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Roundup of selected state health developments, second-quarter 2020

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July 24, 2020

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While struggling with the impact of COVID-19, states marched ahead in the second quarter, considering health coverage initiatives begun before 2020, including reviews of innovation waivers, single-payer health coverage and a public health option. Lawmakers in three states — Idaho, Indiana and Virginia — passed laws imposing pharmacy benefit manager (PBM) oversight. Despite the pandemic, Massachusetts, New Jersey, and Washington, DC required employers and health insurers covering residents to file state reports for 2019 coverage. Insurance laws tackled during the quarter include benefit mandates, insulin cost sharing and gender nondiscrimination. Other health-plan-related issues involve coordination of benefits with auto insurance in Michigan, as well as facilitating telepsychology and cross-border mental health treatment in a growing number of states. Paid leave laws continued to proliferate, including additional COVID-19-related leave, new paid sick leave in Colorado and Washington, DC's universal paid leave (UPL) launch.

State health coverage initiatives

State innovation waivers under Section 1332 of the Affordable Care Act (ACA) have tended toward reinsurance programs for high-cost conditions. A Department of Health and Human Services (HHS) report reviews states' progress using the waivers. However, states are facing COVID-19 headwinds in other health coverage initiatives, slowing efforts to expand coverage. New Mexico released a study on its single payer healthcare system that reveals funding challenges. Washington's governor vowed to move forward on the state's public health plan option.

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Innovation wavers

An HHS Center for Consumer Information and Insurance Oversight (CCIIO) review of ACA Section 1332 waivers found that 12 of the 13 waivers approved to date allow states to implement their own reinsurance programs. ACA Section 1332 waivers, first available in 2017, permit a state to pursue innovative strategies that provide its residents with access to affordable, quality healthcare. The waiver must not increase the federal deficit, reduce the availability of comprehensive, affordable health coverage or decrease the number of state residents covered.

The report includes tables displaying each state reinsurance program's first year of operation, program parameters, premium reductions, market participation and funding sources. In addition to federal funding, some states have made appropriations, imposed assessments on medical providers and facilities, charged health insurer fees, or implemented a combination of these approaches.

At least two of these state programs could have an impact on self-insured plan sponsors. In 2018, Maine imposed "a market-wide assessment" that includes self-insured plans. More recently, Oregon enacted legislation (2019 Ch. 2, HB 2010) expanding its assessment to stop-loss insurance beginning in 2020 at a rate of 2% gross quarterly premiums derived from health plans in Oregon.

New Mexico

A New Mexico single-payer health plan could significantly reduce the state's uninsured population, but assumptions considered in a recently released actuarial analysis would leave the program underfunded by approximately $5.8 billion over the first five years. The study was requested after a legislative proposal (HB 295/SB 279) to implement such a program failed to pass in 2019. The "health security plan" (HSP) would roll existing state and federal healthcare programs into the system and eliminate all but supplemental health insurance offered in the state. Employers would have to pay a portion of workers' premiums to the state plan.

The report estimated that the HSP would increase employer contributions to the healthcare system, with cost increases primarily falling on businesses that hadn't previously offered health benefits and employers that continued offering self-insured health plans to their employees. The bills called for requesting a federal waiver to assist with the funding, but it's not certain that money would be available. Whether the legislature will take any further action on the issue when it reconvenes in 2021 is unclear.

Washington

In a letter to the Washington State Health Care Authority, Gov. Jay Inslee reiterated his support for Cascade Care, the state's proposed public healthcare option. A 2019 law (Ch. 364, SB 5526) calls for the state's insurance exchange to offer a public option that uses the standard bronze, silver and gold plans, beginning in 2021. All insurers offering coverage on the exchange must include a standard plan. Given

the challenges in the current COVID-19 emergency, Inslee noted that "Cascade Care may take a preliminary approach in its initial year," but he fully expects it "to flourish in future years."

A Cascade Care Stakeholder Workgroup has set teleconferences in August, September and October to discuss the program's implementation. Earlier this year, the workgroup proposed 2021 standard plans and insurer guidance for participation of health plans in the Washington health benefit exchange. Standard plans are expected to be available for the next open enrollment — Nov. 1 through Dec. 15, 2020 — for coverage in plan year 2021.

PBM regulation

In an effort to increase oversight of PBMs, Idaho, Indiana and Virginia have enacted laws requiring registration or licensing with a state agency and imposing specified restrictions and obligations. To what extent, if any, these mandates would affect self-insured plans is unclear. Self-insured plan sponsors may want to confer with their PBMs to determine compliance issues.

Idaho

PBMs can't operate in Idaho unless they are registered with the state's Department of Insurance, under a new law (2020 Ch. 117, HB 386) that took effect July 1. The legislation also bans pharmacist gag clauses, requires maximum allowable cost disclosures, prohibits retroactive denial of certain adjudicated claims and requires PBMs to establish a process for pharmacists to appeal generic drug reimbursements.

Indiana

A new Indiana law (2020 Ch. 68, S 241) requires PBMs operating in the state to obtain a license from the Department of Insurance. The law sets out PBM requirements for equal access to all in-network pharmacies; outlines pharmacy contract terms; and specifies claim-processing procedures, including appeals. The measure also includes provisions addressing costs, rebates, disclosures and reporting obligations. Insurance regulators are responsible for adopting rules to specify licensure, financial, reporting and other standards. PBMs have until Dec. 31, 2020, to obtain a license to do business in Indiana and provide services for any health provider contract beginning Jan. 1, 2021.

Virginia

PBMs can't operate in Virginia unless licensed with the State Corporate Commission, under a new law (Ch. 219, HB 1290) that takes effect Oct. 1. The legislation prohibits spread pricing and bans reimbursing a pharmacist an amount less than what the PBM pays its own affiliates. The measure includes an *any-willing-pharmacist* provision, sets out recordkeeping and reporting obligations, and excludes mail-in pharmacies and PBM affiliates from network adequacy determinations.

Individual mandate reporting

Guidance from Massachusetts, New Jersey, and Washington, DC, outline employer reporting obligations for residents subject to individual health coverage mandates. These states required 2020 reporting for the 2019 plan year, despite other permitted delays resulting from COVID-19 emergencies. Massachusetts also updated coverage standards.

Massachusetts

Massachusetts announced dollar limits on deductibles and out-of-pocket costs for minimum creditable coverage (MCC). Beginning Jan. 1, 2020, maximum deductibles undergo annual adjustments tied to federal indexing. Updated rules also clarify MCC criteria for health arrangements provided by religious organizations to their members.

In Bulletin 01-20, the Commonwealth Health Insurance Connector Authority announced 2020 MCC in-network maximum deductibles at $2,550 for individual coverage and $5,100 for family coverage. If a plan has separate prescription drug deductibles, those amounts can't exceed $310 for individual coverage and $620 for family coverage, and the overall maximum deductible still applies.

For the 2021 plan year, Bulletin 05-20 sets the MCC maximum deductibles at $2,700 for individual coverage and $5,400 for family coverage, and prescription drug deductibles at $330/$660 for individual/family coverage.

The MCC rules set the in-network out-of-pocket maximum (OOPM) to match the federal ACA limits. The 2020 in-network OOPM announced in the 2020 Notice of Payment and Parameters is $8,150 for individual coverage and $16,300 for family coverage. Under the 2021 Notice of Payment and Parameters, those amounts will rise to $8,550 and $17,100. For more detail, see Massachusetts sets dollar limits for individual-mandate coverage.

New Jersey

Regulators confirmed that New Jersey's 1095 reporting, due to the Division of Taxation by May 15, would not receive any additional extension. By that date, health coverage providers, including insurers and self-insured group health plans, had to submit a 1095 health coverage form for each primary enrollee provided minimum essential coverage (MEC) in 2019 who was a New Jersey resident. This reporting requirement applies to MEC provided to both part-year and full-year New Jersey residents. However, reporting doesn't include COBRA beneficiaries who moved to New Jersey after terminating employment.

Penalties for failure to file are $50 per form and up to $50,000 per company. Employers with fewer than 100 forms to file can register to use fillable forms. Employers with 100 or more forms to file must file electronically in the system used for W-2 submissions. Fully insured companies should file 1095 forms

with New Jersey only if their insurer does not. Employers can submit questions to the state's dedicated website.

Washington, DC

Washington, DC's Office of Tax and Revenue (OTR) confirmed it wouldn't delay the June 30 filing deadline for plan sponsors to report MEC. Starting in 2019, DC began requiring all residents to maintain MEC or face a possible tax penalty. Recent guidance notes that applicable entities required to file federal IRS returns (Form 1095-B or 1095-C) for a particular tax year must file the same returns electronically with OTR through MyTax.DC.gov, using the prescribed layouts and file formats. If a multijurisdictional employer elects to remove non-DC residents from its OTR filing, the employer must file a revised Form 1094-C to reflect the revised Form 1095-C submissions.

The guidance also addresses the forms to submit, the use of third parties to file and the penalties for failure to comply. In addition, OTR has provided FAQs (in Excel format).

Insurance

State insurance laws and regulatory guidance imposed coverage requirements for specific treatments, capped insulin cost sharing, and clarified coverage for gay and transgender individuals.

Health benefit mandates

Colorado enacted fertility preservation coverage in insured plans. A New York emergency rule requires first-dollar coverage for essential workers' behavioral health treatment.

Colorado

New Colorado legislation (2020 Ch. 106, HB 20-1158) requires insured health plans issued or renewed in Colorado on or after Jan. 1, 2022, to cover diagnosis and treatment for infertility and standard fertility preservation services. According to American Society for Reproductive Medicine guidelines, coverage must include three completed oocyte retrievals with unlimited embryo transfers. Fertility treatment coverage, including prescription drug coverage, can't include any cost sharing or limits that don't apply to other covered medications or medical services. Religious employers can apply for an exclusion but must notify employees of the exclusion.

New York

New York Insurance Circular Letter No. 10 and an emergency regulation (N.Y. Comp. Codes R. & Regs. tit. 11, § 52.16(r)) require health insurers to provide in-network outpatient behavioral health coverage for "essential workers" in New York without cost sharing. The requirement exempts high-deductible health plans (HDHPs) qualifying for health savings accounts (HSAs), as defined in Internal Revenue Code Section

223. The regulation is effective for 90 days from May 2, at which point the Department of Financial Services (DFS) may issue a further guidance.

Essential workers include healthcare workers, first responders, and individuals employed in any position within a nursing home, long-term care facility or other congregate care setting during the COVID-19 emergency. The term also includes individuals who directly interact or interacted with the public while working, including auto service and repair workers, bank employees, childcare staff, mental health counselors, delivery workers, clergy, food service workers and several other occupations.

While the requirement applies only to New York insured plans, the circular letter "strongly encourages" New York-licensed third-party administrators to seek approval from plan sponsors to apply the same provisions to their administrative services arrangements with self-funded plans.

Insulin cost sharing

Three states — New Mexico, Utah and Washington — imposed cost-sharing caps on insulin, responding to skyrocketing costs. Colorado and Illinois enacted similar laws in 2019 and earlier in 2020, respectively.

New Mexico

Health insurance policies in New Mexico with plan years beginning on or after Jan. 1, 2021, can't require an individual with diabetes to pay more than $25 for a preferred formulary prescription insulin drug or a medically necessary alternative per thirty-day supply. A new law (2020 Ch. 36, HB 292) restricts cost sharing but doesn't include indexing of the amount. The law also authorizes an advisory group to study the cost of prescription drugs for New Mexico consumers and make recommendations on increasing accessibility.

Utah

Insured health plans issued on or after Jan. 1, 2021, that cover insulin will have to comply with new cost-sharing requirements. Cost sharing for at least one insulin prescription in each therapy category can't exceed $30 for a 30-day supply before any plan deductible applies — under the new law (2020 Ch. 310, HB 207). Certain exceptions apply for plans that meet other coverage criteria.

The plan can condition coverage at these cost-sharing levels on the covered individual participating in wellness activities for diabetes, purchasing the insulin at an in-network pharmacy or choosing an insulin prescription from the lowest tier of the health benefit plan's formulary.

Washington

A new Washington law (2020 Ch. 245, SB 6087) requires health plans issued or renewed on or after Jan. 1, 2021, that cover insulin for diabetes treatment to cap total cost sharing at $100 per 30-day supply. Insulin

must be covered before any deductible applies and the participant's cost share must apply toward the deductible. If insulin is removed from the list of preventive care drugs (identified by Treasury and the Internal Revenue Service) that an HSA-compatible HDHP can cover on a predeductible basis, the state law provides an exception. The law applies to insured policies issued in Washington and may apply to insured plans issued elsewhere that cover Washington residents. The cost restriction expires after 2022.

Gender nondiscrimination

California and New York have confirmed their requirements for nondiscrimination based on sexual orientation and gender identity in healthcare and coverage. These positions align with a recent US Supreme Court ruling, but contrast with recently revised ACA Section 1557 nondiscrimination rules for federally funded healthcare programs and activities.

California

The state's rules on gender nondiscrimination in healthcare continue apply to California insurance plans and HMOs, despite federal changes to the ACA Section 1557 rules, according to an Insurance Commissioner notice and a Department of Managed Health Care letter. The revised Section 1557 rule, in part, removes the healthcare and health coverage protections for transgender individuals from the 2016 regulation. The commissioner's notice concludes that the federal rule doesn't preempt state mandates, including California laws barring discrimination in insured products' eligibility, coverage and pricing.

New York

New York insurance regulators announced final regulations outlining coverage requirements for gender dysphoria, non-gender-specific services and HIV-prevention pre-exposure prophylaxis (PrEP). The rules bar health insurers from discriminating based on sexual orientation, gender identity or expression, or transgender status. An insured plan in New York can't deny, limit or otherwise exclude covered, medically necessary services or treatments for gender dysphoria and must provide certain utilization-review appeal rights for treatments denied as medically unnecessary. Insurers also must provide cost-free PrEP preventive coverage for people at high risk for HIV. The ACA preventive-care mandate requires the same preventive coverage for all nongrandfathered plans beginning on or after July 1, 2020.

Other health-related developments

Issues arising in three states could have some impact on employer-sponsored health coverage. Michigan regulators offered some clarity on the state's automobile insurance reform coordination of benefits. Pennsylvania and Virginia have joined Psychology Interjurisdictional Compact (PSYPACT), which could facilitate expanded access to mental health treatment, including via telemedicine.

Michigan

"Qualified health coverage" under the Michigan Auto Insurance Reform Law doesn't include a health plan with "*any* annual individual deductible over $6,000," according to informal guidance from the state Department of Financial and Insurance Services. Thus, even if *only the annual out-of-network individual deductible* of a health plan exceeds $6,000, the health plan will not be considered qualified health coverage.

As of July 1, the law allows residents to waive or substantially reduce personal injury protection (PIP) insurance if they can demonstrate that they have qualified health coverage: Medicare Parts A and B or medical coverage that doesn't exclude or limit coverage for injuries related to motor vehicle accidents and has an annual individual deductible of $6,000 or less.

A self-insured employer-sponsored health plan that is not qualified health coverage could have less exposure to motor vehicle accident medical costs. That's because employees and dependents without qualified health coverage who reside in Michigan will have to elect minimum PIP medical coverage of $250,000 when purchasing or renewing their auto insurance and cannot rely on their employer's plan to pay a substantial portion of the medical costs.

Pennsylvania and Virginia

Two more states have enacted laws authorizing participation in PSYPACT, the interstate compact between states that facilitates the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries. Licensed healthcare providers can apply to practice telepsychology and/or to conduct temporary in-person, face-to-face sessions in PSYPACT states, depending on the certificate issued.

Virginia, effective Jan. 1, 2021, and Pennsylvania, effective July 7, 2020, have joined 13 other states as participants: Arizona, Colorado, Delaware, Georgia, Illinois, Missouri, Nebraska, New Hampshire, Nevada, North Carolina, Oklahoma, Texas and Utah. PSYPACT officially became operational in April 2019. Licensing requirements were finalized in February 2020.

Paid leave

Paid leave laws drew much attention in the second quarter. States took action to add or update COVID-19-related leave, expand or explain state paid family and medical leave laws, and push forward paid sick leave mandates. A California appellate court outlined criteria needed for unlimited vacation plans to avoid the state's use-it-or-lose-it ban.

COVID-19 leave

State and local governments continue to implement, expand and update paid leave requirements to ease some of the economic strain on employees unable to work due to COVID-19. In the second quarter of 2020, new emergency paid leave or temporary expansion of existing benefits is available in the following jurisdictions: California, Los Angeles, San Francisco, New York, Washington, and Washington, DC. Many of the state and local emergency paid sick leave changes replicate the federal Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), which doesn't preempt any state or local paid leave mandates. Some of these mandates reflect the FFCRA's provisions, but apply to employees of larger employers that are not covered by the federal law. For more information, see States, cities tackle COVID-19 paid leave.

San Francisco

Due to California's paid family leave (PFL) expansion that began July 1, San Francisco employees may also qualify for expanded supplemental employer pay for new child bonding.

For PFL leave that begins on or after July 1, a 2019 law (SB 83) expands the maximum PFL duration from six to eight weeks to bond with a new child or care for a family member with a serious health condition. San Francisco's paid parental leave ordinance (PPLO) requires employers to supplement their employees' California PFL benefits so they receive full pay while on parental leave, subject to an annual cap.

As a result of the change in state PFL benefits, supplemental pay for eligible employees will also increase from six to eight weeks. When covered employees qualify for eight weeks of California PFL benefits, they are also entitled to eight weeks of San Francisco PPLO supplemental compensation from their employer. The city has amended the ordinance to reflect the change. For more detail, see San Francisco aligns paid parental leave law with state family leave.

California

An uncapped vacation policy must comply with California's vacation-payout law for terminating employees, if the policy has an implied cap and the employer fails to inform employees about their rights, according to a state appellate court (*McPherson v. EF Intercultural Found., Inc.,* No. B290869 (Cal. Ct. App. 2d April 1, 2020)). However, truly unlimited time-off policies may escape the law if certain conditions are met. Employers that have or are looking to institute an unlimited vacation policy in California may want to review the court's guidelines and adjust written policies accordingly. For more on the ruling, see California appeals court examines unlimited vacation policies.

Colorado

A new Colorado law (2020 Ch. 294, SB 20-205), effective immediately, replaces the state's Health Emergency Leave with Pay (HELP) rules covering specified business segments. The law now requires all

employers in the state, regardless of size, to provide emergency paid sick leave equivalent to the FFCRA's requirements through 2020 for each employee who is not covered by the federal law.

Beginning in 2021, the Healthy Families and Workplaces Act requires employers — including Colorado public employers — to provide one hour of paid sick leave for every 30 hours worked. The measure caps annual accruals and annual use at 48 hours. Accrual begins on date of hire, and employees can use paid sick time as it accrues in one-hour increments. An employer can frontload an amount that meets or exceeds the accrual requirement at the beginning of the year. Carryover is required, but unused accruals don't have to be paid at termination of employment. If rehired within six months, an employee's unused, accrued sick leave must be reinstated. Certain notice and recordkeeping obligations apply, as do anti-retaliation provisions.

Employees can use paid sick time for their own or a family member's (defined broadly) health needs, closures due to a public health emergency, and issues related to domestic violence or sexual assault. Employers with existing paid time-off plans that meet or exceed the requirements of the state mandate don't have to provide additional time off.

Additional paid sick leave (at least 80 hours for full-time employees and the hours worked in a 14-day period for part-time employees) is required for mandatory quarantine and isolation in public health emergencies, such as the current COVID-19 emergency. Employers can count unused, accrued paid sick leave toward this supplemental requirement.

Illinois

Illinois paid sick leave legislation (HB 2343) received House consideration during a special session after a COVID-19 hiatus. The Healthy Workplace Act, in its current form, would require employers to provide employees with one hour of paid sick time for every 40 hours worked, up to a minimum of 40 hours of leave. Accrual would begin on the effective date of the law for current employees and the hire date for new employees. Employees could begin using paid sick time 180 days after accruals begins.

Employees could use the time for their own or a family member's health needs, closures due to a public health emergency and issues related to domestic violence. The bill includes an expansive definition of family member. An employer could require reasonable documentation of the need for leave after three consecutive missed workdays.

Unused accruals would carry over annually but wouldn't have to be paid at termination of employment, and usage could be capped at 40 hours per year. Employers with existing paid time-off plans that meet or exceed state requirements wouldn't have to provide additional time off. Certain notice and recordkeeping obligations would apply. The bill also includes anti-retaliation provisions. It's unclear whether lawmakers will move forward with this or a similar bill when the legislature reconvenes.

Washington

Washington labor regulators' FAQs address the state's paid sick leave law (Wash. Rev. Code § 49.46.200 *et seq.*) that took effect Jan. 1, 2018. The law applies to all employers, regardless of size, that conduct business in the state and have employees covered by the state's minimum wage law. Covered employees accrue one hour of sick leave for every 40 worked. After 90 days on the job, employees can begin using paid sick leave to care for their own or a family member's health needs, certain closures due to a public health emergency, or domestic violence issues. Employers may cap carryover at 40 hours and do not have to pay out accrued, unused time.

Employers that provide paid leave satisfying the law's requirements don't need to provide additional leave but may need to coordinate the Washington sick leave with their existing leave programs. The FAQs don't explain how the law interacts with the state's paid family and medical leave law but do address recordkeeping, notice and disclosure obligations for the employer and employee, verification, and the pay rate during leave. The guidance stresses that employers should provide policies or other guidelines that outline reporting expectations when an employee intends to use paid sick leave and should administer those policies consistently.

Washington, DC

Washington, DC's universal paid leave (UPL) program began offering benefits on July 1. New developments and updated information on the program during the past year include the final regulations on employer contributions and employee benefits. The city also issued guidance detailing which employees are covered by the law and how employers can request to have an employee excepted from coverage. Employers will need to coordinate UPL with other leave policies and mandates, including the temporary federal and DC COVID-19 leave laws. For more detail, see Washington, DC's paid leave program starts July 1.

Related resources

- States, cities tackle COVID-19 paid leave (updated regularly)
- San Francisco aligns paid parental leave law with state family leave (July 21, 2020)
- Massachusetts sets dollar limits for individual-mandate coverage (June 19, 2020)
- Justices' Title VII ruling on LGBTQ bias has health benefit impacts (June 15, 2020)
- California appeals court examines unlimited vacation policies (May 21, 2020)
- DOL and IRS issue COVID-19 guidance on emergency paid leave (April 29, 2020)

- Roundup of selected state health developments, first-quarter 2020 (April 22, 2020)
- 2020 state paid family and medical leave contributions and benefits (Feb. 14, 2020)
- Michigan's automobile insurance reforms may cost group health plans (Nov. 13, 2019)
- DC details employer reporting for individual health coverage mandate (Aug. 20, 2019)
- Accrued paid leave mandates expand state sick leave law totals (July 1, 2019)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)

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