Roundup of selected state health developments, first-quarter 2022

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In this article

A flurry of legislative activity started off the year, with 46 of 50 state legislatures in session. Prescription drug pricing and pharmacy benefit manager (PBM) restrictions took the spotlight as California, Michigan, Nebraska, New York, Oklahoma, Washington and West Virginia enacted new laws. Paid leave also garnered attention as California, Connecticut, Maine, New Mexico, Oregon, Washington and Washington, DC, looked to expand existing programs or considered new paid leave mandates. Illinois, New York and Washington updated their health plan reporting requirements. Insurance coverage mandates for services like contraceptives and abortion passed in California, Maine, New Jersey and Washington. Several states — including Indiana, Washington and Wisconsin — joined an interstate compact that makes it easier for group health plans to provide mental health services via telehealth.

Prescription drugs

As state legislatures focused on prescription drugs, the National Academy for State Health Policy (NASHP) issued a report — *Drug price transparency laws position states to impact drug prices* — on transparency programs in 14 states. The report includes a state-by-state transparency law comparison chart, a similar chart on prescription drug affordability review initiatives and several state-specific reports. Although Congress continues to debate how to lower the cost of insulin (see, for example, S 3700 and HR 6833), California and Washington joined at least 19 other states in passing laws capping costs for patients.

State legislatures are increasingly including self-funded ERISA plans within the scope of laws regulating PBMs. This trend may continue in light of recent decisions — *Pharm. Care Mgmt. Ass'n v. Wehbi*, No. 18- 2926 (8th Cir. Nov. 17, 2021) and *Rutledge v. Pharm. Care Mgmt. Ass'n*, 140 S. Ct. 812 (2020) — that have held ERISA preemption does not apply to these state laws.

California

The California Senate approved an insulin cost-sharing bill (SB 473) for fully insured medical plans situsedin California. Cost sharing for insulin prescriptions would not exceed $35 per month per dosage. The bill prohibits applying a deductible for diabetes-related services, including glucose monitors, insulin pumps and ketone urine test strips. These provisions would take effect for policy years starting in 2023. The bill contains no exception for high-deductible health plans (HDHPs) paired with health savings accounts (HSAs), but IRS guidance (Notice 2019-45) has expanded the definition of HSA-compatible "preventive care" to include insulin and other diabetes-related services.

Michigan

Michigan passed three prescription drug laws aimed at controlling drug costs by regulating PBMs that provide services on behalf of group health plans to Michigan residents. Enacted Feb. 23, these laws address licensing, transparency, network adequacy, spread pricing, medication limits, affiliated pharmacy preferences, and disclosures between a pharmacy and a participant. The PBM Licensure and Regulation Act (2022 Pub. Act 11, HB 4348), effective Jan. 1, 2024, sets out parameters for PBM licensing and regulates PBM practices and contracts with pharmacies. Effective upon enactment, another law (2022 Pub. Act 12, HB 4351) amends Michigan's Third Party Administrator (TPA) Act to include PBMs in the definition of a TPA. The third law (2022 Pub. Act 13, HB 4352), also effective on enactment, amends the state's Public Health Code to require certain pharmacy disclosures.

Whether these laws apply to self-funded ERISA plans is unclear. For more detail, see Michigan enacts three new prescription drug laws (March 10, 2022).

Nebraska

The PBM Licensure and Regulation Act (LB 767) creates a licensure program for PBMs that provide services to health benefit plans in the state. The law restricts a number of PBM activities occurring within the state, including the following:

- PBMs may not prevent pharmacy disclosure of total cost and other information to covered persons.
- PBMs may not require a covered person to pay more than the lesser of the cost-sharing amount or a covered drug's cash price and must accumulate the amount toward the deductible and out-of-pocket maximum.
- PBMs must regularly update and disclose to pharmacies the maximum allowable cost price list.
- PBMs must include any Nebraska pharmacy in a specialty network if the pharmacy accepts the PBM's contractual terms and meets a specialty pharmacy accreditation from any nationally recognized independent accrediting organization.

The law's scope focuses on PBMs that contract with health benefit plans, defined as "a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse" healthcare costs. The impact on self-funded plans whose PBMs work with

both fully insured and self-funded plans is unclear. The law applies to any contract or health benefit plan issued, renewed, recredentialed, amended or extended on or after Jan. 1, 2023.

New York

New York enacted a PBM registration law and a prescription drug formulary law.

PBM law. The law (2021 Ch. 828, SB 3762) requires PBMs operating in New York to register with the state Insurance Department. The registration requirement will apply to PBM contracts made or renewed on or after June 1, 2022, under legislation (2022 Ch. 128, SB 7837) that delayed the original March 31 effective date. As of Dec. 31, 2023, all registrations will expire, and PBMs will have to obtain a state license by Jan. 1, 2024, and adhere to state regulations.

The new requirement does not apply directly to self-funded ERISA plans. However, some PBM changes to comply with the law and any ensuing regulations could affect a plan sponsor's prescription drug coverage, whether insured or self-funded. For more detail, see New York to regulate pharmacy benefit managers (March 3, 2022).

Drug formulary law. Effective for plan years starting on or after Jan. 1, 2023, the drug formulary law (2022 Ch. 99, SB 7767) prohibits fully insured plans from making the following formulary changes during a plan year:

- Removing a drug, unless the federal Food and Drug Administration recommends removal
- Moving a drug to a higher cost-sharing tier for a person who is already taking the drug or has a condition that existed on or before the plan year started and would be treated by the drug, unless a generic equivalent or interchangeable biological product is added at the same time
- Adding utilization management restrictions

To remove a drug from the formulary or change cost sharing for a drug, a plan must provide participants notice at least 90 days before the start of a plan year.

Oklahoma

A 2021 law (HB 2678) requires health insurers and PBMs that administer pharmacy benefits for health plans to credit any amount paid by an enrollee or on behalf of an enrollee by a third party toward the enrollee's cost-sharing amount. The provision amends the state's unfair claims practices law, which defines "health benefit plan" to exempt self-insured ERISA plans but to include both self-funded and fully insured multiple-employer welfare arrangements. The new provision took effect Nov. 1, 2021, and a federal district court has upheld the law against an ERISA preemption challenge (*Pharm. Care Mgmt. Ass'n v. Mulready*, No. 5:19-cv-00977 (W.D. OK April 4, 2022)).

The Oklahoma Insurance Department issued a bulletin in late October 2021, identifying a conflict for fully insured HSA-eligible HDHPs required to count third-party payments toward an enrollee's out-of-pocket expenses. Recently enacted 2022 legislation (HB 3495) fixes this issue by imposing the requirement

only after an enrollee has met the deductible of an HSA-compatible HDHP, unless the benefit is covered as preventive care.

Washington

Washington passed three laws that affect prescription drugs.

Prescription drug affordability board. Effective June 9, a law (2022 Ch. 153, SB 5532) creates a five-member prescription drug affordability board that will review prices in the state for up to 24 drugs per year. The board will work with the state's Health Care Authority to set upper payment limits, when appropriate, for up to 12 drugs per year, beginning Jan. 1, 2027. Any upper payment limit for a prescription drug will apply to all drug purchases by a fully insured entity whenever the drug is dispensed or administered — whether in person, by mail or by other means — to an individual in the state.

An employer-sponsored, self-funded plan may (but is not required to) elect to adhere to the upper payment limits established by the board. Any health plan savings attributable to the program must be used to reduce consumers' out-of-pocket costs.

Prescription cost-sharing accumulation. For policy years starting in 2023, another law (2022 Ch. 228, SB 5610) requires fully insured plans operating in the state to count prescription drug cost sharing toward the deductible and out-of-pocket maximum, regardless of payment source. The mandate applies only to prescription drugs without a generic or therapeutic-equivalent preferred drug in the health plan's formulary. However, that restriction doesn't apply if the patient is purchasing the drug through prior authorization, step therapy or a utilization-review exception process. The law does not apply to grandfathered plans under the federal Affordable Care Act (ACA). The law also exempts HSA-eligible HDHPs, but only to the extent necessary to preserve an enrollee's ability to claim tax-exempt HSA contributions and withdrawals.

Insulin cost-sharing limits. Also for policy years starting in 2023, a third law (2022 Ch. 10, SB 5546) reduces Washington's cost-sharing limits on insulin to $35 for a 30-day supply. The current cost-sharing limit is $100 for a 30-day supply. The law makes no distinction between in-network and out-of-network providers. The law expires at the end of 2023. If IRS removes insulin from its list of preventive care services eligible for first-dollar coverage in an HSA-qualifying HDHP, the law requires an insurer to set cost sharing at the minimum level that preserves the enrollee's ability to make or receive tax-exempt HSA contributions. For more detail, see Washington enacts numerous benefit, insurance and related laws (April 14, 2022).

West Virginia

West Virginia passed a law (2022 Ch. 159, HB 4112) that amends the Pharmacy Audit Integrity Act to include PBM activities occurring in the state on behalf of self-funded plans. A 2021 law (Ch. 164, HB 2263) providing consumer freedom of choice for pharmacies left questions about the measure's application to self-funded plans. Under the 2021 law, health plans must accept any willing pharmacy and cannot require participants to purchase prescription drugs exclusively through a mail-order pharmacy or

to pay greater cost sharing for drugs not purchased through a mail-order pharmacy. The 2022 law extends those protections to self-funded plans with West Virginia participants.

The 2022 law also adds new provisions to existing law that:

- Prohibit some specialty drug restrictions
- Ban imposing additional pharmacy credentialing for network participation beyond what the state requires
- Require disclosing specialty drug subnetworks to the state insurance commissioner

The law applies to plan years starting in 2023 or later.

Paid leave

State paid leave efforts continued across the country as the prospects for federal legislation dimmed. Some jurisdictions — like California, Connecticut and Washington, DC — addressed COVID-19 leave. Leave expansion also landed on the agendas of jurisdictions like Oregon, Washington and Washington, DC. As the quarter ended, new paid family and medical leave (PFML) legislation advanced in Delaware (2022 Ch. 301, SB 1) and Maryland (2022 Ch. 48, SB 275). New Mexico is considering adding a PFML program. Maine's new vacation law has a potential impact on the state's existing earned paid leave law.

COVID-19

California

California passed a new supplemental paid sick leave (SPSL) law (2022 Ch. 4, SB 114), the third iteration of the state's pandemic paid leave requirement for employers. Previous legislation (2021 Ch. 13, SB 95) that revived and expanded a 2020 SPSL requirement (2020 Ch. 45, AB 1867) expired Sept. 30, 2021. The law requires employers with more than 25 employees nationwide to provide up to 80 hours of SPSL to covered employees unable to work or telework for COVID-19-related reasons. SPSL provided or taken in 2021 does not count toward the 2022 amount.

The SPSL mandate applies retroactively to Jan. 1, 2022, and expires Sept. 30, 2022. Employers must grant an employee's request for retroactive reimbursement of unpaid leave taken in 2022 before the law's effective date (Feb. 9) that otherwise would have qualified for SPSL. A new webpage from the Department of Industrial Relations (DIR) provides a series of FAQs on the law.

The 80-hour allotment is divided into two 40-hour banks: up to 40 hours if an employee or family member tests positive and another 40 hours for specified reasons. Employers may request documentation of a positive test.

Covered reasons for COVID-19 SPSL include a quarantine/isolation order, medical opinion to self-quarantine, school closure, COVID-19-related medical appointment, vaccine appointment or COVID-19

vaccine/booster-related symptoms. These reasons generally include family members. For more detail, see States, cities tackle COVID-19 paid leave (regularly updated).

Connecticut

A recent state Department of Labor notice clarifies how Connecticut employees may use PFML for COVID-19-related absences. A COVID-19 exposure or even diagnosis is not necessarily a serious health condition that qualifies for PFML income-replacement benefits. To qualify, an employee must have a serious health condition that requires an overnight stay in a medical care facility, causes more than three consecutive days of incapacity requiring medical treatment, or results in or exacerbates a chronic condition that causes occasional periods of incapacity and requires healthcare provider treatment at least twice a year.

An eligible employee may receive PFML benefits to serve as a caregiver to a family member exposed to or diagnosed with COVID-19, but only if the family member's healthcare provider certifies that the family member's exposure/diagnosis satisfies the serious health condition standard. For more detail, see States, cities tackle COVID-19 paid leave (regularly updated).

Washington, DC

Amendments to the city's Accrued Sick and Safe Leave Act provide paid leave for employees and their children to get COVID-19 vaccines and recover from any side effects. Emergency legislation amending the law took effect Nov. 18, 2021, and was replaced by temporary legislation (2022 Act 24-255) that will expire Oct. 1, 2022.

For any employee who started work at least 15 days before the leave request, employers must provide up to two hours of paid leave per injection (including boosters) and up to eight hours of paid leave for any side effects occurring within 24 hours of each injection (including boosters). Employees can use the paid leave for themselves or a child younger than 18. Paid vaccination leave is in addition to any other paid leave provided under an existing employer leave policy, contract or collective bargaining agreement. Vaccination leave is capped at 48 hours per employee in a year, beginning Nov. 5, 2021.

Leave expansion

Oregon

Effective April 1, a permanent rule from Oregon's Bureau of Labor and Industries expands the reasons for paid sick and safe leave during a public health emergency. Accrued paid leave can be used for:

- A Level 2 (be set) or 3 (go now) emergency evacuation order issued by a public official, if the affected area includes either employer's place of business or the employee's home address
- A determination by a public official that the air quality or heat index is at a level jeopardizing the employee's health

This rule is identical to a temporary rule in effect from Aug. 6, 2021, through Jan. 17, 2022. Oregon's paid sick and safe leave law provides other reasons for leave. For more detail, see Roundup: State accrued paid leave mandates (April 29, 2022).

Washington

Two laws aim to improve and enhance the family and medical leave (FML) law that began providing wage-replacement benefits in 2020.

The first law (2022 Ch. 233, SB 5649) amends the FML program to expand qualifying reasons and reduce paperwork requirements. Beginning June 9, family leave is available provide leave during the seven calendar days after the death of a qualifying family member (i.e., a family member for whom the employee could have taken medical or child-bonding leave before the relative died). Also beginning June 9, the first six weeks after childbirth automatically qualify as medical leave, without the employee having to show a serious health condition. Finally, the FML law's exemption of employers with collective bargaining agreements (CBAs) in existence on Oct. 19, 2017, will expire at the end of 2023.

The second law included in a supplemental budget bill (2022 Ch. 297, SB 5693) authorized additional funds for the state's Family and Medical Leave Insurance account. The law provides another $350 million to ensure that the account will not operate at a deficit. The increased funding aligns with calculations by the state's Employment Security Department (ESD). Washington's PFML program is funded by employer and employee contributions. For more detail, see Washington enacts numerous benefit, insurance and related laws (April 14, 2022).

Washington, DC

Washington, DC, employers will see a reduced tax rate effective July 1 under the city's universal paid leave (UPL) program, while employees may gain expanded benefits. The move follows the city's chief financial officer's March 1 certification of "sufficient funding to enact the maximum level of benefits authorized by current law (12 weeks for qualifying parental, medical and family leave and 2 weeks for pre-natal leave), and to lower the employer contribution rate to 0.26%, without affecting solvency." This would be the second increase to UPL benefits in the last year. In October 2021, medical leave expanded from two to six weeks, and employees gained two weeks of leave for prenatal care.

Mayor Muriel Bowser's 2023 budget proposal would delay the increased duration of paid leave benefits from July 1 to Oct. 1. The scheduled contribution rate decrease would remain in place. In addition, the budget proposal would make permanent the elimination of the one-week waiting period implemented due to the COVID-19 outbreak but set to expire on April 16, 2023, one year after DC's public health emergency order expired.

PFML consideration

New Mexico

A New Mexico law (SM 1) commissions a cross-functional team to study PFML and make recommendations by Oct. 1. PFML faces challenges in the state, where less than 5% of employers have workforces large enough to be subject to federal Family and Medical Leave Act. New Mexico has seen worker shortages due to increasing caregiving responsibilities during the COVID-19 outbreak. The state addressed paid sick leave last year in the Healthy Workplaces Act. For more detail, see New Mexico enacts paid sick leave law (May 19, 2021).

Paid vacation

Maine

Amendments (Ch. 561, LD 225) to the state's pay on separation law (26 MRSA § 626) require employers with 10 or more employees (including state and local government employers) and a "vacation policy" to pay out unused vacation time. The law does not apply to employees subject to a collective bargaining agreement that addresses payment of vacation on cessation of employment. The law will take effect on Jan. 1, 2023.

The implications for unused accrued paid leave required by the Maine Earned Paid Leave law (MEPL) remain to be seen. Under the MEPL and its regulations, covered employers must provide up to 40 hours of accrued paid leave per year that employees can use for any reason, including vacation. A covered employer does not have to pay out unused accrued paid leave on separation, unless the employer's policy provides otherwise. Whether the new law requiring payout of "unused paid vacation accrued pursuant to the employer's vacation policy" includes unused paid leave accrued under the MEPL isn't clear. Clarifying guidance from Maine's Labor Department would be helpful.

Health plan reporting

Group health plans received clarifications and updates about reporting responsibilities in three states. Employers with Illinois employees must now provide them with a comparison of their plan against a plan offering the state's essential health benefits (EHBs). New York announced its 2022 covered-lives assessment (CLA) rate for healthcare payors that report and pay directly to the state. Washington's Partnership Access Lines (WAPAL) assessment rates have decreased for the remainder of the 2022 fiscal year.

Illinois

Under a 2021 law (Pub. Act 102-0630, SB 1905), employers that offer group health coverage to Illinois employees must provide a comparison of the employer plan's covered benefits against the EHBs that state-regulated individual health insurance policies must provide. The law took effect when signed on Aug. 27, 2021. In early 2022, regulators updated FAQs to explain how to complete the form when an

employer's plan covers an EHB, but not to the same extent as the state's benchmark plan. Instead of "Yes," the proper response in column E is to state "Yes, partially" or "Partially" and explain the discrepancy. This will entail a review of the page citations to the benchmark plan for medical and pediatric dental benefits. The Illinois Department of Labor now considers a "Yes" response for a partially covered EHB as "misinformation." For more detail, see Illinois mandates health plan disclosure with EHB comparison (Feb. 10, 2022).

New York

New York posted its 2022 regional covered-lives assessment (CLA) rates and percentage surcharges for graduate medical education (GME) under the state's Health Care Reform Act (HCRA). The HCRA imposes on "electing" health claim payors — including self-funded plans — an annual CLA, which is based on the number of covered individuals (and families) who live in New York. The state lets payors "elect" to pay the CLA per covered individual directly to the state's Professional Educational Pool. Nonelecting payors are not subject to the annual CLA but may incur significantly higher GME percentage surcharges on certain in-state hospital expenses. The annual GME CLA/percentage surcharge along with an indigent care surcharge are two distinct payments imposed by the HCRA. For more detail, see New York announces 2022 HCRA covered-lives assessment rates (Jan. 31, 2022).

Washington

The WAPAL fund announced a reduced monthly assessment rate of $0.07 per covered life, effective Feb. 15 through the remainder of the state's fiscal year 2022 ending June 30. Washington imposes a CLA with reporting obligations on health plan payers. Quarterly reports are due within 45 calendar days after the end of each calendar quarter and must contain information on covered individuals who reside in the state. Though the reports and assessments are due quarterly, the assessments are computed on a monthly basis.

The amended rate applies to activity in the fourth quarter of 2021. This rate applies to all ages of covered lives. Any assessed entity that remitted a Q4 CLA payment at the prior $0.13 rate should receive an automatic refund.

Insurance

This year saw expansion of abortion coverage in California, a broader definition of a disabled child in Maine, an increase in the duration of contraceptive coverage in New Jersey and Washington's alignment of state balance-billing requirements with federal law.

California

California passed an abortion coverage law (2022 Ch. 11, SB 245) that applies to managed healthcare plans and fully insured medical plans sitused in California. Plans must cover abortions and related services without any cost sharing (no deductible, copayment or coinsurance), effective for policy years

starting in 2023. Utilization management and review are also prohibited for these services. An HSA-eligible HDHP may impose a deductible in accordance with federal law.

Maine

Maine's law (2022 Ch. 520, LD 1798) expands the definition of a dependent under health insurance coverage sitused in the state to include a disabled child of any age. The term "disability" is defined as a "physical, mental, intellectual or developmental disability that renders a person incapable of self-sustaining employment." A parent must provide proof of disability within 31 days of the child turning age 26. After the dependent turns 28, an insurer may annually require additional proof of ongoing disability. The law took immediate effect when signed March 29.

New Jersey

New Jersey expanded its existing contraceptive mandate (2019 Ch. 361, AB 5508) to require up to 12 months (increased from six months) of contraceptive prescriptions at one time and at no cost to participants. The revised law (2021 Ch. 376, SB 413) applies to fully insured plans sitused in the state that are delivered, issued, executed or renewed on or after Jan. 1, 2023.

Washington

Effective March 31, changes (2022 Ch. 263, HB 1688) to the state's balance-billing program align it with the federal No Surprises Act (NSA), enacted by the 2021 Consolidated Appropriations Act (Pub. Law. No. 116-260). Highlights include:

- Updates every other year through 2030 to the claims data used to determine the qualifying payment amount
- Confirmation that the state's arbitration process applies instead of the NSA's independent dispute resolution process until at least July 1, 2023; air ambulance services will continue to be subject to state law beyond that date
- Authorization for the Office of the Insurance Commissioner (OIC) to enforce state law and NSA protections by assessing civil penalties of up to $100 per affected individual per day
- An OIC report and recommendations by Oct. 1, 2023, on how to include ground ambulance services in balance-billing protections

While the law applies to fully insured plans underwritten in the state, Washington allows self-funded plans to elect to follow its balance-billing law. For more detail, see Washington enacts numerous benefit, insurance and related laws (April 14, 2022).

Telehealth

Ohio enacted a telehealth law that requires cost-sharing parity between telehealth and in-person healthcare providers. Several states joined the Psychology Interjurisdictional Compact (PSYPACT), an interstate compact facilitating the practice of mental health services.

Ohio

Under a new law (2021 Act 65, HB 122), fully insured health plans covering Ohio residents must reimburse telehealth providers for covered services at the same or a lower cost-sharing level that applies to in-person providers. Prior law required telehealth coverage but didn't ban higher cost sharing for those services. The new law requires health plans to cover telehealth services on the same basis and to the same extent that the plan covers in-person health services. The new provisions took effect March 23.

PSYPACT

PSYPACT is particularly relevant for telehealth services. Licensed healthcare providers can apply to practice telepsychology and/or to conduct temporary in-person, face-to-face sessions in PSYPACT states, depending on the certificate issued. PSYPACT services are now available in a majority of states. Indiana (2022 Pub. L. No. 65, SB 365), Washington (2022 Ch. 5, HB 1286) and Wisconsin (2021 Act 131, AB 537) are the latest states to join PSYPACT.

Other benefit-related issues

Single-payer healthcare and mandated long-term care (LTC) insurance are two areas where a couple of states are testing the waters but grappling with major cost considerations. California and New York considered a single-payer system, but the legislation did not make significant progress.

Single-payer efforts

California and New York lawmakers resurrected statewide universal healthcare proposals that failed to gain traction in in 2021. These efforts continue to face an uphill battle.

California started the year considering carryover legislation (AB 1400) to establish a comprehensive, universal single-payer healthcare coverage and cost-control system. The proposed program would have covered a wide range of medical benefits and other services, such as LTC, and would incorporate health benefits and standards of existing federal and state laws. In its current iteration, the bill lacked funding details other than proposed federal waivers — including ACA Section 1332 innovation waivers — and current state healthcare expenditures. The bill died at the end of January after failing to pass in at least one chamber.

New York's still pending legislation (AB 6058, SB 5474) would provide a universal single-payer health plan for every state resident. Part of the funding would rely on federal waivers and existing state expenditures. Additional funding would come from two taxes: a progressively graduated payroll tax and a

graduated tax on other taxable income, such as interest, dividends and capital gains. A board would operate the New York Health Program and negotiate provider reimbursements. No cost sharing would apply to covered treatments and services, which would include LTC.

To date, the only state (Vermont) that enacted a single-payer plan abandoned the project after reviewing cost estimates. How California or New York would overcome similar hurdles is unclear.

Long-term care

Early into its legislative session, Washington passed two laws addressing concerns related to its first-of-its-kind LTC mandate.

The first law (2022 Ch. 1, HB 1732) delays implementation of the state's LTC program by 18 months. This postpones the start of premium collections from Jan. 1, 2022, to July 1, 2023, and the availability of benefits from Jan. 1, 2025, to July 1, 2026. Employers that already withheld contributions from employees' paychecks had to issue refunds by May 27, within 120 days after the law took effect. In addition, individuals born before Jan. 1, 1968, may qualify for reduced benefits if they have paid the required premiums for at least one year.

The second law (2022 Ch. 2, HB 1733) requires the state ESD to accept premium exemption applications beginning Jan. 1, 2023, for the following individuals:

- Employees whose primary residence is outside Washington
- US active military spouses and domestic partners
- Certain disability-rated US veterans
- Temporary worker nonimmigrant visa holders

For all state-approved exemptions, employees must provide an exemption notice to their employers before premium collection can be discontinued. Employees granted one of these exemptions remain permanently ineligible for the state coverage unless they lose the exemption — for example, due to military discharge, a divorce, or a change in immigration status or residence.

For more detail, see Washington changes long-term care law (April 13, 2022).

Related resources

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- Washington enacts numerous benefit, insurance and related laws (April 14, 2022)
- Washington changes long-term care law (April 13, 2022)

- Michigan enacts three prescription drug laws (March 10, 2022)
- New York to regulate pharmacy benefit managers (March 3, 2022)
- 2022 health law and policy outlook (Feb. 24, 2022)
- Illinois mandates health plan disclosure with EHB comparison (Feb. 10, 2022)
- New York announces 2022 HCRA covered-lives assessment rates (Jan. 31, 2022)
- States update group health plan sponsor reporting obligations (Jan. 21, 2022)
- Roundup of selected state health developments, fourth-quarter 2021 (Jan. 21, 2022)
- 2022 state paid family and medical leave contributions and benefits (Jan. 19, 2022)
- Colorado high court bans use-it-or-lose-it vacation policies (Nov. 30, 2021)
- Washington, DC, amends and extends paid family and medical leave (Nov. 2, 2021)
- States seek to rein in Rx costs and pharmacy benefit managers (Oct. 26, 2021)
- Washington adds tight exemption timeline to long-term care law (May 3, 2021)
- Maine's earned paid leave begins accruing Jan. 1, 2021 (Nov. 12, 2020)

Other Mercer resource

- Life, absence and disability

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