Roundup of selected state health developments, third-quarter 2024

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Nov. 1, 2024

In this article

By July 2024, most state legislatures had officially (or practically) adjourned for the year. New insurance coverage mandates dominated activity in the third quarter, with California and Illinois leading the way. Paid family and medical leave (PFML) laws saw minor changes, along with expected announcements of 2025 rates. A long-awaited state supreme court decision struck down Michigan's existing paid sick and safe leave (PSSL) law, replacing it with an earlier version originally approved in 2018. States were mostly quiet on the prescription drug (Rx) front, although Alaska did enact a comprehensive bill applicable to fully insured plans. Likewise, telehealth received only scant attention. San Francisco announced changes for its two major healthcare ordinances.

Insurance

California and Massachusetts passed infertility coverage laws. New California laws also addressed coverage of medical care following a rape or sexual assault, preventive care services and the use of artificial intelligence (AI) in utilization reviews. A Delaware law mandated abortion-related coverage without cost sharing. Illinois enacted eight new laws addressing a variety of coverage issues. New Hampshire restricted prior authorization. Puerto Rico established cybersecurity rules for insurers.

Note: An employer's self-funded ERISA plan is generally beyond the scope of state insurance laws. However, it may be prudent to compare current benefits offered with any new state insurance mandates to ensure employer-sponsored benefits are keeping pace for recruiting, retention and other reasons, particularly in states where an employer has a large employee population.

California

Four laws impose new requirements on fully insured plans and healthcare service plans (including health maintenance organizations (HMOs)):

- **Fertility and infertility coverage (2024 Ch. 930, SB 729).** The definition of infertility is revised to include "a person's inability to reproduce either as an individual or with their partner without medical intervention." Large group market health plans (100 or more employees) must cover diagnosis and treatment of fertility and infertility, including in vitro fertilization (IVF) — up to three completed oocyte retrievals with unlimited embryo transfers in accordance with accepted guidelines — that was previously excluded from the coverage mandate. Small group market health plans must offer fertility/infertility coverage as an option, but employers are not required to include these services in their plan. Cost sharing and waiting periods (including fertility medications) cannot differ from those applicable to non-fertility benefits. Existing law prohibits fertility/infertility coverage discrimination on the basis of many protected categories, including domestic partner status, gender expression, gender identity and sexual orientation. The law does not apply to individual policies or Medi-Cal. A religious employer exemption was retained. The effective date is plan years starting on or after July 1, 2025, except that the effective date for the state governmental plan (CalPERS) is July 1, 2027.
- **Rape/sexual assault treatment (2024 Ch. 971, AB 2843).** Plans must cover emergency room medical care and follow-up treatment (medical or surgical services) for victims of rape or sexual assault for nine months after treatment starts on a pre-deductible basis and without cost sharing. Coverage of follow-up treatment applies to services received from in-network providers and emergency providers; coverage extends to nonparticipating, nonemergency providers if timely access to in-network providers is unavailable. Plans may not condition coverage on the filing of a police report or charges or a final conviction. An exception exists for HSA-qualifying high-deductible health plans (HDHPs). The effective date is plan years starting on or after July 1, 2025.
- **Preventive services (2024 Ch. 708, AB 2258)**. Plans may not impose cost sharing on preventive services, as defined under the Affordable Care Act (ACA). The scope also includes home test kits for sexually transmitted diseases. Civil penalties up to $10,000 may be imposed for each violation. The law is in response to the *Braidwood Management v. Becerra* decision, which has cast doubt on the future of the ACA's preventive services mandate. Litigation continues. The effective date is plan years starting on or after Jan. 1, 2025.

AI in utilization review (**2024 Ch. 879**, SB 1120). Health plans may not use AI or contract with an entity using AI for medical necessity determinations. For this purpose, AI includes algorithms and other software tools. Use of AI for other utilization review and management must comply with specific requirements. The effective date is Jan. 1, 2025.

California generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, as long as both an employer's principal place of business and a majority of employees are located outside of California. These laws do not affect self-funded ERISA plans.

Delaware

Delaware addressed abortion-related services and doula coverage:

- **Abortion-related services (2024 Ch. 402, HS 2 for HB 110).** Individual and group health insurance, HMOs and Medicaid must cover abortion-related services without referral, prior-authorization, or cost sharing up to a $750 annual maximum per participant. The $750 cap does not apply to the state's health plan. A plan may not require a referral or prior authorization. Certain religious employers may obtain an exclusion from the carrier, but must still cover pregnancy termination services necessary to preserve the life or health of the covered individual. HSA-qualifying HDHPs are exempt from the cost-sharing prohibitions if the requirement would cause them to lose their status under federal law. The insurance and HMO provisions of the law will take effect for plan years starting on or after Jan. 1, 2026. The Medicaid and the state health plan provisions will take effect on Jan. 1, 2025.
- **Doula coverage (2024 Ch. 420, HB 362).** The scope of coverage includes support and assistance during labor and childbirth, prenatal and postpartum support and education, breastfeeding assistance and lactation support, parenting education and support after pregnancy loss. The law requires coverage for a minimum of six 90-minute visits (three each for prenatal and postpartum) and attendance during labor and birth. Plans may apply deductibles and other cost sharing and limit coverage to certified or registered doulas under standards similar to those applicable to the state's Medicaid program, which already covers doulas. The law will take effect for plan years starting in 2026.

It is not clear whether Delaware applies its insurance laws on an extraterritorial basis to fully insured plans issued in another state. These laws do not apply to affect self-funded ERISA plans.

Illinois

Illinois enacted many health insurance laws, highlighted by Governor JB Pritzker's health insurance reform law, the Health Care Protection Act (2024 Pub. Act 103-0650, HB 5395).

Here's a summary of the laws:

- **Health Care Protection Act.** Five major provisions in the law take effect on Jan. 1, 2025, unless otherwise indicated. First, the law bans step therapy for mental and emotional disorders (effective Jan. 1, 2025) and authorization of alternative covered medications as a loophole around the prohibition (effective Jan. 1, 2026). Second, plans are barred from using prior authorization for inpatient mental health services and concurrent review or retrospective denials for the first 72 hours after admission (effective Jan. 1, 2025). Third, drug formularies must be publicly posted by Oct. 1, 2025. Fourth, network adequacy standards must be at least as good as those for the Health Insurance Marketplace. Finally, a $5,000 monthly penalty applies for failure to maintain accurate network directories, with a self-audit reporting mandate every 90 days.
- **Infertility coverage (2024 Pub. Act 103-0751, SB 773).** Fully insured plans must cover diagnosis and treatment of infertility, including IVF, and preimplantation screening and diagnosis of a fertilized

egg in certain circumstances. The current fertility coverage mandate applies only to the state employee plan and to private employer plans covering 25 or more employees. The new mandate applies to all private employer plans, governmental plans, school plans, HMOs, limited health service organizations and voluntary health services plans effective for plan years starting in 2026. Beginning Jan. 1, 2026, all plans other than private employer plans covering 25 or fewer employees must also cover an annual menopause health visit for individuals 45 years an older, without cost sharing (unless coverage would disqualify an HSA-qualified HDHP).

- **Pregnancy-related coverage (2024 Pub. Act 103-0720, HB 5142).** Currently, fully insured plans, governmental plans, school plans, HMOs, limited health service organizations and voluntary health services plans must cover pregnancy and newborn care. For plans starting on or after Jan. 1, 2026, these plans must also cover at least 12 months of postpartum care. In each case (pregnancy, newborn care and postpartum care), coverage includes care provided by perinatal doulas, licensed midwives and lactation consultants and extends to home births, home visits and support during labor, abortion or miscarriage. Coverage includes necessary equipment and medical supplies. Cost sharing is only permissible for home births and certain pregnancy or postpartum related mental health and substance use disorder (MH/SUD) required coverages. The law provides an HDHP exception for this mandate and the state's existing abortion-related coverage mandate, which also prohibits cost sharing effective Jan. 1, 2026.
- **Prior authorization (2024 Pub. Act 103-0718, HB 5493).** Effective Jan. 1, 2025, fully insured plans will be prohibited from requiring prior authorization for care from a licensed obstetrician or gynecologist.
- **AI in utilization review (2024 Pub. Act 106-0656, HB 2472).** Effective Jan. 1, 2025, fully insured plans will need to meet minimum requirements to the extent they use AI (called "algorithmic automated processes") in utilization review for medical necessity. Specifically, any initial adverse benefit determination must be made by a clinical peer (i.e., a healthcare professional) and any subsequent appeal must be reviewed by a clinical peer. Automated processes must use objective, evidence-based criteria compliant with accreditation standards. Plans' procedures must include all criteria set by licensed physicians along with a program integrity system.
- **Dependent coverage (2024 Pub. Act 103-0700, HB 5258).** Fully insured plans providing dependent coverage renewing on or after Jan. 1, 2026, will have to cover parents and stepparents who meet the qualifying relative dependent definition in § 152(d) of the Internal Revenue Code.
- **Short-term, limited duration insurance (STLDI) (2024 Pub. Act 103-0649, HB 2499).** Effective Jan. 1, 2025, insurers will no longer be able to provide STLDI policies. The law appears to apply on an extraterritorial basis to policies issued in another state.
- **Colonoscopies (2024 Pub. Act 103-0800, HB 2385).** Fully insured plans, as well as state and local governmental plans, will need to cover colonoscopies when deemed medically necessary, without limitation based on age. (The initial proposal was for ages 39-75). The current mandate requires coverage for colonoscopies determined to be medically necessary after an initial screening. The ACA

preventive health services standard (which requires no-cost, in-network coverage) is age 45. The law will take effect for plan years starting in 2026.

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

Massachusetts

A budget law (2024 Ch. 140, HB 4800) includes a provision requiring fertility coverage when a participant has a diagnosed medical or genetic condition that may directly or indirectly cause fertility impairment by affecting reproductive organs or processes. Fertility coverage must include procurement, cryopreservation and storage of gametes, embryos or other reproductive tissue. Coverage must be provided to the same extent that coverage is provided for other pregnancy-related procedures. The fertility mandate applies to state governmental plans, fully insured plans, nonprofit hospital service corporations, medical service corporations and HMOs.

The mandate took effect retroactively on July 1, the start of the budget year. It is not clear whether Massachusetts applies its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

New Hampshire

The primary aim of 2024 Ch. 172 (SB 561) was to align prior authorization criteria with utilization review standards and procedures for managed care health benefit plans. Typically, insurers have latitude in this area. Here's a summary of the law:

- Turnaround times of 72 hours (urgent claims), seven calendar days (electronic nonurgent claims) and 14 calendar days (nonelectronic, nonurgent claims); the federal standard is 72 hours and 15 days, respectively
- Peer-to-peer review requirement when requested by a healthcare provider
- Standards for developing clinical review criteria
- Disclosure of prior authorization requirements
- Publication of performance indicators
- Qualifications for reviewers making medical necessity determinations

The law will take effect on Jan. 1, 2025. New Hampshire generally applies its insurance laws on an extraterritorial basis to fully insured plans issued in another state, if the principal worksite of employees is in New Hampshire. The law does not affect self-funded ERISA plans.

Puerto Rico

The Oficina del Comisionado de Seguros (OCS) — Puerto Rico's insurance department — issued Rule 108, establishing cybersecurity standards in the insurance industry, investigation standards and required incident reporting to OCS. The rule uses the National Institute of Standards and Technology (NIST) general framework for managing cyber risks. HIPAA security standards are also based on NIST. Penalties are up to $10,000 per violation. Covered entities have to implement the standards on or about March 10, 2025.

PFML

California will prohibit employers from requiring employees to use unpaid vacation time before PFML starts. Connecticut, Massachusetts, New Jersey and New York announced their 2025 rates. The Massachusetts high court issued an employer-friendly decision on accrual of vacation and sick time benefits during PFML. Oregon issued another round of final regulations. Washington regulations addressed a program payment coordination issue. Washington, DC increased the employer contribution, retroactive to July 1, and enacted temporary legislation to address an ongoing short-term disability (STD) coordination issue.

California

Under 2024 Ch. 949 (AB 2123), employers can no longer require employees to use up to two weeks of unused paid vacation before receiving family temporary disability insurance benefits, after Dec. 31. For details on PFML laws, see 2024 state paid family and medical leave contributions and benefits (Sept. 3, 2024).

The Employment Development Department finalized regulations related to a 2018 law that added qualifying military exigencies as a permitted use of paid family leave (PFL) benefits under the state's family temporary disability insurance program, beginning in 2021. The regulations made other technical changes:

- Mandatory completion of a content-specific military assist certification (Part E of the Claim for PFL Benefits Form DE 2501F) for qualifying exigencies
- Clarification that no more than one care provider may claim PFL benefits for a qualifying exigency in an eight-hour period, and no more than three care providers in a 24-hour period
- No more requirement for claimants to verify Social Security numbers

Technically, these regulations will take effect on Jan. 1, 2025. For details on this and other pending state regulations, see Keep an eye on these pending state regulations (Sept. 24, 2024).

Connecticut

The 2025 employee contribution rate will remain at 0.5% of wages (up to the Social Security maximum wage base of $176,100), per a recent CT Paid Leave Authority announcement. Employer contributions are not required under the program. The maximum PFML benefit is equal to 60 times the state minimum wage, which will increase from $15.69 to $16.35 per hour in 2025. As a result, the maximum PFML benefit will increase from $941.40 to $981.

Massachusetts

The 2025 rates were announced, and a state supreme judicial court ruled on an accrual issue.

The Department of Family and Medical Leave announced that its 2025 contribution rates will remain at 2024 levels: 0.88% of wages up to the Social Security maximum wage base. Employers with 25 or more Massachusetts employees will contribute 0.42%; their employees will contribute 0.46%. Employers with fewer than 25 workers in the state do not have to contribute but must collect and remit employee contributions of 0.46% for leave — 0.18% (family) and 0.28% (medical). The maximum weekly benefit will increase from $1,149.90 (2024) to $1,170.64 (2025).

The top court in Massachusetts ruled in *Bodge v. Commonwealth* that the state's PFML law does not require employers to accrue vacation and sick time during PFML. In the case, state troopers argued for accrual during protected leave, contrary to the state government's policy.

New Jersey

New Jersey posted some rate changes for 2025. Temporary disability insurance (TDI) and family leave insurance (FLI) together constitute PFML in the state. Employers will have to collect and remit contributions up to the $165,400 taxable wage base for 2025, up from $161,400 in 2024. The 2025 maximum TDI/FLI weekly benefit rate of $1,081 reflects an increase from $1,055 in 2024. In 2025, employees will contribute 0.33% of wages for FLI (0.09% for 2024) and 0.23% of wages for TDI after two years of zero contributions.. Employers pay the balance of TDI plan costs, and are not required to contribute to FLI.

New York

New York's Department of Financial Services posted rates for 2025 PFL benefits. Employee PFL contributions will increase from 0.373% (2024) to 0.388% (2025) of an employee's wages. The maximum annual employee contribution will increase from $333.25 (2024) to $354.53 (2025). Employers do not contribute to the PFL fund. New York also has a disability benefits law, where employee contributions are set by statute at 0.5% of wages up to a maximum of $0.60 per week.

Oregon

The Oregon Employment Department finalized its Batch 11 PFML regulations:

- Revisions to the definitions of “workday” and “work week” and calculations for those periods
- Revised benefit eligibility to align with a 2024 law and clarification that employees eligible for worker’s compensation are not eligible for Paid Leave Oregon benefits
- Confirmation of what information employees must provide about eligibility and allowable documents to verify bonding leave, medical leave, other family leave and safe leave claims
- Alignment with the 2024 law changes regarding benefit offsets for child and spousal support, and restitution for crime victims
- Clarification of employer penalties for willful misrepresentation related to employee claims
- Confirmation of the anniversary date of equivalent plans with an effective date of Sept. 3, 2023

Oregon’s PFML program is fully underway. More information is available on the Paid Leave Oregon webpage.

Washington

Washington saw new coordination rules, made changes to the 2025 maximum benefit limit, and announced 2025 premiums.

The Employment Security Department (ESD) published final rules that prioritize employer payments to three programs: PFML, WA Cares (the state’s long-term care mandate) and unemployment insurance. When it is unclear where an employer’s payment should be allocated among the PFML, WA Cares and unemployment programs, ESD will post the payment to outstanding balances in the following order:

- First, to the unemployment fund, if money is owed
- Second, to the PFML fund, if money is owed
- Finally, to the WA Cares fund

The rules took effect on Sept. 6.

ESD also posted its maximum weekly benefit amount for 2025. Benefits are calculated at 90% of an employee’s average weekly wage (AWW) up to 50% of the state AWW (updated to $1,714 for 2025, almost a 6% increase from $1,618 in 2024), and 50% for AWW over 50% of the state’s AWW. As a result, the maximum weekly benefit for 2025 will be $1,542, up from $1,456; the minimum weekly benefit remains at $100 for 2025.

Starting Jan. 1, 2025, the premium rate will increase to 0.92% of wages, with employers paying 28.48% and employees paying 71.52% of the total premium. Premiums are paid on wages up to the Social Security maximum wage base. Businesses with fewer than 50 employees are not required to pay the employer portion.

Washington, DC

The FY2025 Budget Support Emergency Act (2024 Act A25-0506, B25-0875) was passed without Mayor Muriel Bowser's signature. One provision increases the maximum employer contribution from 0.62% to 0.75% for Universal Paid Leave (UPL) coverage, the District's PFML program. Funds collected in excess of what is needed to keep the UPL fund solvent could be used for general purposes outside of the UPL program. The new UPL contribution rate of 0.75% was effective beginning July 1.

Washington, DC continued its extension of an employee protection under its UPL law, related to insured short-term disability (STD) benefits. As background, existing law prohibits STD insurance from offsetting benefits based on an employee's estimated or actual UPL benefits. However, this permanent provision does not apply to STD insurance policies issued outside of Washington, DC. Consequently, the DC Council and Mayor periodically enact temporary legislation applying the STD insurance offset prohibition to policies issued elsewhere. The latest law is Act A25-0536 (B 870), which extends the extraterritorial prohibition to May 1, 2025. The prohibition does not apply to self-insured STD or other temporary disability benefits, which could include salary continuation.

Other leave-related issues

California enacted two leave laws. Cook County, Illinois repealed a COVID-19 leave law. A new Massachusetts law provides leave for pregnancy loss and related events. A Michigan supreme court decision restored an employee-friendly version of its PSSL law.

California

The state passed two laws affecting its PSSL mandate:

- Violence victims leave (**2024 Ch. 967**, AB 2499). Family members will have domestic violence protections under the state's PSSL law. An employer may require PSSL and federal FMLA leaves to run concurrently if the reason triggers both laws. For details on PSSL laws, see Roundup: State accrued paid leave mandates (Oct. 25, 2023).
- Agricultural employees leave (**2024 Ch. 525**, SB 1105). PSSL coverage will extend to agricultural employees who work outside and take time off to avoid smoke, heat or flooding conditions created by a local or state emergency.

Both laws will take effect on Jan. 1, 2025.

Illinois — Cook County

The COVID-19 Vaccination Rights for Employees and Employer Obligations Ordinance was repealed effective July 17. Under the ordinance, employers could not require employees to obtain vaccines outside of work hours. Instead, employees could use accrued paid time off. If vaccination was required by the employer, the employer had to provide up to four hours of paid time off per dose.

Massachusetts

A new Massachusetts law primarily addressing midwifery care and out-of-hospital birth options also amended the state's PSSL law. Under 2024 Ch. 186 (HB 4999), covered employers must provide leave to address an employee's or spouse's physical and mental health needs due to pregnancy loss or a failed assisted reproduction, adoption or surrogacy. The law will take effect on or about Nov. 21.

Michigan

The Michigan Supreme Court reversed a lower court decision and invalidated legislative changes to the Earned Sick Time Act (ESTA) and the Improved Workforce Opportunity Wage Act (the Wage Act).

In a 4-3 decision, the state supreme court ruled in *Mothering Justice v. Attorney General* that the original version of the ESTA and the Wage Act should be in effect instead of the amended version approved by the legislature in the same session. The ESTA is the state's PSSL law; the Wage Act sets the state's minimum wage. In 2018, the original versions were part of a November ballot initiative. However, the legislature adopted both measures in September (removing the initiative from the ballot) and then adopted amended versions after the election. Among other items, the amended version of the ESTA changed the accrual rate, accrual use cap and carryover; the amended version of the Wage Act slowed the timetable for minimum wage increases.

This "adopt-and-amend" approach was held to violate the state constitution. As a result, the original versions of both laws will take effect 205 days after the July 31 opinion date, i.e., Feb. 21, 2025. The amended versions of both laws will remain in effect until then. Here is a comparison of the original and amended versions:

Provision	Original (takes effect Feb. 21, 2025)	Amended (in effect now through Feb. 20, 2025)
Accrual rate	1 hour for every 30 hours worked	1 hour for every 35 hours worked
Annual accrual cap	None	40 hours
Annual use cap	72 hours (10 or more employees); 40 hours (fewer than 10 employees)	40 hours
Carryover of unused leave	Unlimited carryover required	Limited to 40 hours
Covered employee	Excludes employees covered by collectively bargained agreement until agreement (CBA) expires	Excludes FLSA overtime exempt employees; part-time, temporary/seasonal, variable-hour employees; employees covered by CBA
Small employer exception	None	Fewer than 50 employees
Preemption of local law	Language explicitly allowing for local laws	Local laws preempted

Michigan's Department of Labor and Economic Opportunity recently issued an FAQ and a brochure about the PSSL changes.

Rx

Alaska imposes new restrictions on PBMs. Delaware and New York laws address PBM-pharmacy interactions. A Pennsylvania law requires reimbursement parity between affiliated and nonaffiliated pharmacies and a rebate pass-through.

Alaska

Per 2024 Ch. 61 (HB 226), registered PBMs will be subject to these limitations:

- 100% pass-through of all manufacturer volume- or market share-based payments to the plan sponsor
- A duty of care to the plan sponsor, benefits administrator and participants, based on standards of prudence and acting in the best interest of those entities and individuals
- An extensive list of insurers' unfair trade practices related to administering prescription drug benefits
- Transparency requirements owed to the plan sponsor

The law will take effect for plans issued or renewed on or after Jan. 1, 2025. Alaska 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.

Delaware

Under 2024 Ch. 421 (SB 272), plans must provide the same level of reimbursement to pharmacies that other providers (including physicians, advance practice registered nurses and physician assistants) receive for performing the same services. Current law allows pharmacists to perform a variety of services, including prescribing birth control, testing and treating for some conditions and prescribing pre-exposure and post-exposure prophylaxis (commonly known as PrEP and PEP). The law will take effect on Jan. 1, 2025.

The law's application to self-funded ERISA plans is unclear, given that it applies to "carriers," broadly defined to include "any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans."

New York

Under 2024 Ch. 396 (SB 9040), PBMs will not be able to prevent or penalize pharmacy disclosures to participants about the pharmacy's cost of a prescription drug or service and the its reimbursement from

the PBM. Existing law defines PBM broadly, potentially including PBMs working on behalf of self-funded ERISA plans.

Pennsylvania

The Pharmacy Benefit Reform Act (2024 Pub. Act 77, HB 1993) was signed into law with the aim of "providing stronger protections for patients in Pennsylvania and increased regulatory oversight." PBMs will have to apply reimbursement parity between affiliated and nonaffiliated pharmacies and will be unable to steer participants to a mail-order or affiliated pharmacy. PBMs will be restricted on how they can define specialty drugs for purposes of designating an exclusive specialty pharmacy network. A 95% rebate pass-through to the plan will be required if rebate negotiation is delegated to the PBM in the contract. The law also establishes network adequacy standards and a PBM reporting program. The law applies to insurance policies approved and pharmacy contracts issued, renewed, or amended after Nov. 14. New reporting requirements will take effect in 2026. The law explicitly exempts PBMs working on behalf of self-funded ERISA plans.

Pennsylvania generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, as long as the employer's principal office is located outside of Pennsylvania.

Telehealth

Alaska extended telehealth permission to out-of-state multidisciplinary teams while Illinois allowed physical therapy to be delivered via telehealth. A new Pennsylvania law requires insured plans to cover telehealth.

Alaska

A new Alaska law (2024 Ch. 13, SB 91) allows out-of-state members of a physician's multidisciplinary team to provide healthcare services, if the service is not reasonably available in the state. The scope of services includes ongoing treatment and follow-up care. Previously, this allowance only applied to out-of-state physicians. The law took effect on Oct. 16.

Illinois

Under 2024 Pub. Act 103-0849 (HB 5087), physical therapy will be permitted via telehealth as long as in-person care is available. Documented clinical justification is required for telehealth to be used as the primary means of delivering physical therapy. The law will take effect on Jan. 1, 2025.

Pennsylvania

Pennsylvania will require fully insured telehealth coverage as a result of the enactment of 2024 Act 42 (SB 739). Fully insured plans must cover medically necessary in-network healthcare services via telehealth to the same extent they cover in-person services, unless the provider fails to comply with

HIPAA and HITECH Act rules. Insurers may not deny coverage solely because services are provided in a telehealth setting. The coverage mandates will apply to Medicaid and the Children's Health Insurance Program (known as CHIP) on Jan. 1, 2026, if certain requirements are met. The law otherwise took effect on Oct. 1.

Pennsylvania generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, as long as the employer's principal office is located outside of Pennsylvania. The law does not affect self-funded ERISA plans.

Other benefit-related issues

New California laws addressed AI and multiple-employer welfare arrangements (MEWAs). San Francisco announced its 2025 Health Care Security Ordinance (HCSO) rates and changes to contractors' medical plan standards under its Health Care Accountability Ordinance (HCAO). New Jersey finalized regulations implementing last year's temporary workers' pay/benefits law. Pennsylvania adopted a new child-care contribution tax credit.

California

California considered numerous AI bills during the session that did not make it to the finish line. One that did was 2024 Ch. 848 (AB 3030). Health facilities, clinics, physician's offices and group practice offices will have to disclose to patients any generative AI used to create written or verbal communications pertaining to clinical information. The effective date is Jan. 1, 2025.

The MEWA laws were:

- **2024 Ch. 398 (AB 2434).** Previously, state law allowed association health plans (AHPs) — a type of MEWA — with large group coverage to offer coverage to employers in the small group market if the AHP met certain requirements, including establishment of the AHP before March 23, 2010. The new law requires the establishment date to have occurred before Jan. 1, 1966. The new law also requires MEWA registration by June 1, 2025. The law — applicable to healthcare service plans (including HMOs) — was set to expire on Jan. 1, 2026, and will now expire four years later.

- **2024 Ch. 374 (AB 2072).** This bill authorizes the Departments of Managed Health Care and Insurance to analyze the impact of MEWAs on the small group market and publish a report by July 1, 2026. Authorization for approved MEWAs — set to expire on Jan. 1, 2026 — will also be extended to Jan. 1, 2030.

California — San Francisco

San Francisco posted its 2025 health care expenditure (HCE) rates under the HCSO, applicable to employers with a San Francisco business registration and at least 20 employees nationally:

Employer size	Number of workers worldwide	2024 expenditure rate	2025 expenditure rate
Large	All employers with 100+ workers	$3.51 per hour	$3.85 per hour
Medium	Businesses with 20–99 workers Nonprofits with 50–99 workers	$2.34 per hour	$2.56 per hour
Small	Businesses with 0–19 workers Nonprofits with 0–49 workers	Exempt	Exempt

The exemption threshold for managerial, supervisory, and confidential employees will increase from $121,372 to $125,405 per year. For details, see San Francisco hikes 2025 Health Care Expenditure rates (Aug. 13, 2024).

The HCAO minimum standards will change on Jan. 1, 2025. The HCAO requires most city contractors to provide health benefits meeting 16 minimum standards, including at least one plan option where self-only medical coverage is free to employees. Alternatively, employers can make a payment to the Department of Public Health, based on an hourly rate for each covered employee.

Here's what will change:

- **Self-only annual out-of-pocket maximum (OOPM).** It must align with ACA requirements, which will be $9,200 (self-only) in 2025, up from the 2024 OOPM is $8,750, based on a California benchmark plan.
- **Separate prescription drug (Rx) deductible.** If a plan has separate medical and Rx deductibles, they will be $3,000 (medical, no change) and $400 (Rx, up from $300) in 2025.
- **In-network (INN) coinsurance** will be 55% in 2025, a change from 60% in 2024.
- **INN primary care copayments** will be $65 per visit in 2025, up from $60 per visit in 2024.

For a comprehensive review of HCAO and related requirements, see San Francisco contractor-lessee health plan standards, pay rates updated (Sept. 3, 2024).

New Jersey

New Jersey's Division of Wage and Hour Compliance finalized rules for its Temporary Workers Bill of Rights law, which took effect last year. The law requires temporary laborers to be paid at least the average rate of pay and cost of benefits (or the cash equivalent) of employees working at the recipient organization. Effective Sept. 16, the final rules define benefits as "employee fringe benefits, including but not limited to, health insurance, life insurance, disability insurance, paid time off (including vacation, holidays, personal leave and sick leave in excess of what is required by law), training, and pension."

Pennsylvania

A new tax law (2024 Pub. Act 56, SB 654) creates an employer child-care contribution tax credit. Starting with the 2025 tax year, most employers in the state will be able to claim a 30% tax credit for contributions to employees' child-care costs. The law requires all employees to have an equal opportunity to receive the employer contribution. The law is silent on whether employer contributions through a § 129 dependent care FSA would count. The Department of Revenue is tasked with issuing regulations.

Related resources

Mercer Law & Policy resources

- Keep an eye on these pending state regulations (Sept. 24, 2024)
- San Francisco contractor-lessee health plan standards, pay rates updated (Sept. 3, 2024)
- San Francisco hikes 2025 Health Care Expenditure rates (Aug. 13, 2024)
- Roundup: State accrued paid leave mandates (Oct. 25, 2023)
- Roundup of selected state health developments, third-quarter 2022 (Nov. 4, 2022)

Other Mercer resources

- Benefits strategy & innovation
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- Life, absence and disability benefits
- MercerRx

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