Roundup of selected state health developments, first-quarter 2021

By Catherine Stamm and Katharine Marshall
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In this article

States kicked off 2021 renewing the struggle to curb prescription drug costs using several approaches. Mental health parity issues drew attention after some changes to the federal law late in 2020. In the first quarter, telehealth services further expanded a year into the COVID-19 pandemic and may become a permanent healthcare feature. Efforts to expand health coverage through state and local programs also garnered some attention. San Francisco has postponed its employer healthcare reporting; New York has updated its covered-lives assessment; and Georgia is considering claim-reporting obligations for some self-insured ERISA plans. New insurance laws and regulations focus on patient cost sharing, balance billing and infertility coverage. Paid leave laws received consideration and, in some areas, expanded due to COVID-19. Other benefit-related activity included clarification of common-law marriage laws in two states, added consumer privacy rights in Virginia, and Washington's long-term care program.

Prescription drugs

State efforts to rein in prescription drug spending take several approaches. In Alabama, a bill pending in the legislature would regulate contract provisions between pharmacy benefit managers (PBMs) and pharmacists, impose certain pricing restrictions, and bar limitations on an insured person's pharmacy choice. Colorado is moving forward with its plans to import prescription drugs from Canada, despite ongoing litigation that could derail those efforts. Wisconsin's governor has proposed a budget that would draw on other states' approaches and impose transparency and disclosure obligations on drug companies, insurers, and PBMs.

Alabama

Legislation (SB 227) passed by the Alabama Senate and pending in the House would expand the state's existing PBM law (AL Code § 27-45A) to bar certain practices in PBMs' contracts with pharmacies and insured health plans. As introduced, the bill would prohibit a PBM from:

- Reimbursing a pharmacy less than the amount the PBM reimburses one of its own affiliated pharmacies or paying a pharmacy an amount different than the contracted amount

- Requiring or steering an insured person to use a mail-order pharmacy or a PBM's affiliated pharmacy
- Limiting — including by using incentives and disincentives — an insured person's ability to select a pharmacy of his or her choice
- Restricting a pharmacist's ability to provide services to insured people

Along with prohibiting spread pricing, the measure would require a PBM to act as a fiduciary for its clients, disclose any conflicts of interest and annually report drug rebate information to health benefit plans. As currently written, the bill would require that insured patients directly receive at the pharmacy counter at least 80% of the savings from prescription drug rebates and discounts that accrue directly or indirectly to health benefit plans. The measure, if enacted, would extend to any covered individual who is employed in or a resident of Alabama.

By closely regulating PBM contracts with pharmacists, the legislation could constrain plan sponsors' pharmacy plan design and may affect PBM costs. In December 2020, the US Supreme Court held that an Arkansas law regulating PBM contracts with pharmacists is not preempted by ERISA because the state law doesn't regulate the ERISA plan itself (*Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540 (U.S. Dec. 10, 2020)).

Colorado

In a move to implement the state's Canadian Drug Importation Program, Colorado regulators announced an invitation to negotiate, soliciting vendors to help oversee the program and the distribution of Canadian drugs imported to Colorado. The Department of Health Care Policy & Financing expects to act as the program's sponsor and oversight entity. Bids are due by April 26.

A 2019 Colorado law (Ch. 183, SB19-005, CO Rev. Stat. § 25.5-2.5-201 to -207) authorized the importation program to give Colorado employers and consumers access to Canada's lower-priced drugs. Effective Nov. 30, 2020, final federal importation rules allow states, tribes, or, in certain circumstances, pharmacists or wholesale distributors to sponsor programs to import certain prescription drugs shipped from Canada. The Pharmaceutical Research and Manufacturers of America (PhRMA) has filed a complaint in federal court seeking to overturn the rule, claiming it poses additional risks to public health and safety.

Wisconsin

Wisconsin Gov. Tony Evers' proposed 2021–2023 executive budget targets controlling prescription drug costs through a number of approaches. According to the budget brief, the governor is calling for the state to:

- Import generic drugs from Canada
- Cap copayments at $50 for a month's insulin supply
- Require insurers to apply certain drug discounts received from drug companies toward an individual's deductible and out-of-pocket maximum
- Require drug companies, insurers, and PBMs to justify price increases, disclose production and marketing costs, report on rebates received, and disclose price concessions received from other companies within the prescription drug supply chain

These efforts would largely be overseen by a newly established Office of Prescription Drug Affordability, which would also set spending targets for public-sector entities and price ceilings for prescription drugs. The governor also recommends requiring PBMs to be licensed to operate in the state.

Other health-related budget proposals call for expanding Medicaid and creating a state-administered public health plan for state residents. It's uncertain which, if any, of the Democratic governor's proposals will survive the Republican-controlled legislative process.

Mental health parity

States, including California, are working to align their health insurance laws with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA requires parity between financial and nonquantitative treatment limitations (NQTLs) for mental health and substance use disorder (MH/SUD) and medical/surgical (M/S) benefits. Recent federal legislation, the Consolidated Appropriations Act, 2021, requires all group health plans to prepare a comparative analysis of NQTLs and disclose it to regulating agencies on request. Kentucky and New York have taken steps to implement a similar requirement at the state level.

California

California's MH/SUD insurance requirements expanded effective Jan. 1, 2021, under legislation (SB 855, 2020 Ch. 151) meant to update and align the state law with MHPAEA. The changes also respond to recent litigation involving improper denial of mental health claims. The California legislation replaces the state's previous requirements that limited mental health coverage parity obligations. The revised requirements significantly broaden mandated coverage standards.

The change in the California law could affect insured health coverage that employers purchase in the state for their employees but won't have a direct impact on self-insured plans. However, the broader implications of a recent federal court order (on hold pending appeal) and increased state enforcement of MHPAEA standards could have consequences for self-insured plans. For more information, see California broadens its mental health parity law.

Kentucky

A new Kentucky mental health parity law (2021 Ch. 15, HB 50) prohibits insured health plans from imposing a NQTL on MH/SUD benefits that doesn't apply to M/S benefits in the same classification. Any medical-necessity criteria or NQTL for MH/SUD benefits in any classification must be comparable to and applied no more stringently than those applied to M/S benefits. This change aligns the state law with MHPAEA.

Insurers must submit an annual report to state regulators describing the process used to develop or select medical-necessity criteria for both MH/SUD and M/S benefits. The report also must identify all NQTLs that apply to covered benefits and services for both MH/SUD and M/S benefits within each benefit classification. The mandate takes effect for insured plan issued or renewed in Kentucky on or after Jan. 1, 2022. Small groups with 50 or fewer employees are exempt.

New York

New York has begun to implement a new requirement for all health insurers in the state to develop a MH/SUD parity compliance program. Regulations issued in 2020 require insurers to establish corporate governance for compliance with state and federal parity rules. The rule does not apply to self-insured plans. As part of the

compliance program, insurers must develop policies that describe the methods used to identify and test financial and nonfinancial limits on benefits, including a comparative analysis of NQTLs. Insurers must have annual internal training on parity compliance and an actuarial certification process for data used to assess parity in financial limits.

This is the latest development in New York's efforts to enhance parity compliance. In 2019, the state began requiring insurers to provide an annual report to the Department of Financial Services detailing specific information about parity compliance, including data on mental health claims and denied appeals and any prior-authorization requirements for services and prescription drugs. Insurers have to provide comparative and other information using a specific template.

Telehealth

Use of telehealth has increased during the COVID-19 pandemic, and the Centers for Medicare & Medicaid Services (CMS) last year announced permanent expansion of Medicare coverage for telehealth services. States likewise have begun to broaden the availability of telehealth services, particularly for mental health. Alabama and Kentucky have joined several other states in an interstate compact to provide mental health services, including through telepsychology. A New York proposal would expand incentives for using telehealth. Utah has added insurance coverage requirements for mental health treatment via telehealth.

Alabama and Kentucky

Alabama and Kentucky have enacted legislation to join the Psychology Interjurisdictional Compact (PSYPACT), the organization announced. Alabama's law (2021 Ch. 116, SB 102) will take effect June 1 and Kentucky's law (2021 Ch. 46, HB 38) will be effective June 29.

PSYPACT, an interstate compact between states, facilitates the practice of telepsychology and temporary in-person, face-to-face psychology practice 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. PSYPACT will begin accepting provider applications for Alabama and Kentucky on each state law's respective effective dates.

Other PSYPACT participating states include Arizona, Colorado, Delaware, Georgia, Illinois, Missouri, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, Pennsylvania, Texas, Utah, Virginia and Washington, DC.

New York

New York Gov. Andrew Cuomo announced a proposal to facilitate access to telehealth, particularly for mental health treatment. The measure would adjust reimbursement incentives to encourage telehealth, eliminate regulatory prohibitions on telehealth delivery, remove location requirements, provide patients and providers with training programs to ease usage, and establish other telehealth usage incentives. The proposal would also require commercial health insurers to offer a telehealth program to members.

The comprehensive reforms would permanently adopt COVID-19-era innovations that have expanded access to physical and MH/SUD telehealth services. The proposal also focuses on developing interstate licensing reciprocity with states in the Northeast region for specialties with historical access shortages. The goal is to ensure sufficient access to medical and behavioral health professionals.

Utah

A new Utah law (2021 Ch. 19, SB 41) mandates telehealth coverage for plans that provide a mental health benefit. A plan must pay for medically necessary treatment of a mental health condition through telehealth services if: (i) the plan covers treatment of the mental health condition through in-person services; and (ii) the insurer determines telehealth treatment of the condition meets the appropriate standard of care. The new mental health provisions apply to insured health plans and took effect when signed by the governor on March 2

The measure amends the state's 2020 telehealth law (UT Code Ann. § 31A-22-649.5), which requires an insured plan to cover all telemedicine services that Medicare covers and to reimburse those services "at a commercially reasonable rate." In addition, a health plan can't impose geographic, originating site or distance-based restrictions on a network telemedicine provider.

State healthcare initiatives

Efforts to expand coverage and reduce costs continue to drive state healthcare initiatives. California lawmakers have once again introduced a bill to establish a single-payer healthcare system, but funding details are absent. Virginia will seek an innovation waiver under the Affordable Care Act (ACA) to establish a reinsurance program to bring down premiums in the individual health insurance market. Seattle, WA's healthcare ordinance for hotel employees withstood an ERISA preemption challenge, but the case may get another hearing.

California

A California bill (AB 1400) would create CalCare, a comprehensive, universal single-payer healthcare coverage and cost-control system. The proposed program would cover a wide range of medical benefits and other services, such as long-term care, and would incorporate existing federal and state health benefit requirements and standards.

CalCare would be free to all California residents with no premium and no cost sharing for treatment or services. A CalCare Board would govern the program, including healthcare provider participation agreements. The measure doesn't stipulate how the plan would impact health insurers. The proposal wouldn't preempt a local jurisdiction from adopting additional health coverage requirements for its residents.

As currently written, the legislation's only funding mechanisms are waivers under Medicare, any federally matched public health program, Section 1332 of the ACA and any other federal programs. The bill requires lawmakers to enact additional legislation to develop a revenue plan in consultation with appropriate officials and stakeholders. The program would only become operative once the CalCare Trust Fund has the revenues to fund implementation costs. Several prior efforts to enact a single-payer plan have failed to pass.

Virginia

A new Virginia law (2021 Ch. 480, HB 2332) calls for the state to seek an ACA Section 1332 innovation waiver for a reinsurance program to stabilize premiums for health benefit plans in the individual market. Under Section 1332, if a waiver program reduces how much the federal government pays in premium tax credits and other ACA subsidies, the state can get those savings directly as federal pass-through funding. State reinsurance programs provide additional dollars to insurers covering individuals with high claim costs or specific conditions, thus lowering the overall premiums that individuals in the risk pool must pay.

An early version of the bill would have imposed an annual assessment equal to 1% of a carrier's net written premiums, with certain exemptions. The final legislation omits the insurer assessments but includes requirements for data submissions, recordkeeping, reporting, and audits of health carriers. It's unclear if a carrier assessment could be added at a later date.

Seattle, WA

In an unpublished opinion, a three-judge panel of the 9th US Circuit Court of Appeals agreed with a federal district court's decision that Seattle's healthcare ordinance for hotel employees does not relate to an employee benefit plan in a manner that triggers ERISA preemption.

Hotels in Seattle with 100 or more guest rooms or suites, whether occupied or not, must comply as covered employers. Certain ancillary hotel businesses with 50 or more employees worldwide also are covered employers. The ordinance defines ancillary businesses as companies in Seattle, including chains and franchises, that routinely contract to provide food and beverages sold on a covered hotel's property or other hotel-related services.

In 2020, a federal district court held that ERISA doesn't preempt the mandate, and the ERISA Industry Committee (ERIC) appealed. The appellate court rejected ERIC's claim that the Seattle mandate is distinguishable from a similar mandated healthcare expenditure for employers in San Francisco that withstood an ERISA challenge. ERIC has said it will ask the full 9th Circuit for a review.

Employer reporting

Plan sponsors' state reporting obligations vary by jurisdiction and often add to existing ERISA reporting responsibilities. In San Francisco, the annual deadline to report healthcare expenditures for calendar-year 2020 has been delayed and may be waived. Georgia lawmakers have proposed adding a comprehensive reporting requirement for healthcare payers as a condition of receiving certain state tax credit, but the viability of this measure remains uncertain. New York has posted its 2021 covered-lives assessment rate for healthcare payers that report and pay directly to the state.

San Francisco, CA

Proposed legislation, currently awaiting the mayor's approval, would waive San Francisco's Health Care Security Ordinance (HCSO) reporting requirement for 2020 due to the COVID-19 public health crisis. In anticipation, the city's Office of Labor Standards Enforcement (OLSE) has issued administrative guidance postponing the calendar-year 2020 reporting deadline for the HCSO and Fair Chance Ordinance for at least six months — to Oct. 31, 2021, or later.

The report for each calendar year typically is due by the end of April of the following year. The HCSO requires employers to spend a minimum healthcare expenditure (HCE) on each employee for each hour worked. Despite the postponed reporting deadline, all HCE payments — including those to City Option — are still due within 30 days of the end of each calendar quarter, or annually by Feb. 28 for self-funded plans.

Georgia

Georgia lawmakers have introduced 2021 legislation (SB 1) to amend the state's All-Payer Claims Database (APCD) enacted in 2020 (Ch. 580, SB 482). If enacted, the measure would require self-insured ERISA plan sponsors that receive tax credits from the state to participate in the program.

State APCD programs require all health insurers to report to state regulators an array of claims and other data about their plans, covered individuals, provider payments, and plan finances. The data populates a comprehensive healthcare information system that insurers, employers, providers, healthcare purchasers and state agencies can use to review healthcare utilization, expenditures and performance in the state.

In 2016, the US Supreme ruled that ERISA preempts a Vermont APCD law that would have required self-insured ERISA plans or their administrator to report this data (*Gobeille v. Liberty Mutual Ins. Co.*, 577 US 312). However, the Georgia approach would mandate reporting as a condition of receiving certain tax credits. How the high court would view Georgia's legislation is uncertain, which could determine whether other states employ the same approach. The proposal has seen little movement in the legislature.

New York

New York has posted its 2021 covered-lives assessment (CLA) rates for graduate medical education under the state's Health Care Reform Act (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 and report the CLA directly to the state's Professional Educational Pool. 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. For more information, see New York announces 2021 HCRA covered-lives assessment rates.

Insurance

Kentucky has added stipulations for certain third-party contributions that may count toward an insured's cost sharing. New York has clarified the coverage requirements for a surrogate mother's healthcare costs under its new surrogacy law. New York also has revised insurance coverage guidelines governing infertility treatment for same-sex couples and single and transgender individuals. Ohio joined several other states to enact a "surprise" medical bill law. Washington, DC is the latest jurisdiction to add a monetary cap to an insured individual's insulin cost. These insurance requirements don't apply to self-insured ERISA plans.

Kentucky

A new Kentucky Law (2021 Ch. 133, SB 44) requires certain third-party contributions to count toward an insured individual's cost-sharing obligation under the plan. The law applies to payments made on behalf of the insured person by state, federal and tribal governments, religious establishments, and nonprofit organizations. The condition doesn't apply to payments made by or on behalf of any organization that receives funding in any form from a healthcare provider. High-deductible health plans are exempt if the contribution would impair an individual's eligibility to contribute to a health savings account. The measure takes effect for insured plans in Kentucky issued or renewed on or after Jan. 1, 2022.

New York

New York health insurers can't exclude coverage for a surrogate's maternity care simply because she's acting as a surrogate. Insurers must cover maternity and childbirth expenses for surrogates to the same extent as other covered individuals. Insurance Circular Letter No. 1 (2021) identifies health coverage issues under a 2020 law that allows paid surrogacy agreements in the state for the first time beginning Feb. 15, 2021. The guidance confirms that the coverage requirements for maternity and preventive care and pregnancy-related screenings apply to surrogates covered under a health insurance policy or contract subject to the insurance law.

The surrogate law (NY Fam. Ct. Act Art. 5-C) addresses the legalities of parentage; contracts between the surrogate and the intended parent or parents, including residency requirements; and court records. The measure details who may act as a surrogate, including age and health requirements, life and health insurance, and legal representation. It also includes contingencies for anonymous donors, multiple births and medical risks.

New York

Gov. Andrew Cuomo announced revised infertility treatment insurance coverage guidelines for same-sex couples, unmarried persons and transgender individuals. Insurance Circular Letter No. 3 (2021) directs health insurers in New York to provide immediate coverage of infertility diagnostic and treatment services, including prescription drugs, for covered individuals unable to conceive due to their sexual orientation or gender identity. The directive withdraws 2017 guidance (Circular Letter No. 7 (2017)) explaining New York's infertility coverage law (NY Ins. Law § 3221(k)(6)) and eliminates the 12-month waiting period for these individuals.

A 2019 law (Part L of Ch. 57, SB 1507) added a three-cycle in-vitro fertilization coverage mandate for large group health plans (more than 100 employees), as well as standard fertility-preservation services when a necessary medical treatment may directly or indirectly impair fertility. That law also eliminated age limits, removed a 12-month coverage requirement, and extended benefits regardless of marital status, sexual orientation, or gender identity.

Ohio

A new law (HB 388) prohibits balance-billing patients who receive unanticipated out-of-network (OON) care in Ohio. Though effective April 12, 2021, the law applies to services beginning nine months later in January 2022, regardless of the plan's renewal date.

The mandate covers health insurers for plans issued in Ohio (and elsewhere to the extent they cover Ohio residents), self-insured nonfederal governmental plans and multiple-employer welfare arrangements. The law doesn't apply to self-insured ERISA plans or allow for their participation.

The new law bans health providers, facilities and ambulance services from billing covered individuals more than in-network cost sharing for emergency services or situations in which the patient was unable to request an in-network provider's services or did not affirmatively consent to receive an OON provider's services at an in-network facility.

The law requires the plan to pay the OON provider — including the healthcare facility or ambulance service — the highest of:

- The in-network negotiated price for the services (or median price if the price varies)
- The usual, customary and reasonable amount
- The amount payable under Medicare Part A or B

Alternatively, a healthcare provider, ambulance service or facility may request to negotiate reimbursement. Any dispute would go to arbitration.

Washington, DC

Beginning Jan. 1, 2022, a new Washington, DC, law (2021 Law L23-0252, B23-920) requires health insurers that cover prescription insulin to limit an insured individual's cost for a 30-day supply to $30, regardless of the quantity or type of covered insulin. Health insurers that cover diabetes devices must limit an insured person's cost sharing to $100 for a 30-day supply of all medically necessary covered diabetes devices. Diabetic drugs and supplies must be covered with no deductible. The amounts will be annually indexed to the medical care component for the local area's Consumer Price Index. The nation's capital joins a growing list of states curbing out-of-pocket insulin costs for insured individuals.

Leave laws

Paid leave laws remain in flux as states continue to grapple with COVID-19 while working to enact paid leave benefits that will remain in place once the pandemic ends. In the first quarter of 2021, state lawmakers and regulators updated COVID-19 leave mandates, expanded employer-provided paid sick and safe leave obligations and considered establishing state paid family and medical leave (PFML) programs.

COVID-19

As the COVID-19 pandemic and its fallout continued into 2021, several state and local governments updated or expanded related paid sick leave mandates. California has extended its supplemental paid sick leave law through September 2021 and expanded the mandate to cover employers with more than 25 employees. In addition, California's November 2020 rule requiring an apparently uncapped amount of paid, protected leave for certain employees who must be "excluded" from the workplace will remain in place pending a court appeal. Illinois has outlined how employers should compensate workers for time off to obtain a vaccination. New York guidance explains how and when employers should compensate employees for COVID-19 leave. New York also mandates four hours of paid time off per injection for employees receiving a vaccine.

State and local update

To alleviate some of the economic strain on employees unable to work due to COVID-19, some state and local authorities implemented new paid leave requirements. Other jurisdictions are modifying existing leave laws or benefit programs to accommodate employees' needs during the pandemic. Many state and local COVID-19 paid leave requirements expired at the end of 2020, but some remain in force and others have been renewed or amended to extend these paid leave obligations into 2021. First-quarter 2021 changes include California's new COVID-19 supplemental paid leave law and Illinois guidance on compensation and paid leave for COVID-19 vaccines. New York has a new law requiring paid leave for employees to get COVID-19 vaccines and has issued guidance on employers' COVID-related paid leave obligations. Many California cities and counties have expanded or renewed paid leave obligations, while Philadelphia has imposed a new public health emergency leave ordinance. For a comprehensive review of the mandates, see States, cities tackle COVID-19 paid leave.

California — COVID-19 SPSL law

A new California law (2021 Ch. 13, SB 95) revives and expands the supplemental paid sick leave (SPSL) requirement that expired at the end of 2020. Employers with more than 25 employees nationwide must provide up to 80 hours of COVID-19 SPSL for covered California employees who are unable to work or telework. The law is retroactive to Jan. 1, 2021. Covered employees on COVID-19 SPSL when the law expires Sept. 30, 2021, may exhaust their leave entitlement. Employers must post a notice of SPSL rights in a conspicuous worksite location or

e-deliver the notice to employees who do not frequent a workplace. The Department of Industrial Relations (DIR) has published FAQs.

Full-time employees and those averaging 40 hours per week can take up to 80 hours of SPSL. Other workers are entitled to the number of work hours normally scheduled over a two-week period. Variable-hour workers are entitled to 14 times their average daily hours worked over a six-month period before the leave began or, if employed fewer than six months, the entire period of employment.

In all cases, leave is available for immediate use on oral or written request by employees unable to work or telework for specified COVID-19-related reasons. SPSL is paid at the highest of the employee's regular rate of pay, the state minimum wage or the local minimum wage, but may be capped at $511 per day and $5,110 in the aggregate per employee. Leave coordination and offset provisions apply.

California — Cal/OSHA litigation

A California court has denied several employer groups' request to bar the state's Occupational Safety and Health (OSH) Board from enforcing the new Cal/OSHA rules while legal challenges continue (*Nat'l Retail Fed'n v. CA Dep't of Indus. Relations*, No. CGC-20-588367 (San Francisco Cnty. Sup. Ct. Feb. 25, 2021)). The court found that emergency injunctive relief was not warranted in light of the pandemic and the public interest in protecting workers and the community. The court also said that plaintiffs' claims likely won't succeed.

In November 2020, Cal/OSHA posted emergency temporary standards (ETS) providing guidance on the detailed elements that employers must include in a COVID-19 prevention program. The ETS establishes mandatory protocols and requires employers to grant apparently unlimited paid, job-protected leave for certain employees who must be "excluded" from the workplace during a COVID-19 outbreak. FAQs provide addition details.

The National Retail Federation and other industry groups announced they are challenging the ETS in state court. The lawsuit claims that regulators improperly rushed to issue emergency regulations by relying on unsupported speculation about a connection between workplace reopenings and increased COVID-19 cases. While the litigation will continue, CAL/OSHA can enforce the ETS provisions.

Illinois

In March, the Illinois Department of Labor issued employer guidance titled "Compensation, paid leave and the COVID-19 vaccine." The guidance is divided into three sections covering mandatory and optional vaccine programs for workers and employee absences to take a family member to get vaccinated.

Mandatory vaccine programs. If an employer requires employees to get vaccinated, the time the employee spends obtaining the vaccine is likely compensable, even if the vaccination occurs outside work hours. Employers should pair mandatory vaccination policies with paid leave for employees to receive all doses of the COVID-19 vaccine. Employers that do not provide paid leave should compensate employees for the time taken to comply with the mandatory vaccine policy.

Optional vaccine programs. Employees that voluntarily get the vaccine should be allowed to use sick leave, vacation time or other paid time off for all doses. Employers should also consider offering flextime for employees to become vaccinated without having to take unpaid time. Alternatively, employers should allow employees the flexibility to take unpaid time off.

Leave to take family members for vaccines. Under the Employee Sick Leave Act (ESLA), employers must allow employees to use employer-provided sick leave benefits for absences due to a family member's medical appointments. A COVID-19 vaccine appointment qualifies as a medical appointment under the ESLA if the employer allows employees to use sick leave benefits to get vaccinations. Therefore, employers should allow employees to use sick leave benefits when taking a qualifying family member to receive the COVID-19 vaccine.

New York

According to recent New York Department of Labor guidance, if an employer requires an employee who is not otherwise subject to a mandatory or precautionary quarantine or isolation order to stay away from work due to COVID-19 exposure or potential exposure, the employer must continue to pay the employee. This obligation applies regardless of whether the exposure or potential exposure occurred at the workplace.

Paid leave continues at the employee's regular rate of pay until the employee is permitted to return to work or becomes subject to a mandatory or precautionary quarantine or isolation order. If the employee becomes subject to a mandatory or precautionary order of quarantine or isolation, the employee is entitled to emergency paid sick leave under the state's COVID-19 sick leave law.

The guidance also indicates that emergency paid sick leave is available for up to three orders of quarantine or isolation. The second and third instances qualify for emergency paid sick leave only if the employee has documentation of a positive COVID-19 test from a licensed medical provider or testing facility. Supporting documentation is not required if the employer provides the test.

New York

A New York law (2021 Ch. 77, AB 3354) requires employers in the state to grant employees up to four hours of paid time off to receive a COVID-19 vaccination. The leave is in addition to any other leave available to the employee, including the state's mandated paid sick leave. The law took effect when signed on March 12 and sunsets at the end of 2022.

New York FAQs on the new COVID-19 vaccination leave confirm that the law is not retroactive, so leave for vaccines taken before March 12 does not have to be paid retroactively. In addition, the leave mandate applies per injection.

PFML

State programs providing eligible employees with partial wage replacement for leave related to serious health conditions and family needs have grown in the past few years, and more states are considering options to establish similar programs. Maryland and New Mexico have pending PFML legislation. Oregon plans to issue PFML regulations by this fall and begin collecting contributions in 2022. Washington has posted guidance to clarify how telecommuting across state lines affects participation in its program.

Multi-state update and chart

As of January 2021, California, Hawaii, Massachusetts, New Jersey, New York, Rhode Island, Washington, and Washington, DC, mandate paid leave for an employee's own health condition. This is the first year that benefits are available through the Massachusetts program. Connecticut contributions began this year, and benefits will follow in 2022. Oregon contributions start in 2022, with benefits first available in 2023. Under Colorado's recent voter-

approved program, contributions will begin in 2023, with benefits available in 2024. Except for Hawaii, 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. The jurisdictions with benefits available this year have announced contribution and benefit calculations for 2021. For details, see 2021 state paid family and medical leave contributions and benefits.

Maryland

Maryland legislation (HB 375), if enacted, would establish a family and medical leave insurance program for any employer with at least one employee working in the state. The measure calls for employers to begin collecting and remitting contributions Jan. 1, 2022. The amount could be up to 0.75% of an employee's wages and would be shared equally by employers and employees. Benefits would be calculated using a formula tied to the state's average weekly wage.

Beginning July 1, 2023, a covered employee who has worked at least 680 hours over the 12–month period immediately preceding the start of leave would qualify to take up to 12 weeks of leave to care for the employee's own or a family member's serious health condition, bond with a new child, handle a qualifying military exigency, or to care for a service member who is next of kin. Employees who exhaust the first 12 weeks of leave due to their own serious health condition could take an additional 12 weeks of leave for another covered reason.

The state's Division of Unemployment Insurance would administer the program. Employers offering a private plan that meets certain requirements could apply for an exemption. A similar Senate bill (SB 211) is under consideration.

New Mexico

New Mexico lawmakers considered a PFML Act (HB 38) that, beginning July 1, 2024, would have given eligible employees up to 12 weeks of paid leave, including intermittent leave, to care for their own or a family member's serious health condition or bond with a new child. The program would have applied to all employees working in the state — regardless of whether the employer is physically located in New Mexico — who contributed to the fund for at least six months during the preceding 12-month period. Self-employed individuals would have had a chance to opt in to the program.

Beginning July 1, 2023, employers would have paid 0.4% of an eligible employee's earnings, and employees would have paid 0.5% to fund the program. Employers that sponsor their own paid family and medical leave plan could have applied annually for an exemption.

The measure called for partial wage replacement based on the employee's average weekly earnings during the 12 months immediately preceding the date of the leave claim, up to a maximum of $60,000 in gross earnings per year. Benefits would equal 100% of covered wages up to the minimum wage, plus 67% of the employee's average weekly wage exceeding that amount up to the state's average weekly wage. The bill failed to pass in the 2021 session: whether the proposal will be reconsidered in 2022 is uncertain.

Oregon

Oregon's PFML Insurance (PFMLI) program will begin collecting employer and employee contributions on Jan. 1, 2022, and paying benefits in 2023. The 2019 legislation (Ch. 700, HB 2005, OR Rev. Stat. Ch. 657B) provides up to 12 weeks of family and medical leave with partial wage replacement so eligible employees can recover from their own serious health condition, care for a family member with a serious health condition, bond with a new child, and

handle issues related to domestic violence, harassment, sexual assault or stalking. An additional two weeks of paid leave may be available for pregnancy- and childbirth-related complications and an additional four weeks of unpaid, job-protected leave under the state's current family leave law. For more on eligibility, benefits, and options for a private "equivalent" plan, see Oregon's paid family and medical leave contributions begin in 2022.

Washington

A recent Washington emergency rule (WA Admin. Code § 192-510-091) clarifies that under the state's PFML program, an employee who worked in Washington before to March 23, 2020, continues to be considered working in the state if the sole reason for working in another state is to work from home due to the COVID-19 outbreak. The guidance applies only if the employee already had a residence in another state before the outbreak and intends to return to working exclusively or mostly in Washington once COVID-19 restrictions are lifted. Employers must continue to collect and remit PFML contributions for these workers and count them on quarterly reports.

Paid sick leave

Employer-provided paid sick and safe leave mandates have multiplied in the past few years. Though many provisions are similar from state to state, some variations in each raise compliance concerns for employers. New Mexico will soon join the group of states that currently impose this obligation.

Multistate overview and chart

New Mexico is the latest among a growing number of states requiring employers to provide paid sick and other accrued leave. To date, 14 states — Arizona, California, Colorado, Connecticut, Maryland, Massachusetts, Michigan, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington — and Washington, DC, have enacted paid sick leave mandates. Maine and Nevada have laws requiring accrued paid time off not limited to sick time. For an overview and chart summarizing these laws (excluding New Mexico's), see Paid sick leave mandates continue to expand at state level.

New Mexico

New Mexico's paid sick leave law (2021 Ch. 131, HB 20) requires employees in the state — including part-time, seasonal and temporary workers — to receive at least one hour of paid leave for every 30 worked to a maximum of 64 hours per year. Unused earned leave must carry over up to the annual 64-hour maximum but doesn't have to be paid at termination. Accruals begin on the later of the date of hire or the mandate's July 1, 2022, effective date. Alternatively, an employer can forgo accruals by front-loading hours each year. Pay is at the employee's regular rate of pay with the same benefits, including healthcare benefits.

The Healthy Workplaces Act applies to employers with at least one employee working in the state but exempts the state and any political subdivision. Employees may use the leave for their own or a family member's health needs; a child's school meetings; and matters arising from domestic abuse, sexual assault or stalking of the employee or a family member. The act has certain notice, posting and anti-retaliation provisions. An employer's existing paid leave program that allows the same amount of time for the same reasons can satisfy the mandate. The state law doesn't preempt any other similar law, including local leave mandates.

Other benefit-related activity

Beyond healthcare and leave laws, other state activity may impact employers' benefit plans. Colorado and Utah have clarified requirements for verifying common-law marriage. Virginia has enacted broad consumer privacy protections that employers may want to review. Washington is moving forward with its state-run, long-term care program that requires employee contributions starting in 2022. The state is also considering a bill that would impose a deadline for employees to opt out of the program.

Colorado

The Colorado Supreme Court has held that a common-law same-sex marriage entered in Colorado may be recognized, even though its formation predates Colorado's recognition of licensed same-sex marriages.

In three rulings issued Jan. 11 (*In re Marriage of LaFleur v. Pyfer*, *In re Marriage of Hogsett v. Neale*, *In re Estate of Yudkin*), the state's high court also set out updated parameters for determining the validity of common-law marriage in the state: A common-law marriage may be established by the mutual consent or agreement of the couple to enter the legal and social institution of marriage, followed by conduct manifesting that mutual agreement. While the manifestation of the parties' agreement to marry need not take a particular form, the refined test of a valid common-law marriage emphasizes the importance of the parties' *mutual* agreement to enter a *marital* relationship.

In the *Hogsett* ruling, the court stated the inquiry into the validity of common-law marriage "is fact-intensive and invasive and forces judges to assess the degree to which a couple's conduct conforms to a marital ideal. Indeed, the common-law marriage doctrine holds relationships to standards that some licensed marriages might not meet if similarly scrutinized." One justice, in a concurring opinion, even urged the legislature to consider abolishing common-law marriage in the state.

Utah

Effective May 15, common-law spouses in Utah must file a petition for an unsolemnized marriage "during the relationship." Recent legislation (2021 Ch. 185, HB 316) adds the petition requirement to the state's common-law marriage statute (UT Code Ann. § 30-1-4.5). The provision doesn't include a timeline or outline filing procedures, which might involve a local county clerk. Employers whose Utah employees seek to add a common-law spouse to a plan may want to ask for this type of documentation once available.

Virginia

Beginning in 2023, a new Virginia law (2021 Ch. 35, HB 2307) grants consumers in the state certain privacy rights. Under the law, businesses must limit personal data collection to what is adequate, relevant and reasonably necessary to the purpose for which the data is processed. Businesses also must establish, implement, and maintain reasonable administrative, technical, and physical security practices to protect the confidentiality, integrity, and accessibility of the data.

The law allows consumers to confirm whether the their personal data is being processed; access and obtain a copy of the data; correct inaccuracies; delete the personal data; and opt out of the having the personal data used for targeted advertising, sales, or similar uses.

A company that conducts business in Virginia or whose products or services target Virginia residents must comply with the law if the company controls or processes personal data of at least 100,000 consumers. That data threshold

drops to at least 25,000 consumers if the company derives over 50% of its gross revenue from the sale of personal data. The law doesn't apply to certain state and federal entities, information protected by the federal Health Insurance Portability and Accountability Act, or identifiable private information required by certain federal policies and laws. The law also exempts certain employment and benefit-related data.

Covered businesses must provide consumers with a "reasonably accessible, clear, and meaningful" privacy notice. This notice must include the categories of processed personal data and their purpose, consumer rights, and information about data shared with third parties.

Washington

Washington legislation (HB 1323) now on the governor's desk would impose a November deadline for employees to purchase their own long-term care (LTC) insurance if they want to opt out of the state program.

Washington's state-run Long-Term Services and Supports Trust Program (2019 Ch. 363, HB 1087) requires employers, beginning Jan. 1, 2022, to collect 0.58% of wages from employees residing in the state through payroll deduction and remit these premium contributions to the program. The 2019 law allows employees with other LTC insurance to waive participation. However, the new legislation would amend the LTC law to limit the availability of this waiver to employees who purchase an LTC policy before Nov. 1, 2021.

Other amended provisions would extend the program to adult workers who were disabled before age 18 and provide tribes a pathway to opt in to the program. Self-employed individuals who want to participate would have to opt in before Jan. 1, 2025 (or within three years of becoming self-employed) and continue to participate in the program until retired or no longer self-employed.

Related resources

Mercer Law & Policy resources

- Mental health parity compliance gets a boost in 2021 spending act (April, 2021)
- States, cities tackle COVID-19 paid leave (April 12, 2021)
- Oregon's paid family and medical leave contributions begin in 2022 (March 11, 2021)
- California broadens its mental health parity law (March 11, 2021)
- Congress extends tax credit for paid family and medical leave (Feb. 12, 2021)
- Paid sick leave mandates continue to expand at state level (Feb. 8, 2021)
- Roundup of selected state health developments, fourth-quarter 2020 (Feb. 3, 2021)
- 2021 state paid family and medical leave contributions and benefits (Jan. 20, 2021)
- New York announces 2021 HCRA covered-lives assessment rates (Jan. 11, 2021)
- Supreme Court upholds Arkansas law regulating PBMs (Dec. 10, 2020)

- States increase group health plan reporting obligation (Nov. 20, 2020)
- California: App-based drivers are contractors — not employees (Nov. 5, 2020)
- Washington state to establish employee-funded long-term care (Oct. 29, 2020)
- New Hampshire targets Rx costs, joins other states to add insulin cap (Sept. 2, 2020)
- Seattle healthcare expenditure for hotels survives ERISA challenge (Aug. 4, 2020)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)
- New York passes paid sick leave mandate (April 9, 2020)
- Common-law marriage raises issues for employer benefits (March 3, 2020)
- Roundup of selected state health developments — second-quarter 2019 (July 29, 2019)
- San Francisco's annual health care expenditure report due April 30 (March 26, 2019)

Other Mercer resources

- Employers urge policy changes as Senate panel examines telehealth issues
- Life, absence and disability
- State paid leaves: Three things employers should do in 2020 besides comply (Jan. 30, 2020)

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