Q2 2026

Benefits Leader

Your Guide to Health & Welfare Compliance

IN THIS ISSUE

STATE FAMILY & MEDICAL LEAVE LAWS	1
UPDATE ON ADA TITLE II DIGITAL ACCESSIBILITY	4
MEDICARE SECONDARY PAYER (MSP) RULES	5
ACA MEASUREMENT PERIODS	10
MEDCOM'S TRAINING OPPORTUNITIES	13
UPCOMING DEADLINES	14

STATE FAMILY & MEDICAL LEAVE LAWS BEYOND FMLA

Michelle Barki, RN, Esq.
Senior Legal Counsel

The federal Family and Medical Leave Act (FMLA) remains the baseline framework for job-protected leave in the United States. In general, this law provides eligible employees of covered employers with up to 12 weeks of unpaid, job-protected leave for specified family and medical reasons. But for many employers and their advisors, the federal FMLA is no longer the whole story. A growing number of states have enacted their own family and medical leave laws or paid family leave programs, often expanding eligibility, adding wage-replacement benefits, or imposing separate notice, payroll, and administrative requirements.

For clients with employees in multiple states, the compliance question is increasingly not whether leave rules apply, but which rules apply when state and federal overlap, and how they are funded and administered.

This article is intended as a practical overview for accounting and payroll professionals, not an exhaustive survey of all state and local jurisdictions.

STATE LEAVE VS. FMLA

Employer Coverage Thresholds

Federal FMLA generally applies to employers with 50 or more employees, but some state laws reach smaller employers. That means a client may have no federal FMLA obligations in a location and still be subject to a state leave mandate.

Paid vs. Unpaid Leave

Many state programs, however, offer partial wage replacement funded through employee payroll deductions, employer contributions, or a combination of both. This creates additional accounting and payroll considerations, including withholding requirements, wage reporting, and coordination with existing employer-paid leave policies.

Job Protection & Wage Replacement

Some states combine paid benefits with job protection, while others separate the two requirements into different statutes. Employers, therefore, need to evaluate both the income-replacement component and the reinstatement or anti-retaliation component.

Expanded Definitions & Qualifying Reasons

States may define family members, qualifying events, and leave duration differently than federal FMLA. Certain programs may also include additional qualifying reasons, such as military-related absences or expanded caregiving categories.

Funding and Administrative Requirements

State programs may require employee payroll deductions, employer registration, periodic reporting, workplace notices, or separate claims processes. For CPAs and other advisors, these operational details can be just as significant as the leave entitlement itself.

Article continues on next page

SELECTED STATE PROGRAMS (COMPACT CHART)

For a multistate employer, the most useful first pass is a "program map" that identifies whether the state provides job-protected unpaid leave, paid wage-replacement benefits, or both, and how the program is funded. The chart below summarizes **selected jurisdictions** (not inclusive) at a high level, focusing on (1) paid family/medical leave or paid family leave programs and (2) broad, unpaid FMLA-type job-protection laws and supplements in selected states. It is not a complete national listing.

Max weeks are shown as "up to" because caps commonly vary by qualifying reason and/or are subject to combined maximums within a benefit year/measurement period. Employers should confirm eligibility, notice, and coordination rules (especially where federal FMLA may run concurrently).

For a detailed chart that includes all states and D.C., please log in to the ***Medcom Bridge portal*** and navigate to **Resources > Brochures > FMLA**.

State	Program Name	Paid vs. Unpaid	Max Weeks	Funding	Compliance Note
California	Paid Family Leave (PFL) via State Disability Insurance (SDI)	Paid (wage replacement); job protection is typically via separate laws	Varies by program rules; not summarized on FTB pages	SDI payroll contributions; CA tax treatment guidance available	FTB guidance focuses on taxability: PFL/SDI is federally taxable but generally not taxable in CA; benefits reported on Form 1099-G and excluded on CA return via Schedule CA adjustment.
Massachusetts	Paid Family and Medical Leave (PFML), plus MA Parental Leave (unpaid)	Paid + job-protected (PFML); separate unpaid parental leave	Up to 20 weeks (medical), up to 12 weeks (family/ bonding), up to 26 weeks combined in a benefit year	State program with required contributions (payroll-based); benefit calculation and waiting period apply	Track combined caps and coordinate PFML with any applicable federal FMLA; also note separate 8-week unpaid parental leave law.
Connecticut	Connecticut Family and Medical Leave Act (CTFMLA)	Unpaid (job-protected)	Up to 16 workweeks in a 24-month period	N/A (job-protection statute)	Duration/measurement period differs from federal FMLA; do not assume the federal 12-week framework controls.
New York	Paid Family Leave (PFL)	Paid + job-protected	Not specified on NY tax page	Employee premium contributions withheld after-tax; reported on Form W-2 (Box 14)	Set up payroll deductions and W-2 reporting; benefits are taxable income; coordinate with federal FMLA, where applicable.

Chart continues on next page

State	Program Name	Paid vs. Unpaid	Max Weeks	Funding	Compliance Note
New Jersey	NJ Family Leave Act	Paid, unpaid, or combination (depending on benefits arrangements)	Up to 12 weeks in a 24-month period	Varies (statute contemplates interaction with benefits)	Evaluate how job-protected leave coordinates with any wage-replacement benefits and employer policies; avoid treating the program as a single "one-stop" rule set.
Maine	Maine Family Medical Leave Requirements (Title 26, § 844)	Unpaid (job-protected)	Up to ten work weeks in any 2-year period	N/A (job-protection statute)	Applies at a lower employer-size threshold than federal FMLA; if employer provides fewer than 10 weeks of paid leave, the balance must be available as unpaid leave.
Oregon	Paid Leave Oregon	Paid	Up to 12 weeks in a 52-week period (up to 14 weeks for certain pregnancy-related situations)	1% payroll contribution; generally 60% employee/40% large employer; small-employer rules; optional self-employed opt-in	Payroll setup is central: withhold/remit contributions, confirm employer-size status, and apply wage caps/ limits by year.
District of Columbia	Universal Paid Leave (UPLF)	Paid	Up to 12 weeks (parental/family/ medical) + up to 2 weeks prenatal	Employer-paid payroll tax (0.75% noted in 2027 publication)	Treat as an employer tax funding a state-run benefit; confirm current rate and taxable reporting (1099-G) for benefits.
Rhode Island	Temporary Caregiver Insurance (TCI) (part of TDI)	Paid (wage replacement); job protection obligations noted	Up to 4 weeks	Employee payroll deductions (finances TDI/TCI)	Confirm deductions and coordinate job protection/return-to-work obligations with employer leave policies and any other applicable statutes.
Minnesota	Minnesota Paid Leave (begins Jan 2026)	Paid	Begins Jan 2026; max weeks not stated in cited MN Revenue materials	State program; administered by DEED; benefits reported on 1099; optional withholding; special federal tax treatment described	Plan now for launch: configure payroll and employee communications around 1099 reporting/ optional withholding, and understand federal tax treatment distinctions described in MN guidance.

Chart continues on next page

State	Program Name	Paid vs. Unpaid	Max Weeks	Funding	Compliance Note
Colorado	FAMLI (Family and Medical Leave Insurance)	Paid (benefits referenced in CO tax guidance)	Not specified on CO tax site	State program; CO income tax subtraction guidance references 1099-G	CO tax materials address how benefits flow through federal income and CO subtraction; program operations/eligibility are administered outside the tax agency site.

TAKEAWAYS FOR ADVISORS

For brokerage firms advising employers on payroll, benefits, and workforce compliance, family and medical leave has evolved into a multijurisdictional concern rather than just a federal issue. State laws may vary regarding employer coverage, leave duration, pay replacement, employee contributions, and administrative reporting. These differences can significantly impact payroll setup and leave coordination.

The key takeaway is simple: **when a client has employees in multiple states, check each state's rules instead of assuming the federal FMLA applies**. The chart in this article highlights selected paid programs and key unpaid FMLA-type statutes for a manageable set of jurisdictions, but it is not a comprehensive 50-state survey. Therefore, reviewing state-specific regulations is crucial before implementing payroll processes, leave policies, or multistate compliance procedures.

ADA TITLE II DIGITAL ACCESSIBILITY DEADLINES EXTENDED

The Department of Justice's ADA Title II web and mobile accessibility rule requires covered state and local government entities to ensure their digital services are accessible to individuals with disabilities. This includes employee benefit enrollment portals, claims tools, wellness platforms, and online benefit communications.

The 2024 final rule established phased-in compliance dates based on population size. However, as published in the ***Federal Register*** on April 20, 2026, the deadlines have been extended. The new compliance dates are:

- **April 26, 2027**, for public entities with populations of 50,000 or more
- **April 26, 2028**, for public entities with populations under 50,000 and all special district governments

The extension provides additional time for state and local government employers to assess health plan enrollment websites, FSA and HRA portals, wellness platforms, and online SPDs or benefit summaries. Employers should use this time to identify potential accessibility gaps and work toward compliance before the applicable deadline.

WHO PAYS FIRST? MEDICARE SECONDARY PAYER (MSP) RULES

Michelle Barki, RN, Esq.
Senior Legal Counsel

For employers with active group health plans, Medicare Secondary Payer (MSP) rules are easy to overlook until they create a problem. But when an employee or dependent becomes eligible for Medicare, these rules determine which coverage pays first, the primary payer, and which pays after that, the secondary payer. Getting that order wrong can lead to claim issues, employee confusion, administrative headaches, and potential compliance exposure.

In this article, we provide a practical overview of MSP rules and key guidance for your employer clients.

WHY THIS MATTERS

- [x] Multigenerational workforces
- [x] Employees working past 65
- [x] More Medicare questions
- [x] COBRA confusion
- [x] Reimbursement risk

WHEN THE EMPLOYER GROUP HEALTH PLAN IS PRIMARY

Generally applies when the individual has coverage based on current employment status and the employer meets the applicable size threshold.

EMPLOYEES AGE 65 OR OLDER: 20+ EMPLOYEES

If an employee age 65 or older is covered under a group health plan because of **current employment**, either their own or a spouse's, and the employer has **20 or more employees**, the **employer plan generally pays first**, and Medicare is secondary.

In plain English: if the employer is large enough and the person's coverage is tied to active work, the employer plan usually pays first.

This rule matters not only for active employees but also for spouses age 65 or older who are covered under the active employee's plan. Employers should not assume that Medicare automatically becomes the first payer just because someone has turned 65.

Article continues on next page

DISABLED INDIVIDUALS UNDER AGE 65: 100+ EMPLOYEES

For individuals entitled to Medicare due to disability and covered under a group health plan based on **current employment status**, the **employer plan is generally primary** if the employer has **100 or more employees**.

Again, the key questions are:

1. Is the coverage tied to current employment?
2. Does the employer meet the 100-employee threshold?

If the answer to both is yes, the group health plan generally pays first.

END-STAGE RENAL DISEASE (ESRD) CASES

Individuals eligible for Medicare due to end-stage renal disease (ESRD) follow separate MSP coordination rules. During the applicable coordination period, an employer group health plan **may be required to pay first, regardless of employer size**.

ESRD cases should never be handled casually. Because these rules differ from the age-65 and disability rules, employers and brokers should carefully review Medicare entitlement dates, dialysis or transplant-related eligibility timing, and the individual's coordination period before making any assumptions about payer order.

WHEN MEDICARE IS PRIMARY

Generally applies to non-active employees or small-employer situations.

SMALL EMPLOYERS BELOW THE APPLICABLE THRESHOLD

If an employer falls below the applicable size threshold, **Medicare typically pays first.**

Example 1: For employers with fewer than 20 employees, Medicare usually pays first for employees or spouses age 65+.

Example 2: For employers with fewer than 100 employees, Medicare usually pays first for disabled Medicare beneficiaries covered due to current employment status.

This is why accurate employee counts matter. A casual or inconsistent approach to counting can lead to incorrect enrollment guidance and incorrect claim assumptions.

Article continues on next page

RETIREE COVERAGE

Coverage offered to retirees is generally not treated the same as coverage based on current employment status. In many retiree coverage situations, Medicare is primary, and the retiree plan pays secondary.

This distinction is important because retirees often assume that employer-sponsored retiree coverage works like active-employee coverage, when, in fact, it does not. Employers should ensure retiree communications clearly explain how coverage coordinates with Medicare.

COBRA COVERAGE

COBRA is a frequent point of confusion. Many employees believe that if they elect COBRA, they can delay Medicare enrollment without consequence or rely on COBRA as if it were active coverage. In many cases, that is not correct.

As a general rule, **COBRA coverage is not treated the same as coverage based on current employment status for MSP purposes**. As a result, **Medicare is often primary** for a Medicare-eligible individual on COBRA.

This also carries practical enrollment consequences beyond MSP, as COBRA generally does not provide the same Medicare enrollment protections as active employment-based coverage. Employers and brokers should encourage employees to seek individualized guidance before assuming COBRA can substitute for Medicare enrollment.

OTHER NON-ACTIVE COVERAGE SITUATIONS

Any time coverage is not tied to current employment status, employers should pause before assuming the group plan pays first. This includes situations involving:

- Retirees and former employees
- Certain severance arrangements
- Other continuation or non-active coverage structures

The core principle is simple: **active coverage and non-active coverage are treated differently**, and that difference often determines whether Medicare is primary.

Article continues on next page

COMMON COMPLIANCE PITFALLS

STEERING EMPLOYEES TO DROP THE GROUP PLAN FOR MEDICARE

One of the biggest MSP risks is improperly steering Medicare-eligible employees or their spouses to leave the employer plan when the employer plan is required to pay first. This can include encouraging active employees age 65+ to move to Medicare, requiring Medicare enrollment to remain on the plan, offering incentives to leave active coverage, or incorrectly communicating that Medicare should pay first. While these actions may be intended to help employees save money, they can create MSP discrimination concerns in active coverage situations.

UNEQUAL BENEFITS FOR MEDICARE-ELIGIBLE INDIVIDUALS

Employers should not offer lesser benefits to active employees or their spouses simply because they are entitled to Medicare. Under MSP rules, Medicare-eligible individuals generally must be offered the same coverage under the same conditions as similarly situated non-Medicare-eligible employees.

Potential red flags include charging higher premiums, reducing benefits after age 65, carving out services expected to be covered by Medicare, or applying special restrictions only to Medicare-entitled individuals.

MISHANDLING MEDICARE PREMIUM REIMBURSEMENT ARRANGEMENTS

Employers sometimes reimburse or directly pay Medicare premiums, such as Part B or Part D, as a benefit for older workers or retirees. However, these arrangements can create compliance concerns because they may be treated as an employer payment plan or another type of group health plan.

Potential risks can arise when employers reimburse premiums on a pre- or post-tax basis, offer stand-alone reimbursement arrangements, substitute Medicare reimbursement for group health coverage, or provide informal premium assistance outside a compliant structure. Even well-intentioned arrangements should be carefully reviewed before implementation.

NEXT STEPS FOR YOUR EMPLOYER CLIENTS

The best broker guidance is practical, repeatable, and tied to everyday administration. MSP compliance is not just a legal issue; it is an operational issue.

1 GATHER CORRECT DATA UP FRONT

Brokers should encourage clients to document:

- Status (employee, spouse, retiree, COBRA, etc.)
- Medicare eligibility reason (age, disability, ESRD)
- Employer size for MSP threshold purposes
- Affiliated entities or controlled group rules affecting counting
- Key coverage and Medicare effective dates

Accurate data is the foundation of correct MSP administration.

Article continues on next page

2 UPDATE HR MATERIALS & COMMUNICATIONS

Brokers should recommend a review of:

- Open enrollment guides
- New hire materials
- Medicare-eligibility FAQs
- COBRA and retiree communications
- HR scripts for employee questions

Materials should clearly explain that Medicare does not always pay first and that payer order depends on active employment status, employer size, and the reason for Medicare entitlement.

A good communication strategy avoids blanket statements like: "Once you turn 65, Medicare becomes primary."

---

3 REVIEW REIMBURSEMENT ARRANGEMENTS

Before reimbusing Medicare premiums, brokers should ask clients:

- Is the arrangement limited to a certain class of individuals?
- Is it tied to active employees, retirees, or both?
- Is it intended to replace major medical coverage?
- Is it documented?
- Has counsel reviewed whether it creates an employer payment plan or other compliance issue?

Informal premium assistance can significant larger compliance concerns.

---

4 COORDINATE INTERNAL TEAMS

MSP compliance is rarely owned by one department. Brokers should advise clients to align teams involved in:

- HR and benefits administration
- Payroll
- Third-party administrators (TPAs)
- COBRA vendors
- Retiree billing teams
- In-house legal or finance stakeholders

Consistency helps reduce claim issues, enrollment errors, and conflicting guidance.

---

5 TRAIN FRONT-LINE HR STAFF

Front-line HR professionals are often the first people employees call when they approach age 65, go out on disability, or move onto COBRA. Brokers should help clients equip those team members with training focused on:

- Fact-specific MSP determinations
- Avoiding one-size-fits-all answers
- Escalating ESRD and disability cases
- Avoiding perceived steering off the plan
- Knowing when to refer employees for additional guidance

A simple decision tree or FAQ can be far more effective than relying on informal verbal guidance.

ACA MEASUREMENT PERIODS: A REFRESHER FOR EMPLOYERS

Michelle Barki, RN, Esq.
Senior Legal Counsel

Many employers still struggle with the Affordable Care Act's look-back rules, and understandably so. But these rules matter because they help determine which employees must be offered health coverage to avoid potential employer shared responsibility penalties under IRC Section 4980H(a).

For employees with steady hours, the answer is often simple. For employees whose hours fluctuate, employers typically use the ACA's look-back measurement method to determine whether they averaged enough hours to be treated as full-time.

HOW IT WORKS: THREE KEY PERIODS

MEASUREMENT PERIOD

Hours are tracked over a defined period.

ADMINISTRATIVE PERIOD

Time to determine eligibility and process enrollment.

STABILITY PERIOD

The employee's status is locked in, regardless of actual hours worked.

WHAT IS A VARIABLE-HOUR EMPLOYEE?

A variable-hour employee falls between clearly full-time and clearly part-time. In other words, the employer cannot confidently determine expected hours at hire.

FULL-TIME

Expected to average 30 or more hours per week

VARIABLE-HOUR

Employer cannot reasonably determine whether the employee is expected to average at least 30 hours per week

PART-TIME

Expected to average below 30 hours per week

Article continues on next page

HOW LONG CAN THESE PERIODS BE?

For ongoing employees, the standard measurement period can be between 3 and 12 months. If an employee measures as full-time, the stability period must be at least 6 consecutive months and cannot be shorter than the measurement period. An administrative period may be used between those periods, but it cannot effectively shorten or extend the measurement or stability period, and generally cannot exceed 90 days.

For new variable-time employees, the initial measurement period is also between 3 and 12 months. Employers may then use an administrative period, but the combined initial measurement period and administrative period generally cannot extend beyond the last day of the first calendar month beginning on or after the employee's first anniversary date—often described as a maximum of 13 months plus a partial month.

WHAT HAPPENS WHEN THE MEASUREMENT PERIOD IS LESS THAN 6 MONTHS?

For ongoing employees who do not measure as full-time, the follow-up stability period cannot exceed the measurement period.

For new variable-time employees who are not measured as full-time, the stability period generally cannot exceed 1 month beyond the initial measurement period and is also capped by the remainder of the first full standard measurement period, plus any administrative period.

THE 3-MONTH/ 12-MONTH PROBLEM

A common mistake employers make is using a 3-month measurement period and then applying a 12-month stability period to employees who are not full-time.

Under ACA rules, the stability period for employees who do not measure as full-time generally cannot be longer than the measurement period. As a result, a 3-month measurement period will typically support no more than a 3-month non-full-time stability period.

While short measurement periods can work, they come with important limitations that employers should understand before implementing them.

Article continues on next page

PRACTICAL TIPS FOR EMPLOYERS

REVIEW YOUR PLAN DESIGN

Ongoing employees and new variable-hour employees are not always treated the same, and employees who measure as full-time are treated differently from those who do not.

BE CAUTIOUS WITH SHORT MEASUREMENT PERIODS

While a 3-month period may seem easier to administer, it often creates compliance issues when the employer also wants a longer stability period for non-full-time employees. Many employers find that longer, more balanced periods are easier to administer and defend.

DOCUMENT VARIABLE-HOUR CLASSIFICATIONS

If a new hire was actually expected to be full-time, classifying them as variable-hour may create ACA exposure later. Consistent hiring and classification practices are essential to avoid mistakes.

THE BOTTOM LINE

ACA measurement period rules are manageable, but they need to be designed carefully. A quick check of your current approaches, especially if you are using a short measurement period and a long stability period, can help prevent costly errors later.

MEDCOM'S TRAINING OPPORTUNITIES

ON THE ROAD TO COMPLIANCE: 5-PART ERISA TRAINING PROGRAM

Jun. 4 – Jul. 2 | Thursdays at 1:00 p.m. ET

A five-week virtual ERISA training for brokers guided by Medcom's compliance experts who will break down key rules, real-world challenges, and practical strategies to help you support your clients with confidence.

COMPLIANCE RECHARGE SERIES

Every other Thursday | 3:00 p.m. ET

A biweekly series designed for benefit brokers & consultants packed with timely insights, actionable guidance, and answers to your toughest compliance questions!

EMPLOYEE BENEFITS & COMPLIANCE TRAINING FOR HR PROFESSIONALS

Jun. 3 - Jul. 22 | Wednesdays at 3:00 p.m. ET

A live, 8-part virtual series designed for HR professionals, focused on key topics in employee benefits compliance. New session on AI in HR added!

HIPAA PRIVACY & SECURITY TRAINING

24/7 On-Demand

This course helps meet annual HIPAA training requirements for any organization handling PHI, including providers, plan sponsors, business associates, third-party administrators, and brokers.

Explore upcoming trainings and register on Medcom's [Learning Hub.]

UPCOMING DEADLINES

JUL 1 — MEDCOM'S FORM 5500 INFO SUBMISSION DEADLINE

Deadline to submit all required Form 5500 information and documentation to Medcom,to support timely filing preparation. Filings received after July 1 may be subject to a $100 late processing fee.

JUL 27 — MEDCOM BEGINS FORM 5500 EXTENSION SUBMISSIONS

Medcom will begin filing extensions for outstanding Form 5500 filings that have not been finalized and signed to help plans meet DOL deadlines.

JUL 31 — REPORT AND PAY PCORI FEE

Employers with self-insured health plans are required to report and pay an annual fee to the Patient-Centered Outcomes Research Institute (PCORI) using IRS Form 720 by July 31 of the year following the end of the plan year.

JUL 31 — FORM 5500 FILING DEADLINE

ERISA welfare benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year unless eligible for an extension by filing Form 5558. For calendar-year plans, this deadline is July 31.

SEP 30 — MEDICAL LOSS RATIO (MLR) REBATES DUE

Fully insured health plans may be eligible for rebates if their issuers do not meet the required MLR percentage. Rebates must be provided to plan sponsors by September 30 following the end of MLR reporting year.

SEP 30 — DISTRIBUTE A SUMMARY ANNUAL REPORT (SAR)

Employers that file Form 5500 must distribute a Summary Annual Report (SAR) to participants within nine months after the close of the plan year. For calendar-year plans, this deadline is September 30.

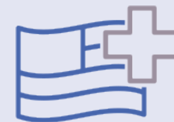
ACA EMPLOYER REPORTING

COBRA PREMIUM BILLING ADMINISTRATION

CONSUMER DRIVEN HEALTH PLANS

HEALTH & WELFARE COMPLIANCE

HIPAA PRIVACY & SECURITY



GOVERNMENT HEALTHCARE PROGRAMS

Connect with us