Roundup of selected state health developments, second-quarter 2022

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In this article

State legislatures and regulatory agencies hit full swing during the second quarter of 2022. Many focused on paid leave provisions — new, revised, clarified and/or validated — with developments in Colorado, Connecticut, Delaware, Illinois, Maryland, New Mexico, New York, Oregon, Virginia and Washington, DC, as well as two other cities. Insulin costs and pharmacy benefit manager (PBM) limitations remained at the forefront as Colorado, Florida, Iowa, Louisiana, Maine, Maryland, Oklahoma, Tennessee, Vermont and West Virginia enacted new laws. Numerous states added coverage mandates to existing insurance laws, including provisions addressing health savings account (HSA) eligibility. Georgia, Oklahoma and Virginia moved to align mental health parity (MHP) protections with federal requirements. Telehealth, surprise billing, association health plans (AHPs) and Washington's long-term care mandate also received attention.

Paid leave

Several states addressed paid family and medical leave (PFML) and sick and safe leave in the first half of 2022. Some expanded or clarified existing laws, while Delaware and Maryland enacted new laws, as did two cities (San Francisco and Bloomington, MN). Virginia adopted a voluntary paid family leave insurance program, perhaps as a precursor to a more substantive law. With no meaningful progress on paid leave at the federal level (see Build Back Better Act's healthcare and paid leave reforms face uncertain future (Jan. 13, 2022)), other states looked to add paid leave provisions, but the bills fell short. Those states included Illinois, Louisiana, Maine, Michigan, Minnesota, Vermont and Wisconsin, among others.

Clarification of existing laws

Colorado

In *Chronos Builders, LLC v. Dep't of Labor and Employment* (No. 22SC78 (June 21, 2022)), Colorado's Supreme Court upheld the state's PFML law (voter-approved Proposition 118), concluding it does not violate the state's Taxpayer Bill of Rights. Contributions start in 2023, and benefits become available in 2024.

Connecticut

Connecticut's Department of Labor and Paid Leave Authority (PLA) has issued a notice template for employers. The notice summarizes two laws: the Connecticut Family and Medical Leave Act (CTFMLA) and the Connecticut Paid Leave Act (CTPL). As of July 1, employers provide the notice to Connecticut employees on hire and every year thereafter. Under proposed regulations, employers can put the notice in an employee handbook or other written employee guidance or separately provide it. Electronic delivery is sufficient. For more detail, see Connecticut readies its paid family and medical leave program (Dec. 2, 2021). As background, PFML became law in 2019. It amended the state's earlier CTFMLA and established the PLA. Paid leave benefits became available this year.

New Mexico

The Department of Workforce Solutions has issued final rules implementing the Healthy Workplaces Act, an accrued paid sick leave mandate that took effect July 1. Highlights include:

- **Front-loading.** This practice is permissible when the year starts if an employer does not recoup used leave through payroll deductions.
- **Payment timing.** Earned leave is due on the same payday as regular wages.
- **Documentation.** If an employer requires documentation for leaves lasting two or more consecutive days, an employee has 14 days after returning to provide it.
- **Termination of employment.** An employer need not pay out unused, earned sick leave in this event.

See the state's paid sick leave webpage for a poster, guide, compliance checklist and FAQs. For more information on the law, see Roundup: State accrued paid leave mandates (April 29, 2022).

Oregon

Contributions for Oregon's PFML insurance (PFMLI) program will start on Jan. 1, 2023. The Employment Department has announced next year's rate will be 1% of wages, the highest amount permitted by statute. Contributions will be subject to a maximum wage base of $132,900, indexed annually using the Consumer Price Index (CPI) for All Urban Consumers, West Region. The contribution split is 60% employee-paid, 40% employer-paid for employers with 25 or more employees. Employers with fewer

than 25 employees do not have to contribute, but if they do, they are eligible for a small employer assistance grant. PFMLI benefits will become available on Sept. 3, 2023. The Paid Leave Oregon website has more information on the program. For more detail, see Oregon's paid family and medical leave contributions delayed to 2023 (Aug. 5, 2021).

Expansion of existing laws

Illinois

While technically not related to paid leave, a new law (2022 Pub. Act 102-1050, SB 3120) broadens the state's unpaid leave for bereavement requirement, in effect since 2016. The mandate previously was limited to a child's death, but beginning on Jan. 1, 2023, covered employees will be able to use bereavement leave for the death of a family member, including immediate family, parents and in-laws, stepchildren and stepparents, grandparents and grandchildren, and domestic partners.

The bereavement leave will also be available after:

- Miscarriage
- Unsuccessful round of intrauterine insemination or an assisted reproductive technology procedure
- Failed adoption match or unfinalized adoption contested by another party
- Failed surrogacy agreement
- Diagnosis negatively impacting pregnancy or fertility
- Stillbirth

The duration of bereavement leave — 10 days — has not changed, and the leave will remain unpaid.

New York

In March 2021, New York passed a law (2021 Ch. 77, AB 3354) requiring paid leave of up to four hours per COVID-19 vaccination. This law was due to expire Dec. 31, 2022. A new law (2022 Ch. 234, AB 9513) extends the expiration date to Dec. 31, 2023. For more detail on COVID-19 leave laws, see States, cities tackle COVID-19 paid leave (regularly updated).

Washington, DC

Effective July 1, Washington, DC, employers now have a reduced tax rate under the universal paid leave (UPL) program, while employees will soon gain expanded benefits.

According to this official announcement, the tax rate is now 0.26% (formerly 0.62%). The rate change applies for the quarter that began July 1. The first PFL tax payment at this new rate will be due Oct. 31 for wages paid to covered employees between July 1 and Sept. 30.

As a result of an emergency budget law for fiscal year 2023 (2022 Act 24-470), an eligible employee's medical leave entitlement will expand on Oct. 1 from six weeks to 12 weeks, with another two weeks for prenatal care. In addition, parental leave and family leave each will expand to 12 weeks from the current eight and six weeks respectively. The overall maximum leave in one year increases from eight weeks to 12 weeks (plus two weeks of prenatal leave) for eligible individuals. The expanded leave entitlement was delayed from the original effective date of July 1. Finally, an FY 2022 emergency budget law (2022 Act 24-0437) eliminates the one-week waiting period for benefits to begin, effective July 25. For background on the UPL law, see Washington, DC, amends and extends paid family and medical leave (Nov. 2, 2021).

New laws

Bloomington, MN

Bloomington has joined three other Minnesota cities (Duluth, Minneapolis and St. Paul) by enacting an earned sick and safe leave requirement (Ordinance No. 2022-31). Employers with five or more employees must provide eligible employees one hour of paid sick and safe time for every 30 hours worked in Bloomington, up to a maximum of 48 hours in a year and 80 hours overall. Employers with fewer than five employees must provide this time-off but may do so on an unpaid basis. Governmental employers (except the city of Bloomington) are exempt. Employees who work at least 80 hours in the city in one year are covered. The ordinance will take effect July 1, 2023.

Delaware

The state's PFML law (2022 Ch. 301, Sen. Subst. 2 for SB 1) applies to employees who qualify for leave under federal Family and Medical Leave Act (FMLA). For an employee's or a family member's serious health condition or a military qualifying exigency, up to six weeks of leave will be available in a 24-month period. Parental leave will be available for up to 12 weeks in a 12-month period. The overall cap will be 12 weeks per year.

Employers with fewer than 10 employees in the state during the past 12 months are not subject to the law. Employers with 10–24 employees in Delaware are subject only to the parental leave requirement.

Starting on Jan. 1, 2025, employers will have to remit contributions to Delaware but may deduct up to 50% of required contributions from wages. A contribution rate of 0.4% of wages will apply toward leave for an employee's health condition. Contributions will be 0.32% for parental leave and 0.08% for family caregiving leave. Indexing of rates will start in 2027 but may not exceed 125% of the prior year's rate. Employers may opt out of the program with an approved private plan covering one or more types of leave. Employers must administer claims.

Starting on Jan. 1, 2026, weekly benefits will be 80% of the covered individual's average weekly wages, subject to a $100 minimum and a $900 maximum in the first two years — 2026 and 2027 — and indexed thereafter.

For more detail, see Delaware enacts paid family and medical leave law (July 7, 2022).

Maryland

Add Maryland to the list of states requiring PFML after enactment of 2022 Ch. 48 (SB 275). Employees qualify for partial wage replacement after working at least 680 hours over a 12-month period. Benefits will become available on Jan. 1, 2025, to care an employee's own or a next of kin's serious health condition, bond with a new child, care for a relative who is a service member, or handle a qualifying military exigency.

Funding will come from employee and employer contributions; any self-employed individuals electing to participate will pay the entire contribution. Maryland's Department of Labor will annually set contribution rates (up to the annual Social Security maximum wage base). Contributions have not yet been set.

Employees will have up to 12 weeks of leave in a rolling year and an additional 12 weeks if the combined purposes are for child bonding and the employee's own serious health condition. Benefits will be 90% of the employee's average weekly wage up to 65% of the state average weekly wage (SAWW) and 50% for wages exceeding the SAWW. The 2025 maximum benefit will be $1,000 and indexed annually thereafter.

For details, see Maryland passes paid family and medical leave law (Aug. 11, 2022).

San Francisco

Voter-approved Proposition G requires employers with 100 or more employees globally to provide up to 80 hours per year of paid public health emergency (PHE) leave to employees who work in the city and county of San Francisco. The ordinance does not apply to certain nonprofit organizations.

Annual allocation will be based on the hours an employee regularly works in a two-week period, up to a maximum of 80 hours per year. A PHE is a local or statewide health emergency declared by a local or state health officer or an air quality emergency when the Bay Area Air Quality Management District issues a "Spare the Air" alert.

The ordinance will take effect Oct. 1. The maximum 2022 leave allocation will be 40 hours. Every Jan. 1 will trigger a new allocation.

Virginia

A new Virginia law (2022 Ch. 131, SB 15) establishes family leave insurance as a class of insurance regulated by the state. Employers are not required to obtain family leave insurance. Policies are expected to cover leave related to child bonding, caring for a family member with a serious health condition and handling military exigencies. The law took effect July 1.

Prescription drugs

Prescription drug costs (especially insulin) continue to be a legislative and regulatory priority. PBMs again were in legislators' focus as several states looked to further restrict activities and practices.

California took a bold step in getting more directly involved in negotiating pricing with manufacturers and supporting the development of biosimilars.

Insulin caps

While Congress has passed insulin cap legislation for Medicare patients and broader measures are pending at the federal level, states have not delayed taking action, with Louisiana, Maryland, Oklahoma and Washington enacting laws in 2022. Last year, Oregon, Rhode Island, Vermont and Washington, DC, passed laws capping a plan member's out-of-pocket costs for insulin.

Louisiana

The new law (2022 Act No. 724, HB 677) prohibits plans from requiring enrollees to pay more than $75 per month for a 30-day supply of insulin. This amount will increase every year, based on the prescription drug component of CPI. In addition, a plan must cover at least one insulin drug from each therapeutic class in the formulary.

The Louisiana insurance law applies to fully insured plans sitused in the state. However, the law defines a "health coverage plan" to include "a self-insurance plan." The new law explicitly exempts excepted benefits, limited-benefit health insurance plans and short-term limited-duration insurance with a term of less than 12 months. The effective date is Jan. 1, 2023, for new plans issued on or after that date and on or before the renewal date for any plans in effect before Jan. 1, 2023 (but no later than Jan. 1, 2024).

Maryland

Maryland's law (2022 Ch. 405, HB 1397) limits insulin copayments to $30 per 30-day supply, applicable to fully insured plans, health maintenance organizations (HMOs) and nonprofit health service plans sitused in the state. In addition, cost sharing for diabetes-related prescription drugs (other than insulin), HIV or AIDS is capped at $150 per 30-day supply. The latter limit is subject to a cost-of-living adjustment every July 1, starting in 2023. The law will take effect for plans issued, delivered or renewed on or after Jan. 1, 2023.

Oklahoma

Oklahoma's law (2022 tit. 36, SB 861) caps insulin copayments at no more than $30 per 30-day supply, applicable to fully insured plans, the state's group plan, multiple-employer welfare arrangements (MEWAs) and self-funded ERISA plans. A prior limit did not apply to self-funded ERISA plans. While not entirely clear for this bill, Oklahoma insurance law generally applies on an extraterritorial basis to any insurer doing business in the state. Thus, Oklahoma insurance laws apply to fully insured plans underwritten in another state for participants who reside in the state. The law will take effect Nov. 1, 2022, regardless of a plan's plan year.

PBMs

Colorado

Colorado passed two PBM laws. First, 2022 Ch. 312 (HB 1122) prohibits PBM discrimination against Section 340B pharmacies, which participate in Medicaid and sell discounted drugs to healthcare organizations serving low-income or uninsured patients. Because the bill applies to PBM/pharmacy contracts, it appears to cover both fully insured and ERISA self-funded plans. This law took effect Aug. 10.

Second, 2022 Ch. 184 (HB 1370) applies to fully insured plans situsued in the state. Starting in 2024, insurers and/or their PBMs will be prohibited from changing a plan's prescription drug formulary during a plan year, with limited exceptions when affected participants receive advance notice. Step-therapy protocols, if required, will have to be based on clinical practice guidelines, and an exemption process will have to be made available. Insurers and/or their PBMs will have to meet rebate pass-through requirements, showing:

- All rebates in the formulary are used to reduce costs for the employer purchasing the plan.
- All estimated rebates received or to be received are used to reduce employer or individual employee costs.

Florida

A new Florida law (Ch. 2022-200, HB 357) subjects health insurers and HMOs providing pharmacy benefits to PBM audit requirements, even if pharmacy payment obligations are transferred to a PBM. These entities must register as a PBM or risk a $10,000 penalty. The law took effect July 1.

Iowa

Iowa regulates PBM processes by enacting 2022 Act 11133 (HB 2384) as follows:

- Requiring all pharmacies to be reimbursed at the same rate as PBM-affiliated pharmacies
- Prohibiting a PBM from assessing any claim-processing, performance-based, network-participation or accreditation fees on a pharmacy
- Prohibiting higher cost sharing than a pharmacy's reimbursement amount
- Permitting a pharmacy to disclose availability of lower-cost drug options to participants
- Imposing a new subjective good-faith and fair-dealing standard on PBMs to any third-party payor
- Requiring PBMs to disclose their maximum allowable cost list

The new law applies to fully insured plans situsued in the state, as well as self-funded governmental plans. Whether self-funded ERISA plans are within the law's scope is not entirely clear. Before

enactment of this law, the PBM statute explicitly excluded a "private single employer self-funded plan." The new law broadens the PBM definition to include "a person who, pursuant to a contract or other relationship with a *third-party payor*, either directly or through an intermediary, manages a prescription drug benefit provided by the *third-party payor"* (emphasis added). However, the legislature's fiscal note describes the law's scope as applying to "individual coverage, fully insured small and large employer groups, self-insured public employees, and the State of Iowa Plan."

The law took immediate effect June 13.

Maine

A Maine law (2022 Ch. 744, LD 1783) requires insurers and PBMs to credit any third-party waiver or discount toward a deductible and out-of-pocket maximum (OOPM). This requirement is limited to situations in which no generic equivalent exists or a participant received prior authorization, a step-therapy override or another exception, or an appeal process.

The law contains an exception for HSA-qualifying high-deductible health plans (HDHPs). How the mandate will apply to self-funded ERISA plans is unclear, given that PBMs are within its scope. Existing Maine law defines PBMs broadly to include entities who contract with a "self-insurance plan." The law will take effect for contracts and policies issued on or after Jan. 1, 2023.

Oklahoma

A federal district court ruled in *Pharmaceutical Care Management Association (PCMA) v. Mulready* that ERISA does not preempt a 2019 Oklahoma law (Patient's Right to Pharmacy Choice Act) applicable to insurers and PBMs. The law contains provisions related to any willing pharmacy, retail-only pharmacy access standards and affiliated pharmacy restrictions, among other things. As a result, the Oklahoma Insurance Department (OID) may enforce the law against PBMs that administer both fully insured and self-funded plans. For information on the original law, see Roundup of selected state health developments — second-quarter 2019 (July 29, 2019).

The decision struck down major portions of the law applicable to Medicare Part D plans.

Tennessee

A major PBM law (2022 Ch. 1070, HB 2661) imposes several restrictions on fully insured plans and self-funded ERISA plans. Among other things, the law:

- Requires PBMs to pay pharmacies a dispensing fee based on current TennCare rates (typically higher than normal)
- Prohibits preferred PBM cost sharing for affiliated pharmacies
- Requires inclusion of any licensed pharmacy in a PBM's network, as long as the pharmacy is willing to accept the same terms and conditions that apply to other in-network pharmacies

Application to ERISA self-funded plans is consistent with a 2021 bulletin issued by the Department of Commerce and Insurance. The law will take effect Jan. 1, 2023.

Vermont

A new law (2022 Act 133, HB 353) focuses on the activities of PBMs and insurers. Provisions will take effect for plan years or contracts starting or renewing on or after Jan. 1, 2023. (PBMs doing business in the state before Jan. 1, 2023, will have a six-month compliance grace period ending on June 30, 2023.) The terms include:

- Covered drug costs to a participant cannot exceed the lesser of the cost-sharing amount, the maximum allowable cost or a drug's cash price.
- Participant cost sharing must apply to the deductible and OOPM.
- A PBM cannot impose additional requirements on a pharmacist beyond what a law or the state's Board of Pharmacy requires.
- Moving a drug to a higher cost tier (or removing it from the formulary) can occur no more than twice per plan year. Participants must receive advance notice of a formulary change.
- PBMs have a fiduciary duty to be fair and truthful to insurers and act in the insurer's best interests (the previous standard required reasonable care).
- PBMs cannot restrict or prohibit disclosures between a pharmacist and a participant.
- A PBM may not reimburse pharmacies that accept Section 340B drugs at a lower rate than other pharmacies or otherwise discriminate against 340B-participating pharmacies.

Additional provisions that will take effect on Jan. 1, 2023, include:

- A PBM-affiliated or mail-order pharmacy may not receive greater reimbursement than other pharmacies.
- Exclusive mail-order programs are prohibited, and cost sharing for mail-order drugs or specialty pharmacies must be in parity to other pharmacies.
- White bagging — dispensing and/or administering a drug in a healthcare setting other than a pharmacy — is prohibited.
- Additional protocols apply to PBM audits.

The law's application to self-funded ERISA plans is unclear. While the law makes no mention of these types of plans, it broadly defines a PBM as "an entity that performs pharmacy benefit management."

West Virginia

This state stayed busy in the second quarter, enacting new legislation and finalizing regulations related to a law passed last year.

New law. 2022 Ch. 158 (HB 4112) amends the Pharmacy Audit Integrity Act to include PBM activities on behalf of self-funded plans operating in the state. Last year, 2021 Ch. 164 (HB 2263) provided freedom of consumer choice for pharmacies. That law requires health plans to accept any willing pharmacy, and participants are not required to purchase prescription drugs exclusively through a mail-order pharmacy or pay greater cost sharing than for mail-order drugs. However, the 2021 law was unclear whether it applied to self-funded plans. By including self-funded plan payors within those provisions, the 2022 law extends those protections to self-funded plans with West Virginia participants.

Other notable provisions in the 2022 law:

- Prohibit certain restrictions related to specialty drugs
- Prohibit additional pharmacy-credentialing requirements for network participation beyond state requirements
- Obligate PBMs to disclose specialty drug subnetworks to the Insurance Commission

The new law will apply to plan years starting in 2023.

Final regulations. New rules clarify the impact of the 2021 law. PBM prohibitions include:

- Imposing contractual gag clauses prohibiting pharmacy disclosures of lower-cost alternatives to patients
- Reimbursing a pharmacy less than the National Average Drug Acquisition Cost (NADAC) or if NADAC data is unavailable, the wholesale acquisition cost
- Reimbursing pharmacies less than what a PBM reimburses an affiliated pharmacy
- Denying a pharmacy's inclusion in a network, as long as the pharmacy agrees to the PBM's terms and requirements

The rules confirm the Insurance Commission's opinion that ERISA does not preempt the law: "[C]ertain sections of this rule that only affect costs, pricing or alter incentives for ERISA plans are not preempted by ERISA and may be applicable." The rules — which took effect July 1 and expire Aug. 1, 2027 — establish a penalty scheme for failures by PBMs (but not employers).

Other developments

California

One provision of a health budget law (2022 Ch. 47, SB 184) enacted June 30 allows the California Health and Human Services Agency to enter into exclusive agreements to lower prices for or address a shortage of generics through the end of 2027.

A separate budget law (2022 Ch. 45, AB 178) allocates $100 million in funding to support development of three low-cost interchangeable biosimilar insulin products and a California-based insulin manufacturing facility. Funding is authorized through June 30, 2026.

A pending bill — SB 853, which passed the Senate in May — would expand the mandated coverage of off-label drug use for life-threatening, chronic or seriously debilitating conditions for fully insured and managed care plans situsedin the state. Plans would need to continue covering a drug during an appeal or review if it is part of an approved ongoing course of treatment. A plan could not limit, decline to cover or impose additional cost sharing for a drug as prescribed, if specified criteria applies. Other restrictions would apply as well. When the law, if enacted, would take effect is unclear.

Insurance

Legislators expanded coverage requirements to address state-specific concerns. Maine expanded its dependent definition with two laws. Several states corrected prior coverage mandates to recognize that an HDHP can only reimburse limited expenses on a predeductible basis.

Coverage mandates

Colorado

Colorado's balance billing law (2022 Ch. 446, HB22-1284) largely changes preexisting law to align with federal requirements under the No Surprises Act (NSA) portion of the 2021 Consolidated Appropriations Act (2021 CAA). The law applies to fully insured plans situsedin the state and took effect Aug. 10. Based on long-standing guidance from the state's Division of Insurance, Colorado's insurance laws also apply to self-funded governmental plans in the state.

A Colorado law (2022 Ch. 101, HB 1008) requires fully insured large-group market plans situsedin the state to cover the diagnosis of and treatment for infertility and standard fertility-preservation services. This law will take effect for plan years starting in 2023.

Connecticut

The fiscal 2022–2023 budget (Pub. Act No. 22-118, HB 5506) requires plans to develop at least two health enhancement programs aimed at insuring access and removing barriers to "essential, high-value clinical services." These programs must include incentives for participants to complete certain preventive

care exams and screenings recommended by the US Preventive Services Task Force. The law will take effect Jan. 1, 2024.

Another Connecticut law (Pub. Act 22-90, substitute SB 358) requires fully insured plans to cover breast and ovarian cancer screenings. Ovarian cancer screening is now mandatory when a physician determines a woman has an increased risk. Breast cancer screening must be covered for women under age 35 with an increased risk. The state already requires breast cancer screening for women ages 35–39. The law will take effect Jan. 1, 2023.

Connecticut law does not apply its insurance requirements on an extraterritorial basis to fully insured plans sitused elsewhere, unless at least 51% of covered employees work in the state.

Hawaii

Hawaii's Gender Affirming Treatment Act (2022 Act 39, HB 2405) adds these requirements for fully insured plans:

- No categorical cosmetic or blanket exclusions of medically necessary gender-affirming treatments or procedures
- An appeals process for claims denied based on medical necessity
- Clear information about coverage of gender-transition services, including appeals

The law specifically applies to health insurers, mutual benefit societies, and HMOs and took effect when enacted June 17. For more information on special health and other benefit issues in the state, see Hawaii employee health and leave benefits may need special attention (Feb. 18, 2022).

Illinois

In the next few years, fully insured plans sitused in Illinois will need to cover these additional services:

Mandated service	Law	Also applicable to	Effective date
Medically necessary **breast reduction** surgery	2022 Pub. Act 102-0731, HB 4271	Self-funded state and local governmental plans	Plan years starting in 2024
Balance billing	2022 Pub. Act 102-0901, HB 4703	N/A	Varies, Jan. 1, 2023, and July 1, 2022
Cleft lip/palate treatment for newborns	2022 Pub. Act 102-0768, HB 4349	Self-funded state governmental plans	Jan. 1, 2024
Genetic testing of BRCA1/BRCA2 genes for breast and ovarian cancer susceptibility	2022 Pub. Act 102-0979, HB 5334	N/A	Plan years starting in 2024

Mandated service	Law	Also applicable to	Effective date
Medically necessary continuous **glucose monitors**	2022 Pub. Act 102-1093, SB 2969	N/A	Plan years starting in 2024
Medically necessary **hormone therapy** to treat menopause induced by a hysterectomy	2022 Pub. Act 102-804, HB 5254	Self-funded state and local governmental plans	Plan years starting in 2024
No copayment for **naloxone hydrochloride** to treat opioid overdoses, with an exception for HSA-eligible HDHPs	2022 Pub. Act 102-1038, HB 4408	N/A	Plan years starting in 2024
Prenatal vitamins	2022 Pub. Act 102-930, HB 4338	N/A	Plan years starting in 2023
Broader coverage of **prostate cancer screening** to include "medically viable methods," with an exception for HSA-eligible HDHPs	2022 Pub. Act 102-1073, HB 5318	N/A	Plan years starting in 2024

Maine

Fully insured plans in Maine will need to cover some fertility benefits, including diagnostic care, treatment and preservation services, under a new law (2022 Ch. 692, LD 1539). A plan may have reasonable limitations but cannot impose a waiting period or deny coverage based on a prior diagnosis or prior treatment. A plan may not limit coverage based on a participant's use of donor gametes, donor embryos or surrogacy. A plan may not impose different requirements based on a protected category in Maine's Human Rights Act. A plan need not cover experimental treatment or nonmedical costs related to donor gametes, donor embryos or surrogacy. The law will take effect for plan years starting in 2024.

Oklahoma

Oklahoma enacted a law (2022 Ch. 294, HB 3504) expanding mammography coverage. Existing law covers women as young as age 35. The new law broadens the definition of mammography to include magnetic resonance imaging and ultrasound. The law provides an exception if the mandate would jeopardize HDHP eligibility for an HSA. Under state precedent dating back to 1981, Oklahoma insurance laws apply to insurers doing business in the state that cover state residents, even if a plan is sitused outside of Oklahoma. The law will take effect Nov. 1, 2022.

Vermont

A new Vermont law (2022 Act 108, HB 266) requires fully insured large-group plans to cover medically necessary hearing aids and related services, with no age limitation. The law will take effect for policy

years starting in 2024. Vermont insurance law generally does not apply to fully insured plans sitused elsewhere, unless one of these two conditions is met:

- The plan covers more than 25 Vermont residents.
- Covered Vermont residents work outside the state.

Dependent definitions

Maine

A new law (2022 Ch. 567, LD 1804) provides a consistent definition of "domestic partners" throughout the state's statutes, including several sections in the insurance title. Two major changes affect fully insured plans and HMOs, which have been subject to a domestic partner coverage mandate since 2001:

- **No registration required.** A domestic partner certificate is no longer necessary for partners to qualify for coverage. Instead, participants need only meet this definition: "unmarried adults who are domiciled together under long-term arrangements that evidence a commitment to remain responsible indefinitely for each other's welfare."
- **No post-termination waiting period.** A participant previously could not enroll a new domestic partner until 12 months after the termination of a prior domestic partner's coverage.

The law took effect when enacted April 7.

Maine continues to apply the federal definition of "tax dependent" for state income tax purposes. As a result, domestic partners must satisfy the Internal Revenue Code's tax dependent test (26 USC § 105(b), which refers to § 152) to qualify for nontaxable health coverage under state and federal income tax laws.

Another law (2022 Ch. 520, LD 1798), applicable to fully insured plans sitused in the state, removes any age requirement for a disabled child to qualify as a dependent. "Disability" is defined as a "physical, mental, intellectual or developmental disability that renders a person incapable of self-sustaining employment." The law took effect when enacted March 29.

HSA corrections

Connecticut

A new law (Pub. Act 22-146, substitute SB 9) corrects an apparent oversight in Pub. Act 21-14 (SB 1003), which required insured health plans to credit third-party discounts or payments toward cost sharing. The 2021 law did not provide an HDHP exception. The new law provides that exception, retroactive to the 2021 law's Jan. 1, 2022, effective date.

Illinois

In 2019, Illinois amended the Managed Care Reform and Patient Rights Act to require HMOs and other insured managed care plans situsued in the state to apply third-party financial assistance for prescription drugs to the plan's deductible and OOPM. A new law (2022 Pub. Act 102-704, HB 4433) provides an HDHP exception. The law took effect when enacted April 22.

Oklahoma

Last October, an OID bulletin (No. LH 2021-5) identified an issue with a 2021 prescription drug cost-sharing law (2021 Ch. 37, HB 2678) that put fully insured HDHPs situsued in the state at risk of losing HSA compatibility if the department fully enforced the law's provisions. In response, the state enacted 2022 Ch. 266 (HB 3495) to correct the issue. The law took effect when enacted May 16.

Virginia

An existing Virginia statute required fully insured plans situsued in the state to "include any amounts paid by the enrollee or *paid on behalf of the enrollee by another person"* (emphasis added) when calculating an enrollee's contribution toward the OOPM and other required cost sharing. A new state law (2022 Ch. 34, HB 1081) provides an HDHP exception for fully insured plans. The law took immediate effect when enacted May 16.

Mental health parity

A few states enhanced mental health parity protections for fully insured plans in light of the nonquantitative treatment limitation (NQTL) requirements in the NSA portion of the 2021 CAA.

Georgia

The Georgia Mental Health Parity Act (2022 Act 587, HB 1013) mirrors the requirements of the federal Mental Health Parity and Addiction Equity Act and the NSA, but imposes additional standards on fully insured plans situsued in the state:

- Insurers must submit by Jan. 1, 2023 (and annually thereafter) their comparative analyses for NQTLs and other information to the insurance commissioner.
- By Jan. 1, 2024 (and annually thereafter), the insurance commissioner will make these reports available to the public.
- Effective July 1, 2022, insurers may not prohibit reimbursement for a patient who sees a mental health provider and a primary care provider on the same day.
- Also effective July 1, 2022, the "medically necessary" standard is defined by statute, not by insurers.

Oklahoma

A new insurance law (2022 Ch. 312, SB 1413) imposes additional MHP requirements. Insurers in the state are already subject to annual MHP reporting but will also have to provide detailed descriptions of the comparative analysis of NQTLs. The law directs OID to provide "standardized reporting templates to ensure compliance." As mentioned above in the Insurance section, Oklahoma insurance laws apply to insurers doing business in the state, even if a fully insured plan is situsted elsewhere. The law will take effect Nov. 1, 2022.

Virginia

Under a new law (2022 Ch. 544, SB 434), Virginia's Bureau of Insurance may request an NQTL comparative analysis from insurers operating in the state. By Nov. 1 of each year, the bureau will issue a report, which will include examples of noncompliance and corrective actions. The law took effect July 1.

Telehealth

A few states offered different solutions for making telehealth more accessible for their populations.

Louisiana

A new law (2022 Act 144, HB 304) requires fully insured plans situsted in the state to cover physical therapy via telehealth. Coverage, cost sharing and claim reimbursements must be equivalent to those for in-person services. Telehealth physical therapy services do not require a previously established in-person relationship. The law will apply to plan years starting in 2023.

New York

New York recently passed its fiscal year 2022–2023 health and mental hygiene budget (2022 Ch. 57, AB 9007), which amends telehealth provisions for fully insured plans and HMOs situsted in the state. Insurers and HMOs must reimburse covered telehealth services on the same basis, at the same rate and to the same extent as in-person services. The law imposes telehealth network adequacy standards. These provisions took effect April 1 and will expire April 1, 2024.

Rhode Island and South Carolina (PSYPACT)

Rhode Island (2022 Ch. 109, HB 7501/SB 2605) and South Carolina (2022 Act 159, HB 3833) are the latest states to join the Psychology Interjurisdictional Compact (PSYPACT), which allows fully insured and self-funded plans in member states to use out-of-state providers. Altogether, 34 states have joined this interstate compact, facilitating the practice of mental health services across state boundaries.

Other benefit-related issues

Much of the NSA portion of the 2021 CAA addresses surprise medical bills and cost transparency, and some states reexamined existing measures to align with — or expand upon — the federal law.

Association health plans (AHPs) continue to be the subject of ongoing litigation at the federal level (specifically, in *New York v. US Department of Labor* (DOL) at the DC Circuit), but this did not stop Virginia and Vermont from delving into the issue. Washington received positive news about its groundbreaking long-term care program from a federal district court.

Texas

The Texas Department of Insurance (TDI) published final rules related to machine-readable files (MRFs), in accordance with a transparency law (2021 Ch. 333, HB 2090) enacted last year. The law applies to insurers, MEWAs and plans sponsored by professional employer organizations in the state. These rules largely mirror federal requirements under the Transparency-in-Coverage (TiC) regulations, except that they still require an MRF for prescription drugs. The prescription drug MRF in the TiC regulations is currently under deferred enforcement, per DOL FAQs Part 49, Q&A-12.

The effective dates of the Texas MRF rules are as follows:

- Insurers with fewer than 1,000 total enrollees: Jan. 1, 2024
- All other entities:
  - No sooner than 180 days after the rules' June 2 effective date — Nov. 29, 2022
  - No later than the earlier of (i) the date enforcement of the federal TiC regulations begins (generally, July 1, 2022, except enforcement of prescription drug provisions has been deferred) or (ii) Jan. 1, 2024

Vermont

A new Vermont law (2022 Act 137, HB 489) increases the state Insurance Division's enforcement of NSA provisions for fully insured plans, including the law's transparency, surprise billing and MHP requirements. In addition, independent external-review requirements for fully insured plans now include adverse claim determinations related to surprise medical billing, consistent with the NSA. The law also prohibits insurer-operated or insurer-controlled AHPs. To form an AHP, an association must have at least 100 members (previously, the threshold was 25) when formed and meet other requirements. The law took effect July 1.

Virginia

New laws provide greater access to AHPs and MEWAs for certain groups. The first set (2022 Chs. 349–350, HB 768/SB 335) permits a fully insured AHP (considered large-group market coverage) consisting of real estate salespeople — including self-employed individuals — as long as the association meets certain requirements, such as existing for at least five years. The second set (2022 Chs. 404–405, HB 884/SB 195) allows nonprofit associations in existence at least five years to form self-funded MEWAs. The laws took effect July 1.

Washington

In late April, a federal district court dismissed a class-action lawsuit looking to halt the WA Cares long-term care mandate (*Pacific Bells, LLC v. Inslee*, No 2:21-cv-01515, (W.D. WA April 25, 2022)). The court concluded that any challenges must occur in state court. As a result, this law is expected to take effect as scheduled.

Related resources

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- Maryland passes paid family and medical leave law (Aug. 11, 2022)
- Delaware enacts paid family and medical leave law (July 7, 2022)
- Roundup of selected state health developments, first-quarter 2022 (May 31, 2022)
- Roundup: State accrued paid leave mandates (April 29, 2022)
- Hawaii employee health and leave benefits may need special attention (Feb. 18, 2022)
- Build Back Better Act's healthcare and paid leave reforms face uncertain future (Jan. 13, 2022)
- Connecticut readies its paid family and medical leave program (Dec. 2, 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)
- Oregon's paid family and medical leave contributions delayed to 2023 (Aug. 5, 2021)
- Roundup of selected state health developments, second-quarter 2021 (July 30, 2021)
- Roundup of selected state health developments — second-quarter 2019 (July 29, 2019)

Other Mercer resources

- Life, absence and disability
- MercerRx

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