Roundup of selected state health developments, third-quarter 2021

By Catherine Stamm, Rich Glass and Katharine Marshall
Oct. 22, 2021

In this article

States clarified or updated health plan reporting and assessment obligations during the third quarter of 2021. Prescription drugs garnered significant attention as state lawmakers continue to tackle ever-increasing costs. Lawmakers addressed a range of health insurance issues, with special focus on aligning mental health and substance use disorder coverage with recent federal developments. Paid family and medical leave (PFML) and COVID-19-related paid leave laws received updates, and Colorado's high court weighed in on use-it-or-lose-it vacation policies. Other benefit-related activity included a court ruling against California's gig worker law, an Illinois health plan disclosure obligation and a step forward for an Oregon public health option.

Health plan reporting and assessments

San Francisco has updated its mandatory health care expenditure (HCE) rates for 2022. The city also has clarified which employees are covered by the requirement, even if working remotely due to public health orders. Massachusetts has updated its minimum creditable coverage (MCC) standards for employers whose plans cover Massachusetts residents. Washington has announced the covered-lives assessment rate for health plans — including self-funded plans — that cover Washington residents. Seattle has set its 2022 rates of hotel industry health coverage expenditures. The 9th US Circuit Court of Appeals has denied an *en banc* appeal looking to find ERISA preempts Seattle's law.

California — San Francisco

San Francisco has posted the 2022 HCE rates required by the city's Health Care Security Ordinance (HCSO) rules. The HCSO applies to all employers that must obtain a San Francisco business registration certificate and have at least 20 employees in any location if at least one works in the city or

county of San Francisco. The city also has consolidated its HCE city options into one. The current and updated HCE hourly rates are as follows:

Employer size	Number of workers	2021 expenditure rate	2022 expenditure rate
Large	All employers with 100+ workers	$3.18 per hour	$3.30 per hour
Medium	Businesses with 20–99 workers Nonprofits with 50–99 workers	$2.12 per hour	$2.20 per hour
Small	Businesses with 0–19 workers Nonprofits with 0–49 workers	Exempt	Exempt

Special rules apply to self-funded plans. For details, see San Francisco updates city option, 2022 health care expenditure rates (Aug.12, 2021).

San Francisco work location

The San Francisco Board of Supervisors also passed an amendment to clarify work location under the expenditure mandate. The HCSO requires providing the HCE for a covered employee when the employer's office *or* worksite is in San Francisco or the employee works from home in San Francisco. However, the employer generally is not required to provide the HCE for a worker doing the same job from a home outside of San Francisco — for example, in Oakland.

The amended ordinance requires HCSO coverage for employees working remotely outside of San Francisco *while public health orders recommend remote work*. Since the city's June 11 public health order removed that recommendation, employees working remotely outside of San Francisco are not covered by the HCE requirement unless the city issues a new public health order recommending remote work.

Massachusetts

The Massachusetts Health Connector has announced 2022 dollar limits on deductibles and other cost sharing for MCC, as required by regulations (956 Mass. Code Regs. 5). The Massachusetts individual mandate, in place since 2007, requires state residents to maintain MCC or face a potential state tax penalty.

Though employers have no obligation to provide MCC for their Massachusetts employees, many employees use their employment-based health coverage to satisfy the mandate. In addition, health plan reporting requirements compel plan sponsors (or their vendors) to determine whether the coverage they offer meets MCC standards.

Deductibles and out-of-pocket maximums receive annual adjustments tied to the Affordable Care Act (ACA)'s premium adjustment percentage used to set in-network out-of-pocket limits for essential health benefits. The regulations also clarify the MCC criteria for health arrangements that religious

organizations provide for their members. For more details, see Massachusetts sets 2022 individual-mandate coverage dollar limits (Aug. 30, 2021).

Washington

Washington regulators have announced a monthly $0.13 per covered life Partnership Access Lines (WAPAL) assessment, effective for quarterly payments due on Nov. 15, 2021. This rate applies to Washington covered lives of all ages. The KidsVax assessment system will automatically apply the correct rate for all timely filed payer assessment reports. Self-funded plan sponsors that haven't done so yet should register and report as soon as possible to avoid penalties.

Under the 2020 law (Ch. 291), initial registration and covered-lives reporting for April through June 2021 were due by Aug. 30. An online survey of all assessable entities' covered lives during those months determined the initial assessment rate. Regular assessments will be due 45 days after the end of each calendar quarter, with the first due Nov. 15, 2021, based on covered-lives counts for July through September 2021.

The state's website includes the following information for health plans — including self-funded plans — covering Washington residents:

- Notice & summary of compliance obligations
- How to register on the self-reporting assessment system
- How to complete a covered-lives report
- A downloadable training webinar

Washington — Seattle

Seattle has announced 2022 calendar-year health expenditure rates that covered hotel industry employers must make to or on behalf of each covered employee for medical care. The ordinance (Mun. Code Ch. 14.28) applies to most businesses that own, control, or operate a Seattle hotel or motel with 100 or more guest rooms and to "ancillary hotel businesses" with 50 or more employees worldwide. The updated expenditure rates are as follows:

Monthly expenditure rates		
Coverage tier	**2021**	**2022**
Employee only	$437	$459
Employee with only dependents	$743	$779
Employee with only a spouse or domestic partner	$874	$916
Employee with a spouse or domestic partner and one or more dependents	$1,310	$1,375

The 9th Circuit denied the ERISA Industry Committee's appeal for an *en banc* hearing of an ERISA preemption challenge to the ordinance. The organization has announced it will appeal the decision to the US Supreme Court. Despite the ongoing litigation, covered Seattle businesses must comply. For more details, see Seattle posts 2022 health expenditure rate for hotel employers (Aug. 17, 2021).

Prescription drugs

Prescription drug costs continue to rankle state lawmakers. After the US Supreme Court last year ruled that ERISA doesn't preempt a state law regulating pharmacy benefit manager (PBM) payments to pharmacies (*Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540 (Dec. 10, 2020)), states have become more assertive in attempting to regulate the industry. While some of these efforts clearly apply only to insured plans, the extent to which self-funded ERISA plans must comply is unclear in other cases. Illinois will focus efforts on a flat-dollar coverage option in insured products. Oregon has authorized an affordability board that will study the impact of prescription drug costs on premium rates. A recent Tennessee bulletin noted that the state's PBM law doesn't provide an exemption for self-funded plans. Texas has new restrictions on certain PBM practices, while Wisconsin has added PBM registration and reporting obligations.

Illinois

A recently enacted package of legislation aims to reduce prescription drug costs. The package includes a lawful donation program for unused prescription drugs (Pub. Act 102-0389, HB 119) and mandates pharmacy price disclosures to patients (Pub. Act 102-0400, SB 1682). Both take effect Jan. 1, 2022. In addition, Pub. Act 102-0391 (HB 1745) calls for health insurers to offer plans in the individual and group market with a flat-dollar cost-sharing amount for prescription drugs.

Beginning Jan. 1, 2023, health insurers that provide prescription drug coverage must offer at least one plan in each service area and at each level (bronze, silver, gold and platinum) that applies a flat-dollar copayment structure to the entire drug benefit. Starting Jan. 1, 2024, that requirement rises to two health plans in each area and at each level.

The flat-dollar copayment structure applies before the deductible. Cost sharing must be reasonably graduated and proportionately related in all tier levels so overall cost sharing doesn't discriminate or discourage individuals with significant healthcare needs from enrolling. The plans must be marketed alongside other plans and appropriately named to aid in plan selection. Nothing in the law requires plan sponsors purchasing insurance in Illinois to include one of these plans. None of these new Illinois provisions applies to self-funded ERISA plans.

Oregon

Under a new law (Ch. 598, SB 844), a newly authorized Oregon Prescription Drug Affordability Board will review prices for nine prescription drugs and at least one insulin product expected to create affordability challenges for health systems or high out-of-pocket costs for Oregon patients.

The drugs for review will come from annual insurer reports to state regulators under a 2018 law (OR Rev. Stat. § 743.025) detailing the following data:

- 25 most frequently prescribed drugs
- 25 most costly drugs as a portion of total annual spending
- 25 drugs that have caused the greatest increase in total plan spending from one year to the next
- Impact of prescription drug costs on premium rates

The board's review criteria will encompass more than a dozen factors, including price, number of prescribed Oregon residents, potential racial inequities, manufacturer price concessions to health insurers and PBMs, cost for therapeutic alternatives, and price impact on patient access to the drug. Beginning Dec. 31, 2022, annual reports to the relevant legislative committees will identify the drugs reviewed and recommendations for increasing affordability.

Tennessee

According to a Tennessee regulatory bulletin, the new requirements in Ch. 569 (HB 1398) apply to PBMs and "covered entities," including self-insured entities and employers that provide health coverage to individuals who are employed or reside in the state. "No exclusions in the PBM laws are carved out to exclude plans currently regulated by ERISA," according to the guidance. Regulators interpret the legislative intent to include self-funded ERISA plans and will enforce the laws accordingly. PBMs will need to work with legal counsel to determine to what extent they can accommodate self-insured plans with designs that Tennessee prohibits.

The law prohibits a PBM from interfering with a patient's right to choose a pharmacy, including through inducement, steering, or offering financial or other incentives. In addition, a covered individual must have the option to receive covered drugs and devices from a physician's office, a hospital outpatient infusion center providing and administering the drug, or a pharmacy without additional cost sharing or limitations.

The measure also bars a PBM from charging a health plan more than the PBM pays a contracted pharmacy for a prescription drug or device. PBMs and covered entities likewise cannot impose additional fees, higher copays or coinsurance, or other penalties for a person with pharmacy benefits coverage to obtain prescription drugs, including specialty drugs. The law requires PBMs to report to the health plan and the patient any benefit percentage that either are entitled to receive as a benefit. Health plans must provide on request covered individuals or their healthcare providers certain prescription drug cost, benefit, and coverage data. The provisions were added to the state's existing PBM law (TN Code Ann. § 56-7-3101 et seq.) effective July 1, 2021.

Texas

A new Texas law (HB 1919) bars certain practices by covered entities: PBMs, health insurers, MEWAs and possibly self-funded plans.

Under the new law, insured health benefit plans — including MEWAs — issued or renewed on or after Sept. 1, 2021, cannot have provisions that:

- Require a patient to use an affiliated pharmacy to receive the maximum benefit
- Require or induce — for example, by reducing cost sharing — a patient to use an affiliated pharmacy

Effective Sept. 1, covered entities are prohibited from engaging in the following practices:

- Soliciting a patient to transfer a prescription to an affiliated pharmacy
- Requiring an unaffiliated pharmacy or durable medical equipment provider to transfer a patient's prescription to a pharmacy or equipment provider affiliated with the covered entity

Wisconsin

A new Wisconsin pharmacy benefit law (2021 Act 9, SB 3) bans pharmacy gag clauses and, effective June 30, requires pharmacists to charge patients the lower of the plan's cost-sharing amount for drugs or the drug's cost without insurance. For plans issued or renewed on or after Jan. 1, 2022, PBMs must be licensed to operate in the state. In addition, health insurers, PBMs, and self-funded state and local health plans must provide covered individuals advance written notice, with limited exceptions, of a formulary change that removes a prescription or increases cost sharing.

Annual PBM reports, initially due to state regulators by June 1, must contain the aggregate rebate amount from the previous calendar year that the PBM received from all pharmaceutical manufacturers and did not pass through to health plan sponsors. The report also must include the percentage of the aggregate retained rebates. Reporting applies to contracts with pharmacies located in Wisconsin.

Health insurance

State lawmakers took on a range of issues regulating insured health plans. California will require large group health plans to cover medically necessary basic healthcare services. Illinois extended fertility insurance benefits to same-sex couples and single individuals. Illinois also set certain parameters for coverage for telehealth services. Rhode Island added a cost-sharing cap for insulin. In addition, Colorado, Illinois and Oklahoma took steps to further mental health coverage. These insurance laws don't apply to self-funded ERISA plans.

California

Large-group health insurance policies issued or renewed in California on or after July 1, 2022, must cover medically necessary basic healthcare services, under legislation (Ch. 636, SB 280) signed by the Gov. Gavin Newsom. "Basic health care services" includes physician services; hospital inpatient and ambulatory care services; diagnostic laboratory services; diagnostic and therapeutic radiologic services; home healthcare; preventive health; emergency healthcare services, including ambulance and

ambulance transport services; and hospice care. Plans also must provide out-of-area coverage for "urgently needed services" for an unforeseen illness or injury for which treatment can't be delayed.

Large-group plans include policies for more than 100 employees. Similar coverage requirements already apply to individual and small-group plans through the ACA's essential heath benefit requirements. The basic healthcare mandate doesn't apply to self-insured ERISA plans or to specialized policies that cover only dental or vision benefits. However, no exemption applies for grandfathered health plans.

The new law also prohibits large-group insurers (including officials, employees, agents and representatives) from marketing practices or benefit designs that will have the effect of discouraging enrollment by individuals with significant health needs. In addition, large-group insurers are barred from discriminating based on race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

The new law imposes a $2,500 fine on large group health insurers violating the nondiscrimination provision (or $15,000 to $100,000 per violation if the discrimination is a general practice or a knowing violation). The penalty does not apply to grandfathered large-group insured plans or policies that cover only dental or vision benefits.

Illinois — fertility coverage

Recent Illinois legislation (Pub. Act 102-0170, HB 3709) updates the state's fertility coverage mandate (215 IL Comp. Stat. 5/356m) to extend benefits to same-sex couples and single individuals in policies covering more than 25 employees. The measure defines infertility as:

- A failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is age 35 or younger, or after six months if the woman is older than 35
    - Conceiving but having a miscarriage does not restart the 12-month or six-month term for determining infertility.
- An inability to reproduce, either as a single individual or with a partner, without medical intervention
- A physician's diagnosis

The measure prohibits imposing any exclusions, limitations or other restrictions on coverage of fertility medications different from the terms that apply to any other prescription medications. Cost sharing, benefit maximums, waiting periods, or other coverage limitations for the diagnosis and treatment of infertility and standard fertility preservation services can't differ from the terms that apply to other benefits. In addition, benefits must be the same, even if the patient participates in fertility services provided by or to a third party.

Illinois — telehealth coverage

A new Illinois law (Pub. Act 102-0104, HB 3300) requires health insurers in the state to reimburse clinically appropriate and medically necessary covered services delivered via telehealth by healthcare professionals acting within the scope of their license or certification. In-network provider reimbursements tor telehealth or in-person services must be at the same rate.

A policy can't require an in-person visit before using telehealth, create geographic or facility restrictions, require healthcare professionals or facilities to provide telehealth services, or require patients to use telehealth or a particular telehealth panel. Utilization-review requirements, treatment limitations, prior authorization or recordkeeping requirements for telehealth services can't be more stringent than the terms for in-person services. In addition, patient cost sharing for telehealth can't be higher than for in-person services.

Rhode Island

Beginning Jan. 1, 2022, Rhode Island insured health plans that cover insulin must cap a patient's total insulin cost sharing at $40.00 per 30-day supply. The drug coverage may not be subject to any deductible. The new law (Ch. 110, HB 5196) doesn't provide any limitations, such as by type of insulin needed. The state's action replicates similar cost-sharing restrictions in other states after a steep rise in the cost of insulin. In addition, IRS Notice 2019-45 expands first-dollar coverage for the drug in high-deductible health plans (HDHPs) paired with health savings accounts (HSAs).

Mental health parity

Two recent events spurred state lawmakers and regulators to step up enforcement of mental health coverage mandates. First, Congress enacted the federal Consolidated Appropriations Act, 2021 (CAA) (Pub. L. No 116-260) requiring group health plans to prepare a comparative analysis of any nonquantitative treatment limits (NQTLs) that apply to mental health/substance use disorder and medical/surgical benefits. Second, a federal court held that a mental health benefit administrator applied overly narrow guidelines when determining whether certain mental health services conformed to generally accepted standards of care (*Wit v. United Behavioral Health*, No. 14-cv-02346-JCS (N.D. Cal. March 5, 2019)).

Under recent legislation, Colorado will require no-cost annual mental health wellness exam coverage. Illinois will ban limits on mental health coverage and require insurers to follow certain medical necessity standards. Oklahoma will ban benefit and age limits for applied behavioral analysis (ABA) in autism treatment coverage.

Colorado

New legislation (Ch. 439, HB 1068) requires Colorado healthcare policies to cover at no cost to the patient an annual mental health wellness examination of up to 60 minutes performed by a qualified mental healthcare provider. The coverage must be at least as extensive as a physical examination and comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

The mandate applies to insured policies and contracts for large employers (more than 100 employees) issued or renewed on or after Jan. 1, 2022, and to individual and small-group policies and contracts issued or renewed on or after Jan. 1, 2023.

The legislation doesn't provide an exception for HDHPs paired with HSAs. However, IRS Notice 2004-23 specifies that first-dollar mental health and substance abuse screenings in an HDHP won't prevent HSA contributions.

Illinois

Illinois has updated its mental health and substance use disorder law, citing the *Wit* case as one reason to enact stronger patient protections. Under the revised law (Pub. Act 102-579, HB 2595), insured health plans issued or renewed in the state on or after Jan. 1, 2023 must cover medically necessary mental health and substance use disorder treatments without setting a specific limit on the duration of benefits or coverage.

Medical-necessity determinations and utilization-review criteria for mental health must follow current generally accepted standards of care. Medical-necessity determinations related to placement must apply the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty. When conducting utilization reviews for substance use disorders, the plan must adhere to the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine. Insurers cannot use more restrictive criteria. Though the Illinois law doesn't apply to self-insured ERISA plans, federal law includes similar requirements.

Oklahoma

A recent Oklahoma bulletin (No. LH 2021-03) provides mental health parity guidance relating to ABA benefits and age limits for treatment of autism spectrum disorder. The bulletin clarifies that health insurance coverage that includes both medical or surgical benefits and mental health or substance use disorder benefits cannot impose additional ABA coverage limitations, whether quantitative (financial, access or other limitations with numerical measures) or nonquantitative basis (medication limitations, medical management or other nonquantitative measures).

Regulators note that the courts and federal agencies have cited MHPAEA violations related to ABA benefit exclusions and other limitations on mental health or substance abuse disorder treatments or benefits that exceed the exclusions or limitations on medical and surgical benefits. The bulletin states that Oklahoma law (OK Stat. tit. 36, § 6060.21(A) and (E)) permitting ABA coverage to have age restrictions, a 25-hour weekly limit and a $25,000 annual cap conflicts with the MHPAEA and the state's similar law (OK Stat. tit.36, § 6060.11). The guidance recommends all carriers that include ABA benefits in their health plans update these plans by Dec. 31 to avoid potentially discriminatory age restrictions and include comparable benefit coverage for mental health or substance use disorder treatments and services.

Paid leave

California has extended its current state disability insurance (SDI) and paid family leave (PFL) benefit rates for one more year. The Colorado high court has determined employer-provided vacation programs can't include use-it-or-lose-it provisions. Colorado regulators have issued draft rules to implement the state's voter-approved PFML law. Massachusetts and Rhode Island have posted PFML rates for 2022. Rhode Island also has extended the duration of allowable paid family leave. New Hampshire has enacted its own unique voluntary PFML program. State and local governments have continued to update mandatory paid leave requirements related to COVID-19.

California

California's SDI and PFL current benefit calculation rates will continue for another year until 2023, under recent legislation (Ch. 78, AB 138). The current rates were initially due to sunset at the end of this year under a 2016 law (Ch. 5, AB 908), but the new law averts a lapse to pre-2018 levels. Benefits for 2022 will continue at 60%–70% of an employee's highest quarterly earnings in a base period divided by 13, capped at the annually adjusted weekly maximum benefit ($1,357 for 2021). Additional legislation (AB 123) would have raised the weekly benefit to 65%-70% of an employee's weekly wage for PFL and the first 12 weeks of SDI claims beginning on or after Jan. 1, 2023, and then to 70%-90% in 2025. However, the governor vetoed that measure. For more details, see Changes to California's paid leave programs coming in 2023 (Oct. 8, 2021).

Colorado

The Colorado Department of Labor and Employment (CDLE) has issued draft regulations for establishing and collecting premiums under the voter-approved paid family and medical leave insurance (FAMLI) program (CO Rev. Stat. § 8-13.3-501-524). The draft clarifies certain terms and employer obligations.

The draft defines wages on which premiums would be based and outlines employers' obligations for collecting and remitting those premiums. Employers will have to remit quarterly premiums by the end of the month after each calendar quarter ends. Under the statute, an employer with 10 or more employees may deduct up to 50% of the required premium from employee wages.

An employer with fewer than 10 employees located in Colorado doesn't have to pay the employer portion of premium, but must collect and remit the employee contribution. CDLE will determine an employer's size for premium collection in 2023 using the employer's first-quarter unemployment insurance reports. The draft includes guidelines for determining whether an employee's work is performed in the state and identifies enforcement actions for reporting noncompliance or errors.

If the regulations are finalized as drafted, the CDLE would notify covered employers about their premium amounts at the start of the month when the premium is due. A payment schedule and additional payment information would be posted online. A hearing on the draft regulations is scheduled for Nov. 3.

Colorado

Colorado employers that provide paid vacation cannot include a forfeiture provision in the policy, the state supreme court has ruled. In *Nieto v. Clark's Market, Inc.*, 2021 CO 48 (June 14, 2021), the court held that employers must pay out all earned vacation on separation, and any agreement permitting forfeiture of earned vacation is void. The ruling reverses an appellate court decision upholding use-it-or-lose-it policies. For more details, see Colorado high court bans use-it-or-lose-it vacation policies (Aug. 24, 2021).

Massachusetts

Massachusetts has posted its 2022 PFML benefit rates. For leave beginning on or after Jan. 1, 2022, weekly benefits will be capped at $1,084.31. The contribution rate will drop from 0.75% to 0.68% of Massachusetts employees' wages up to the Social Security taxable wage base. Unless granted an exemption, employers with 25 or more Massachusetts employees will contribute 0.336%, a drop from 0.372% in 2021. Employers with fewer than 25 workers in the state don't have to contribute, but must collect and remit employee contributions of 0.344% — 0.12% for family leave and 0.224% for medical. The 2022 state average weekly wage — used in the benefit calculation — is $1,694.24.

New Hampshire

New Hampshire's Granite State Paid Family Leave Act will require family leave insurance benefits for state government employees and provide a voluntary opt-in for other employers and anyone whose employer does not opt into the program. The state is expected to solicit bids from qualified insurance carriers by March 31, 2022, for a program start date of Jan. 1, 2023.

The law provides six weeks of partial wage replacement for child bonding, caring for a family member with a serious health condition, handling qualifying exigencies due a family member's military deployment, and/or caring for an ill or injured service member. The act also provides medical leave for private and nonstate public employees, but only if their employer does not provide short-term disability insurance. For more information on the program, see New Hampshire enacts voluntary paid family leave program (July 15, 2021).

Rhode Island

Rhode Island has updated its maximum and minimum weekly benefits for temporary disability and family leave. For leave beginning on or after July 1, 2021, a maximum benefit of $978 will apply, an increase from $887. Rhode Island's 2021 taxable wage base remains unchanged at $74,000, with an employee contribution of 1.3% of wages.

Paid family leave benefit extension

Legislation (Ch. 178, HB 6090) amending the law allows up to five weeks — an increase from four weeks — to bond with a new child or care for a family member with a serious health condition for qualifying leave beginning on or after Jan. 1, 2022. The measure further lengthens the duration of this

leave to six weeks for leave beginning in 2023. The state will continue to cap combined family and disability leave at 30 weeks.

COVID-19

California's supplemental paid sick leave mandate expired at the end of September, but Massachusetts has extended its COVID-19 emergency paid sick leave requirement until April 2022. Many local emergency paid leave provisions related to COVID-19 have expired, while others — like Los Angeles County's mandate — have been extended. Cook County, IL, has enacted an ordinance establishing COVID-19 vaccination rights for employees, adding to the growing list of state and local laws with which employers must comply. For more, see States, cities tackle COVID-19 paid leave (regularly updated).

Other benefit-related issues

Other state activities may affect employee benefit plans. California's gig worker law was thrown back into limbo by a state court. Illinois is calling for employers — including those that self-fund their group health plans — to disclose certain health coverage information to new hires and compare plan benefits to the state's required essential health benefits (EHBs). Oregon is looking into establishing a public health coverage option for state residents.

California

A California Superior Court judge has ruled that the 2020 ballot measure (Proposition 22) exempting app-based transportation (ride-sharing services) and delivery driver companies from having to classify their workers as employees instead of independent contractors is unconstitutional. Companies like Uber, Lyft and DoorDash had backed the gig worker measure to be exempt from a 2019 law (Ch. 296, AB 5) that codified an "ABC" test to determine if workers are employees entitled to state labor law protections and benefits.

Illinois

Employers must make additional health plan disclosures to their Illinois employees under a new state law (Pub. Act 102-0630, SB 1905). An employer that offers group health insurance must provide — at hire, annually and on request — a comparison of the employer plan's covered benefits with the EHBs that individual health insurance regulated by the state must provide. Employers may provide the written disclosure by email or post it on a website that employees regularly access. Employers must maintain disclosure records for at least one year.

The Department of Insurance (DOI) will provide the EHB information to employers for the comparison disclosure. The Department of Labor enforces the mandate. Penalties for noncompliance range from $500 to $5,000, depending on employer size and the number of offenses. However, employers first receive 30 days' notice to correct any noncompliance.

The law took effect when signed Aug. 27. However, it doesn't include any specific compliance dates or details for obtaining information from the state's DOI. Regulators may provide more detail, but the law doesn't require doing so. Whether ERISA preempts this requirement is unclear.

Oregon

Oregon will review possibilities for implementing a public health coverage option. A new law (Ch. 507, HB 2010) calls for the state's Health Authority and the Department of Consumer and Business Services to create a strategy to implement a public health coverage option. The plan would be available in the individual health insurance market and possibly for small groups.

Regulators will analyze:

- A potential state innovation waiver under the ACA
- Populations most in need of new coverage options
- The public option's possible effect on the overall stability of insurance markets
- The impact of the American Rescue Plan Act of 2021
- The use of a state-based technology platform
- Adverse consequences of certain design elements
- The need for additional subsidies, such as premium assistance or cost-sharing subsidies

By Jan. 1, 2022, a report to the legislature must make recommendations on operating structure and governance, leveraging existing state-backed plans or networks, plan design, cost-containment options, and other considerations. Other than the possibility of obtaining an ACA waiver, the law doesn't address funding.

Related resources

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- Changes to California's paid leave programs coming in 2023 (Oct. 8, 2021)
- Massachusetts sets 2022 individual-mandate coverage dollar limits (Aug. 30, 2021)
- Seattle posts 2022 health expenditure rate for hotel employers (Aug. 17, 2021)
- Top 10 compliance issues for health and leave benefits in 2022 (Sept. 7, 2021)
- Colorado high court bans use-it-or-lose-it vacation policies (Aug. 24, 2021)

- San Francisco updates city option, 2022 health care expenditure rates (Aug. 12, 2021)
- Roundup of selected state health developments, second-quarter 2021 (July 30, 2021)
- Mercer, ERIC comment on CAA prescription drug reporting rules (July 23, 2021)
- New Hampshire enacts voluntary paid family leave program (July 15, 2021)
- Mental health parity compliance gets a boost in 2021 spending act (April 13, 2021)
- California broadens its mental health parity law (March 11, 2021)
- 2021 state paid family and medical leave contributions and benefits (Jan. 20, 2021)
- Supreme Court upholds Arkansas law regulating PBMs (Dec. 10, 2020)
- States increase group health plan reporting obligations (Nov. 20, 2020)
- Colorado voters approve paid family and medical leave law (Nov. 10, 2020)
- California: App-based drivers are contractors — not employees (Nov. 5, 2020)
- New Hampshire targets Rx costs, joins other states to add insulin cap (Sept. 2, 2020)
- San Francisco posts 2021 health care expenditure rates (Aug. 31, 2020)
- New California laws affect health insurance, leave, other HR policies (Feb. 19, 2020)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)

Other Mercer resources

- Life, absence and disability

Note: Mercer is not engaged in the practice of law, accounting or medicine. Any commentary in this article does not constitute and is not a substitute for legal, tax or medical advice. Readers of this article should consult a legal, tax or medical expert for advice on those matters.