Roundup of selected state health developments, second-quarter 2024

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In this article

This year has been relatively quiet for states adding new paid leave laws, but several states applied a new coat of paint to existing laws. Two states — Kentucky and South Carolina — added paid family leave (PFL) as an optional form of insurance coverage. Idaho and Kentucky passed significant pharmacy benefit manager (PBM) laws, which may impact self-funded ERISA plans. Prior authorization continued to be a focus in 2024; new Colorado, Oklahoma and Vermont laws restricted the practice for fully insured plans. Alabama will make a childcare tax credit available to employers over the next three years. Mississippi approved a plan to establish a state-based health insurance marketplace.

Paid family and medical leave (PFML)

Colorado enacted a law addressing PFML overpayments and increased benefit limits. Connecticut passed laws modifying existing provisions and specifying certain procedural steps for appeals. Kentucky and South Carolina became the latest states to offer optional PFL insurance coverage, joining Alabama, Arkansas, Florida, Tennessee and Virginia. Maryland pushed back its PFML program start dates. Delaware and Minnesota made tweaks to their PFML laws. Oregon issued a temporary order addressing documents for claim verifications and increased its minimum and maximum benefit limits. Rhode Island expanded benefits under its temporary caregiver insurance (TCI) law and raised its temporary disability insurance (TDI) rates. Washington released caregiving leave rules.

Colorado

PFML overpayments law. SB 24-155 includes these provisions:

- A judgment may be assigned, released or commuted and is not exempt from creditors' claims or legal actions.

- The Family and Medical Leave Insurance (FAMLI) Division has a reimbursement right from a workers' compensation insurer or self-insuring employer if an employee's combined receipt of PFML and workers' comp benefits for the same injury or illness exceeds 100% of workers' comp benefits.
- The FAMLI Division now has access to workers' comp records and Department of Revenue tax information for PFML purposes.

The law will take effect on or about Aug. 7.

Benefit limit increase. Effective July 1, Colorado's state average weekly wage (SAWW) increased from $1,421.16 to $1,471.34, in turn affecting FAMLI calculations. The maximum weekly benefit (currently set at $1,100) will remain unchanged, increasing in 2025 to $1,324.21 (90% of the new SAWW). FAMLI benefit calculations are based in part on SAWW. Specifically, benefits equal 90% of an employee's weekly wage (up to 50% of SAWW), plus 50% of amounts exceeding 50% of SAWW, up to the maximum weekly benefit. As a result, many covered employees currently on PFML saw a slight increase as of July 1.

Connecticut

Changes. Pub. Act 24-5 (SB 222) implements these changes to the PFML law:

- **Payments.** Employees may receive concurrent income replacement benefits from a state victim compensation fund; otherwise, PFML benefits do not run concurrently with any other state or federal income-replacement program. Employers must register and submit payments to the PFML Insurance Authority. Failures are now subject to a penalty.
- **Employer annual report.** Starting this year, the deadline will move from July 1 to Sept. 1.
- **Disclosures.** Healthcare providers must display an informational poster no later than Oct. 1.
- **Employee overpayments.** The law sets up a penalty/interest scheme for overpayments and attempted fraud.
- **Family Violence Leave Act change.** The law currently requires up to 12 days of leave related to family violence. The scope was expanded to include victims of sexual assault.

Other than the annual report deadline, the changes will take effect on Oct. 1.

Appeals. Pub. Act 24-102 (SB 220) significantly expands a covered employee's appeal rights after a determination is made by the labor commissioner regarding a PFML denial or imposition of fraud-related penalties initially issued by the state Department of Labor. Appeal of the commissioner's determination is available to the Hartford Judicial District Superior Court. The law has little practical impact on employers.

Delaware

Delaware changed the scope of its PFML law, which starts contributions next year and benefits in 2026. Specifically, SB 248 exempts from PFML coverage employees covered by a collective bargaining agreement and due to the nature of the industry may never qualify as covered individuals; on the other hand, companies using a professional employer organization are considered an employer for PFML purposes. The law took effect on June 30.

Kentucky

The state now allows PFL to be offered as group insurance, either as a part of or a rider to a disability income policy or as a separate policy, per 2024 Ch. 99 (HB 179), effective April 5. The policy must provide income replacement for employees on leave to bond with a new child, to provide care for a family member with a serious health condition or to address a qualifying exigency, or to care for a family member that is in the armed forces or a first responder. Paid leave under the policy must be available for a minimum of two weeks in a 52-week period.

Maryland

The start dates for contributions (July 1, 2025) and benefits (July 1, 2026) were further delayed, per 2024 Ch. 266/Ch. 267 (SB 485/HB 571). In addition, the law:

- Modified definitions of “wages” (aligned with the unemployment insurance law) and “covered employee” (specifying hours worked requirement applies to work in the state)
- Authorized Maryland’s Department of Labor (MDL) to establish reasonable fees for private plans
- Revised the average weekly wage calculation, based on the highest of the prior four completed calendar quarters for which quarterly reports were required
- Authorized MDL to assess appeal costs against an employer or insurer if a covered individual wins an appeal

For details, see Maryland revises paid family and medical leave (May 3, 2024) and Maryland paid family and medical leave overview (May 9, 2024).

Minnesota

Here are the PFML highlights of 2024 Ch. 127 (HF 5247, Art. 73), which also addresses other leave and telehealth requirements and coverage mandates, discussed elsewhere in this GRIST:

- **Covered employment.** Employees are covered if (i) 50% or more of employment during the calendar year is in Minnesota; or (ii) 50% or more of employment is not in Minnesota or any other single state, but some employment is in Minnesota and the individual lives in the state at least 50% of the year.

- **Covered individual.** Individuals must meet the earnings requirement with wages provided for covered employment.
- **Benefit year.** It will start on the first day of leave.
- **Benefit amount.** If an employee changes employers during the base period, the weekly benefit amount will equal the highest quarter of wages in the base period.
- **Intermittent leave.** The minimum increment will be one calendar day.
- **Excess payments.** Employees receiving more than the usual salary must refund the excess to the employer or the Paid Leave Division. Disability benefits may be offset by PFML benefits.
- **Former employees.** Private plans must continue PFML benefits for former employees until they are hired by another employer, up to a 26-week maximum.
- **Small employers.** A small employer premium rate will apply to employers with 30 or fewer employees and an average wage of 150% or less of the state average wage.
- **No more acknowledgement.** New hires will no longer be required to sign a notice receipt acknowledgement if an employer can otherwise demonstrate notice delivery.
- **Premium rates.** The first premium rate adjustment can occur before Jan. 1, 2026.

Most of these provisions will take effect on July 1, 2025 or Jan. 1, 2026. For other details, see Minnesota passes paid family and medical leave law (July 10, 2023).

Oregon

Oregon's Employment Department issued a temporary order related to its Paid Leave Oregon (PLO) program. The order clarifies allowable documents and information needed to verify PLO claims for leaves related to child bonding, serious health conditions and safety reasons. The rule also describes a process for assigning legal representatives for incapacitated claimants. The rule is now in effect and will expire on Sept. 10.

Oregon also revised the state average weekly wage, which in turn changes PLO benefit limits. On July 1, the SAWW increased from $1,269.69 to $1,307.17. The minimum weekly PLO benefit increases from $63.48 to $65.36, and the weekly maximum increases from $1,523.63 to $1,568.60. These changes took effect for benefit years starting on or after July 7. Employees whose paid leave benefit year started before this date were unaffected. Contribution rates and the benefit calculation remain unchanged. For further details, see this Paid Leave Oregon resources page.

Rhode Island

TCI. HB 7171/SB 2121increases the duration of TCI coverage over two years. TCI is available for child bonding and care for a seriously ill family member. Duration is currently capped at six weeks per benefit year. The duration will change to seven weeks on Jan. 1, 2025, and to eight weeks on Jan. 1, 2026.

TDI. Effective July 1, the Department of Labor and Training changed the TDI maximum weekly benefit from $1,043 to $1,070. This TDI increase applies to leaves starting on or after July 1. The state's TDI and temporary caregiver law includes a dependent allowance, which increases benefits as much as 35% for up to five dependents. Accordingly, the maximum weekly TDI benefit for employees with five or more dependents increases from $1,408 to $1,444, also effective July 1.

South Carolina

Per 2024 Act 206 (HB 4832), employers may provide PFL insurance, either as an amendment/rider to a group disability or life insurance policy or as a separate policy. The PFL insurance must provide at least two weeks of partial wage replacement for leave related to new child bonding, caring for a family member with a serious health condition or a family member injured in the line of duty, and a military exigency. The law took effect on May 21.

Washington

Adopted rules, now in effect, amend the definition of "placement" and clarify child-bonding leave eligibility. Specifically, placement includes a legally finalized adoption. The 12-month bonding period starts when the adoption is legally finalized, if no leave was previously taken. Employees are entitled to up to 12 weeks of leave for placement of a child.

Other leave-related issues

A Colorado law protecting living organ donors has leave-related implications. Connecticut changed several parts of its paid sick and safe leave (PSSL) law. Illinois and Chicago issued final rules related to their paid leave laws. Minnesota added bereavement as a qualifying reason under its earned sick and safe time (ESST) law and clarified employee rights during parental leave. New York's budget bills addressed leaves for prenatal and COVID-19-related reasons, as well as lactation breaks. Oregon's family leave regulations addressed an uncommon situation, based on a July 1 transition date.

Colorado

HB24-1132 prohibits employer adverse actions when an employee becomes an organ donor. While the law confirms that organ donation leave is not mandated, it requires an employer to provide accrued leave under existing policies applicable to similar situated employees. In addition, employment protection exists during the "prohibited period," which starts 30 days before an employee's organ donation and ends 90 days afterward. Current insurance law already mandates fully insured coverage for healthcare services related to organ donation. The law took effect June 3.

Connecticut

Pub. Act 24-8 (HB 5005) modifies existing PSSL law in several ways:

- **Covered employees/employers.** Current law only provides PSSL to "service workers" and only applies to employers with 50 or more Connecticut employees. As of Jan. 1, 2025, PSSL will apply to all employees, except seasonal employees. The employer size threshold will decrease as follows:

Covered employer threshold	Effective date
50 or more Connecticut employees	Current through Dec. 31, 2024
25 or more Connecticut employees	Jan. 1, 2025
11 or more Connecticut employees	Jan. 1, 2026
One or more Connecticut employees	Jan. 1, 2027

- **Accrual.** Previously one hour per 40 hours worked, the new rate will be one hour per 30 hours worked. The annual accrual and use maximums will remain at 40 hours per benefit year.
- **Waiting period.** It will change from 680 working hours to 120 calendar days of employment.
- **Permitted uses.** New reasons will be a public health emergency or risk of exposure to a communicable disease at work or school, and a family member being a victim of family violence or sexual assault.
- **Benefit amount.** Employers will have to pay the greater of an employee's hourly wage or the minimum wage in effect during leave.
- **Frontloading.** Frontloading eliminates the need for carryover (employees are permitted to carry over up to 40 hours of unused accrued PSSL each year).
- **Equivalent policies.** An employer's existing sick leave policy (or vacation, paid time off, or unlimited PTO policy) complies with the law if it not only has the same (or more) permitted uses but also is subject to the same conditions (e.g., documentation and discipline for misuse of leave).
- **Transfers.** Employees transferred to another division, entity or worksite of the same employer retain their paid sick leave balance.
- **Prohibitions.** Employers may not require: (1) employees to search for or find a replacement, or (2) employee documentation if PSSL is for a permitted use.
- **Notice.** Employers must provide a written notice upon hire or Jan. 1, 2025, whichever is later. Employers must include sick leave hours accrued and used in employee wage records.

Except for the employer-size phase-in, these provisions will take effect on Jan. 1, 2025. For details on Connecticut's PSSL law, see Roundup: State accrued paid leave mandates (Oct. 25, 2023).

Illinois

The Illinois Department of Labor (IDOL) issued final rules on the state's Paid Leave for All Workers Act (PLAWA), now in effect. These regulations make changes to last year's proposed regulations. Here is a summary:

- **Preexisting policies.** Employers with a bona fide paid leave policy in effect before 2024, providing 40 hours of PL for any reason to all employees (prorated for part-timers), do not have to change the policy to comply with the law. Employers may also maintain a preexisting policy for some workers and one meeting PLAWA standards for others. A paid sick leave or vacation policy can have additional requirements (e.g., two weeks advance notice and manager approval) as long as time off can be used for any reason.
- **Accrual/carryover.** Paid leave accrues in 15-minute increments; work periods must be counted on a minute-by-minute basis or may be rounded up to the next 15 minutes. The final rules allow a 40-hour carryover cap.
- **Leave denials.** Employers with a written policy disclosed to employees may deny leave requests in certain limited circumstances in order to meet the employer's operational needs. The proposed rules gave a nonexhaustive list of relevant factors. The final rules replace these factors with a three-part test: (1) the policy is disclosed to employees, (2) denial is based on limited circumstances related to operational needs, and (3) the policy is consistently applied without denying an adequate opportunity to use eligible leave.
- **Employer notice.** The final rules retain several notice requirements from the proposed rules in these circumstances: use of a PTO policy to comply with PLAWA, frontloaded amounts upon hire (if applicable), changes in leave policy (as soon as practical) and a change in frontloading to accrual or vice versa (at least 30 days in advance of the 12-month period).
- **Requirements removed.** The final rules eliminate the need for paystub reporting. Also, the IDOL model notice no longer needs customization.

Illinois — Chicago

Chicago's Department of Business Affairs and Consumer Protection issued final rules on the city's Paid Leave and Paid Sick and Safe Leave Ordinance, which took effect on July 1. The ordinance requires up to 40 hours of PSSL and up to 40 hours of paid leave for any reason (PLAR). Here is a summary of the final rules:

- **Benefit year.** Employers may select any 12-month period.
- **Carryover.** Employees are entitled to carry over up to 80 hours of PSSL and up to 16 hours of PLAR from the prior benefit year.

- **Frontloading.** As an alternative to accrual, employers may frontload 40 hours of each leave on the first day of the benefit year. PLAR frontloading eliminates the need for PLAR carryover; the same does not apply to PSSL.
- **Leave approvals and denials.** An employer's policy can include a reasonable pre-approval process, based on business operations. The final rules include a nonexhaustive list of five factors for denying leave, including significant impact on business operations and whether the job provides a critical need or service. Leave denials must be in writing and state a policy rationale.
- **Employer notice.** A new, annual frontloading notice is required where applicable.

Minnesota

Under 2024 Ch. 127 (HF 5247, Art. 11), bereavement is now a permitted ESST reason. Employers need not provide leave in increments less than 15 minutes and cannot require leave in increments greater than four hours. Earnings statements can omit available and used ESST hours. Volunteer or paid on-call firefighters and ambulance personnel, elected officials, and family farm employees are not covered. Additional recordkeeping requirements apply. These provisions are now in effect. For other Minnesota ESST details, see Minnesota adopts paid sick and safe leave requirement (Sept. 27, 2023). This law also made changes to the state's PFML, telehealth and insurance laws; for a summary, see those respective sections for details.

Also, 2024 Ch. 110 (SF 3852, Art. 2) amends the state's parental leave law, which requires up to 12 weeks per year of unpaid leave. Effective Aug. 1, employers may not reduce the length of leave by any period of paid or unpaid leave taken for prenatal care medical appointments. Employers must maintain health coverage during parental leave as long as the employee pays the employee share of the benefit cost.

New York

Paid prenatal leave. Under 2024 Ch. 55 (AB 8805), employees eligible for paid sick leave under current law will have an additional annual allotment of up to 20 hours of paid leave for prenatal care. The leave is available for pregnancy-related healthcare services received by an employee, including physical exams, medical procedures, monitoring and testing and pregnancy-related discussions with a healthcare provider. Employers need not pay out unused leave upon employment separation. This provision will take effect on Jan. 1, 2025.

Paid COVID-19 sick leave. Under 2024 Ch. 56 (SB 8306), the required paid leave mandate expiration date was extended by one year to July 31, 2025. Paid leave applies when an employee is subject to a COVID-19 quarantine or isolation order, with varying duration:

- **Large (100+) and public employers:** 14 days
- **Medium (11-99) employers and small employers (1-10, net income greater than $1 million):** five days, plus unpaid leave through the end of the quarantine or isolation period

- **Small employers (1-10, net income up to $1 million):** unpaid leave for all of the quarantine or isolation period

Practically, given the infrequency of COVID-19 quarantine and isolation orders, this leave type is unlikely to arise over the next year. More information is available on a governmental webpage.

Lactation breaks. An additional provision (now in effect) amends Labor Code, allowing up to 30 minutes of paid break time for lactation purposes. Previously, the law only required reasonable unpaid break time. Paid time for lactation must now be provided each time an employee has a reasonable need to pump or nurse (e.g., every 3 hours) for up to three years following childbirth. The state Department of Labor published these resources:

- FAQs
- Policy document
- Employer fact sheet
- Employee fact sheet

Oregon

Oregon Family Leave Act (OFLA) regulations allow employers to rescind a designation of approval for OFLA-protected leave scheduled to occur on or after July 1, but the employer must notify the employee in writing ASAP and no later than June 1. OFLA applies to employers with 25 or more employees in the state.

Prescription drugs (Rx)

Idaho and Kentucky passed sweeping PBM laws with an uncertain application to self-funded ERISA plans. A Louisiana law addresses PBMs' Rx pricing. A Maryland law focuses on Rx prior authorization and e-prescribing practices. Oklahoma laws addressed pharmacy audits and allowed enforcement of the PBM laws by the state attorney general. Rhode Island passed a law related to fully insured plans' reimbursement of clinician-administered prescription drugs. A Tennessee agency confirmed its state's PBM laws apply to self-funded ERISA plans. Two Vermont laws aim to control Rx costs via oversight by a state board and to restrict certain PBM practices.

Idaho

The state enacted 2024 Ch. 247 (HB 596), which:

- Requires practically all PBMs to pass along 100% of any manufacturer rebates to the plan for the sole purpose of offsetting cost sharing and deductibles and reducing participant premiums
- Bans spread pricing

- Prohibits a PBM from charging a plan a higher dispensing fee (including pharmacist's service and overhead) than what it pays a pharmacy
- Establishes Medicare Part D as the minimum standard for network adequacy
- Limits a PBM's ability to set up a network that requires accreditation standards inconsistent with or more stringent than federal and state requirements (not applicable to specialty drugs)
- Bars PBMs from taking adverse actions against a pharmacy for disclosing to participants any information the pharmacy deems appropriate

The law will take effect on Jan. 1, 2025. Its application to self-funded ERISA plans is unclear. The statute broadly defines PBMs to include those that work on behalf of third-party administrators. Idaho applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Kentucky

The state passed a broad PBM law (2024 Ch. 104, SB 188), which:

- Restricts use of preferred networks (including ones steering participants to PBM-affiliated pharmacies)
- Forbids steering and use of mandatory or incentivized mail-order programs
- Imposes network adequacy standards
- Requires a minimum dispensing fee per drug fill (initially $10.64, adjusted in 2027 and beyond by the state board of pharmacy)

Most of the law will take effect for renewals occurring on or after Jan. 1, 2025. Kentucky generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

The law's application to self-funded ERISA plans is unclear. While it excludes self-funded plans offered by hospital and health systems with pharmacies, it applies to any "[s]elf-insured plan … to the extent permitted by ERISA." The bill also contains this repeated phrase: "To the extent permitted under federal law."

Louisiana

Under 2024 Act No. 768 (SB 444), PBMs must reimburse a contracted pharmacy at least an amount equal to the acquisition cost for the covered drug, device or service. The minimum reimbursement requirement does not apply for pharmacies that own more than five shares or a 5% interest in a pharmaceutical wholesale group purchasing organization or vendor of any covered drug, device or service. The law also does not apply to the state governmental plan. The law will take effect on Jan. 1, 2025.

The law's application to self-funded ERISA plans is unclear. PBMs operating in the state — including Caremark, Express Scripts and OptumRx — are already subject to state licensing and transparency requirements. Louisiana generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Maryland

Under 2024 Ch. 847/848 (HB 932/SB 791), fully insured plans must establish a free, online prior authorization and e-prescribing system by July 1, 2026. Beginning Jan. 1, 2025, prior authorization approvals will be valid for the lesser of 90 days or the course of treatment. Maryland generally does not apply its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Oklahoma

Two laws were enacted that essentially accomplish the same purpose by amending two different state laws. SB 1670 amends the Pharmacy Audit Integrity Act. HB 3376 amends the Patient's Right to Pharmacy Choice Act (the law at issue in the *Mulready* case, where a writ of certiorari is currently pending before the US Supreme Court; see Roundup of selected state health developments, third-quarter 2023 (Nov. 15, 2023)). Both laws give the attorney general authority to create implementing regulations. They also exempt employers sponsoring self-funded ERISA plans from the definition of a PBM, unless they administer prescription drugs without the utilization of a third party. The laws took immediate effect on May 15.

Rhode Island

HB 7365/SB 2086 prohibits insurers from interfering with a patient's right to obtain a clinician-administered drug from an in-network provider or pharmacy of choice. Pharmacy reimbursements must be at a rate equal to payments between the insurer and a preferred pharmacy. The law will take effect on Jan. 1, 2025. Rhode Island generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Tennessee

Tennessee's Department of Commerce and Insurance amended its 2023 PBM regulations, addressing variety of topics. Of note, the regulations articulate the Department's view on ERISA preemption and self-funded plans. Consistent with a 2021 bulletin, the Department concluded that these regulations apply to PBMs administering self-funded ERISA plans:

> *Both the definition of covered entity and of pharmacy benefits manager, found in Tenn. Code Ann. § 56-7-3102(1) and (5), respectively, clearly and unambiguously apply to self-insured entities and plans governed by ERISA. Further, Tenn. Code Ann. §§ 56-7-3122 and -3209 make self-insured ERISA plans subject to Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32, respectively.*

For background, see Roundup of selected state health developments, third-quarter 2021 (Oct. 22, 2021).

Vermont

Two laws were enacted. First, 2024 Act 134 (SB 98) directs the Green Mountain Care Board (an independent, five-member board established in 2011) to create a framework and methodology for an Rx cost control program. The final plan is due Jan. 15, 2026. This law essentially turns the Board into a prescription drug affordability board. Vermont joins a growing list of states with prescription drug affordability boards (including Colorado, Maine, Massachusetts, Maryland, Minnesota, New Jersey, New York, Ohio, Oregon, New Hampshire and Washington).

Second, 2024 Act 127 (HB 233) imposes PBM restrictions and license requirements:

- Inclusion of third-party financial assistance in cost sharing if there is no generic or interchangeable biological equivalent (subject to an exception for HSA-qualified high-deductible health plans)
- Ban on spread pricing
- Prohibition against requiring cover persons to pay more than the lesser of the applicable cost sharing, the maximum allowable cost or the cash amount payable for a drug after applying known discounts
- No contract prohibition against — or penalty or contract termination for — pharmacy disclosures to participants
- Prohibition against a PBM requiring a pharmacy to pass through a covered person's copayment to the PBM

The law took effect on July 1. The law applies to fully insured plans with beneficiaries who are employed or reside in Vermont. The law's application to self-funded plans is unclear.

Insurance

A new Colorado law focuses on prior authorization practices. Minnesota laws mandated coverage of abortion services and gender-affirming care. Three Oklahoma laws address prior authorization, fertility preservation and ground ambulance rates. A Vermont law tightened prior authorization requirements.

Colorado

HB24-1149 applies to insurers offering health and Rx benefits, private utilization review organizations and PBMs, imposing website disclosure requirements and annual attestations related to prior authorization. These entities must eliminate prior authorization that does not promote quality and equity or substantially reduce costs. Prior authorization is allowed no more than once every 3 years for an FDA-approved chronic maintenance drug, except under specified conditions. Otherwise, a prior authorization

is good for a calendar year, up from 180 days. By Jan. 1, 2027, an electronic transmission system is required for prior authorizations.

Other than the electronic system, the law will take effect on Jan. 1, 2026. Colorado generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Minnesota

Two laws were enacted. In addition to the PFML and ESST changes described in other sections of this GRIST, 2024 Ch. 127 (HF 5247, Art. 57, Sections 2 and 39) adds these insurance coverage mandates:

- Abortions and abortion-related services, including pre-abortion services and follow-up services, must be covered. Cost sharing may not exceed what is required for similar covered services. A religion-based exemption is available (also applicable to the gender-affirming care law described below).
- The provider-recommended transfer of a mother or newborn to a different medical facility must be covered without cost sharing (subject to an HSA-qualified HDHP exception).

Both provisions will take effect for plan renewals starting in 2025.

As a result of 2024 Ch. 114 (SF 4097), fully insured plans must cover medically necessary gender-affirming care, including medical, surgical, counseling or referral services (including telehealth) supporting and affirming gender identity or expression, if legally permitted. The law will take effect on Jan. 1, 2025.

Minnesota generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state, unless the plan covers fewer than 25 state residents. The law does not affect self-funded ERISA plans.

Oklahoma

Three insurance laws were enacted.

First, the Ensuring Transparency in Prior Authorization Act (HB 3190) reduces insurers' and utilization review entities' prior authorization determination deadlines to 72 hours (urgent claims) and seven days (nonurgent claims), compared with the federal ERISA standard of 72 hours and 15 days, respectively. In addition, a prior authorization application programming interface (API) must be in place with covered health plans beginning on or after Jan. 1, 2027, and with providers by that same date. These rules do not apply to Rx.

Second, Corinne's Law (SB 1334) requires fully insured plans and the state's Employees Insurance Plan to cover standard fertility preservation services when cancer treatment may cause iatrogenic infertility in individuals within reproductive age. Standard fertility preservation services do not include storage. Plans may not use prior authorization. Religious employers may request an exemption from the coverage requirement.

Finally, the Out-of-Network Ambulance Service Provider Act (HB 2872) sets ground ambulance rates. A government entity located where the services originate can set the default rate. Otherwise, the rate will be the lesser of 325% of Medicare or the billed charge. Cost-sharing shall not exceed the in-network amount and out-of-network ambulance service providers cannot balance bill the enrollee. The mandate applies to fully insured plans and state and local government-sponsored self-insured plans.

These laws will take effect on Jan. 1, 2025. Oklahoma generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. These laws do not affect self-funded ERISA plans, other than the state's plan.

Vermont

For fully insured plans, prior authorization is prohibited for at least one readily available asthma controller medication from each class and mode of administration, and all healthcare services provided by an in-network primary care provider, as a result of 2024 Act 111 (HB 766). Prior authorization must occur within 24 hours (urgent claims) and two business days (nonurgent claims). Prior authorizations remain valid for the greater of the course of treatment (up to five years) or one year. The law also creates standards and exceptions for step-therapy protocols. The requirements apply to Rx.

The law will generally take effect on Jan. 1, 2025. Vermont generally does not apply its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Telehealth

Several states adopted interstate compacts, which facilitates the use of telehealth via out-of-state service providers. Connecticut made permanent some temporary telehealth rules that were scheduled to sunset on June 30. A new Michigan insurance law addresses reimbursement parity and telehealth coverage requirements. Tennessee removed a significant telehealth restriction applicable to fully insured plans. Vermont renewed its payment parity law. Washington, DC adopted new telehealth standards.

Interstate compacts

State	Provider or practice type	Effective date	Law
AL	Dieticians	When seventh state joins	Act 2024-366 (SB 207)
AZ	Counseling	When 10th state joins	2024 Ch. 77 (SB 1173)
CO	Out-of-state healthcare providers	Jan. 1, 2026	SB24-141
MN	Professional counseling, occupational therapy, physical therapy and audiology/speech-language pathology	When 10th state joins	2024 Ch. 127 (HB 5247, Arts. 25-32)
	Physician assistants, dentists/dental hygienists and social workers	When seventh state joins	

State	Provider or practice type	Effective date	Law
	Speech-language pathology assistants	July 1, 2025	
MS	Mental health services through the Psychology Interjurisdictional Compact (known as PSYPACT)	April 9	SB 2157
RI	Audio-speech pathology	When 10th state joins	HB 8219/SB 2173
	Occupational therapy	June 25	HB 7945/SB 2623
	Professional counseling	When 10th state joins	HB 7141/SB 2183
SC	Professional counseling	When 10th state joins	2024 Act 289 (SB 610)
VT	Occupational therapy	When 10th state joins	2024 Act 112 (HB 247)

Connecticut

Pub. Act 24-110 (HB 5198) made three major changes: (1) allowing telehealth providers to use audio-only telephone to provide services; (2) allowing telehealth services from any location to patients at any location; and (3) requiring reimbursement parity between telehealth and in-person providers. The law also repeals a provision that permanently allows out-of-state mental or behavioral health services providers to practice telehealth in the state, instead applying a June 30, 2025 expiration date.

Connecticut generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Michigan

Under 2024 Pub. Act 52 (HB 4131), fully insured medical and dental plans must provide reimbursement parity between in-person and telehealth services. Also, plans may not require a healthcare professional to provide services through telehealth, unless contractually required and clinically appropriate.

The law will take effect for plan renewals occurring on or about April 1, 2025. Michigan generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Tennessee

A new law (2024 Ch. 1027, HB 2857/SB 1881) permanently removed an existing requirement — which had been waived during the COVID-19 outbreak — effective May 28. Under the previously suspended law, a service provider needed to have an in-person encounter with a patient in the prior 16 months to allow for provider-based telemedicine.

Tennessee generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Vermont

Current law — requiring fully insured plan reimbursement parity between audio-only telephone and in-person healthcare services — was set to expire on Jan. 1, 2026. 2024 Act 108 (HB 861) repeals the expiration date. The law still provides a parity exception for value-based contracts between an insurer and provider for audio-only telephone services.

The law will take effect on Jan. 1, 2025. The law does not affect self-funded ERISA plans.

Washington, DC

Mayor Muriel Bowser signed the Health Occupations Revision General Amendment Act (2024 Act A25-0479, B25-0545), a portion of which adopts part of the model telehealth law recommended by the Uniform Law Commission. Specifically, the law allows the establishment of a practitioner-patient relationship through telehealth instead of requiring an in-person visit. Telehealth providers who are not licensed or registered in the District may provide services in two situations:

- There is an existing relationship and the patient is either in the District temporarily or a District resident and the services do not exceed 120 days (or longer, if future regulations permit)
- The provider is part of an interstate compact in which the District participates (currently, the District is a member of PSYPACT), which facilitates the practice of mental health services across state boundaries).

The law has been sent to Congress for mandatory review. Projected effective date is Aug. 1.

Other benefit-related issues

Alabama created a childcare tax credit for employers. San Francisco updated its rates under the Health Care Accountability Ordinance (HCAO). A Mississippi law gave the green light for establishing a state insurance exchange. Vermont initiated a study of a public insurance option. Washington reduced its Washington Partnership Access Line rates while Seattle announced 2025 rate increases under its hotel industry medical care mandate.

Alabama

For the 2025-2027 tax years, Act 2024-303 (HB 358) authorizes an employer tax credit equal to 75% of eligible expenses incurred by an employer (100% for employers with fewer than 25 employees in the state), up to $600,000 per year for each employer. Eligible expenses include:

- Payments to childcare facilities or employees for childcare
- Payments to childcare facilities to reserve services
- Construction, renovation, expansion or repair of a childcare facility

Tax credit funding is limited to $15 million for 2025, increasing by $2.5 million in each of the next two years.

California — San Francisco

The HCAO requires most city contractors to provide health benefits meeting minimum standards. Alternatively, employers can pay the city based on a covered employee hourly rate. The rate, starting July 1, is $6.75 per hour ($270-per-week cap), up from $6.35 per hour ($254-per-week cap). Mercer has received informal guidance that the Department of Health will issue new group health plan standards, likely by the end of the summer, effective on Jan. 1, 2025. For details on the HCAO, see Reviewing San Francisco contractor-lessee health plan, pay rules (Feb. 22, 2024).

Mississippi

HB 1647 authorizes the insurance commissioner to establish a state exchange under the Affordable Care Act. The law does not provide a time frame. When operational, Mississippi will be the 19th state (plus Washington DC) — and the first in the southeast US — to offer a state exchange.

Vermont

A budget law (2024 Act 113, HB 833, Sec. E306.1) allocates $150,000 to the state's Agency of Human Services for an insurance market analysis focused on a public option or other means for uninsured residents to buy into Medicaid. The report is due by Jan. 15, 2025.

Washington

The state has a behavioral health care covered-lives assessment and reporting obligation for health plan insurers and self-funded plan sponsors with covered state residents. The rate changes every July 1. The new rate is $0.06 (down from $0.07) per covered life. Assessments help to cover the costs of psychiatry and behavioral sciences consultation and referral lines overseen by the Washington State Health Care Authority. For details on WAPAL, see Some states require group health plan sponsor reporting (Dec. 5, 2023).

Washington — Seattle

The city announced 2025 monthly rates applicable to covered hotel industry employers for medical care:

Coverage category	2025 rate	2024 rate
Employee only	$561	$530
Employee & dependent(s)	955	902
Employee & spouse/domestic partner	1,124	1,062
Employee & family	1,686	1,592

The ordinance (Mun. Code Ch. 14.28) applies to most businesses that own, control, or operate a Seattle hotel or motel with 100 or more guest rooms and to "ancillary hotel businesses" with 50 or more employees worldwide.

Related resources

Mercer Law & Policy resources

- Maryland paid family and medical leave overview (slide deck) (May 9, 2024)
- Maryland revises paid family and medical leave (May 3, 2024)
- Reviewing San Francisco contractor-lessee health plan, pay rules (Feb. 22, 2024)
- 2024 state paid family and medical leave contributions and benefits (Jan. 31, 2024)
- Some states require group health plan sponsor reporting (Dec. 5, 2023)
- Roundup of selected state health developments, third-quarter 2023 (Nov. 15, 2023)
- Roundup: State accrued paid leave mandates (Oct. 25, 2023)
- Minnesota adopts paid sick and safe leave requirement (Sept. 27, 2023)
- Minnesota passes paid family and medical leave law (July 10, 2023)
- States, cities tackle COVID-19 paid leave (Feb. 15, 2023)
- Roundup of selected state health developments, third-quarter 2021 (Oct. 22, 2021)

Other Mercer resources

- Health benefits strategy
- Employee benefits broker
- Life, absence and disability benefits
- MercerRx