Roundup of selected state health developments, second-quarter 2023

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In this article

Legislative activity typically peaks in the second quarter of a year, and 2023 was no exception. Paid leave continued to make news as Florida, Minnesota, Tennessee, and Texas adopted new paid family and medical leave (PFML) laws. Other states modified existing laws, including Maryland, which delayed its PFML program by one year. Paid sick and safe leave (PSSL) drew attention, with Minnesota again enacting a law that will take effect next year. Costs of prescription drugs (particularly insulin) are an ongoing concern, with Florida, Maryland, North Dakota, and Texas enacting laws that appear to apply to fully insured and self-funded health plans. A few states — including Florida and Washington — expanded the availability of telehealth services. Several states — including Colorado, Florida, Louisiana, Montana, South Carolina, Texas and Washington — addressed coverage of fertility and/or abortion services in insured plans. Other legislative highlights centered on association health plans (AHPs) and domestic partner rights and benefits.

PFML

Minnesota's PFML law provides up to 20 weeks of leave per benefit year. Optional insurance products will soon be available in Florida and Texas, while Tennessee added a tax credit for employers voluntarily offering PFML. In Maryland, PFML contributions will start Oct. 1, 2024, and benefits will become available Jan. 1, 2026. Colorado and Oregon finalized rules ahead of benefits starting Sept 3, 2023, and Jan. 1, 2024, respectively. Washington changed its existing program.

Colorado

Colorado's Family and Medical Leave Insurance (FAMLI) Division continues to adopt new and revise previously adopted regulations:

- **Program integrity (adopted May 25, 2023)**. The division and a private plan may seek recovery of benefit overpayments and premium underpayments, the latter "by any legal means available." Recovery may be waived if it is "against equity and good conscience."
- **Investigations, determinations and appeals (adopted May 25, 2023).** Employees, family members and others with a "workplace relationship" can file complaints. When investigated, employers must take steps to preserve relevant records in accordance with federal law.
- **Job protection, anti-retaliation and anti-interference (adopted May 25, 2023).** These rules contain examples of retaliation and interference, including the use of a person's immigration status to negatively impact PFML rights. Job restoration requires reinstatement to the same or an equivalent position.
- **Coordination of benefits and reimbursement of advance payments (amendments adopted May 25, 2023).** The definition of "employer-provided paid leave" for PFML purposes now excludes other types of leave like short- and long-term disability (STD and LTD), paid parental leave, or other paid family leave. A "bank of time off solely for … paid family and medical leave" is newly defined as meeting the state program's purposes but must be separate from accrued vacation, accrued sick time or paid time off (PTO). The revisions continue to allow accrued paid leave to top off payments when the employer and employee mutually agree and clarify that employer-provided paid family leave (e.g., parental bonding time), STD, and LTD can offset benefits received from the state.

For details on PFML in Colorado and other states, see 2023 state paid family and medical leave contributions and benefits (Feb. 1, 2023).

Florida

Ch. 2023-149 (HB 721) creates a new line of family leave insurance. Insurers may offer this coverage as a rider or an amendment to a disability policy or as a separate policy. Family leave policies must provide all or part of wages for bonding leave within the first 12 months of a child's birth or adoption/foster care placement, care-giving leave for a family member with a serious health condition, and leave for a qualifying exigency. Coverage excludes wage replacement for leave for an employee's own serious health condition. The law took effect July 1.

Maryland

Ch. 2023-149 (HB 988/SB 828) delays the state's PFML mandate by one year and makes other program changes. Start dates for contributions and benefits change to Oct. 1, 2024, and Jan. 1, 2026, respectively. The employer-employee contribution split — previously set between 25% to 75% — is now

50%–50%. The maximum contribution rate is 1.2% of wages up to the Social Security maximum wage base ($160,200 in 2023). Other changes include:

- Addition of domestic partners to the family member definition
- Removal of the requirement to exhaust all employer-provided leave (vacation, paid sick leave or other leave) before receiving state benefits, although an employer may require coordination with other benefits
- Expansion of qualifying reasons to include bonding leave and time off during the foster care, kinship care, and adoption processes
- Private plan employee contributions capped at the maximum rate set by the state Department of Labor

Minnesota

As a result of 2023 Ch. 59 (HF 2), covered employers must provide paid family leave for bonding with a new child, caring for a family member with a serious health condition, handling qualifying exigencies, addressing safety matters (i.e., domestic abuse, sexual assault, or stalking), and taking medical leave for the employee's own serious health condition. Employers with one or more employees in the state must comply with the law. Seasonal hospitality employees who work 150 or fewer days in any 52-week period are not entitled to PFML. Self-employed individuals may opt into the PFML program.

Contributions and benefits start Jan. 1, 2026. Contributions are set at 0.7% (up to the Social Security maximum wage base), split evenly between employers and employees. A lower contribution rate applies to employers with fewer than 30 employees. In addition, more than $650 million in state funding will seed the program. Medical leave and family leave (including for qualifying exigency and safety reasons) are each capped at 12 weeks in a benefit year. The maximum combined leave is 20 weeks in a benefit year.

Employers can satisfy the PFML requirements with an approved private plan consisting of employer self-funded benefits, insurance or both. Employers with approved private plans for just medical or just family leave must contribute 0.3% or 0.4% of wages, respectively, to the state program.

For details, see Minnesota passes paid family and medical leave law (July 10, 2023).

Oregon

Paid Leave Oregon (PLO) saw several developments.

First, 2023 Ch. 66 (SB 31) authorized the Oregon Employment Department (OED) to delay the launch of PFML benefits if the trust fund was not solvent. The OED director had until Aug. 11 to make this call and determined that the trust fund is solvent, so no delay is needed.

Second, 2023 Ch. 120 (SB 912) addresses rules on benefit recoupment and ineligibility, penalties for delinquent contributions, and noncompliant employer equivalent plans. The law will take effect Sept. 3.

Third, 2023 Ch. 292 (SB 913) changes the wage limit used for contributions from $132,900 to the Social Security maximum wage base. Other changes focus on hearing procedures, eligibility rules for self-employed individuals and tribal government employees, and an expansion of the circumstances in which OED may disclose PFML information. The law will primarily take effect on Sept. 3, except the contribution and disclosure rules will go into effect Jan. 1, 2024.

Fourth, 2023 Ch. 203 (SB 999) changed provisions of the unpaid/paid Oregon Family Leave Act (OFLA) and PFML requirements:

- The OFLA definition of family members now includes domestic partners. OFLA also includes family members by affinity, as defined under PLO. Most of the administration will occur via Frances Online.
- Job protection rights are revised. If an equivalent position at the original workplace is unavailable on an employee's return from leave, the employer must offer an equivalent position within 50 miles of the job site, if available. If several positions are available, the first offer must be at the location closest to the former job site.
- Employers may deduct catch-up benefit contributions up to 10% of gross pay on an employee's return to work.
- The one-year period for determining OFLA leave duration currently can be based on the calendar year, a fixed 12-month period (e.g., a fiscal year), a 12-month period measured forward from the date of the employee's first OFLA leave or a 12-month period measured backward from the date the employee uses any OFLA leave. However, starting July 1, 2024, the one-year period must be the 52-week period starting on the Sunday immediately before the leave start date. This change will match the PLO definition for benefit year. See this guidance.

Except as otherwise noted, all of the above provisions will take effect Sept. 3.

Finally, OED updated the state's average weekly wage, which changes the PFML benefit limits. The weekly minimum increases from $61 to $63.48; the weekly maximum increases from $1,469 to $1,523.63. These changes take effect when PFML benefits start Sept. 3. Contribution rates and the benefit calculation remain unchanged. For further details, see this PLO resources page.

Another law changed Oregon's PFML and unpaid family leave provisions; see *Other benefit-related issues*.

Rhode Island

As required annually, the Department of Labor and Training raised the maximum weekly benefit for temporary disability insurance (TDI) and temporary caregiver insurance (TCI) from $1,007 to $1,043. The state's TDI/TCI law includes a dependent allowance, which increases benefits by as much as 35% for up to five dependents; the maximum benefit for workers with five dependents increased from $1,359 to $1,408. All increases took effect for leaves starting on or after July 1.

Tennessee

The Tennessee Works Tax Act (2023 Ch. 377, HB 323/SB 275) includes a PFML tax credit. For the 2024 and 2025 tax years, employers will receive a franchise and excise tax credit for paid family and medical leave benefits that comply with Section 45S of the federal Internal Revenue Code. For details, see this Department of Revenue notice.

Texas

HB 1996 creates optional employer-sponsored insurance coverage for paid family leave through a separate policy or an amendment or a rider to a disability policy. Qualifying reasons are a family member's serious health condition; bonding in the first 12 months of a child's birth, adoption, or foster care placement; a qualifying exigency; a military family member's injury in the line of duty; and other reasons specified in the policy.

Washington

Two minor PFML developments occurred:

- The rate calculation methodology is changing and a solvency surcharge from the family-leave portion of the rates will be eliminated under 2023 Pub. L. No.116 (SB 5286).
- Employers, third-party administrators (TPAs) and employees may obtain information related to an employee's PFML claim from the state's Employment Security Department (ESD), as a result of 2023 Ch. 375 (SB 5586). Employer/TPA use of this data is only for administering leaves and benefits. The law will take effect Jan. 1, 2024.

Paid sick leave

Minnesota's new paid sick leave program may be a challenge for employers already subject to local paid leave laws in the state. In Massachusetts and Michigan, pending litigation may require changes to current laws. Legislation enacted in Colorado, Connecticut and Georgia amends current leave requirements.

Colorado

2023 Ch. 313 (SB 23-017) adds three reasons for using accrued paid sick leave:

- Grieve, attend funeral/memorial services or deal with financial/legal matters after a family member's death
- Care for a family member whose school or place of care has closed for various reasons, including inclement weather

- Evacuate a residence due to inclement weather; lost power, heating, or water; or any other unexpected occurrence or event

The law took effect on or about Aug. 7. For details on Colorado's and other states' accrued PSSL laws, see Roundup: State accrued paid leave mandates (April 29, 2022).

Connecticut

Pub. Act No. 23-101 (SB 2) provides two more reasons for taking PSSL:

- A "mental health wellness day" for an employee's emotional and psychological well-being
- A parent whose child is a victim of family violence or sexual assault (previously, only applicable when an employee was a victim)

The law will take effect Oct. 1.

Georgia

Even though no state PSSL mandate exists, Georgia requires employers with at least 25 employees to cover the care of immediate family members under any sick leave policy other than STD/LTD insurance. 2023 Act 90 (SB 61) removed the law's previous July 1 expiration date.

Massachusetts

A federal district court has concluded that the state's earned sick time law (in effect since 2015) does not apply to the airline industry, due to federal preemption under the Airline Deregulation Act (*Air Transport Ass'n of Am. v. Campbell*, No. 18-cv-10651 (D.MA June 2, 2023) This injunction applies to in-flight employees and ground crew. An airlines advocacy group noted abuses around major holidays and Super Bowl week, causing flight cancellations.

Michigan

A case (*Mothering Justice v. Att'y Gen.*) pending before the state supreme court should finally resolve the fate of the Earned Paid Sick Leave Act. The state legislature enacted a more employee-friendly voter initiative before the vote took place, thereby removing the initiative from the ballot. However, in the same legislative session, lawmakers amended the measure to a less employee-friendly version. Plaintiffs have argued that the original version should be reinstated. Michigan's minimum wage law is also at issue. For details, see Roundup of selected state health developments — third-quarter 2022 (Nov. 4, 2022).

Minnesota

A PSSL mandate included in a state budget act (2023 Ch. 53, SF 3035) requires covered employers to provide at least one hour of sick and safe leave for every 30 hours worked, capped at 48 hours annually. Covered employees must work at least 80 hours per year in Minnesota. The law will take effect Jan. 1, 2024.

The carryover limit for unused accrued leave is 80 hours. Alternatively, employers can negate the carryover obligation by frontloading either 48 hours with a payout of unused time at year-end or the full 80 hours with no payout. The law does not preempt more generous local leave laws. Four Minnesota cities currently have PSSL laws: Bloomington, Duluth, Minneapolis and St. Paul. All four have the same or less generous accrual rates than the state law. Only Duluth (at 64 hours) has a higher annual cap.

Other leave-related issues

Massachusetts revised its parent leave rules. Nevada now includes sexual assault as a reason to take job-protected leave under state law. A new Virginia law allows unpaid leave for organ donations.

Massachusetts

The Massachusetts Commission against Discrimination (MCAD) issued guidelines and a brief guide on the state's Parental Leave Act (PLA), which provides up to eight weeks of unpaid leave for the addition of child by birth or adoption. Parental leave runs concurrently with the state's PFML mandate and federal FMLA. This guidance highlights distinctions between the parental leave and PFML laws, including:

- **Employee eligibility.** PFML has a minimum earnings requirement and a seven-day waiting period to receive benefits. The PLA has no earnings requirement, but the leave is only available to full-time employees with at least three months' tenure.
- **Intermittent leave.** Under both laws, parental leave is available on an intermittent or a reduced-schedule basis with an employer's agreement. However, under the PLA, an employee's request to take leave on an intermittent or a reduced schedule may not be "unreasonably denied."
- **Employee notice.** The PLA requires at least two weeks' notice, absent reasons beyond an employee's control; PFML requires at least 30 calendar days' notice, absent unusual circumstances.
- **Multiple events.** Unlike PFML and FMLA — which prescribe a maximum duration per benefit year for birth and adoption — the PLA rules allow eight weeks of unpaid leave for each event. The guidance gives an example of twins. PFML would provide paid leave for the first 12 weeks; the employee could take an additional four weeks of unpaid leave under the PLA.

Nevada

As a result of 2023 Ch. 207 (AB 163), sexual assault situations are now a qualifying reason for state-protected leave (paid or unpaid). The maximum duration for this leave — previously available only for incidents of domestic violence — is 160 hours per 12-month period. Sexual assault is defined by the criminal statute. The law will take effect Jan. 1, 2024.

Virginia

Employers with 50 or more employees (whether nationally or in the state is unclear) must provide up to 12 weeks of unpaid organ donation leave in a 12-month period under 2023 Ch. 751 (SB 1086). Eligible employees must have:

- At least 12 months of employment with the same employer
- At least 1,250 hours of employment during the prior 12-month period
- Medical-necessity documentation

Most states require this type of leave only for state and local government employees. The law took effect July 1.

Prescription drugs (Rx)

Several states passed pharmacy benefit manager (PBM) laws that arguably apply to self-funded plans. These laws fan the flames of the ERISA preemption debate and the scope of the US Supreme Court's 2020 *Rutledge* decision. For a further discussion of this topic, see Is ERISA preemption at risk of being preempted? (Feb. 23, 2023). The Colorado and Florida laws specifically target spread pricing — when a PBM charges a plan more than the acquisition cost. Cost-sharing caps on insulin and other historically high-cost drugs are another area of activity. Texas has particularly focused on Rx issues, passing half a dozen laws. For details on legislative trends, see State legislatures continue to focus on Rx (June 29, 2023).

Colorado

Colorado passed four Rx laws:

- **Spread pricing ban.** 2023 Ch. 158 (HB 23-1201) prohibits spread pricing, effective for plan years starting after 2024.
- **Mandatory registration.** 2023 Ch. 160 (HB 23-1227) requires PBM registration (starting in 2024) and creates an enforcement/penalty scheme.
- **Oversight.** 2023 Ch. 162 (HB 23-1225) extends the Sept. 1, 2026, sunset date for the state's Prescription Drug Affordability Board (PDAB) by five years and increases the number of reviewable drugs. PDAB's authority applies only to fully insured plans.
- **Third-party payments.** 2023 Ch. 351 (SB 23-195) requires fully insured plans to apply third-party Rx payments toward participant cost sharing — including deductibles and out-of-pocket maximums (OOPMs). The requirement applies only to when drugs lack a generic equivalent or biosimilar, are used with approval (granted in advance or through an exception/review/appeal)m or are part of a required step-therapy program. Fully insured high-deductible health plans (HDHPs) designed to work

with health savings accounts (HSAs) are exempt. The law will take effect staring with the 2025 plan year.

Colorado 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 plans.

Florida

The Prescription Drug Reform Act (Ch. 2023-29, SB 1550) is a sweeping PBM law applicable to fully insured and self-funded plans for plan years starting in 2024 or later. Highlights include:

- A spread-pricing ban
- 100% rebate pass-through of manufacturer rebates to the group health plan for the sole purpose of offsetting cost sharing and reducing participant contributions
- Restrictions on preferred networks (including a prohibition on affiliated pharmacy-only networks), mail-order prescriptions and specialty pharmacies
- Increased transparency

The extent to which the law covers self-funded plans has sparked some debate. The statutory language contains two provisions that do not appear entirely consistent. On the one hand, the law includes “self-insured employer health plans” in its definition of a “pharmacy benefits plan or program.” On the other hand, the law states that it “is not intended, nor may it be construed, to conflict with existing, relevant federal law.” Clarification from the Office of Insurance Regulation would be helpful.

Indiana

Rebates and transparency for fully insured plans are the focus of 2023 Pub. L. No. 166 (SB 8):

- **Rebates.** Insurers must pass through 100% of rebates to plan sponsors, providing them with an option to decrease participant cost sharing at the point of sale (POS) by some or all rebates.
- **Transparency.** Insurers must provide annual disclosures to plan sponsors, and PBMs must provide reports to the Department of Insurance every six months.

Penalties of up to $10,000 apply to violations. The law took effect July 1. Indiana 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 plans.

Minnesota

As a result of 2023 Ch. 57 (SF 2744), fully insured plans must limit participant Rx cost sharing for chronic diseases (specifically, diabetes, asthma and allergies requiring an epinephrine auto-injector). These

limits are $25 for a one-month Rx supply and $50 for one month of related medical supplies. Cost sharing is not subject to deductibles, except under HSA-eligible HDHPs.

The law will take effect for plan years starting in 2025 or later. Minnesota applies its laws on an exterritorial basis to fully insured plans issued in another state if either the employer is based in Minnesota or has at least 25 employees residing in the state. The law does not affect self-funded plans.

Montana

Montana addressed diabetes in two ways:

- **Cost-sharing cap.** 2023 Ch. 463 (SB 340) caps insulin cost sharing ($35 for a 30-day supply) under fully insured plans and self-funded multiple employer welfare arrangements (MEWAs). The law exempts other self-funded plans.
- **Coverage requirement.** 2023 Ch. 520 (HB 612) mandates that fully insured plans cover diabetes self-management training and education. These plans must cover up to 20 visits for the initial year and up to 12 visits in later years once the 20-visit limit is reached. The law does not affect self-funded plans.

Both laws will take effect for 2024 and later plan years. Montana generally does not apply its laws on an extraterritorial basis to fully insured plans issued in another state.

Nebraska

A broad-based law (LB 92) includes a $35 insulin copay cap for a 30-day supply. This provision (effective plan years starting on or after Jan. 1, 2024) applies to fully insured plans and self-funded plans exempt from federal law (e.g., church plans, nonfederal governmental plans). Nebraska does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

Nevada

Effective Oct. 1, PBMs must be licensed, and fully insured plans face restrictions on making drug formulary changes in a plan year under 2023 Ch. 429 (SB 57). Insurers removing a drug from a formulary may not add it back a higher cost in the same plan year, with limited exceptions. Nevada 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 plans.

New Mexico

Legislation focuses on diabetes coverage and general participant out-of-pocket Rx costs:

2023 Ch. 50 (HB 53) imposes network adequacy standards for the treatment or management of diabetes, mandates coverage of diabetic medical equipment, and implements a penalty scheme for reimbursement delays. The law will take effect for plan years starting in 2024 or later. New Mexico already has a $25 cap on insulin cost sharing for a 30-day supply.

2023 Ch. 206 (SB 51) requires all Rx discounts received by fully insured plans to apply to participant cost sharing. The law also prohibits lower cost sharing for a PBM-affiliated pharmacy. Participant cost at the POS may not exceed the lowest of the cost-sharing amount, amount paid by an uninsured individual, sum of what the insurer pays the pharmacy and the cost-sharing amount or the value of the manufacturer's rebate to the insurer or PBM. The law generally will take effect Jan. 1, 2024.

New Mexico does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

North Dakota

2023 Ch. 208 (SB 2378) imposes several prohibitions on PBMs administering Rx benefits for fully insured and self-funded plans, including:

- Steerage to a mail-order program or affiliated pharmacy
- Interference with a participant obtaining a clinician-administered drug (i.e., "white-bagging") from the participant's preferred provider
- Requirement of a home infusion pharmacy to dispense clinician-administered drugs

The law took effect Aug. 1.

Rhode Island

Rhode Island enacted insurance laws imposing cost-sharing caps on specialty drugs and epinephrine auto-injectors:

- 2023 Ch. 233 (SB 871) caps participant payments at $150 for a 30-day supply of a specialty drug, as defined by Medicare Part D (the Centers for Medicare & Medicaid Services (CMS) set its specialty-drug tier threshold at $830 for calendar-year 2023).
- 2023 Ch. 263 (SB 575) requires coverage of a two-pack of epinephrine injectors every plan year.

Both laws will take effect for plan years starting after 2024. Rhode Island applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. These laws do not apply for self-funded plans.

South Carolina

2023 Act 30 (SB 520) requires PBMs to disclose in-network alternatives when participants are steered to an affiliated pharmacy. PBMs must allow participants to select the in-network pharmacy of their choice (with an exception for high-cost drugs with an average wholesale price exceeding 300% of the federal poverty guidelines). The law imposes an "any willing pharmacy" requirement (with exceptions for specialized delivery drugs). PBMs are held to a good faith and fair dealing standard. The law also bans

retroactive adjudication of Rx claims, except in limited situations. The law generally will take effect for plan years starting in 2024 or later, but whether the measure applies to self-funded plans is unclear.

Texas

Texas focused on drug costs and insurance coverage in enacting six laws:

- **Disclosure requirements.** SB 622 requires fully insured plans, HMOs, self-funded professional employer organization (PEO) plans and MEWAs to provide Rx disclosures (including eligibility, cost-sharing and utilization-management requirements, along with formulary alternatives) to plan participants and prescribing providers on request. These plans may not restrict or prohibit providers from telling participants about the cash price of a drug, lower-cost options, or clinical alternative drugs. The law will take effect for plan years starting 2025. Insurers with fewer than 10,000 participants may request a 12-month extension of the effective date and a temporary exception from the requirements.
- **Cost-sharing requirements.** HB 999 compels fully insured plans, HMOs and MEWAs to apply third-party Rx payments toward a plan's cost sharing (including deductibles and OOPMs). This requirement applies only if a generic equivalent or biosimilar does not exist or the participant went through prior authorization, step therapy, or an exception/appeal process. The law does not contain an exception for HSA-eligible HDHPs.
- **White-bagging ban.** HB 1647 prohibits "white bagging" of clinician-administered drugs by fully insured plans, HMOs, self-funded PEOs, school district plans, and MEWAs if the participant has a chronic, complex, rare, or life-threatening medical condition. Other limitations also apply.
- **Step-therapy limitations.** HB 1337 bars fully insured plans, HMOs and MEWAs from imposing Rx step-therapy protocols for serious mental illnesses in adults, unless a generic or pharmaceutical equivalent is available in the formulary.
- **Preauthorization limitation.** HB 755 limits fully insured plans, HMOs, MEWAs, self-funded PEOs, and school district plans to one prior authorization per plan year for drugs treating an autoimmune disease, hemophilia, or von Willebrand disease (with some limitations).
- **Rx importation.** HB 25 creates a wholesale Rx importation program from Canada, authorizing the state Health and Human Services Commission to obtain needed approvals from the federal Food and Drug Administration (FDA). For several years, the FDA has been working on a pathway for importation.

Except for the Rx disclosure requirements, these laws will take effect for plan years starting in 2024 or later. Texas applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Washington

Under 2023 Ch. 48 (SB 5300), fully insured plans may not take the following actions when refilling an antipsychotic, antidepressant, antiepileptic or other drug to treat a serious mental illness (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*):

- Substitute a nonpreferred drug with a preferred drug in a given therapeutic class
- Increase participant cost sharing during a plan year

For these protections to apply, a participant must be medically stable on the drug, and the provider must continue to prescribe it. Nevertheless, plans may require a generic substitute or add/remove (in limited circumstances) drugs from the formulary during the plan year. The law will take effect in 2025 but does not affect self-funded plans. Washington applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Telehealth

Several states joined interstate compacts. One Florida law expands telehealth services, while another prohibits the use of telehealth for abortion-related services. Hawaii, Louisiana and Nebraska require a level of reimbursement parity between telehealth and in-person providers. For information on telehealth legislative trends, see What we're seeing with state telehealth legislation in 2023 (June 1, 2023).

Here is a chart of recent state efforts to join interstate telehealth compacts:

State and law	Type of interstate compact	Effective date
Florida. Ch. 2023-140 (HB 33)	Psychology Interjurisdictional Compact (PSYPACT)	July 1
Indiana. 2023 Pub. L. No. 21 (SB 73)	Occupational therapy	July 1
Indiana. 2023 Pub. L. No. 98 (SB 160)	Professional counseling	July 1
Iowa. 2023 Ch. 156 (HB 671)	Licensed professional counselors	July 1
North Dakota. 2023 Ch. 390 (SB 2205)	PSYPACT	Aug. 1
Washington. 2023 Ch. 58 (HB 1069)	Licensed professional counselors	July 23
Washington. 2023 Ch. 53 (HB 1001)	Audiology and speech-language pathology	July 23

Florida

Two Florida laws address telehealth:

- Pub. L. No. 2023-63 (HB 267) brings audio-only healthcare services (including those provided by out-of-state practitioners) under the state's telehealth statute and rules. The law took effect July 1.

- Pub. L. No. 2023-21 (SB 300) prohibits state-regulated physicians and telehealth providers from using telehealth to prescribe abortion medications. The law took effect April 13.

Hawaii

As a result of 2023 Act 107 (HB 907), fully insured plans must provide reimbursement parity between telehealth and in-person services, except for audio-only mental telehealth services (for which reimbursement rates equal to 80% of the amount for in-person services are permissible). An in-person or video visit must take place within six months of the first audio-only mental health service for the 80% reimbursement rate to apply. The law took effect June 22, 2 and will expire Dec. 31, 2025.

Louisiana

Under 2023 Act No. 336 (HB 41), the law requiring coverage and payment parity for physical therapy (PT) delivered via telehealth and in-person visits will extend to occupational therapy (OT). In both cases, coverage and payment for in-person and telehealth services should be equivalent unless the parties contractually agree otherwise. Cost sharing for covered telehealth benefits cannot exceed the cost sharing for the same in-person services, and telehealth services cannot be subject to annual maximums that don't apply to in-person services. Numerous other coverage requirements for PT delivered via telehealth will extend to telehealth delivery of OT. The law will apply to new health plans issued on or after Jan. 1, 2024. Existing health plans in effect before 2024 must comply on or before their renewal date but no later than Jan. 1, 2025. The law does not affect self-funded plans.

Nebraska

LB 296 requires reimbursement parity for telehealth services in some instances. Payment parity is required only if the telehealth provider also provides in-person services or is employed by or has privileges at a facility that provides in-person services. The law will apply to fully insured plans starting Jan. 1, 2024.

Insurance

Colorado, Maine, Vermont and Washington mandated abortion coverage for fully insured plans, while Florida and South Carolina passed laws restricting abortion. New laws in Louisiana, Montana and Texas require fertility coverage in certain situations. Legislation enacted in Nevada and Vermont mandates gender transition coverage. Colorado and Nevada enacted laws restricting fully insured plans' use of step therapy. An Arkansas law will apply utilization-review rules to self-funded plans.

Arkansas

State utilization-review requirements for prior authorizations related to hematology or oncology evaluation or treatment — including appeal deadlines of two days (for urgent healthcare services) and four days (for nonurgent services) — now affect self-funded plans under 2023 Act 501 (HB 1274). That is

because the law defines a utilization-review entity to include self-funded TPAs. The law took effect on or about Aug. 1.

Colorado

2023 Ch. 69 (SB 23-189) imposes three new coverage mandates:

- **Abortion.** Insured health plans must cover abortion without cost sharing. Several exceptions exist, including plans sponsored by employers with sincerely held religious objections to abortion and an HSA-eligible HDHPs. This provision will take effect for large-group plans starting in 2025; for individual and small-group plans, the effective date depends on whether the US Department of Health and Human Services (HHS) determines this coverage is an essential health benefit.
- **Sexually transmitted diseases.** Fully insured plans must cover without cost sharing counseling, prevention, and screening for sexually transmitted infections, as well as HIV prevention drugs and services necessary for continued use (including office visits, testing, vaccinations, and monitoring). This provision will take effect for plan years starting in 2025 or later.
- **Step-therapy limitations.** Fully insured and Medicaid plans cannot require step therapy or prior authorization for FDA-approved HIV treatment or preventive drugs included in the plan formulary as of March 1, 2023. This provision took immediate effect April 14 and extends through June 30, 2027.

The law does not affect self-funded plans.

Connecticut

Pub. Act No. 23-171 (HB 6669) prohibits the following in contracts between fully insured plan carriers and providers:

- All-or-nothing clause requiring a plan to include all provider members in a network
- Anti-steering clause restricting a plan from encouraging care from a provider's competitor
- Anti-tiering clause restricting use of tiered networks
- Gag clause restricting a provider's or insurer's ability disclose cost or quality information

The act also authorizes a statewide drug discount program (established by the state comptroller) for all state residents. Hospitals and health systems must not charge a facility fee for outpatient services, except emergency rooms and observational stays. Insurance contracts in effect on July 1, 2016, do not have to comply with this prohibition until the contract's expiration, renewal or amendment .

The law will take effect July 1, 2024.

Florida

Florida passed one law restricting gender-affirming services/treatments and another allowing providers to refuse to provide care in certain circumstances:

- **Transgender care.** Ch. 2023-90 (SB 254) prohibits puberty blockers, hormones, medical and surgical gender dysphoria treatments for individuals under age 18. Only physicians (not nurse practitioners) can provide gender-affirming care to adults who give informed consent through a process the Board of Medicine will specify. The law also bans use of state funds for gender-affirming care, including the state group health insurance program and Medicaid (and possibly public hospitals). The law is now in effect, except for provisions subject to a preliminary injunction in ongoing litigation (*Doe v. Ladapo*, No. 23-114 (N.D. FL June 6, 2023).
- **Medical conscience protections.** Ch. 2023-57 (SB 1580) allows healthcare providers and payers (including insurers and group health plans) to deny care or refuse to pay for care because of moral, ethical, or religious objections to the specific healthcare service. Providers and payers with a conscience-based objection must show consistency with governing documents and similar materials. However, healthcare provision or payment cannot be denied because of race, color, religion, sex, or national origin. A payer includes an insurer, employer, health plan, HMO or "any other entity that pays for, or arranges for the payment of, any health care service." The measure may raise issues under various federal laws but has not faced any legal challenges to date. The law took effect July 1.

Georgia

The CATCH Act (2023 Act 242, SB 20) requires fully insured plans issued in the state to provide an adequate provider network, including mental health/substance use disorder specialists. The act also prohibits restrictions on telehealth providers and services that do not apply to in-person services. The law will take effect for insured plan years starting in 2024 but does not cover self-funded plans. Georgia does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in other states.

Indiana

2023 Pub. L. No. 203 (HB 1004) tackles claims data sharing and encourages small employers to fund health reimbursement arrangements (HRAs):

- **Claims data sharing.** The law requires insurers and self-funded TPAs to provide a plan sponsor certain claims data within 15 business days of a request but no more than twice a year. Noncompliance is subject to a $1,000 penalty per day. This provision took effect July 1.
- **HRA funding.** For 2024 and 2025, small employers can receive tax credit of up to $400 per covered employee (decreasing to $200 in 2025) if they contribute an equal or greater amount than the tax credit to the employee's HRA. The tax credit is limited to employers with fewer than 50 employees. State funding is capped at $10 million per year.

Louisiana

The Medically Necessary Fertility Preservation Act (2023 Act No. 299, HB 186) requires plans to cover fertility preservation services (including three years of storage costs) when cancer treatment or any other medically necessary treatment could cause infertility. Preauthorization is prohibited, but cost-sharing and coverage limits are permissible. Whether self-funded plans must comply is unclear. The law applies to a "health coverage plan," including any "employee welfare benefit plan," but excludes excepted benefits or short-term, limited duration insurance. The law will take effect for new plans on or after Jan. 1, 2024. For existing plans, the effective date is on the earlier of the renewal date or Jan. 1, 2025.

Under 2023 Act No. 453 (SB 109), a minimum allowable reimbursement rate applies for out-of-network (OON) ground ambulance providers. The minimum rate will be either an amount agreed to in a contract or set by ordinance of a local government entity where services originate; or if no contract or ordinance applies, 325% of Medicare rates. Any cost sharing is limited to what applies to in-network services, and OON providers cannot balance-bill participants. The law, which took effect Aug. 1, covers to fully insured plans and self-funded governmental plans but excludes other self-funded plans.

Louisiana applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Maine

Fully insured plans must provide abortion services without cost sharing (including deductibles, copayments and coinsurance) as a result of 2023 Ch. 347 (LD 935). An HSA-related exception for HDHPs exists. The law will take effect for plan years starting in 2024 and beyond. Maine 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 plans.

Montana

Under 2023 Ch. 782 (SB 516), fully insured individual and group plans must cover medically necessary fertility services when a participant is diagnosed with cancer, and the treatment may cause infertility. Coverage may be subject to standard plan cost sharing. The law will take effect for plan years starting in 2024 and later. The law does not affect self-funded plans.

Nevada

Two laws address step therapy while another mandates gender-affirming care:

- 2023 Ch. 151 (SB 194) requires fully insured plans to establish and communicate an exemption and appeals process for step-therapy protocols, which must be based on medical or scientific evidence, when available. Certain state governmental plans are exempt. The law will take effect Jan. 1, 2024.
- 2023 Ch. 269 (SB 167) prohibits fully insured plans, HMOs and state Medicaid plans from requiring a step-therapy protocol before covering an FDA-approved drug for a psychiatric condition if an

authorized provider reasonably expects each drug required earlier in the protocol to be ineffective. The law took effect July 1.

- 2023 Ch. 376 (SB 163) requires fully insured plan coverage of medically necessary care for gender dysphoria and gender incongruence. Blanket exclusions of treatments or procedures are prohibited if the plan covers the same services for purposes other than gender transition or affirmation. Plans may impose certain requirements prior to coverage of surgical treatments for minors, including provider recommendations, an approved treatment plan and parental consent. Carriers must consider the most recent World Professional Association for Transgender Health (known as WPATH) standards of care when making medically necessary determinations. The law also prohibits plan discrimination based on actual or perceived gender identity. The measure took effect for plan years starting on or after July 1.

These laws do not affect self-funded plans.

New York

Amendments (2023 Ch. 138, SB 1066/AB 1709-B) to the state's insurance, criminal and civil statutes aim to safeguard reproductive health service providers engaged in a "legally protected activity." This term includes insurance coverage of reproductive health services or care (including through telehealth), regardless of where a patient is located. Providers are protected from extradition, arrest and legal proceedings in other states. The provisions also prohibit insurers from taking adverse actions related to medical malpractice insurance coverage. The law took effect June 23.

North Dakota

A new law (2023 Ch. 285, HB 1095) requires fully insured plans to offer selected participants a comprehensive medication-management program from a pharmacist. Participants must meet certain requirements, like having a diagnosed heart or other chronic condition requiring five or more drugs. The law will take effect for plan years starting in 2025 or later. North Dakota 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 plans.

South Carolina

Effective May 25, the Fetal Heartbeat and Protection from Abortion Act (2023 Act No. 70, SB 474) restricts abortions after six weeks of pregnancy, except in medical emergencies or cases of rape, incest, or fatal fetal anomalies. In addition, fully insured individual and group health plans must cover contraceptives, unless individuals or entities have sincerely held religious objections to contraceptives. The law also prohibits using state-funded employer contributions to the state health plan to reimburse abortion expenses, with the same exceptions described above. South Carolina applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Texas

Four new laws address insurance coverage:

- **Cash payments.** HB 2002 requires fully insured plans to apply a participant's out-of-pocket cash payments to the deductible and OOPM when a claim is not submitted because the cash price is less than a plan's negotiated rate. Carriers must establish a procedure for participants to claim the credit.
- **Fertility preservation.** HB 1649 mandates fertility preservation coverage (not including storage costs) by fully insured plans, HMOs and MEWAs for participants receiving medically necessary cancer treatments that may impair fertility.
- **Prohibited terms in provider contracts.** HB 711 prohibits four network-related provisions in contracts between a general contracting entity whether this applies only to insurers or also to self-funded TPAs is unclear) and a provider: anti-steering, anti-tiering, gag clauses and most-favored-nation pricing. The law aims to increase competition, reduce costs and improve transparency. The legislation generally took effect June 12, but the anti-steering and anti-tiering bans will take effect on the earlier of Dec. 31 or a contractual amendment eliminating one or both provisions.
- **Ground ambulance coverage.** SB 2476 requires fully insured plans, HMOs and some state governmental plans to cover OON emergency medical transportation services (excluding air ambulances) at a rate approved by the Texas Department of Insurance or the lesser of either the provider's charge or 325% of Medicare rates. The law applies to services provided on or after Jan. 1, 2024 and expires Sept. 1, 2025.

Except where noted, these laws do not affect self-funded plans.

Vermont

With the passage of 2023 Act 15 (SB 37), Vermont defines "legally protected health care activity" to encompass gender-affirming and reproductive health services. The law requires fully insured plans and Medicaid to cover abortions, abortion-related care, and medically necessary and clinically appropriate gender-affirming care at the same (or better) cost-sharing rates that apply to other covered physical or mental conditions. The law also protects providers in an interstate telehealth compact, allows pharmacists to prescribe emergency contraception, prohibits pregnancy centers from engaging in "false and misleading advertising" (currently being contested in litigation), and bars "abusive litigation."

The law's emergency contraception provisions will take effect Sept. 1, 2023, while the insurance provisions will apply for plan years starting in 2024 and beyond. The interstate telehealth compact provisions took effect July 1, and the remaining provisions generally took effect May 10.

Vermont's insurance laws apply on an extraterritorial basis to state residents covered by fully insured plans issued in other states if more than 25 residents are covered or at least one enrolled state resident works in Vermont. The insurance provisions in the law do not affect self-funded plans.

Washington

Under 2023 Ch. 194 (SB 5242), fully insured plans, the state's governmental health plan and student health plans must cover abortion services without participant cost sharing if the plan covers maternity care. The law has an HSA-related exception for HDHPs. The law will take effect for plan years starting in 2024. The law does not affect self-funded plans.

Washington, DC

For plan years starting in 2025 or later, the Copay Accumulator Amendment Act (2023 Act 25-102, Law 25-0026) requires fully insured plans to apply Rx discounts or payments made on behalf of a participant toward a plan's cost sharing, including deductibles and OOPMs, in two circumstances: The drug has no generic equivalent or biosimilar covered by the plan, or the participant has satisfied the plan's preauthorization, step therapy, or exception process. The law makes an exception for HSA-eligible HDHPs. Washington, DC, applies its insurance laws on an extraterritorial basis to its residents covered by fully insured plans issued in another state. The law does not affect self-funded plans.

Other benefit-related issues

AHP issues arose in Florida and Virginia, while Texas expanded its MEWA law. New rates went into effect July 1 for San Francisco's Health Care Accountability Ordinance (HCAO).

Florida

Ch. 2023-212 (HB 897) amends the state's rules for AHPs to obtain approval as a MEWA. In some respects, these revised rules mirror the federal final AHP regulations vacated by a district court in 2019. The law allows a trade, industry, or professional association and a "*bona fide* group" to form an AHP. A *bona fide* group may form for the primary purpose of offering and providing health coverage as long as at least one substantial business purpose for the group exists. Working owners continue to be ineligible to participate in Florida. The law took effect June 9.

Oregon

A new law (2023 Ch. 20, HB 2032) removes the same-sex limitation for registered domestic partnerships. This change affects the state's employment discrimination law and PFML law, which includes domestic partners as family members. For details on domestic partner laws, see Domestic partner benefits remain popular but present challenges (July 11, 2023).

San Francisco

The HCAO requires most city contractors to offer health benefits meeting minimum standards or pay the city an annually indexed fee based on an hourly rate for each covered employee. Effective July 1, the rate increased from $6.10 per hour (capped at $244 per week) to $6.35 per hour (capped at $254 per

week). For details, see San Francisco updates contractor-lessee health plan standards, pay rates (Aug. 31, 2022).

Texas

Newly enacted laws address MEWAs, transgender care for minors, balance billing, and preemption of local laws affecting benefits, among other things.

- **MEWAs.** Under HB 290, employers can establish a MEWA if each employer has a principal place of business in the same region. The region must not exceed Texas boundaries or a metropolitan statistical area. The existing provision for forming a MEWA with five or more businesses in the same trade or industry remains an alternative, but working owners can qualify as both an employer and an employee under the revised law. In addition, a MEWA no longer has to wait at least two years before offering benefits if it meets the alternative requirements in HB 290. MEWAs are subject to major insurance laws, including required levels of reserves and OON claim dispute resolution. The new law applies to MEWAs obtaining an initial certificate of authority on or after Jan. 1, 2024.
- **Transgender care for minors.** SB 14 prohibits transgender medical care — including puberty blockers, hormones and surgery — for minors and prohibits public funds from directly or indirectly facilitating prohibited care. The law provides limited exceptions for minors who began a course of treatment before June 1, 2023, that included at least 12 therapy sessions. Related services (like counseling and psychotherapy) are not prohibited. The law does not address gender transition coverage by fully insured plans or self-funded plans, instead targeting physicians and healthcare providers, which are not defined to include group health plans. The law will take effect Sept. 1.
- **Balance-billing opt-in.** HB 1592 allows self-funded plans to opt into the state's extensive balance-billing restrictions and OON dispute resolution procedures. The law will take effect Sept 1, and the Texas Department of Insurance must adopt rules by Dec. 1.
- **State preemption of certain local laws.** HB 2127 prohibits municipal and county laws in nine areas, including matters governed by the state's Insurance and Labor Codes. This halts recent efforts by Austin, Dallas and San Antonio to enact PSSL mandates (previously put on hold by court orders). For details, see Roundup of selected state health developments — third-quarter 2019 (Oct. 28, 2019).

Virginia

A 2022 state law allows AHPs to cover real estate salespeople, many of whom are self-employed. Since then, the CMS has sent a series of warning letters (most recently on May 31) to the Virginia Bureau of Insurance, advising that the law violates ERISA. A final CMS determination and/or enforcement action may soon follow.

As background, AHPs are a type of MEWA, used by associations and other business groups to offer lower-cost coverage. MEWAs are subject to both state and federal regulation. Final federal regulations

expanding the scope of AHPs are currently stayed in ongoing litigation; for details, see Litigation, legislation leave AHP guidance in flux (May 2, 2019).

Washington

The state has enacted a health data law and finalize regulations for the PFML and long-term care (LTC) programs.

Washington's My Health My Data Act (2023 Ch. 191, HB 1155) aims to protect consumer health data. However, the law does not extend to protected health information of covered entities (including health plans) and business associates under the federal Health Insurance Portability and Accountability Act (HIPAA). The state law also exempts data of individuals "acting in an employment context." The law applies to entities doing business in Washington but exempts government agencies and tribal nations. Most provisions will take effect March 31, 2024 (June 30, 2024, for certain small businesses).

The ESD has adopted rules on reporting, placement, elective coverage and designated representatives under both the PFML and Long-Term Services and Supports laws. These rules took effect July 1.

Related resources

Mercer Law & Policy resources

- Domestic partner benefits remain popular but present challenges (July 11, 2023)
- Minnesota passes paid family and medical leave law (July 10, 2023)
- 2023 state paid family and medical leave contributions and benefits (Feb. 1, 2023)
- Roundup of selected state health developments — third-quarter 2022 (Nov. 4, 2022)
- San Francisco updates contractor-lessee health plan standards, pay rates (Aug. 31, 2022)
- Roundup: State accrued paid leave mandates (April 29, 2022)
- Roundup of selected state health developments — third-quarter 2019 (Oct. 28, 2019)
- Litigation, legislation leave AHP guidance in flux (May 2, 2019)

Other Mercer resources

- State legislatures continue to focus on Rx (June 29, 2023)
- What we're seeing with state telehealth legislation in 2023 (June 1, 2023)
- Is ERISA preemption at risk of being preempted? (Feb. 23, 2023)
- Life, absence and disability benefits

- MercerRx
- Voluntary benefits

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