Roundup of selected state health developments, second-quarter 2021

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In this article

Through the second quarter of the year, states enacted a range of prescription drug laws on cost sharing and pharmacy benefit manager (PBM) regulation. Expanded telehealth use, availability and provider reimbursement parity also received attention. Some states added or clarified health plan assessments that apply to insured and self-insured plans and fund certain state health programs. New health insurance laws focus on cost sharing and mental health coverage. Two states — Colorado and Nevada — enacted public health options for state residents, but New York's single-payer health plan proposal died in committee. Paid sick, family and COVID-19 leave laws continued to draw action in several locations. Other benefit-related issues include a New Jersey severance pay mandate, a New York requirement for participant cards identifying self-funded health plans, and a clarification of Washington's long-term care (LTC) program.

Prescription drugs

As COVID-19 issues receded, a focus on drug pricing and related costs attracted state lawmakers' attention. The steep rise in prescription drug costs — insulin in particular — has spurred states to impose cost-sharing limits. The pace of new PBM laws accelerated in 2021 after the US Supreme Court held that ERISA doesn't preempt Arkansas's law regulating PBM pharmacy reimbursements. States have been looking at regulating other PBM activities and contract provisions that could withstand a preemption challenge.

State actions nationwide

The National Academy for State Health Policy (NASHP) has posted a chart of state drug-pricing laws since 2017 across multiple categories, including PBMs, transparency, importation and cost sharing. PBM laws accounted for 108 laws across 45 states, according to the report. As of July 7, 18 states imposed pharmacy cost-sharing restrictions, and 17 passed drug transparency laws.

The site also tracks the status of prescription drug proposals. Legislation proposed in 2021 through July 7 includes 109 PBM bills, 62 cost-sharing bills and 43 transparency measures under consideration or newly signed into law.

The charts include bill and law information on drug importation, affordability reviews, unsupported price hikes and other pricing requirements.

Insulin limits

After the 2020 notice announcing Medicare's temporary pilot program limiting cost sharing for insulin, several states have acted to impose similar caps on commercial health insurance. In the second quarter of 2021, Vermont added a monthly cap on insulin cost sharing in insured health plans. Arkansas sought to require that drugmakers share any coupons or cost savings for insulin only with the patient.

Arkansas

Beginning Jan. 1, 2022, a new Arkansas law (Act 1104, HB 1709) will prohibit pharmaceutical drug manufacturers that sell insulin in the state from providing discounts for insulin products except in the form of coupons to end users only. Banned discounts include price concessions, rebates and assorted fees paid by the manufacturer. The legislation adds the new section to the state's consumer protection law (AR Code § 4-86-111). The state attorney general can investigate potential violations and sue pharmaceutical manufacturers that fail to comply.

The law could face a legal challenge similar to a Maryland law prohibiting price gouging in the sale of prescription drugs. Maryland's law was found to be unconstitutional (*Assoc. for Accessible Meds. v. Frosh*, No. 17-2166 (4th Cir. April 13, 2018)).

Vermont

Effective Jan. 1, 2022, a revised Vermont law (VT Stat. Ann. tit. 8, § 4089i(h)) caps insulin cost sharing at $100 per month. Insurance Bulletin No. 220 clarifies that a health plan offered by a health insurer or PBM must limit a beneficiary's total out-of-pocket responsibility for prescription insulin to $100 per 30-day supply, regardless of the amount, type or number of insulin medications prescribed for the beneficiary. The monthly out-of-pocket spending limit applies regardless of whether the beneficiary has satisfied any health plan deductible. Individuals receiving prescriptions for a longer-term supply may be billed more in a month, but the cost can't exceed $100 for every 30-day supply (e.g., $300 for a 90-day supply).

PBMs

After last year's US Supreme Court decision in *Rutledge v. Pharm. Care Mgmt. Ass'n*. (141 S. Ct. 474 (2020)), state lawmakers enacted or considered a wide range of restrictions and requirements for PBMs, including their contracts with participating pharmacies. At least 10 states enacted new or added to existing PBM laws. Some of the new provisions involved pharmacy reimbursements, bans on "steering" and spread pricing, increased transparency, application of third-party payments, pharmacy choice, and fiduciary obligations. In some cases, the extent to which these laws will impact self-funded ERISA plans — if at all — is unclear.

Alabama

Alabama's new law (2021 Act 341, SB 227) to expand the state's existing PBM regulation (AL Code § 27-45A) bars PBM contracts with pharmacies and insured health plans from having certain practices with respect to covered individuals. The final version omits an earlier proposed requirement that insured purchasers directly receive at the pharmacy counter at least 80% of the rebates and discounts that accrue directly or indirectly to health benefit plans.

However, the law retains provisions that prohibit a PBM from:

- Reimbursing a pharmacy less than the amount the PBM reimburses one of its own affiliated pharmacies or paying other than the pharmacy's contracted amount
- Requiring or steering an insured person to use a mail-order pharmacy or a PBM's affiliated pharmacy
- Limiting — including through 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

The new law also prohibits spread pricing, requires a PBM to act as a fiduciary for its clients and includes certain disclosure obligations. The law extends to any plan covering an Alabama resident or an individual employed in the state, but exempts self-funded ERISA plans. The new provisions apply to PBM contracts entered into on and after Oct. 1, 2021.

Arkansas

Recently signed Arkansas legislation (2021 Act 665, HB 1804) expands the scope of reporting obligations under the state PBM law's (AR Code § 23-92-501 *et seq*.) to include data on third-party administrators (TPAs) for self-funded health benefit plans, including governmental plans. The measure also calls for rules establishing a PBM network adequacy standard at least as strict as the federal standards for Tricare or Medicare Part D. The amendments take effect July 28, 2021.

PBMs must quarterly report for each healthcare payer — now including TPAs — certain aggregate rebate amounts received by the PBM, distributed to the payer and passed on to enrollees. Additional information must include amounts paid by the payer to the PBM and amounts a PBM paid for pharmacist services.

California

California legislation (SB 524) approved in the state Senate and under consideration in the Assembly would bar health plans that provide prescription drug coverage — including employer-sponsored, self-funded medical plans — from requiring patients to use a particular pharmacy or pharmacies if other network pharmacies can provide the services or medication. The bill still permits a self-funded plan or its agent (e.g., a PBM) to offer financial incentives to use a particular pharmacy or pharmacies.

To what extent ERISA could preempt this proposal if enacted is unclear. The Senate Health Committee's bill analysis notes that while ERISA preempts state regulation of self-funded plans, the US Supreme Court's *Rutledge* decision held that ERISA does not preempt Arkansas' PBM provider reimbursement requirements. Though the California bill regulates "steering," not "reimbursement" as in *Rutledge*, the analysis concludes that the same type of reasoning applies. Only a court can determine the applicability of ERISA preemption.

Colorado

New Colorado legislation (2021 Ch. 217, HB 1237) authorizes the state's Department of Personnel to establish a competitive "reverse auction" process — which could eventually open to private plans — for selecting the state

health plan's PBM services through automated, transparent bidding conducted online. The state will seek vendors by Nov. 1, 2022, that can meet certain technology specifications to develop the process.

After the first PBM reverse auction has been completed, private-sector health plans "with substantial participation by Colorado employees and their dependents" will have the option to participate in a joint purchasing pool with the state in subsequent auctions.

Montana

The new Montana Pharmacy Benefit Manager Oversight Act (2021 Ch. 501, SB 395) establishes PBM licensing requirements, prohibits certain PBM practices, requires transparency and maximum allowable cost (MAC) reporting, and mandates network adequacy standards.

Beginning Jan. 1, 2022, the measure requires licenses for PBMs providing services to state residents enrolled in health plans and multiple employee welfare arrangements (MEWAs). Mandatory disclosures to insurers and plan sponsors include certain rebates and fees received, exclusivity arrangements, utilization data, and claim information. Annual reports with additional information also will be due to state regulators.

Oklahoma

Recently enacted Oklahoma legislation (2021 Ch. 37, HB 2678) requires health insurers and PBMs when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost sharing to include any amount paid by an enrollee or on behalf of an enrollee by a third party. Whether the requirement applies self-insured plans is unclear. However, the new provision amends the state's unfair claims practices law, which defines "health benefit plan" to exempt self-insured ERISA plans other than MEWAs. The new provision takes effect Nov. 1, 2021.

Tennessee

A new Tennessee law (2021 Ch. 569, HB 1398) prohibits a PBM from interfering — including through inducement, steering, or offering financial or other incentives — with a patient's right to choose a pharmacy. The measure bars a PBM from charging the health plan more than the PBM pays a contracted pharmacy for a prescription device or drug, including a specialty drug. The provisions were added to the state's existing PBM law (TN Code Ann. § 56-7-3101 *et seq.*), effective July 1, 2021.

The legislation also imposes on PBMs a fiduciary responsibility to report to the health plan and patient any benefit percentage that either one is entitled to as a benefit. Regulations may clarify what this means for plan sponsors. The measure imposes on health plans an obligation to provide certain prescription drug cost, benefit and coverage data if requested by covered individuals or their healthcare providers. These provisions were added to the state's pharmacy benefits law (TN Code Ann. § 56-7-3201 *et seq.*), effective July 1, 2021 and Jan. 1, 2022, respectively.

Texas

A new Texas law (2021 Ch. 142, HB 1763) tightens restrictions on PBMs and certain health plans providing prescription drug benefits. The new law prohibits a plan from reducing pharmacy payments after adjudication, except as part of an audit. A PBM can't pay an affiliated pharmacy or pharmacist more than what the PBM pays a nonaffiliated pharmacy. The law applies to contracts issued or renewed on or after Sept. 1, 2021, for health

insurers, HMOs, self-funded church and school district health plans, and self-funded plans offered by a MEWA or professional employer organization (PEO). The law does not otherwise apply to employer self-funded health plans.

Virginia

Virginia legislation (2021 Ch. 304, HB 2007) establishes prescription drug transparency procedures, effective Jan. 1, 2022. The law calls for annual April 1 reporting by health insurers covering prescription drugs, PBMs and prescription drug manufacturers. State health regulators will contract with a "nonprofit data services organization" to collect, store and make available the information on its website.

Under the new law, health carriers must disclose the names of the 25 most frequently prescribed covered outpatient prescription drugs, those with the greatest cost, and those with the greatest year-over-year cost increases. The report also must include the percent increase in annual net spending for prescription drugs and additional data on specialty drugs. PBMs that contract with the carriers also must annually report information on wholesale acquisition costs (WACs), rebates, negotiated discounts and other pricing details. Manufacturers will have to report data on WACs for brand name, generic and biosimilar drugs.

West Virginia

West Virginia legislation (2021 Ch. 164, HB 2263) adds a “freedom of consumer choice for pharmacy” provision to its existing pharmacy regulation (WV Code § 33-51). The new law requires PBMs and health insurers to allow covered individuals to choose their own pharmacy or pharmacist. The selected pharmacist has the right to participate in the plan if the pharmacy agrees to the insurer’s terms, which must be equal for all providers in the same benefit category, class or copayment level. In addition, participants can’t be required to purchase prescription drugs exclusively through a mail-order pharmacy or to pay greater cost sharing than for items purchased from a mail-order pharmacy. Additional restrictions and reporting requirements apply. The changes will apply to all PBMs and insured health benefit plans issued or renewed on or after Jan. 1, 2022, that provide pharmaceutical benefits to any West Virginia resident.

Telehealth

A drive to expand access to healthcare has prompted states to relax certain restrictions on telehealth services. At the same time, some are requiring reimbursement parity for in-person and telehealth providers rendering the same service in an insured plan. Telehealth expanded considerably during the COVID-19 pandemic, when many day-to-day in-person healthcare services shut down, and healthcare need was highest. Lawmakers who see the need for more healthcare resources have been advocating for increased access to telehealth.

Arizona

Recently signed Arizona legislation (2021 Ch. 320, HB 2454) expands telehealth coverage and mandates provider reimbursement parity, effective immediately for all insured contracts issued, delivered or renewed in the state. The measure allows audio-only telehealth services for mental health and substance use disorder treatment if audio-visual services aren’t available. Audio-only technology also may be used for other health treatments if patients and providers have an established relationship and audio-visual equipment isn’t available. Patients can access telehealth services from any location. Regulators may clarify whether this includes access from outside the state.

Under the new law, insurers must reimburse providers for telehealth services at the same level as in-person services and can’t limit telehealth coverage — including for ancillary services — for otherwise covered benefits.

Insurers can't require healthcare providers to use a particular telehealth program as a condition of network participation. In addition, any provider documentation and recordkeeping obligations can't be more stringent for telehealth services than for in-person treatment.

The Telehealth Advisory Committee, established as part of the new law, will determine telehealth best practices, including potentially further expanding audio-only treatment.

Arkansas

Arkansas has eased telemedicine restrictions in legislation (2021 Act 829, HB 1063) that allows use of audio-only treatment for certain patients. The measure amends the existing state law (AZ Code § 17-80-401 *et. seq.*) to allow treatment by an Arkansas-licensed healthcare professional who has access to personal health records and uses any technology deemed appropriate, including the telephone, to diagnose, treat and. if clinically appropriate, prescribe noncontrolled drugs for a patient located in Arkansas. A health record may be created using telemedicine if it consists of relevant clinical information needed to treat a patient, and the telehealth visit meets the same standard of care as an in-person visit.

Under the existing law, insured health plans can't impose higher cost sharing or limits on telemedicine than on in-person visits. Patient cost sharing must be equal for telemedicine and network providers. The new provisions also prohibit a plan from requiring covered individuals to choose telemedicine-only providers rather than their regular doctor. To qualify for health plan coverage, audio-only telehealth communications must be in real time, interactive and substantially meet the requirements for otherwise covered healthcare services under the health plan. The new requirements took effect on April 21.

Georgia

Georgia has amended its telehealth law (GA Code Ann. § 33-24-56.4) to allow healthcare providers to use telehealth technology from home and patients to use it from anywhere, including home, school or workplace. Audio-only technology is permissible when no other means of real-time, two-way communication is available. The legislation (2021 Act 188, HB 307) bars health insurers from requiring an in-person consultation or contact before a patient receive telemedicine services from a healthcare provider. Insured health plans must pay for a telemedicine service on the same basis and at the same rate as an in-person service. However, insured health plans don't have to cover audio-only for any service except mental or behavioral health. In addition, plans can't impose a separate deductible, utilization limits or prescription drug restrictions for telehealth services that don't apply for in-person services. Patients can't be restricted in their telehealth choices to a particular vendor or other third party. The new provisions took effect on May 4, but it's unclear whether health plans have to comply as of that date.

Nebraska

Nebraska has amended its telehealth law (NE Rev. Stat. § 44-312) to allow certain audio-only treatment, effective immediately. The amendments (LB 400) expand the definition of telehealth to include audio-only individual behavioral health services for an established patient when appropriate or for crisis management and intervention. Health insurers in the state can't deny coverage for the service solely because it's audio-only or originating from any location where the patient is located. The measure also eases consent requirements, allowing patients to give verbal consent during the telehealth consultation, followed within 10 days by a signed paper or electronic written consent statement that becomes part of the patient's medical record.

Oklahoma

Oklahoma has expanded telehealth under a new law (2021 Ch. 420, SB 674) that mandates coverage of appropriately provided telemedicine for otherwise covered services. In addition, insurers must pay telehealth providers on the same basis and at no less than the reimbursement rate as for the same or substantially similar in-person services. Patients can't face increased cost sharing or a separate deductible for using telehealth, and only federal prescribing restrictions may apply.

Under the law, telehealth includes live audiovisual interaction between a patient and a healthcare professional, including through mobile phone applications. The interaction can use asynchronous mechanisms, such as "store and forward transfers" or online exchange of health information, but doesn't include audio-only technology. The new law takes effect Jan. 1, 2022.

Oregon

Oregon has amended its telehealth law (OR Rev. Stat. § 743A.058) to allow the use of audio-only technology, effective immediately. However, the legislation (2021 Ch. 117, HB 2508) prohibits using email, fax machines or text messaging. The law applies to health plans (as defined in OR Rev. Stat. § 743B.005) and dental-only plans. Insured health and dental plans can't deny otherwise covered benefits merely because the services are rendered via telemedicine or restrict a provider to only in-person treatment.

Other insurance restrictions bar a plan from imposing additional certification, location or training requirements for telemedicine; charging different annual dollar maximums; or adding prior authorization requirements that don't apply to in-person visits. A plan must pay the same reimbursement for a health service, regardless of whether the service is provided in person or using any permissible telemedicine application or technology. However, a plan may use value-based payment methods, including capitated, bundled, risk-based or other value-based payment methods.

Wyoming

A new Wyoming law (2021 Ch. 83, SB 52) requires insured health plans subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) to cover treatments via telehealth. The plans can't charge a covered individual higher cost sharing and must pay the mental health provider at the same rate paid for in-person treatment. The measure took effect on April 5.

Health plan assessments

Group health plan assessments in New Mexico, New York and Washington garnered attention in the second quarter. A state premium tax surcharge for insured plans in New Mexico and covered-lives fees for insured and self-funded plans in New York and Washington will help fund certain state healthcare programs.

New Mexico

Gov. Michelle Lujan Grisham announced a new law (2021 Ch. 136, SB 317) that increases the state's health insurance premium surtax from 1% to 3.75%, starting Jan. 1, 2022, to create a new Health Care Affordability Fund. The fund will be used to reduce healthcare premiums and cost sharing for New Mexico residents who purchase coverage on the state's health insurance exchange and to reduce premiums in the small group market. The fund will also help pay for other health coverage initiatives for uninsured New Mexico residents.

New York

New York's Department of Health (DOH) has responded to inquiries about the application of the state's Health Care Reform Act (HCRA) to dental coverage. Some self-funded plan sponsors have recently received vendor notices stating that dental claims for services rendered in New York would soon be subject to HCRA surcharges. According to DOH, nothing has changed in how HCRA applies to dental coverage.

Dental services received in a traditional, stand-alone dentist's office or practice are not subject to HCRA surcharges. As noted in the HCRA FAQs (Sec. VII, Q&A 4), however, when an HCRA-designated provider delivers dental services, the surcharge applies at rates based on the third-party payor's election status. Designated providers may include general hospitals and their extension clinics, diagnostic and treatment centers providing comprehensive primary care, and diagnostic and treatment centers providing ambulatory surgical services.

DOH noted that a recent HCRA review revealed that some surcharge reports omitted claims for dental services performed at community treatment centers that are part of a hospital system. DOH alerted affected vendors to this issue, and vendors in turn have been notifying clients. Due to the significant impact HCRA surcharges can have on "non-electing payors," self-funded plan sponsors may want to review their electing status with their health and dental administrators.

Washington

Beginning July 1, 2021, Washington health carriers, self-insured health plans and MEWAs must pay a covered-lives assessment to help to fund the Partnership Access Lines (PAL) program under a 2020 law (Ch. 291). The PAL program consists of four services that help providers manage their patients' mental health and psychiatry needs.

Health Care Authority (HCA) FAQs note that health plans will owe a percentage of the costs for the PAL services in proportion to the number of covered Washington residents. Final regulations (WA Admin. Code Ch. 182-110) require health plans to register and submit quarterly covered-lives reports within 45 days after the end of each quarter, with the first quarter of measurement from July 1 to Sept. 30, 2021. Invoices, issued on filing the covered-lives report, are due on receipt, with a 30-day grace period. KidsVax, the TPA contracted to calculate and administer the assessments, will begin reaching out to assessed entities later this summer with more information and will request they submit a covered-lives report to set a baseline necessary for program implementation.

Health insurance

States passed new health insurance laws related to cost sharing, mental health or both. Two states — Connecticut and Louisiana — will require third-party payments in insured plans to count toward the patient's cost-sharing obligation. This type of state legislation has become a growing trend since the US Department of Health and Human Services issued guidance on the topic last year. That guidance clarified that group health plans and insurers may — *but are not required to* — count toward the out-of-pocket maximum any form of direct cost reductions, including coupons, that drug manufacturers offer to enrollees purchasing specific medications, regardless of whether a generic equivalent is available. Employers with insured, high-deductible health plans (HDHPs) underwritten in these states should review the new laws' implications for eligibility to make or receive health savings account (HSA) contributions. New Mexico has banned cost sharing for mental health treatment. Washington requires gender-affirming treatment in compliance with federal law.

Connecticut

Effective Jan. 1, 2022, a new Connecticut law (2021 Pub. Act 14, SB 1003) requires insured health plans to credit any third-party discount or payment toward patient cost sharing for the covered benefit. This provision doesn't apply to self-funded ERISA plans. For PBM contracts entered into with insurance carriers on or after Jan. 1, 2022, the PBM must credit any third-party discount or payment for a covered prescription toward patient cost sharing.

Louisiana

A new Louisiana law (2021 Act 431, SB 94) requires insured health plans to apply to an individual's cost sharing any amounts paid by another person on behalf of the covered individual. Employers with fully insured HDHPs underwritten in Louisiana or covering Louisiana employees may need to review the HSA-eligibility implications of this new law. The measure took effect June 21, but whether health plans must comply as of that date is unclear.

New Mexico

Beginning Jan. 1, 2022, New Mexico legislation (2021 Ch. 136, SB 317) will prohibit patient cost sharing for behavioral health services in all group health coverage. The ban extends to treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders. The scope of covered services include inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, and all medications, including brand-name pharmacy drugs when generics are unavailable. The cost-sharing ban is set to sunset on Jan. 1, 2027.

First-dollar mental health coverage in an HDHP, as required under the new law, would prevent participants from making or receiving HSA contributions under federal law. But state regulators issued Bulletin 2021-007, noting "New Mexico public policy" favors HSAs and the language in the new law "should not be applied literally if it would lead to an unintended, and absurd consequence." The regulators concluded that SB 317 was not intended to — and does not — apply to an HSA-qualifying HDHP.

Washington

Under a new Washington law (2021 Ch. 280, SB 5313), health plans issued or renewed on or after Jan. 1, 2022, may not deny or limit coverage for medically necessary gender-affirming treatment, and a plan can't apply categorical cosmetic or blanket exclusions. Gender-affirming treatment benefits must comply with the federal MHPAEA and the Affordable Care Act (ACA). The measure specifies that gender-affirming treatment can be prescribed to "two spirit, transgender, nonbinary, intersex, and other gender diverse individuals." Regulators may add more detail in future guidance.

Washington insurance law applies to insured health plans issued in the state and often to health plans issued elsewhere for any covered Washington residents. Plan sponsors will need to confirm with carriers whether the mandate applies.

State health coverage initiatives

As federal healthcare reforms languish, at least three states considered or enacted initiatives in the second quarter. Colorado and New Mexico enacted public-option coverage that will be available on their health insurance exchanges. However, New York missed at another attempt to move forward on a single-payer health system.

Colorado

Recently signed legislation (2021 Ch. 241, HB 1232) calls on the Insurance Commissioner to establish rules by Jan. 1, 2022, for standardized health plans to be offered on Connect for Health Colorado. Carriers will have to offer gold, silver and bronze plans in the areas where the carriers currently offer individual and/or small group coverage.

Premiums for the plans, slated to begin Jan. 1, 2023, must be at least 5% lower than a comparable benefit plan in 2021. Premiums must be 10% lower in 2024 and 15% lower in 2025. These amounts will be adjusted for medical inflation in the individual and small group markets. Regulators may require healthcare providers, including hospitals, to participate in a standardized plan. Additional requirements apply for network adequacy, cost-sharing limits and provider reimbursement rates. Colorado joins Washington and Nevada in adding the public option.

Nevada

Nevada legislation (2021 Ch. 537, SB 420) establishes a public health plan option for individuals and small groups on the state's health insurance exchange. Under the new law, each health plan offered must be an ACA qualified health plan with premiums at least 5% below a "reference premium" based on Medicare or the lowest cost silver plan.

All carriers that provide Medicaid or Children's Health Insurance Program plans in the state must submit a good-faith proposal to participate. All health plan providers that participate in the state employee benefit plan or Medicaid must participate in at least one public option network and accept new patients. Provider reimbursement rates will be tied to certain federal rates.

The program, slated to begin in 2026, will be developed and managed by three state agencies: insurance, health and human services, and the exchange. Regulators must apply for waivers under ACA Section 1332 to bring Medicaid into the public option program.

New York

New York lawmakers considered legislation (AB 6058) that would have provided a universal single-payer health plan for every state resident. Funding would have come from two taxes: a progressively graduated payroll tax and a graduated tax on other income, such as interest, dividends and capital gains. Under the proposal, a board would operate the New York Health Program and negotiate provider reimbursements. No cost sharing would apply to treatment and services, which would include LTC.

How such a program would interact with an employer's existing group health plans is unclear. Insurers couldn't sell competing products but could sell other health products, such as retiree health benefits. Certain provisions would apply to cross-border employees; out-of-state residents working in New York would pay the tax but receive a credit.

This legislation died in committee at the close of New York's 2021 legislative session. While some New York lawmakers reportedly intend to continue to push the bill in the next session, single-payer efforts in New York and other states have repeatedly faltered in the past.

Paid leave

States took action on paid leave laws, including sick leave, family and medical (PFML) programs and COVID-19 emergency leave. While some states took action to ban or delay certain paid leave mandates, such as delayed

implementation of Oregon's PFML program, others moved ahead, such as Seattle, Washington's paid sick leave enforcement. Other state actions include Montana's ban on local paid sick leave mandates, New Mexico's paid sick leave requirement, and Virginia's new short-term disability (STD) insurance provisions.

COVID-19 leave

Cities in northern California are requiring paid leave for grocery and drug store workers to get vaccinated, as well as hazard pay to supplement regular wages. California, Massachusetts, Oregon and the city of Chicago have published guidance on COVID-19 vaccines in the workplace and the obligation of an employer with a vaccination requirement to pay employees for their time getting vaccinated. Washington has temporarily amended its PFML program so workers can more easily satisfy the hours-worked eligibility criteria for paid leave during the pandemic. A new emergency ordinance in Los Angeles County requires paid leave for COVID vaccines, and new guidance confirms paid sick leave in Seattle can be used for vaccines.

A new Massachusetts law requires employers to provide COVID-19 emergency paid sick leave, with costs reimbursed through a $75 million state fund. The mandate will expire Sept. 30, unless the fund runs out or state officials give earlier notice of imminent exhaustion of the fund.

Nevada now requires employers to provide paid leave for employees to get vaccinated. Sonoma County, CA, extended its emergency paid leave ordinance and is requiring a new allotment of paid leave, which can be offset by the state-required leave. Maryland passed a law requiring public health emergency leave for essential workers, and New York has issued guidance reminding employers that employees can use paid sick leave for side effects of COVID-19 vaccines.

While some new paid leave mandates have been enacted, several others have — or soon will — expire as COVID-19 emergency declarations are repealed.

Montana

Under recent Montana legislation (2021 Ch. 398, SB 301), a political subdivision may not enact, administer or otherwise require an employer to provide employees with a wage or employment benefit not required by state or federal law. As local jurisdictions in many states have enacted paid sick leave mandates or healthcare expenditures, some states have passed laws prohibiting these local ordinances. The Montana law doesn't apply to a political subdivision's wage or employment benefits for its own employees.

New Mexico

New Mexico's new paid sick leave law (2021 Ch. 131, HB 20) will take effect July 1, 2022. The Healthy Workplaces Act will require employers to provide employees working in the state — including part-time, seasonal or temporary workers — at least one hour of earned sick leave for every 30 worked, up to a maximum of 64 leave hours per year. The law applies to employers with at least one employee who works in the state, but exempts the state and any political subdivision. For more detail, see New Mexico enacts paid sick leave law.

Oregon

Oregon legislation (HB 3398) delays implementation of the state's Paid Family and Medical Leave Insurance (PFMLI) program. Premium contributions under the 2019 law (OR Rev. Stat. Ch. 657B) were originally scheduled to begin Jan. 1, 2022, with PFMLI benefits for eligible employees starting Jan. 1, 2023. Due to the drain on its

resources to address COVID-19 issues, the Oregon Employment Department (OED) asked the legislature to enact a delay.

Under the revised timeline, contributions will begin Jan. 1, 2023. Regulations currently due out Sept. 1, 2021, will be delayed one year, and the PFMLI program will begin paying benefits in September 2023. The OED has cited the need for the delay to develop policy and administrative rules before collecting contributions, build a modernized technology platform, coordinate with partner agencies responsible for components of the program, and review employers' equivalent private plans.

Virginia

New STD income-protection coverage issued in Virginia will soon have to include at least 12 weeks of coverage after childbirth, if the insurance policy covers disability due to childbirth. The law (2020 Ch. 935, SB 567) applies to new STD policies issued on or after July 1, 2021. Guidance from the State Corporation Commission confirms that the law doesn't apply to renewals on or after that date and applies only to STD policies. Insurers can't impose an elimination period to reduce the required 12 weeks of benefits immediately after childbirth, but may impose a pre-existing condition exclusion.

Seattle, Washington

The Seattle Office of Labor Standards has announced a settlement with a multinational food service company to settle allegations under the city's Paid Sick and Safe Time (PSST) and Secure Scheduling ordinances. The city claimed employees could not access their PSST balances while business operations were suspended for COVID-19 health and safety reasons, and the employer failed to provide pay for schedule changes ahead of suspending business operations.

The settlement highlights that Seattle workers have the right to access PSST when their large employer (250+ full-time employees worldwide) shuts down for any health or safety reason, even if the shutdown is not ordered by a public health official and even if those workers are furloughed. The PSST ordinance, which went into effect on Sept. 1, 2012, requires large employers to provide one hour of paid sick leave for every 30 hours worked.

Other benefit-related developments

Other benefit-related issues received states' attention in the second quarter. New Jersey's severance mandate received a setback in a pending ERISA preemption challenge when a federal court denied the state's effort to have the case dismissed. New York will now require insurers — including TPAs administering self-funded plans — to provide participants ID cards specifying whether the plan is insured or self-funded. Washington employers will soon have to begin collecting LTC program premiums from individuals who haven't purchased their own coverage by Nov. 1, 2021.

New Jersey

A federal court in New Jersey has denied the state's motion to dismiss a case seeking to halt implementation of the 2020 amendments to the state's Millville Dallas Airmotive Plant Job Loss Notification Act (*The ERISA Industry Committee v. Asaro-Angelo*, No. 3:20-cv-10094). Under the amended law (2021 Ch. 423, SB 3170), laid-off employees — including part-time workers — must receive to one week of severance pay for each full year of employment. Employers that provide employees with fewer than 90 days' notice must pay an additional four weeks of severance.

The complaint alleges that the amendments considerably increase employers' ongoing administrative burdens, requiring continuous monitoring of all terminations to determine when severance benefits must be paid. Challengers argue that severance pay plans, like pension and health plans, are subject to ERISA when they require an ongoing administrative program. The plaintiffs say state law amendments are therefore preempted because they require an employer to create an employee benefit plan covered by ERISA.

New York

A recent New York regulation (NY Comp. Codes R. & Regs. tit. 11, § 52.69) requires insurers to supply each primary insured and dependent over 18 with a health insurance ID card within 30 days of the coverage's effective date. The mandate applies to plans that provide coverage for comprehensive hospital, surgical and medical care, but not stand-alone dental or vision coverage. Each card must specify whether the plan is insured or self-funded.

The card also must include the name of the insured, dependents and the insurer (if fully insured); the plan name and health provider network; and the type of plan, such as preferred provider or point of service. Additional details, such as contact information, cost-sharing requirements and prescription drug coverage, must also be included. The new rule took effect April 22.

Washington

Beginning Jan. 1, 2022, Washington's LTC insurance law requires employers to collect 0.58% of wages through payroll deduction from employees working in the state and remit those premium contributions to the state-run Long-Term Services and Supports (LTSS) Trust Program. A recent change to the law (2021 Ch. 113, HB 1323) allows employees to opt out of the program only if they have purchased private LTC coverage by Nov. 1, 2021.

Recently adopted exemption rules confirm that applications for an exemption from the LTC program will be accepted by the department only from Oct. 1, 2021, through Dec. 31, 2022. An employee's exemption will be effective the quarter immediately after approval. Additional rules are under development. For more details, see Washington adds tight exemption timeline to long-term care law.

Related resources

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- New Mexico enacts paid sick leave law (May 19, 2021)
- Washington adds tight exemption timeline to long-term care law (May 3, 2021)
- Roundup of selected state health developments, first-quarter 2021 (April 26, 2021)
- Oregon's paid family and medical leave contributions begin in 2022 (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)

- Mental health parity compliance gets a boost in 2021 spending act (Jan. 25, 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)
- 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)
- 2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead (June 3, 2020)
- New Jersey expands mass layoff law, severance entitlement (Feb. 25, 2020)
- IRS expands predeductible preventive care for HSA-qualifying health plans (July 23, 2019)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)
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- Life, absence and disability
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