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Roundup of selected state health developments, third-quarter 2026

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Highlighting the third quarter of 2026, California was the most active state, with developments on paid family and medical leave (PFML), prescription drug coverage, and insurance mandates, among other activity. Several states updated PFML rates for next year, and Minnesota and New York City issued guidance on their paid sick and safe leave (PSSL) laws. Courts ruled on pharmacy benefit manager (PBM) laws in Arkansas and Illinois, upholding the former and stopping the latter. Delaware passed four insurance laws. Alaska and Pennsylvania enacted telehealth laws. Finally, new Medicaid-related laws in California and New Jersey affecting employers in those states were challenged in court.

PFML

California broadened eligibility for qualifying exigency leave under its paid family leave (PFL) law. Colorado, Connecticut, Massachusetts, Minnesota, New Jersey, and New York published their 2027 rates. Colorado also made minor changes to its regulations. Maine and Massachusetts addressed

medical and family leave contributions for federal tax purposes. Washington, DC, decreased the duration for two types of PFML and reduced the maximum weekly benefit. For details on PFML laws, see State paid family and medical leave contributions and benefits (October 19, 2026), Paid family and medical leave — snapshots across the US (slide deck) (October 19, 2026), and Virginia hits 'back of the net' on PFML; who's next? (June 24, 2026).

California

As a result of 2026 Ch. 729 (AB 2054), the definition of "covered active duty" will change, expanding eligibility for qualifying exigency PFL in these ways:

- Deployment can be domestic instead of just foreign.
- State active duty and training are included.
- National Guard members are covered.

These changes are effective no later than July 1, 2028, or sooner once PFL is incorporated into the state Employment Development Department's integrated claims management systems.

Colorado

Colorado decreased the overall contribution rate from 0.88% (2026) to 0.86% (2027) of wages. Employers with 10 or more employees nationally must contribute half of that amount. Smaller employers need not contribute, but covered employees must still contribute the other half.

In addition, the Family and Medical Leave Insurance (FAMLI) Division adopted slight revisions to their regulations. Here are the highlights:

- **Benefits.** An employee can submit a "Neonatal Care Leave Certification Form," signed by a healthcare provider, in order to document the leave. Separately, if an employee replaces the absence with additional work meant to offset the absence (e.g., picking up a shift to cover their absence), it is not considered PFML.
- **Private Plans.** Private plan approval will now last indefinitely until/unless otherwise terminated. The duration has been eight years.

Connecticut

By statute, the maximum weekly benefit is 60 times the state minimum wage. The 2027 hourly minimum wage will increase by 3.2% from $16.94 to $17.48, increasing the maximum weekly benefit from $1,016.40 (2026) to $1,048.80 (2027), up to the Social Security maximum wage base (SS max).

Maine

Maine updated its employer FAQs and employee FAQs to address taxation of PFML benefits in 2026 and the changes that will occur in 2027 under the public program. The tax guidance does not apply to private plans. Here is a summary:

- **Tax treatment of benefits.** For 2026, the Maine Department of Labor (MDOL) is treating medical leave benefits as income, issuing a Form 1099-G. These benefits will not be subject to FICA withholding in 2026. For 2027 and beyond, MDOL will treat the taxable portion of medical leave benefits as wages. The program administrator (Aflac) will withhold and remit FICA, and issue a Form W-2.
- **Employer portion of FICA.** Starting in 2027, MDOL will pay the employer portion of FICA and cover any associated costs "during the initial phase of the program to reduce complexity." MDOL reserves the right to change course in the future.
- **Continued payment of wages.** Some employers may want to continue an employee's compensation while a claim is pending and during the seven-day waiting period (applicable to medical leaves only). If so, these payments are considered an advance against earnings and can be deducted from a future paycheck if the employee is later approved for benefits in the same week. The employee must agree in writing. Remember that employees can use accrued paid sick, vacation, or other PTO during the medical leave waiting period, and employers and employees may mutually agree to top off PFML benefits with these accrued paid leaves.

Massachusetts

Tax treatment of benefits. Massachusetts specifies the contribution allocation between medical and family leave. Currently, employees pay 40% of the medical leave benefit and 100% of the family leave benefit. Effective January 1, 2027, 2026 Ch. 101 (HB 5470) changes the allocation: Employees will pay 100% of the medical leave contribution and 40% of the family leave contribution. The result will not alter the overall contribution split between employer and employee but has the effect of changing the tax consequence for benefits. As a result of the change, medical leave benefits will be tax free to employees.

2027 rates. Here are the rates:

Limits	2027	2026
Required employer contributions (% of wages)		
• 25 or more Massachusetts employees (medical leave portion only)	0.0%	0.42%
• Fewer than 25 Massachusetts employees	0.42%	0.0%
Required employee contributions	0.46%	0.46%
• Family leave portion	0.28%	0.18%
• Medical leave portion	0.18%	0.28%

Limits	2027	2026
Maximum annual wage base	SS max	SS max
Maximum weekly benefit	$1,284.61	$1,230.39

For additional background on the federal tax treatment of PFML contributions and benefits, see IRS clarifies taxation of state and DC PFML contributions, benefits (January 13, 2026).

Minnesota

The maximum weekly PFML benefit is equal to 100% of the state average weekly wage (AWW). Effective October 1, the state AWW is $1,476, up from $1,423.

New Jersey

Here are the 2027 rates for temporary disability insurance (TDI) and family leave insurance (FLI), which together constitute PFML in the state:

Limits	2027	2026
Taxable wage base	$177,100	$171,100
Maximum TDI/FLI weekly benefit	1,158	1,119

New York

Here are the 2027 rates for FLI and the disability benefits law (DBL) which together constitute PFML in the state:

FLI/DBL Rates & limits	2027	2026
Employee PFL contribution rate	0.452%	0.432%
Maximum annual employee PFL contribution limit	$451.81	$411.91
Employee DBL contribution rate	No change	0.5%
Maximum weekly employee DB contribution limit	No change	$0.60

Washington, DC

Two laws together made immediate and permanent changes to leave duration, the maximum weekly benefit, and solvency for Universal Paid Leave (UPL), Washington, DC's PFML law. The Fiscal Year 2027 Budget Support Emergency Act (Act 26-0416, B26-0724) took immediate effect on August 13, making temporary changes that expire on November 11. The Fiscal Year 2027 Budget

Support Act (Act 26-0418, B26-0661) is now law after a required Congressional review period and carries forward the same changes made by the emergency law. Here is a summary of the changes that apply to UPL claims filed on or after October 1:

- **Duration.** Family leave drops from 12 to six weeks, and medical leave drops from 12 to 10 weeks in a 52-week period. Parental leave and prenatal leave remain at 12 and two weeks, respectively. The maximum duration in a 52-week period also stays at 12 weeks. For claims on or after October 1, 2030, family leave and medical duration will return to the current 12-week levels.
- **Maximum weekly benefit.** The cap will decrease from $1,190 to $1,100, and will be increased annually thereafter based on inflation.
- **Solvency issues.** The legislation requires six months of solvency in the UPL fund. Benefit payments will stop if the fund falls below three months of solvency and will not restart until the fund has nine months of solvency.

Other types of leave

California expanded its bereavement leave law. Illinois will require employers with more than 25 employees to provide paid jury duty leave. A Michigan law gives employers a corporate income tax credit for paid organ donation leave. San Francisco reduced the eligibility requirements under its Paid Parental Leave Ordinance (PPLO). For details on PSSL laws, see Roundup: State accrued paid leave mandates (July 23, 2025).

California

Under 2026 Ch. 679 (SB 1149), the family member definition for job-protected bereavement leave will include one designated person identified by the employee every 12 months. A designated person is any individual related to the employee by blood or whose association with the employee is the equivalent of a family relationship. The law takes effect January 1, 2027. Employers with five or more employees must provide up to five days of bereavement leave upon the death of a family member, currently limited to a spouse, child, parent, sibling, grandparent, grandchild, or domestic partner. Leave can be unpaid and must be used within three months of the date of death. Employees can use vacation, personal leave, accrued sick leave, or paid time off. The expanded family member definition aligns with recent changes to other state leave laws. For background, see Bereavement leave policies present legal considerations for employers (May 30, 2024).

California — San Francisco

The PPLO requires employers with at least 20 employees worldwide to provide up to eight weeks of child-bonding leave at 100% of wages, subject to a weekly cap. To be eligible, employees must meet these four requirements:

- Work for the current employer at least 180 days

- Be eligible for state PFL benefits for new child bonding
- Work at least eight hours per week in San Francisco
- Work at least 40% of total hours in San Francisco

This benefit typically is a top-off payment because California's PFL law applies. A PPLO amendment reduces the first eligibility requirement to 90 days, effective on January 1, 2027, for employers with 100 or more employees, and on January 1, 2028, for employers in the 20-99 range.

Illinois

Under 2026 Pub. Act 104-0683 (HB 4844), employers with more than 25 employees must pay employees while on jury duty at their regular rate of pay. The law has no duration or reimbursement cap. Current law requires employers of all sizes to provide job-protected leave. Employees must notify employers by giving a copy of the summons within 10 days of issuance. The law will take effect January 1, 2027.

Michigan

Per 2026 Pub. Act 39 (SB 301), employers will receive a nonrefundable 100% corporate income tax credit for providing up to 12 weeks of paid organ donation (including bone marrow) leave, starting with the 2026 tax year. The employer must maintain a written organ donation leave policy, and all other leave benefits must be exhausted. The state already provides an employer tax credit (also capped at 12 weeks) for paid adoption leave.

Rx

The Arkansas Insurance Department imposes an annual reporting requirement; an appeals court upheld its application to self-funded ERISA plans. Another appeals court concluded that an Arkansas PBM law's network adequacy requirements were preempted by ERISA. A California law is the subject of an ongoing ERISA preemption challenge. A separate California insurance law addresses prescription drug access. Portions of an Illinois PBM law were stopped in court.

Arkansas

The Seventh Circuit Court of Appeals affirmed a lower court decision in *Central States SE & SW Areas Health & Welfare Fund v. McClain*, concluding that ERISA did not preempt Rule 128. Under the rule (in effect since late 2024), plans must pay pharmacies "fair and reasonable" dispensing fees and report pharmacy compensation data to the state. However, the Court suggested that the ERISA preemption argument may have greater force with respect to the law's reporting provision when new ERISA Sec. 726 takes effect for plan years starting 30 months after February 3, 2026, as a result of the Consolidated Appropriations Act, 2026. That provision imposes upon plans uniform reporting requirements for similar pharmacy compensation data.

The Eighth Circuit Court of Appeals affirmed a lower court decision in *Flowers v. Caremark PCS Health*, holding that two parts of existing law — provisions on mail-order delivery and network adequacy — were preempted by ERISA. Specifically, the court saw the law's geographic coverage restrictions as an attempt to "bulldoze through [ERISA's] objectives, requiring PBMs to tailor and retailor their networks — and perhaps even build new brick-and-mortar pharmacies — to comply with a set of exacting particularities."

California

Lawsuit. A federal district court dismissed an ERISA preemption case brought by the Pharmaceutical Care Management Association (PCMA), contesting PBM fiduciary duties imposed by 2025 Ch. 605 (SB 41) and effective since 2019. The judge concluded that PCMA failed to show the law "requires PBMs to alter their business practices and imposes concrete, nonspeculative compliance burdens on PBMs." The judge granted PCMA the right to amend its complaint, which it did in mid-August.

New law. Under 2026 Ch. 1007 (SB 1094), fully insured plans cannot limit or exclude coverage of a previously approved drug if the prescriber continues to prescribe it, and it is appropriately prescribed and considered safe and effective. Existing law already requires this continuing coverage of health care service plans (including HMOs). Under the new law, fully insured plans and health care service plans may require participants to try biosimilar or interchangeable biological products if these conditions are met:

- The prescriber did not indicate "Do not substitute."
- The substitute's net plan cost is lower.
- Cost sharing is based on net cost and is the same or less than before.
- The plan provides at least 60 days' advance notice.
- The prescriber is not required to seek a new prior authorization.
- Utilization is not limited to a biosimilar in which the plan, PBM, or affiliated entity has direct or indirect financial interest when another biosimilar is available.

The law also requires these plans to cover at least one biosimilar or interchangeable biological product if lower net cost than the reference product. The law will take effect for plan years starting in 2027. By October 1, 2027, these plans must report to the Department of Managed Health Care (DMHC) and Department of Insurance (CDI) on biosimilar prescribing, particularly how it affects premiums and cost sharing.

Illinois

A federal district court enjoined the reporting and network design (anti-steering) requirements of the Prescription Drug Affordability Act as applied to ERISA-covered plans, first effective this year.

The court ruled on ERISA preemption grounds, concluding: "The State's strong interest in enforcing its own laws must yield to Congress's decision more than 50 years ago to expressly preempt 'any and all State laws as they may now or hereafter relate to any employee benefit plan.'"

Insurance

California passed laws requiring adolescent hearing aid coverage and heightened mental health parity compliance, prohibiting transgender identity discrimination, and adjusting participant notice requirements when provider network status changes. Delaware enacted four insurance laws, including ones requiring coverage for menopause, mental health conditions, and vaccines, as well as a law requiring reference-based pricing (RBP) for hospital services. A Hawaii law requires fully insured plans to cover standard fertility preservation services when medically necessary treatment might cause iatrogenic infertility. The Menopause Equity and Care Act makes Illinois the latest state to mandate fully insured coverage of perimenopause conditions.

California

Mental health parity (2026 Ch. 915, AB 2011). Fully insured plans and health care service plans must meet federal regulations, rules, and other guidance under the Mental Health Parity and Addiction Equity Act (MHPAEA) that existed on January 1, 2025. DMHC and CDI are tasked with issuing guidance. The law takes effect January 1, 2027. However, many of the provisions in the federal regulations — issued on September 23, 2024 — had an effective date for plan years starting on or after January 1, 2025. Notably, last year the federal tri-agencies announced a nonenforcement policy on these rules.

Hearing aids (2026 Ch. 966, SB 331). The Let California Kids Hear Act requires fully insured large group plans to cover medically necessary hearing aids and related services for participants under age 21. These plans may cap coverage at $3,000 per hearing aid device and limit new hearing aids to once every three years, unless the existing hearing aids are no longer functional or no longer meet the participant's medical needs and cannot be altered. Coverage is on a pre-deductible basis, subject to exception for HSA-qualifying high-deductible health plans. Coinsurance is capped at 10%. The law takes effect for plan years starting in 2028.

Transgender identity (2026 Ch. 903, AB 1876). The Fair Care for All Act prohibits fully insured plans and health care service plans from discriminating based on race, color, national origin, age, disability, or sex. Sex-based discrimination includes sex characteristics (including intersex traits), pregnancy and related conditions, sexual orientation, gender identity, and sex stereotypes. Among the prohibitions is a denial or categorical exclusion of gender transition services or other gender-affirming care. The law appears to take effect on January 1, 2027.

Participant notices (2026 Ch. 306, AB 2613). In recent years, plan sponsors have seen health system contract negotiations affect network access. Under existing law, health care service plans must provide at least 60 days written notice to participants assigned to a provider terminating from the network or assigned to a provider that has admitted at least one enrollee to a

terminating acute care hospital in the past 12 months. Under the new law, the notice must be sent by email or text if the participant has opted into electronic communications. In addition, notice upon a provider's contract renewal or decision not to terminate the contract is required within 10 business days of approval by DMHC. The law appears to take effect on January 1, 2027.

Clarification. Health care service plans include HMOs subject to California law.

Delaware

Menopause (2026 Ch. 482, SB 319). All individual, group, and blanket insurance policies must cover medically necessary diagnostic services and treatment for menopause, perimenopause, and related symptoms. The mandate includes FDA-approved hormone replacement therapy (HRT). HRT prior authorization and step therapy are prohibited.

Mental health conditions (2026 Ch. 480, SB 22). The law expands an existing insurance requirement coverage of serious mental illnesses and drug and alcohol dependencies, expanding the scope to encompass medically necessary services for mental health (MH) and substance use disorders (SUDs), as required by the MHPAEA. Plans must place at least one formulation of each FDA-approved SUD drug on the lowest-cost formulary tier. Plans must also cover medically necessary out-of-network services without additional cost to participants if in-network options are unavailable. If a plan covers MH/SUD benefits in any classification, it must provide meaningful benefits for that disorder in every classification for which medical or surgical benefits are provided. Insurers must provide a copy of the nonquantitative treatment limitation analysis to participants, prospective participants, and providers within 30 days of request.

Vaccines and other preventive services (2026 Ch. 419, HB 338). The law, now in effect, requires fully insured plans to cover at no cost, vaccines and other preventive services that were recommended as of January 1, 2025, by the Advisory Committee on Immunization Practices, Health Resources and Services Administration, and the United Sates Preventive Services Task Force. Vaccine coverage also extends to other immunizations that were supported by national clinical guidelines or standards of care in effect on January 1, 2025. Plans may not deny coverage for preventive care items and services simply because they are not currently recommended by these federal entities.

SB 319 (menopause coverage requirement) and SB 22 (MH/SUD coverage requirements) are effective for policies issued, renewed, or modified on or after December 31, 2027.

RBP law (2026 Ch. 348, SS 2 for SB 1). Starting with insurers' 2028 rate filings, the costs of inpatient, outpatient, and emergency department services at hospitals cannot exceed a Medicare RBP target, defined as a percentage of the full Medicare rate. Percentages will be as follows:

Filing year	Percentage of Medicare	
	Outpatient	Inpatient & emergency
2028/2029 (for 2029/2030 plan years)	275%	310%

Filing year	Percentage of Medicare	
	Outpatient	Inpatient & emergency
2030/2031 (for 2031/2032 plan years)	250%	275%
2032 & beyond (for 2033 & later years)	250%	250%

Different Medicare pricing targets apply to the state's one free-standing children's hospital, as well as the state governmental health plan. Exceptions exist, including services provided by Medicare-dependent rural hospitals and urban Medicaid hospitals.

This law has gone through several iterations, given considerable push-back from hospitals. However, a recent report cited a RAND study, showing Delaware with some of the highest hospital prices in the country. Once the department of insurance (DOI) issues regulations, fully insured plans must offer a value-based care program compliant with DOI standards. Existing law sets a floor for plans' primary care spending through the 2026 plan year (11.5% of total medical care cost); the new law continues the 11.5% floor after January 1, 2027.

Hawaii

Under 2026 Act 218 (HB 1864), insurers, mutual benefit societies, and HMOs must provide standard fertility preservation services for any insured who may undergo medically necessary treatment that may directly or indirectly cause iatrogenic infertility. This excludes experimental procedures, third-party assisted reproduction (e.g., donor egg, sperm retrieval, surrogates, and gestational carriers), and cryopreservation storage. The law will take effect for plan years starting in 2027.

Illinois

Under 2026 Pub. Act 104-0793 (HB 5284), individual and group fully insured health plans must cover treatments related to perimenopause, effective for plan years starting in 2028. Current law requires coverage for menopause treatments, including all FDA-approved hormonal and nonhormonal options. The expanded coverage must include medications for menopause-related osteoporosis and nonhormonal therapies for vasomotor symptoms. Plans covering more than 25 employees must also cover at no cost to plan members 45 years or older annual perimenopause health visits, subject to an exception for HSA-qualifying high-deductible health plans. Current law already requires this for menopause. In addition, the state's Human Rights Act was amended to ban employment discrimination and harassment based on menopause-related conditions, effective January 1, 2027.

Extraterritorial application of laws in this section

Here is a summary of how the laws in this section apply on an extraterritorial basis to fully insured plans issued in another state:

Not applicable. Illinois generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued outside the state.

Unclear. It is not fully clear whether Delaware applies its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

California. With a few exceptions (like domestic partner and fertility coverage), California generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, as long as both an employer's principal place of business and a majority of employees are located outside of California.

Hawaii. This state generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. While the law does not affect self-funded ERISA plans, those plans are uncommon in the state given the state's preapproval requirement.

All of these insurance laws do not apply to self-funded ERISA plans. For a discussion on extraterritoriality, see this Beyond state lines: A primer on insurance law extraterritoriality (March 26, 2025).

Telehealth

A new Alaska law requires fully insured plans to reimburse telehealth providers at the same rate as in-person providers. Pennsylvania enacted a law that enables the state to join a professional counseling compact. For background on a multistate psychology compact, see this PSYPACT gets an A (for access, among other things) (May 29, 2025).

Alaska

Per 2026 Ch. 57 (HB 14), fully insured plans must reimburse all telehealth services, including behavioral health, at the same rate as in-person services. An exception allows for a geographic pay differential to reimburse out-of-state providers. This portion of the law will take effect January 1, 2027. Alaska generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Pennsylvania

Under 2026 Act 23 (SB 604), the state joined the professional counseling compact. Interstate compacts like these have the effect of broadening access to mental health services across state lines.

Other benefit-related issues

California's increased benefit tax linked to Medicaid funding still requires additional approval and is now in litigation. New Jersey's Medicaid-related employer assessment is also in the courts. See

States eye Medicaid taxes that could affect employers (July 30, 2026). San Francisco published its Health Care Security Ordinance (HCSO) rates and Health Care Accountability Ordinance (HCAO) standards for 2027. Seattle issued the 2027 rates for its hotel industry healthcare mandate.

California

At the end of June, Governor Gavin Newsom signed 2026 Ch. 24 (SB 1250). The law aims to significantly increase the tax on managed care organizations (MCOs), which include HMOs subject to state law. The tax funds Medicaid (called Medi-Cal in the state) and is applicable to the 2027, 2028, and 2029 calendar years. The tax is subject to approval by Centers for Medicare and Medicaid Services, unless the state Director of Health Care Services certifies that the tax is federally permissible. For details, see Roundup of selected state health developments, second-quarter 2026 (August 5, 2026).

On July 6, the California Assembly Republican Caucus sent a letter imploring CMS to deny approval. The group argued that the law's "practical effect is a new tax on health plans that will ultimately be passed on to employers, workers, retirees, and families through higher health insurance premiums." On October 1, the California Association of Health Plans and others sued the state Department of Health Care Services over the MCO tax, arguing that it violates Proposition 35, which created rules for the expenditure of the MCO tax collected.

California — San Francisco

HCSO. San Francisco published its 2027 health care expenditure (HCE) rates — up over 9% from 2026. The revised HCE rates are:

Employer size	Number of workers worldwide	2027 expenditure rate (per hour)	2026 expenditure rate (per hour)
Large	All employers (100+ workers)	$4.49	$4.11
Medium	Businesses (20-99 workers) Nonprofits (50-99 workers)	2.99	2.74
Small	Businesses (0-19 workers) Nonprofits (0-49 workers)	Exempt	Exempt

The exemption threshold for managerial, supervisory, and confidential employees will increase from $128,861 to $131,763 per year. The HCSO applies to all employers required to have a San Francisco business registration certificate and with at least 20 employees in any location, as long as at least one works in San Francisco. See San Francisco boosts 2027 Health Care Expenditure rates (September 11, 2026).

HCAO. Starting in 2027, San Francisco contractors and lessees (and their subcontractors and subtenants) must comply with new HCAO health plan standards for covered employees. Among the 16 HCAO standards, there are three changes:

Standards	2027	2026
In-network, self-only out-of-pocket maximum	$12,000	$10,000
Maximum medical deductible	3,200	3,000
Maximum prescription drug deductible	500	400

As a reminder, compliant coverage cannot include an employee contribution for self-only coverage. In addition, plans must meet either of these requirements:

- Adherence to all 16 HCAO standards
- A gold- or platinum-level plan written in California (or having at least a 76% actuarial value) that covers 100% of the deductible (employer HRA/HSA contributions count) and meeting 11 of the 16 standards

See San Francisco contractor-lessee health plan standards, pay rates updated (August 10, 2026).

New Jersey

Some New Jersey employers face a new annual assessment when workers receive Medicaid coverage under AB 5324, starting with the July 1, 2026–June 20, 2027 tax year. For details, see Roundup of selected state health developments, second-quarter 2026 (August 5, 2026). Four trade groups sued, arguing the law is barred because of ERISA preemption and violation of the Due Process Clause of the Fourteenth Amendment of the US Constitution. Employers should assess if the law will apply to them and prepare to examine the state's numbers when notices arrive, possibly in advance of filing an appeal.

Washington — Seattle

The city announced the 2027 monthly rates that covered hotel industry employers must make to or on behalf of each covered employee for medical care. Rates will increase based on family status:

Monthly expenditure rates (by coverage tier)	2027	2026
Employee only	$702	$612
Employee with only dependents	1,195	1,043
Employee with only a spouse or domestic partner	1,404	1,225
Employee with a spouse or domestic partner and one or more dependents	2,106	1,837

The ordinance applies to most businesses that own, control, or operate a Seattle hotel or motel with 100 or more guest rooms and to "ancillary hotel businesses" with 50 or more employees worldwide. For background, see Seattle posts 2023 health expenditure rate for hotel employers (July 5, 2022).

Related resources

Marsh Law & Policy resources

- State paid family and medical leave contributions and benefits (October 19, 2026)
- Paid family and medical leave — snapshots across the US (slide deck) (October 19, 2026)
- San Francisco boosts 2027 Health Care Expenditure rates (September 11, 2026)
- San Francisco contractor-lessee health plan standards, pay rates updated (August 10, 2026)
- States eye Medicaid taxes that could affect employers (July 30, 2026)
- Virginia hits 'back of the net' on PFML; who's next? (June 24, 2026)
- IRS clarifies taxation of state and DC PFML contributions, benefits (January 13, 2026)
- Some states require group health plan sponsor reporting (December 3, 2025)
- Roundup: State accrued paid leave mandates (July 23, 2025)
- PSYPACT gets an A (for access, among other things) (May 29, 2025)
- Beyond state lines: A primer on insurance law extraterritoriality (March 26, 2025)
- Bereavement leave policies present legal considerations for employers (May 30, 2024)
- Seattle posts 2023 health expenditure rate for hotel employers (July 5, 2022)

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- Benefits strategy & innovation
- Life, absence, and disability benefits
- MercerRx
- MercerWell
- Voluntary benefits

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