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New Jersey Joins Earned Sick Leave Party

On May 2, 2018, Governor Phil Murphy signed a law (**A1827**) that requires employers to provide earned sick leave to their employees who work in New Jersey. The law takes effect on October 29, 2018.

Two important notes about this law:

- First, this law applies to employers without regard to size. It provides benefits to any employee working in New Jersey without regard to employment status, i.e., both full-time and part-time employees are eligible for the benefit.
- Secondly, this new state-wide law supersedes the existing earned sick leave ordinances enacted by 13 New Jersey local jurisdictions, specifically, Bloomfield, East Orange, Elizabeth, Irvington, Jersey City, Montclair, Morristown, New Brunswick, Newark, Passaic, Paterson, Plainfield and Trenton. Hopefully, future guidance will address coordination issues that may arise for leave accrued under one of these ordinances. In addition, the law contains a provision that prohibits any other local city or municipality in the state from enacting a paid sick leave law.

Employers subject to the law. Employer is defined as any person, firm, business, educational institution, nonprofit agency, corporation, limited liability company, or other entity who employs employees in the State of New Jersey, including a temporary help service firm. Where a temporary help service firm places an employee with client firms, the earned sick leave is accrued on the basis of the total time worked on assignment with the temporary help service firm rather than separately for each client firm to which the employee is assigned. Public employers who provide sick leave in accordance with another New Jersey law are exempt from this earned sick leave law.

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Eligible employees. An eligible employee is one who works for the employer for compensation. Employees in the construction industry who are covered under a collective bargaining agreement and certain per diem health care workers are not eligible for the benefit.

Amount of paid sick leave. An eligible employee is entitled to earn one hour of paid sick leave for every 30 hours worked.

Accrual, Frontloading, Carryover and Cap. Employees begin to accrue earned sick leave on the effective date of the law (October 29, 2018). Following the effective date of the law, individuals will begin to accrue leave on their date of hire. An employee can begin using accrued earned sick leave 120 days following the date of hire; after 120 days, sick leave can be used as it is accrued. Individuals with existing accrued leave prior to the enactment date of this law can continue to use it in accordance with the employer's policy.

Accrued sick leave carries over from year-to-year, subject to a 40-hour per year limit. An employer can choose to provide paid sick leave on an accrual basis; or, the employer can front-load 40 hours of paid sick leave on the first day of each benefit year. Regardless of the method, an employee may use up to 40 hours of sick leave per benefit year unless the employer provides a higher amount. A benefit year refers to a regular and consecutive twelve month period, as determined by an employer.

In lieu of a carryover, an employer has the option to pay-out unused earned sick leave in the last month of its benefit year. If the employer opts to do this, then the employee must decide within 10 days of receiving the employer's offer whether to accept or decline the pay-out. If the employee agrees to receive a pay-out, then he/she can choose whether to receive the full amount of unused earned sick leave, or 50% of the amount of unused earned sick leave and then carry over the remaining balance of the 40 hours. If the employee agrees to a payment for the full amount, then the employee is not entitled to carry-over any earned sick leave.

An employee and employer may, by mutual agreement, arrange for the employee to work additional hours during the same pay period to avoid the use of and payment of earned sick leave.

If individual is terminated or otherwise separated from employment and returns to work within 6 months, then any unused accrued sick leave will be reinstated upon the re-hired date.

Use of paid sick leave. Leave can be taken for the following reasons:

- To attend to one's own needs, or to attend to the needs of a family member, for the diagnosis or treatment of a physical or mental condition, including preventive care services. For this purpose, *family member* includes:
  - A child, whether biological, adopted, foster or step, or a legal ward of an employee, a child of the employee's domestic partner or civil union partner, or a grandchild;
  - A spouse, domestic partner, civil union partner;
  - A parent, whether biological, adoptive, foster or step; a legal guardian of an employee or his/her spouse, domestic partner, or civil union partner; or, a person who stood in loco parentis of the employee or his/her spouse, domestic partner, or civil union partner when he/she was a minor child;
  - A sibling or grandparent of the employee or of the employee's spouse, domestic partner or civil union partner; or
  - Any other individual related by blood to the employee or whose close association with the employee is the equivalent of a family relationship.
- To obtain psychological or physical services, or to attend to legal matters as a result of domestic or sexual violence.
- Due to a closure of the employee's worksite, or closure of his/her child's school or childcare provider as a result of a declared public health emergency.
- To attend a school-related conference, meeting, function or other event requested or required by a school administrator, teacher, or other professional staff member responsible for the child's education, or to attend a meeting regarding care provided to the child in connection with the child's health conditions or disability.

Coordination with employer's existing PTO policy. An employer who has a paid time off (PTO) policy that meets or exceeds the benefits as required above will be in compliance with this law.

Notice Requirements

- ***Employee Notice Obligation.*** When the need for leave is foreseeable, an employer may require up to a 7-day advanced notice of the leave together with the expected duration of the leave. The employee may be required to make a reasonable effort to schedule the leave in a manner that would not unduly disrupt the operations of the employer. When the need for leave is unforeseeable, the employee must notify the employer as soon as practicable. For a leave of absence exceeding three or more consecutive days, an employer may require reasonable documentation to substantiate the need for the leave.

- ***Employer Notice Obligations.*** An employer is required to provide written notification of the earned sick leave benefit to its employees upon hire, as well as upon request. The notice must be provided in both English and Spanish, as well as in the primary language of the majority of the employer's workforce. In addition, the employer is required to post a notice of the provisions of the earned sick time benefit in a conspicuous place at its worksite locations.

Record Retention. Employers are required to retain records demonstrating compliance with the requirements of the law for a period of five years.

Prohibition of Retaliation. An employer is generally prohibited from taking any adverse employment-related action or retaliation against employee's right to use accrued paid sick leave.

Confidentiality Requirements. Employers must keep medical information relating to an employee or his her family member confidential. Such information can only be disclosed to the affected employee, or with his/her permission.

Enforcement Agency and Internet Resources. The New Jersey Department of Labor and Workforce Development (LWD) (http://nj.gov/labor/) enforces the provisions of this law. The LWD's Commissioner is directed to implement a multilingual outreach program to inform employers, employees, parents, and health care providers about the availability of earned paid sick leave law.

PARITY IS THE LAW, SAYS RECENT MENTAL HEALTH GUIDANCE

In an on-going effort to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the 21st Century Cures Act ("Cures Act"), the Departments of Labor, Treasury and Health and Human Services jointly issued several pieces of guidance on April 23, 2018, much of which relates to the changes made by the Cures Act (see *Benefit Implications Contained in New Law, Benefit Beat*, 1/10/17).

Of particular note, the Cures Act requires additional non-quantitative treatment limitation standards and appropriate disclosure requirements. The newly issued guidance comprised of Proposed FAQs, a report to Congress, an enforcement fact sheet, a self-compliance tool, as well as a revised disclosure template focus, in large part, on these matters. Following are highlights of this guidance.

Proposed FAQs

As background, the MHPAEA requires mental health services to be treated in a substantially similar manner to all covered medical and surgical services under a health plan, including:

- Cost-sharing requirements, such as deductibles, co-payments, coinsurance, and out-of-pocket expenses; and,
- Treatment limitations, such as frequency of treatments, number of visits, days of coverage, or similar plan limits.

Not only does the law apply to quantitative limits, such as financial and treatment limits, but also to non-quantitative limits. Specifically, plans cannot impose medical management standards on mental health services that would limit or exclude benefits based on medical necessity or appropriateness, or based upon whether the treatment is experimental or investigative that are more stringent than those imposed for covered medical or surgical benefits. In the **Proposed FAQs,** by way of example, FAQs 2 and 3 address parity with regard to exclusions for experimental and investigative services under a health plan. Accordingly, if a plan imposes an experimental or investigational restriction that allows an exception, it cannot include a blanket exclusion for applied behavioral analysis (ABA) therapy to treat certain children with autism spectrum disorder.

Similarly, plans cannot impose a different evidentiary standard or designated rating that is more stringent for mental health benefits than for medical/surgical benefits. Further, FAQs 4 and 5 address parity with regard to treatment guidelines relating to prescription drug benefits.

Several proposed FAQs address differences relating to a plan's network standards for purposes of varying levels of step therapy, provider reimbursements, and availability of providers within a network. The tri-governing agencies emphasize that plan features that apply to medical-surgical benefits must be comparable to those that apply for mental health and substance abuse services.

Proposed FAQs 11 and 12 address the importance of updating plan materials, specifically, provider directories, to ensure current information is available to participants and enrollees. Under ERISA, if a plan utilizes a network of providers, then its summary plan description (SPD) must contain an up-to-date, accurate, and complete general description of the participating provider network. The provider directory can be provided as a separate document that accompanies the plan's SPD as long as it is furnished automatically, without charge and the SPD contains a statement to that effect. Any changes made to the document can be communicated to participants by way of a summary of material modification. Similarly, the Affordable Care Act (ACA) requires insurers to make available an up-to-date, accurate, and complete provider directory to enrollees.

Whether required by ERISA or by the ACA, updated provider information can be provided electronically as long as the relevant electronic disclosure methodologies are followed.

Comments on the proposed FAQs are due by June 22, 2018.

Additional guidance included in the package include the following:

- **Updated model disclosure notice.** The Cures Act included a provision that allows plan participants to request information about plan coverage, or solicit information from the plan following an adverse determination of their mental health or substance abuse benefits to support an appeal. The tri-governing agencies released a **revised model notice** that can used for this purpose. It is not mandatory for individuals to use a notice of this nature, but it allows individuals or their representatives a means in which to solicit benefit information. Group health plan sponsors or administrators are required to provide the requested information to the individual within 30 days of receipt.

- **MHPAEA Self-Compliance Tool.** Another requirement of the Cures Act is the creation of a self-audit tool to assist plans sponsors and insurers in their efforts to ensure and improve compliance with the MHPAEA. To this end, the agencies released the **Self-Compliance Tool for the MHPAEA** that contains an overview of the requirements of the law, together with illustrations of parity, as well as compliance tips. This document is scheduled to be updated on a biennial basis, as appropriate.

- An **MHPAEA Enforcement Fact Sheet** which reflects that in fiscal year 2017, out of 187 investigations where MHPAEA applied, the Department of Labor's Employee Benefit Security Administration cited 92 violations for MHPAEA noncompliance. Almost half of the violations related to failure to comply with the provisions that require parity for non-quantitative treatment limit purposes.

As mentioned in last month's *Benefit Beat*, there appears to be an uptick in enforcement action by the tri-governing agencies, as well as litigation relating to compliance with these rules. Taken together with the new package of guidance, plan sponsors should expect continued enforcement of the MHPAEA law.

The $50 HSA Dilemma

The health savings account (HSA) contribution limit for family coverage returns to $6,900. As you may know, the Tax Cuts and Jobs Act re-worked the way cost of living adjustments are calculated. As a result of this change in the law, in March, the family contribution limit for HSAs, which had been set for 2018 at $6,900, was reduced to $6,850 (see *Revised 2018 Cost of Living Adjustments, Benefit Beat*, 3/12/18).

The IRS issued guidance on April 26, 2018 in response to much angst about this $50 reduction and has returned the limit to $6,900. Further, the IRS grants tax relief by way of **Revenue Procedure 2018-27** to individuals who may have already received a distribution of an excess contributions based on the $6,850 limit. This guidance sets forth procedures for repayment and reporting of the excess contribution.

Medicare Part D Adjustments for 2019

The Centers for Medicare and Medicaid Services have released the **2019 adjustments** *(note Attachment VI)* for Medicare Part D prescription drug benefits. Following are select modified limits relating to the standard drug benefit and the retiree drug subsidy.

Standard Benefit Design	2019	2018
Deductible	$415	$405
Initial coverage limit	$3,820	$3,750
Out-of-pocket Threshold	$5,100	$5,000
Maximum Cost Sharing in Catastrophic Coverage Portion of Benefit:		
▪ Generic/Preferred Multi-Source Drug	$3.40	$3.35
▪ Other	$8.50	$8.35

Retiree Drug Subsidy Amounts	2019	2018
Cost Threshold	$415	$405
Cost Limit	$8,500	$8,350

IRS Guidance: Paid Family Leave Credit

One of the provisions of the Tax Cuts and Jobs Act (TCJA) added a new employer tax credit for wages paid to qualifying employees during any period in which an employee is absent from work due to a family and medical leave event (see *Employer Credit for Paid Family and Medical Leave, Benefit Beat*, 1/16/18).

On April 9, 2018, the IRS issued its initial implementation guidance about this credit in the form of **Frequently Asked Questions.** While the IRS indicates that it will be issuing further guidance, following are some clarifications made by this set of FAQs.

An employer is eligible for a general business tax credit under Code Section 45S if it has a separate written policy in place that allows all qualifying full-time employees a minimum of two weeks of annual paid family and medical leave. The policy must also allow non-full time qualifying employees a comparable amount of leave on a pro rata basis. It is important to note that this credit is available to an employer without regard to whether it is subject to the federal Family and Medical Leave Act, as long as the employer maintains the written policy that meets the wage payment criteria.

For purposes of the credit, a *qualifying employee* is one who has been employed by the employer for at least one year, and whose compensation for the preceding year does not exceed 60% of the compensation threshold for highly compensated employees (less than $72,000 in 2017).

Amount of credit. For leave payments of 50% of normal wage payments, the credit amount is 12.5% of wages paid on leave. If the leave payment is more than 50% of normal wages, then the credit is raised by 0.25% for each one percent by which the rate is more than 50% of normal wages. Thus, if the leave payment rate is 100% of the normal rate, i.e., is equal to the normal rate, then the credit is raised to 25% of the on-leave payment rate. The maximum leave allowed for any employee for any tax year is 12 weeks.

Leave paid by a state or local government is not taken into account. Paid leave such as vacation leave, personal leave, or other medical or sick leave provided by the employer is not to be considered leave for which the credit would be available

An employer is required to reduce its deduction for wages or salaries paid or incurred by the amount determined as a credit. Further, any wages taken into account in determining any other general business credit cannot be used in determining this credit.

The FMLA tax credit is only available for a two-year period beginning January 1, 2018 and ends December 31, 2019.

Model FMLA Forms Scheduled to Expire Soon

The Department of Labor's (DOL) Wage and Hour Division provides model Family and Medical Leave Act (FMLA) forms that can be used by employers to assist in satisfying their notice obligations, such as the obligation to provide information to employees of their eligibility, rights and responsibilities under the law, as well as the certification form to report the need for FMLA leave in the event of an employee's or his/her family member's serious health condition. These model FMLA forms are currently scheduled to expire on May 31, 2018.

Under federal law, these model forms must be submitted for review and approval in order to be re-issued. The DOL has requested a review of these forms for re-authorization for use, without change in the substance of the forms. It is anticipated that once approved, the forms will be re-issued with a new expiration date.

In the meantime, employers are encouraged to continue using the existing forms until further notice. Following are the relevant FMLA forms scheduled to expire on May 31, 2018:

- Form WH-380-E *Certification of Health Care Provider for Employee's Serious Health Condition*

- Form WH-380-F *Certification of Health Care Provider for Family Member's Serious Health Condition*
- Form WH-381 *Notice of Eligibility and Rights & Responsibilities*
- Form WH-382 *Designation Notice*
- Form WH-384 *Certification of Qualifying Exigency For Military Family Leave*
- Form WH-385 *Certification for Serious Injury or Illness of Current Servicemember for Military Family Leave*
- Form WH-385-V *Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave*

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