective immediately. This means PBMs and TPAs should furnish the ERISA Sec. 408(b)(2) disclosure in connection with upcoming renewals or extension (or when entering into new contracts).

Employer Action

These changes pose a significant shift in access to information from PBMs and will be helpful to employers in managing their health plans and fiduciary compliance. However, implementation will be a lengthy process as many of these changes will happen for plan years beginning on or after August 3, 2028. We will most likely receive guidance from the regulators well before the effective date to assist in the implementation process.

For now, plan sponsors of ERISA covered group health plans should begin obtaining ERISA 408(b)(2) compensation disclosures for PBMs and TPAs in connection with their next renewal. Otherwise, plan sponsors should await further guidance as these new changes begin to take effect. We anticipate that PBMs, TPAs, and carriers will also communicate their intended efforts to comply with this new law.

Annual Out-of-Pocket Maximum Adjustments Announced for 2027

Issued date: 02/17/26

The Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2027. For purposes of employer-sponsored health plans, the guidance includes the limits on annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for non-grandfathered group medical plans for plan years that begin in 2027.

Change to the Out-of-Pocket Maximums

Non-grandfathered group medical plans will see a significant increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2027, as follows:

- $12,000 for self-only coverage (up from $10,600 for 2026)
- $24,000 for coverage other than self-only (up from $21,200 for 2026).

Note: The out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans ("HDHPs") that are compatible with health savings account ("HSA") eligibility.

Employer Action

For non-grandfathered group medical plans, update out-of-pocket limits for plan years beginning on or after January 1, 2027.

USPS Clarifies Postmark Rule: What Employers and Employees Need to Know

Issued date: 03/02/26

Effective December 24, 2025, the U.S. Postal Service (USPS) implemented a change to how postmark dates are assigned. The rule located in the "Postmarks and Postal Possession" in the Domestic Mail Manual clarifies that the official USPS postmark date is not the date a mail piece is *dropped off*, but the date it is first *processed* by an automated USPS sorting facility.

This clarifying change can have significant implications for employers, plan sponsors, and employees who rely on mail service to meet legal deadlines.

USPS Postmark Date

According to the USPS, the postmark date represents when USPS automation equipment first processes the mail item and **not** when:

- The item is handed to a postal clerk
- Dropped at a local post office
- Placed in a blue collection box
- Placed in a residential or business mailbox

Because mail is now routed from local offices to regional processing centers, several days may pass between drop off and the automated postmark. Individuals or business that rely on the mailing date, the USPS encourages customers to visit a post office location to receive a manual postmark date so that the date matches the date of mailing.

Implications for Employees and Employers

Many federal and state compliance deadlines rely on a timely postmark, including:

- Tax filings, payments, and extensions (e.g., Forms 1095, ESRP responses, PCOR filings, etc.)
- ERISA and health plan notices (e.g., HIPAA special enrollment requests, SPDs, SARs, SMMs, etc.)
- COBRA notices
- Claims and appeals submissions
- Leave or disability notices (e.g., FMLA, state mandated leave, medical certifications, etc.)
- FSA/HRA substantiation or reimbursement claims
- Other regulatory filings or contractual notices requiring “mailed by” documentation

If the postmark occurs after a statutory deadline even when the employee or the employer mailed the item on time, it may be considered late. Employees that miss delivery deadlines can result in lost appeal rights, denied reimbursements, and denied or termed benefits. Employers may face excise tax or penalty violations under the Internal Revenue Code and civil penalties under ERISA.

Employer Action

Employers should consider the following to ensure timely mail-in delivery:

- Update internal mailing procedures by requiring time sensitive documents be mailed using methods that provide verified mailing dates (e.g., manual postmark, certified mail, proof of mailing).
- Discuss with carriers, TPAs/stop loss providers, COBRA administrators, and Payroll or tax vendors to confirm any changes to mail-in requirements.
- Encourage employees to use verified mailing options and update plan communications (e.g., SPD, claims/appeals procedures).
- Use electronic delivery whenever permitted to ensure plan notices are delivered timely.

DOL Proposes New Independent Contractor Rule

Issued date: 03/16/26

In late February, the Department of Labor (DOL) issued proposed rules that would rescind the 2024 Independent Contractor Rule and reinstate a modified version of the 2021 Independent Contractor Rule for determining whether a worker is an employee or independent contractor under the Fair Labor Standards Act (FLSA), Family Medical Leave Act (FMLA), and Migrant and Seasonal Agricultural Worker Protection Act (MSPA).

Background

The analysis for determining employee verses independent contractor status has been in flux for the last several years. In 2021, final rules were issued that provided an economic realty test that focused on two core factors. In 2024, the 2021 rules were replaced with a new set of final rules that established a six-factor test, which was similar to pre-2020 guidance. Then, in 2025, the DOL issued a field technical bulletin stating they would no longer enforce the 2024 final rules, and instead employers could rely on pre-2020 guidance.

New(ish) Proposed 2026 Independent Contractor Rule

On February 26, 2026, the DOL proposed to once again revise this analysis and go back to a two-core factor test.

Two Core Factors (Most Heavily Weighted)

- **Nature and degree of control over the work:** the individual controls aspects of the work such as setting work schedules and choosing assignments, works with little or no supervision, and is able to work for others.

- **Opportunity for profit or loss based on initiative or investment:** the individual has an opportunity to earn profits or incur losses based on his or her exercise of initiative (such as managerial skill or business acumen or judgment) or management of his or her investment or capital expenditures to further his or her work.

If both these factors support the same conclusion as to employee versus independent contractor status, there is a higher likelihood that is the individual's correct classification.

The analysis would also include three other factors, especially in the case where the two core factors do not point to the same classification.

Three Additional Factors

These carry less weight but remain part of the totality of the circumstances review:

- **Skill required:** this factor favors independent contractor status when the work requires skill or specialized training that the employer does not provide. If the work does not require specialized skills beyond training supplied by the employer, the factor leans toward employee status.

- **Permanence of the relationship:** the employer and individual's relationship is "by design definite in duration or sporadic," this supports an independent contractor. Whereas a long-term relationship is more indicative of employee status.

- **Whether the work is part of an integrated unit of production:** this factor supports independent contractor status when the individual's work can be separated from the employer's overall production process. Conversely, it supports employee status when the individual's work forms an integral part of the employer's unified process for producing a good or delivering a service.

Emphasis on Actual Practice

Under the proposed rule, the DOL reiterates its view from the 2021 rules that determining whether an individual is economically dependent on a potential employer should focus on what actually occurs in practice—not merely on what a contract allows or suggests. The DOL emphasizes that evaluating the "circumstances of the whole activity" requires looking at both actual practices and contractual rights, but the true "reality" of the working relationship is reflected in how the work is carried out day-to-day rather than in "theoretical or contractual possibilities."

Why This Matters to Employee Benefits

Correctly distinguishing employees from independent contractors in plan administration is important because most benefit laws, such as ERISA, ACA, COBRA, HIPAA, and Section 125 apply only to employees. Misclassification can lead to offering benefits to ineligible individuals, jeopardizing a plan's tax-favored status, triggering ACA employer-mandate penalties, COBRA notice failures, and inconsistencies with plan documents that expose the employer to fiduciary and operational risks.

The proposed regulations provided several examples applying these factors to help in the analysis.

Employer Action

Although this is only a proposed rule, employers should consider the following:

- Review current independent contractor relationships - analysis of worker classifications should be done by employment law counsel

- Evaluate risk areas by identifying roles where control is high or profit/loss opportunity is limited

- Stay alert for the final rule and be prepared to update internal processes and training

- Comment period ends April 28, 2026

2025 RxDC Reporting Reminder

Issued date: 03/20/26

The Centers for Medicare and Medicaid Services ("CMS") recently released updated Prescription Drugs Data Collection ("RxDC") instructions for reporting 2025 data; there are no substantive changes to the instructions from last year.

The deadline to report 2025 RxDC data to CMS is June 1, 2026.

Carriers, third-party administrators ("TPAs"), pharmacy benefit managers ("PBMs") and other vendors who assist plans with RxDC reporting usually send out survey and information requests for data from plan sponsors. Responses to these data requests are due well in advance of the June 1 deadline (a date in March or April is common).

In some cases, usually certain self-funded plans with carve-out benefits, the employer will need to submit some of the files to CMS to complete reporting.

Background

Group health plans and health insurance carriers offering group health coverage must submit information annually about prescription drugs and health care spending to CMS.

CMS is supposed to issue a biannual public report based on the data collected in the RxDC reporting to highlight prescription drug pricing trends and the impact of prescription drug costs on rates. Although, to date, this report has not been published.

RxDC reporting consists of nine total spreadsheets that are uploaded to the CMS HIOS program. Spreadsheets include a plan list (P2 is used for group health plans) and eight data files (D1 through D8), plus a "narrative response." In some situations, a TPA or PBM will not handle every spreadsheet or filing and not every data spreadsheet is applicable to every group health plan. The RxDC instructions indicate which data files are applicable to group health plans based on the benefits provided.

Filing Responsibility

- For fully insured plans (with no carve out benefits) the carrier will usually submit RxDC reporting on behalf of the plan. Employers with a fully insured plan should obtain written confirmation that the carrier will handle this requirement on behalf of the plan. If the insured plan has a written agreement requiring the health insurance carrier to complete and file the RxDC reporting, the carrier is responsible for compliance.

- For self-funded plans and level-funded plans, the plan sponsor is responsible for compliance. TPAs, PBMs and other vendors may compile and submit RxDC reporting on behalf of the self-funded or level-funded plan. However, the plan remains liable for any reporting failures or violations. It is important to obtain specific information from vendors servicing the self-funded plan as to how they support RxDC compliance.

Employer Action

- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2025 data and submit RxDC reporting.

    - Obtain assurances in writing from vendors who will submit on behalf of the plan and request documentation of successful submission.

- Timely respond to any carrier, TPA, PBM or other vendor survey requests for information in order to complete reporting on behalf of the plan.

- Identify any circumstances where the employer will be responsible for submitting any of the information to CMS via HIOS

    - For example, when an employer offers a self-funded health plan where stop loss insurance is carved out, the employer may be responsible for furnishing stop loss information by filing a P2 and D1 with HIOS.

- If needed, review whether a HIOS account has been established. If not, set up a HIOS account well before the filing deadline. It can take up to 2 weeks to establish. Information on creating an account and navigating HIOS is available in HIOS RxDC User Manual and RxDC HIOS Access Guide.

PBM Litigation Survives Motion to Dismiss

Issued date: 03/20/26

ERISA fiduciary litigation against health plan sponsors is on the rise. Specifically, plan participants, as plaintiffs, have alleged fiduciary breaches by plan sponsors for failing to monitor the service providers managing pharmacy benefit managers ("PBMs").

While several similar lawsuits have been dismissed, last week a federal court allowed a prohibited transaction claim to proceed. While it is too early to tell what the impact of this decision will be in the context of future litigation it is an interesting development and something to watch.

Background

On March 13, 2025, a class action lawsuit was brought by current and former JPMorgan employees alleging that JPMorgan breached its ERISA fiduciary duties of prudence and loyalty and also engaged in ERISA prohibited transactions by mismanaging the prescription drug component of JPMorgan's self-funded group health plan. Specifically, the plaintiffs allege that JPMorgan, through its PBM arrangement with CVS Caremark:

- grossly inflated drug prices relative to acquisition cost;
- increased costs through spread pricing;
- increased costs through retained rebates;
- increased costs through specialty drug classifications; and
- engaged in prohibited transactions.

These actions caused plaintiffs injury in the form of increased out-of-pocket costs and premiums.

On June 3, 2025, JPMorgan filed a motion to dismiss.

Motion to Dismiss, Opinion and Order

In a decision issued on March 9, 2026, the District Court:

- Dismissed the ERISA fiduciary-breach claims as the challenged conduct did not involve fiduciary functions.
- Held that plaintiffs did not have standing as to their higher premium theory. The court found participant premium increases were too speculative to serve as the basis for standing.
- Held the plaintiffs have standing because they allege personal financial loss because of out-of-pocket overpayments for prescription drugs, allowing the ERISA prohibited transaction claims against JPMorgan to proceed.

Fiduciary Breach Claims Dismissed

Plaintiffs alleged JPMorgan breached their fiduciary duties of prudence and loyalty primarily through the way they structured the plan's prescription drug program.

The District Court held that decisions about PBM pricing models, formularies, specialty drug treatment, and whether to adopt pass-through or carve-out arrangements are plan design decisions ("settlor functions") and not fiduciary acts subject to ERISA's fiduciary standards.

Prohibited Transactions Claims Allowed to Proceed

The District Court's decision allows the ERISA prohibited transaction claims to proceed. Briefly, the plaintiffs alleged that JPMorgan engaged in a prohibited transaction by transferring plan assets to their PBM in exchange for services with compensation that is unreasonable.

The decision relies on prior precedent established by the Supreme Court which clarified that ERISA plaintiffs only need to plausibly allege the elements of a prohibited transaction claim to survive a motion to dismiss. Briefly, the elements to a prohibited transaction claim are:

1. the plan engaged in a transaction;
2. the fiduciary knew or should have known the transaction involved the furnishing of goods or services; and
3. the transaction was between the plan and a party in interest; in this case the party in interest is the PBM.

The District Court found the plaintiffs sufficiently pled the elements of a prohibited transaction claim.

However, the District Court did note that JPMorgan may have ample defenses to the claim that it engaged in a prohibited transaction. Such defenses will likely be raised as this claim proceeds through the litigation.

What This Means

It is unclear how this litigation will be resolved. Both parties may seek to appeal the District Court's decision.

It is interesting to note that this is the third lawsuit of its kind and the only one to survive a full motion to dismiss. The decision reinforces the rule that while employers retain broad discretion over health plan design, PBM compensation structures and service-provider payments remain a key area of ERISA litigation risk.

Employer Action

Although there are no action items for employers, it is always advisable to review compliance with general fiduciary duties and check agreements with PBMs for the reasonableness of fees.

New Illinois Laws Effective in 2026

Issued date: 03/30/26

A few notable laws are going into effect in Illinois related to commuter benefits and mandated medical benefits. Below is an overview of these amendments.

Commuter Benefits

Effective January 1, 2026, the Transportation Benefits Program Act ("TBPA") has been expanded to include part-time employees for both eligibility to participate in the employer's commuter benefit plan and inclusion in the employee count to determine employer applicability under the law. Historically, the TBPA only applied to Illinois employers with at least 50 full-time employees located in certain counties and townships and full-time employees who averaged at least 35 hours of service per week. All employees, except workers in the construction industry subject to a collective bargaining agreement, are now eligible for pre-tax commuter benefits after completing 120 days of employment and subject to the rules and jurisdiction of the Regional Transportation Authority ("RTA").

Amendments to the Illinois Insurance Code

Several new mandated benefits are going into effect in connection with 2026 renewals. These provisions generally apply to fully insured health plans issued in Illinois. Insured health plans issued in other states and ERISA-covered self-funded health plans are not required to comply.

- **Menopausal Symptoms** – Expands coverage of hormone treatments for menopausal symptoms when medically necessary, instead of being limited to only symptoms related to a hysterectomy.
- **Wigs and Scalp Prostheses** – Require coverage of one wig or scalp prosthesis at least once every 12 months when hair loss is due to alopecia, chemotherapy, or radiation treatment for cancer or other conditions.
- **Generic Drugs** – Require coverage of the temporary substitution of brand-name eligible prescription drugs due to a supply issue until the generic drug version is available where the patient's dosage cannot be adjusted to allow for a different drug option.

- **Prescription Inhalers** – Limit the amount charged, without deductible requirements, to a maximum of $25 per 30-day supply and $50 within 30 days for all covered prescription inhalers.

- **Colonoscopies** – Require coverage for medically necessary colonoscopies without cost-sharing unless providing the coverage would disqualify a high-deductible health plan for health savings account eligibility. Although the ACA requires non-grandfathered medical plans to cover preventive colonoscopies with no cost-sharing, this rule expands coverage to diagnostic colonoscopies recommended by a physician for patients with symptoms or an existing condition.

- **Molecular Breast Imagery ("MBI") and Magnetic Resonance Imaging ("MRI")** – Require coverage for medically necessary MBIs and MRIs, regardless of the patient's gender. **This specific amendment also amended the County, Municipal and School Codes so it is also applicable to self-funded group health plans sponsored by Illinois state and local government entities, including public schools.**

Employer Action

Covered employers should extend transportation benefits to part-time employees and include part-time employees in the count to determine employer applicability under the law.

Carriers issuing and renewing group health plan policies in Illinois should have already made the necessary changes to the plan designs to comply with the law. Communication should be distributed by the carriers to the plan sponsors on the effects, if any, these amendments may have on their plans.

Self-funded governmental employers should work with their TPAs and stop loss carriers to comply with these new requirements. If necessary, plan documents should be updated to include these amendments.

New Jersey To Expand Leave Laws

Issued date: 03/31/26

On January 17, 2026, Governor Phil Murphy signed A3451/S2950, legislation that significantly expands employer obligations and employee rights under several New Jersey leave programs. The law broadens coverage under the New Jersey Family Leave Act ("NJFLA"), expands employee eligibility, creates new job-protection rights for employees receiving Temporary Disability ("TDI") or Family Leave Insurance ("FLI") benefits, and changes how employers must coordinate with New Jersey Earned Sick Leave ("NJESL").

These changes take effect July 17, 2026.

Key Highlights

- **Coverage Expanded to Smaller Employers:** NJFLA will now apply to New Jersey employers with 15 or more employees, including out-of-state employees.
- **Employee Eligibility Expanded:** Employees will qualify for NJFLA after three months of employment and 250 hours worked in the prior 12 months.
- **Job protection extended to TDI/FLI:** Employees receiving TDI or FLI benefits must be returned to the same or equivalent position.
- **Employee Choice in Order of Leave Benefits:** Eligible employees may determine the order in which they use NJESL and TDI/FLI, though they cannot receive more than one paid benefit at the same time.

Current NJFLA Requirements

Under current law, New Jersey employers with 30 or more employees must provide 12 weeks of unpaid, job-protected leave in a 24-month period for:

- Caring for a seriously ill family member,

- Bonding with a newborn or newly adopted/foster child, or
- Caring for a child during a public health emergency when schools or childcare facilities are closed.

Employees are eligible after 12 months of employment and 1,000 hours worked in the preceding 12-month period.

Summary of Changes Under the New Law

Covered Employer Expanded to Include Smaller Employers

Effective July 17, 2026, NJFLA applies to employers with 15 or more employees, inclusive of out-of-state employees.

Employee Eligibility Expanded

Employees will qualify for NJFLA after:

- 3 months of employment, and
- 250 hours worked in the prior 12 months.

This provision greatly expands the population eligible for job-protection leave, including many part-time and newly hired employees. Employers should anticipate potential staffing challenges and review workforce planning strategies.

New Job-Protection Rights for TDI/FLI Leave

Currently, TDI and FLI provide only wage replacement; job protection applies only if the leave also qualifies under NJFLA or federal FMLA.

Under the new law, employees receiving TDI or FLI must be restored to their prior position or an equivalent position with the same pay, benefits, seniority, and working conditions—even if the leave does not otherwise qualify under NJFLA or FMLA.

The law also provides a variety of remedies if an employer fails to reinstate an employee after the leave including:

- Assessment of civil fines not less than $1,000 (maximum $2,000) for a first offense,
- An injunction to restrain continued violation,
- Reinstatement to the same or equivalent position with full fringe benefits and seniority rights,
- Compensation for lost wages, and
- Payment of reasonable attorney fees.

Note. This represents a major expansion of job-protection rights. Eligibility for TDI and FLI is broader than NJFLA, therefore employees may now receive up to 26 weeks of job-protected leave in certain circumstances. Clarification will be needed from the state to determine whether the law creates a new, standalone job-protection entitlement for all TDI/FLI leaves, or job protection only when TDI/FLI overlaps with NJFLA-qualifying reasons. The distinction has significant operational and compliance implications.

Employee Ability to Choose Order of Leave Benefits

If an employee is eligible for earned sick leave under New Jersey's Earned Sick Leave Law and also eligible for TDI or FLI, "the employee shall have the option of using either the earned sick leave or whichever is applicable (TDI or FLI) and may select the order in which the different kinds of leave are taken, but will not receive more than one kind of paid leave simultaneously during any period of time."

> ***Note.*** This provision appears to allow employees eligible for NJESL as well as TDI or FLI the ability to "stack" the leave rather than having the leave run concurrently. Guidance will be critical to determine how employers should manage sequencing, documentation, and payroll coordination

Employer Action

New Jersey employers should begin preparing now for the changes effective July 17, 2026, by:

- Reviewing and revising leave policies,
- Updating employee handbooks and internal procedures,
- Assessing administrative systems for tracking and coordination of multiple state leave programs,
- Training HR and managers on the new requirements, and
- Communicating updated rights and obligations to employees.

Given the significant impact of these changes and the complex interplay across NJFLA, TDI, FLI, and NJESL, we expect further guidance.

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