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Roundup of selected state health developments, first-quarter 2020

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States began this year by tackling ongoing concerns about health coverage and costs, insurance mandates, employee paid and unpaid leave programs, and other benefit issues carried over from 2019. But the COVID-19 emergency overtook state agendas, as legislators and regulators pivoted to address the urgent concerns raised by the pandemic. States pushed through insurance guidance to ease the impact on patients, employers and the healthcare system. Many jurisdictions also broadened or established leave programs to meet the immediate needs of employees and their families. This GRIST summarizes select state developments and COVID-19 efforts in the first quarter of 2020.

State healthcare programs

As the year began, states looked to address healthcare costs and ongoing funding. A Connecticut executive order calls for setting healthcare growth benchmarks and providing transparency. New York posted the 2020 covered-lives assessment (CLA) rates imposed by its Health Care Reform Act (HCRA).

Connecticut

Executive Order No. 5 from Connecticut's governor directs the Office of Health Strategy (OHS) to develop by Dec. 1 annual healthcare cost growth benchmarks for calendar years 2021–2025. The benchmarks would be based on total healthcare spending — the per-capita sum of all healthcare expenditures from public and private sources in the state for a given calendar year. OHS must also develop quality benchmarks for plans beginning in 2022, submit annual healthcare spending growth reports, and monitor accountable care organizations and alternative payment models. Another executive order (No.

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6) directs the Department of Social Services to develop a transparency strategy for Medicaid cost and quality that examines performance over time against other states' Medicaid programs.

New York

New York posted its 2020 CLA rates for graduate medical education under the state's HCRA. The HCRA imposes on "electing" health claim payers — including self-funded plans — an annual CLA, which is based on the number of covered individuals (and families) who live in New York. The state lets payers "elect" to pay the CLA per covered individual directly to the state's Professional Educational Pool.

The CLA rates and surcharges vary among eight regions, and the applicable rate depends on where the covered individual resides or receives in-state hospital care. New York City has the highest annual CLA for electing payers: $173.53 per individual with self-only coverage and $572.66 per individual with family coverage. However, in Long Island, the CLA per covered individual shrinks to $60.60 (self) and $199.97 (family). The CLA drops as low as $8.85 (self) and $29.19 (family) in the Utica region.

Nonelecting payers are not subject to the annual CLA but may incur significantly higher surcharges on certain in-state hospital expenses. The annual CLA/surcharge mandate is one of two distinct payments under the HCRA.

Reporting

While New Jersey and San Francisco have delayed or cancelled employers' annual healthcare reporting obligations, Vermont has kept the April 25 deadline for employers' quarterly reports and payments under the state's play-or-play mandate.

New Jersey

Updated New Jersey guidance delays employers' state health coverage filing requirements from March 31 to May 15. By May 15, health coverage providers, including insurers and self-insured group health plans, must provide the New Jersey Division of Taxation a copy of IRS Form 1095-B or 1095-C for each primary enrollee who was a New Jersey resident and received minimum essential coverage in 2019. This applies to both part-year and full-year New Jersey residents. For health coverage reporting, a part-year resident is a primary enrollee who lived in New Jersey for at least 15 days in any month. No extension applies for forms that were due to primary enrollees by March 2.

San Francisco

Due to COVID-19 emergency, the San Francisco Office of Labor Standards and Enforcement (OLSE) is not requiring employers to submit the 2019 annual reporting form for the Health Care Security Ordinance (HCSO) and the Fair Chance Ordinance. This report typically is due by the end of April. Employers must

continue to make health care expenditures (HCEs) on behalf of their covered employees by making City Option payments and/or paying for health insurance. City Option payments and other HCEs are due within 30 days of the end of each calendar quarter, and annually by Feb. 28 for self-funded health plans.

Vermont

Vermont tax regulators have published an updated *Guide to the Health Care Fund Contribution Assessment* for employers subject to the state's play-or-pay mandate. Vermont law (32 Vt. Stat. Ann. § 10503) requires employers with more than four full-time equivalent employees lacking qualifying health coverage to pay a quarterly assessment. Employers that don't owe an assessment must still file a quarterly return. The updated guidance gives instructions for calculating any amount owed; addresses special situations, such as employee probationary periods; and includes a decision tree to facilitate compliance. Vermont hasn't waived or delayed the first-quarter report and contribution due April 25.

Insurance

Action on insurance laws, regulations and compliance continued to target drug costs, wellness, surprise medical bills, mental health parity and contraceptive coverage. However, state lawmakers and regulators shifted their focus as the COVID-19 pandemic emerged in the first quarter of 2020.

Continued concerns

A California report shows how drug costs have impacted health coverage premiums in the state. The state also is considering legislation to impose certain restrictions on health plans' wellness programs. Colorado has issued surprise-billing regulations. New Hampshire's review of insurers has found some didn't fully comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). New Jersey has expanded its contraceptive coverage mandate, including coverage of sterilization and over-the-counter products.

California prescription drug costs

Prescription drug cost growth in California during 2018 significantly outpaced increases in overall medical expenses, according to the Department of Managed Health Care (DMHC). The *Prescription Drug Cost Transparency Report* looks at the impact of the cost of prescription drugs on health plan premiums over the first two reporting years — 2017 and2018.

Key findings indicate California health plans paid nearly $9.1 billion for prescription drugs in 2018, an increase of more than $400 million from 2017. Prescription drugs accounted for 12.7% of total health plan premiums in 2018. Manufacturer drug rebates represented about 11.7% of the $9.1 billion spent on prescription drugs in 2018. Specialty drugs made up only 1.6% of all prescription drugs dispensed but

accounted for 52.6% of total annual spending on prescription drugs. Generics accounted for 87% of all prescribed drugs but only 22.4% of the total annual spending on prescription drugs.

California wellness programs

In January, the California Assembly passed a bill (AB 648) outlining wellness plan requirements and restrictions for health insurers, HMOs and employers. The measure prohibits retaliating against employees who decline to participate in a wellness program, imposes certain disclosure obligations and sets privacy restrictions. While the bill prohibits health insurers and HMOs from charging higher premiums for individuals who don't participate in wellness programs, it doesn't ban differing employer contribution amounts for participants vs. nonparticipants.

Privacy provisions would limit the collection, dissemination, retention and use of any personal information; restrict data collection to records reasonably necessary to operate the wellness program; require destroying personal data after the plan ends or the employee terminates; and mandate programs comply with state and federal privacy laws. Insurers, HMOs and employers would also have to post a written explanation "reasonably likely to be understood by an employee" on their websites.

The extent to which ERISA might preempt the bill's employer requirements is unclear. The legislation is currently under review in the Senate and may undergo revisions. The timing of any movement on the bill is uncertain, particularly in the current environment.

Colorado

Colorado has posted regulations for out-of-network (OON) provider reimbursement for emergency and nonemergency care. Insurers must reimburse based on the provider's location in geographic rating areas established by the Division of Insurance. The regulations establish arbitration program requirements for payment disputes and standards for carrier disclosures of a covered person's financial responsibility for emergency and nonemergency services rendered by OON providers. The regulations implement a portion of 2019 surprise billing legislation (Ch. 171).

New Hampshire

New Hampshire insurance regulators have found that Anthem and Harvard Pilgrim did not fully comply with the MHPAEA's nonquantitative treatment limitations (NQTLs). Under the federal law, any processes, strategies, evidentiary standards or other factors used to set provider reimbursement rates for mental health/substance use disorder (MH/SUD) services must be comparable to and applied no more stringently than the factors used to set rates for medical/surgical (M/S) services. However, the review found Anthem and Harvard Pilgrim reimburse MH/SUD providers at levels very close to Medicare rates, while reimbursing virtually all M/S provider specialties at levels much higher than Medicare rates.

The insurers dispute the findings but have entered into separate settlements with the state's Insurance Department. During a two-year monitoring period, the insurers will develop a written, analytic framework to demonstrate provider reimbursement comparability; reevaluate MH/SUD fee schedules to assure that reimbursement practices are comparable; and improve MH/SUD provider networks.

New Jersey

A recent New Jersey law (2019 Ch. 361) expands the state's contraceptive coverage mandate. Besides covering prescription contraceptives for women, New Jersey HMOs and insured plans issued or renewed on or after April 15 must cover on an in-network basis any contraceptive drug, device or product approved by the US Food and Drug Administration (FDA) and any related services. Coverage must extend to FDA-approved, over-the-counter products without a prescription. A plan may provide a therapeutic equivalent if deemed medically appropriate by the patient's healthcare provider. Coverage must include voluntary sterilization of men and women, with cost sharing allowed only for sterilization of men covered by high-deductible health plans (HDHPs) meeting health savings account (HSA) standards.

Reaction to COVID-19

Beginning in early March, state insurance regulators began scrambling to address issues caused by the COVID-19 emergency. New York and other states provided COVID-19 guidance for insurers. Some states have banned cost sharing for not only COVID-19 testing but also treatment. A number of states are easing insurance protocols, such as utilization review and preauthorization; expanding telehealth; and permitting early prescription refills. Additional guidance has called for extending grace periods for late premium payments.

New York

Due to the COVID-19 emergency and increased demand for inpatient hospital services, New York Insurance Circular Letter No. 8 (2020) advises insurers in the state to suspend for 90 days the following:

- Preauthorization review for scheduled surgeries or hospital admissions
- Concurrent review for inpatient hospital services
- Retrospective review for inpatient hospital services and emergency services at in-network hospitals
- Preauthorization requirements for inpatient rehabilitation and home healthcare services after an inpatient hospital stay
- Medical-record submission requirements for emergency hospital admissions
- Internal and external appeal timeframes for hospitals

- Nonessential hospital payment audits and the overpayment recovery period

Self-insured ERISA plans don't have to comply with these steps. However, third-party administrators are "strongly encouraged" to apply these provisions to their administrative services arrangements with self-funded plans.

States acting to expand COVID-19 coverage

To address the COVID-19 pandemic, many states are stepping up to ensure that gaps in private health insurance do not create barriers to testing and treatment. Federal law requires health insurers, including employer plans, to waive cost sharing for COVID-19 tests and related items and services. A Commonwealth Fund map summarizes state actions requiring or recommending insurers expand coverage of key services beyond the minimum federal standard, including premium moratoriums, early prescription refills, prior authorization limits, and telehealth.

States issuing COVID-19 cost-sharing guidance

Even before Congress took action, some states started requiring that insurers waive cost sharing for COVID-19 screening. Initial concerns about this policy change jeopardizing HSA eligibility for individuals with HDHPs resolved when IRS Notice 2020-15 let HDHPs cover COVID-19 testing and treatment free of cost sharing, even if individuals have yet to satisfy their deductibles.

States issuing guidance on COVID-19 cost sharing and other issues for insured health plans include Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Maryland, Massachusetts, Missouri, Nevada, New Jersey, New Mexico, New York, Tennessee, Vermont, Washington, West Virginia and Wisconsin. For more details, see COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020).

States asking insurers to extend premium payment deadlines

State regulators have begun asking insurers to extend premium payment deadlines in light of the COVID-19 outbreak. Here are the states that have requested premium payment grace periods so far, but more states are expected to issue guidance in the coming months:

- California's March 18 notice from the insurance commissioner calls for a 60-day insurance premium grace period.

- Colorado Bulletin No. B-4.105 directs health carriers, for the duration of the COVID-19 emergency, to make reasonable accommodations to prevent businesses and employees from losing coverage due to premium nonpayment. Such steps should include an extension of premium grace periods or deferrals, a waiver of late-payment fees or interest, and a moratorium on cancellations for nonpayment.

- Indiana Insurance Department Bulletin 252 requests all insurers and HMOs in the state to institute a moratorium on policy cancellations and nonrenewals for nonpayment of premiums and institute a 60-day grace period from March 19 to May 18.

- Louisiana Emergency Rule 40 imposes a moratorium on policy cancellations and nonrenewals for policyholders in the state during the COVID-19 outbreak. The rule applies to life, health, accident, disability and other forms of insurance. The rule also suspends the prompt payment law; insurers may pend claims during any period of premium nonpayment. The rule expires May 12.

- Maryland Insurance Administration Bulletin 20-10 encourages life, health, property and casualty insurers doing business in the state to make reasonable accommodations for individuals and businesses unable to make premium payments due to the COVID-19 emergency. Such accommodations could include suspension of premiums, extension of billing due dates and premium grace periods, and waiver of installment and late-payment fees. Insurers also should encourage policyholders to use electronic payment methods, although no specific mandate applies.

- New Jersey Executive Order No. 123 requires a minimum 60-day grace period to pay insurance premiums for health and dental plans issued in the state. The governor's order also sets a minimum 90-day grace period to pay premiums for life insurance and certain other forms of insurance. Insurers must pay otherwise covered claims incurred during the emergency grace period and cannot use nonpayment of premiums as a reason to attempt recouping any paid claims.

- New York regulators have announced an emergency regulation requiring insurers to allow life insurance policyholders to defer paying premiums for 90 days.

- Ohio Insurance Department Bulletin 2020-30 requires health insurers to give insureds the option of deferring premium payments, interest free, for up to 60 days. The bulletin also requires plans to continue covering enrolled workers at an employer's request, despite any work-hour decrease that might make them ineligible and despite any "actively at work" or similar requirements. Plans also must provide special enrollment on and off the federal exchange to individuals who lose coverage. The mandate applies to health insurers, HMOs, self-insured nonfederal governmental plans and multiple employer welfare arrangements (MEWAs). It doesn't apply to self-insured ERISA plans.

- Oregon's temporary emergency order from the Department of Consumer and Business Services requires all insurance companies to extend grace periods for premium payments, postpone policy cancellations and nonrenewals, and extend deadlines for reporting claims.

- Washington's Office of the Insurance Commissioner has issued an emergency order directing, in part, that individual and group health plans allow a grace period of at least 60 days to pay premiums. Certain disclosures apply. The emergency order also requires no-cost coverage of influenza A and B,

COVID-19, and other respiratory virus diagnostic tests, as well as the related provider visit; and waiver of preauthorization for certain long-term care or home health services after hospital discharge,

Leave

In the past few years, state leave laws — unpaid or paid sick days and paid family and medical leave — have proliferated. These efforts have taken on added urgency due to the COVID-19 pandemic.

Existing paid family and medical/disability leave programs

Six states and Washington, DC, have some combination of paid family and/or medical/disability leave in place. These jurisdictions have updated contribution rates, limits, benefit caps and other relevant information for 2020. Massachusetts has continued to trickle out guidance for its paid family and medical leave (PFML) program, which has begun collecting contributions for benefits that will become available in 2021. New York has enacted a statewide paid sick leave mandate taking effect later this year. Amendments to Washington's law clarify the PFML program now in effect.

Updated rates and benefits

As of 2020, California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island, Washington, and Washington, DC, mandate paid leave for an employee's own health condition. Except for Hawaii and Puerto Rico, these jurisdictions also require paid family leave for bonding with a new child, caring for a seriously ill or injured family member, and certain other purposes. Each jurisdiction has posted its 2020 contribution rates, taxable wage base, and maximum weekly benefit amounts. New York's and Puerto Rico's disability benefits are set by the law and don't change from year to year. For more details, see 2020 state paid family and medical leave contributions and benefits (Feb. 14, 2020).

This is the first year that PFML benefits are available in Washington state and Washington, DC. Massachusetts plans to begin benefits in 2021; Connecticut contributions begin in 2021, and benefits will follow in 2022; and Oregon contributions start in 2022, with benefits first available in 2023. Other states, including Colorado, were looking to enact similar laws in 2020 before the COVID-19 health emergency began.

Massachusetts

Beginning in 2021, the Massachusetts PFML program will let eligible employees take protected leave with partial wage replacement to bond with a new child, care for a family member with a serious health condition, handle a military exigency or address their own serious health conditions. Employee and any required employer contributions began Oct. 1, 2019. For more details, see Massachusetts readies for paid family and medical leave (Jan. 13, 2020).

In January, the Department of Family and Medical Leave (DFML) provided guidance for employers that will seek reimbursement for payments to an employee under a temporary disability, family or medical leave plan or policy during a period of PFML that, together with the state benefit, exceed the employee's average weekly wage. Employers won't receive reimbursement for payments attributed to sick leave, annual leave, vacation, personal leave or paid time off. Employers will have to substantiate that payments to employees were for a PFML qualifying reason.

April guidance (Notice 2020-A) provides a Department of Insurance (DOI) template for carriers to use in seeking approval of PFML policies. Insurance carriers must submit their policy forms for DOI review on or before June 3. Previously approved employers with fully insured private plans must use policy form numbers to verify the use of an approved policy during their renewal period. The DFML's website will be updated to describe renewal procedures at a later date.

New York

A recently enacted New York law (2020 Ch. 56, Part J) requires employers to provide up to 56 hours of paid sick leave per year to employees. The mandate applies to employers of all sizes — but requires fewer hours of paid leave at smaller employers — and goes into effect on Sept. 30. New York is just the latest state to require employer-paid time off.

Employers with one or more employees must provide at least one hour of accrued paid sick leave for every 30 hours worked. Accrual begins on the first day of employment for new hires and upon the law's effective date for current employees. The new mandate adds to the state's existing paid leave benefits available to New York employees, including temporary disability and paid family leave programs. A separate New York law provides emergency paid sick leave for COVID-19.

Washington

Recent legislative changes (2020 Ch. 125) to clarify paid time off (PTO) for purposes of supplemental benefits under Washington's PFML take effect immediately. PTO includes vacation, personal, medical, sick, compensatory or any other paid leave offered by an employer under an established policy. Employees may receive PTO during the PFML one-week waiting period. However, any PTO received during the remaining PFML weeks must be reported, unless it's a supplemental benefit. Supplemental benefits can include salary continuation payments and PTO intended to be in addition to an employee's PFML benefit amount. The measure also adds a son- or daughter-in-law to the list of qualifying family members and includes other amendments, including minor changes to voluntary plan compliance.

COVID-19 leave

The pressing need for COVID-19 leave for an employee's or a family member's illness or inability to work due to a quarantine or an isolation order has spurred states and many municipalities to take further

action. The National Conference of State Legislatures (NCSL) has been tracking states' COVID-19-related legislation, including leave. In addition to federal efforts, multiple states and large municipalities have moved ahead with emergency paid leave regulations, legislation and executive orders. Washington, DC, has expanded unpaid leave protections under its Family and Medical Leave Act.

States and cities taking action on COVID-19 leave

To alleviate some of the economic strain on employees unable to work due to COVID-19, some state and local authorities have begun to implement new paid leave requirements. Other jurisdictions are modifying existing leave laws or benefit programs to accommodate employees' needs during the pandemic. New emergency paid leave or temporary expansion of existing benefits is available the following jurisdictions: Arizona, California, Los Angeles, San Francisco, San Jose, Colorado, Michigan, New Jersey, New York, Philadelphia, Rhode Island, Seattle, and Washington, DC. For more information, see States, cities tackle COVID-19 paid leave (April 15, 2020).

State COVID-19 legislative tracker

The NCSL Coronavirus Resources for States outline pending and enacted COVID-19-related state legislation, including measures on health and paid leave, in more than half the states and Washington, DC. Legislation includes packages to appropriate funds for medical supplies, treatment, stabilization of public health services and other COVID-19-related expenditures. Other bills require paid sick leave and job protections for employees ordered to quarantine and first-dollar insurance coverage for COVID-19 testing and treatment.

Washington, DC

Washington, DC's new ordinance (B23-0718) broadens job protections for employees under the DC Family and Medical Leave Act (DC FMLA) due to COVID-19. The law generally provides unpaid, job-protected leave for employees who work for one year and 1,000 hours for an employer with at least 50 DC employees. Over a 24-month period, employees may use up to 16 weeks of family leave to care for a family member with a serious health condition or bond with a new child and up to 16 weeks of medical leave for an employee's own serious health condition.

The ordinance adds a "declaration of medical emergency leave" and eliminates the employment duration and DC employee thresholds for this new leave entitlement. The unpaid, job-protected leave is available to any employee who has received a government or healthcare professional's recommendation to self-quarantine or self-isolate.

Other employer issues

Unrelated to the pandemic, employers may want refresh their understanding of common-law marriage and its implications for employee benefits. In February, a Utah appellate court clarified the necessary elements to establish a common-law marriage in the state. Eight states and Washington, DC, continue to allow couples to establish common-law marriages — that is, valid marriages created by the couple's mutual agreement and public behavior, without an official license and solemnization.

Utah

In a case seeking to divide assets after long-term cohabitation, the Utah Court of Appeals held that a common-law marriage doesn't exist for a couple who "did not hold themselves out as a married couple" (*Rivet v. Hoppie*, 2020 UT App. 21 (Feb. 13, 2020). In its review of the facts, the court noted that a Utah statute (Utah Code Ann. § 30-1-4.5) outlines the elements required for a common-law marriage. A couple must be of legal age, capable of giving consent and able to enter a solemnized marriage under Utah law; have cohabited; mutually assume marital rights, duties and obligations; and hold themselves out — and have a uniform and general reputation — as spouses. Because this couple didn't satisfy the last element, no common-law marriage existed.

Related resources

Mercer Law & Policy resources

- Roundup: COVID-19 resources for employers (regularly updated)
- States, cities tackle COVID-19 paid leave (regularly updated)
- New York passes paid sick leave mandate (April 9, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- Common-law marriage raises issues for employer benefits (March 3, 2020)
- New California laws affect health insurance, leave, other HR policies (Feb. 19, 2020)
- 2020 state paid family and medical leave contributions and benefits (Feb. 14, 2020)
- New York announces 2020 HCRA covered-lives assessment rates (Jan. 21, 2020)
- Roundup of selected state health developments, fourth-quarter 2019 (Jan. 21, 2020)
- Massachusetts readies for paid family and medical leave (Jan. 13, 2020)

- Mental health parity FAQs address nonquantitative limits, disclosures (Dec. 17, 2019)
- Vermont reissues employer health plan assessment reporting guidelines (Sept. 24, 2019)
- Roundup of selected state health developments — second-quarter 2019 (July 29, 2019)
- Roundup of selected state health developments — first-quarter 2019 (May 8, 2019)

Other Mercer resources

- Read this if you have at least one employee working in San Francisco (April 2, 2020)
- Grab some ibuprofen: State mandates may create reporting headaches (June 20, 2018)
- Life, absence & disability

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