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Roundup of selected state health developments, fourth-quarter 2019

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In this article

As 2019 came to a close, efforts to expand health coverage spurred initiatives in two states — Colorado and Georgia — while five other states and Washington, DC, moved forward with their individual health coverage mandates. State and federal regulators continued to explore prescription drug importation to curb drug costs. States also wrestled with potential limits on their authority to regulate pharmacy benefit managers (PBMs). Insurance activity near year-end focused on a range of topics: balance-billing, prescription drug cost limits, mental health parity, reproductive health and association health plans (AHPs). Paid leave laws also garnered states' attention, along with various issues that have benefit implications, such as employee vs. independent contractor classification, employer health plan reporting, state tax limits on commuter fringe benefits and coordination of benefits with automobile insurance.

State coverage initiatives

Initiatives for expanding and stabilizing health coverage received attention again last quarter. Colorado is accepting comments on establishing a public health insurance option. Georgia sought comments on expanding Medicaid and obtaining an innovation waiver under the Affordable Care Act (ACA) for a reinsurance program.

Colorado

Colorado regulators have unveiled an initial proposal for a public health coverage option, consistent with legislation (2019 Ch. 206) enacted earlier last year. The Colorado Division of Insurance and the Department of Health Care Policy and Financing sought stakeholder input and actuarial analysis to design an option available to all state residents and sold by state-licensed insurers through Connect for

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Health Colorado, the state's health insurance exchange. The agencies will jointly oversee implementation. No new taxes are planned to finance the public option. Instead, "minimal" state funds and pass-through funding via an ACA Section 1332 innovation waiver will pay for the program. The goal is to have a public option available by Jan. 1, 2022.

Georgia

Georgia accepted public comments until Dec. 3 on proposals to seek two federal waivers to implement the state's Patients First Act. The waivers — a 1115 Medicaid waiver and a 1332 ACA state innovation waiver — would revamp the state's healthcare landscape:

- The 1115 waiver seeking a partial Medicaid expansion would provide coverage to residents below the federal poverty level (FPL) rather than up to 133% of FPL as required for a 90% federal match.

- The 1332 waiver would provide pass-through funds to establish a reinsurance plan, as other states have done. However, Georgia also seeks to take residents off the HealthCare.gov enrollment platform and establish a state-specific subsidy program in place of current federal subsidies for exchange coverage. Residents would have to enroll for coverage through private web brokers and insurers.

Under the 1332 waiver, health plans wouldn't have to cover all essential health benefits, and the state subsidies could also be used for short-term, limited-duration plans as well as other products, such as critical illness, dental or vision policies. If funding reaches a state-set cap, qualifying residents would be put on a waiting list for subsidies. Similar proposals from other states thus far haven't received approval from the US Department of Health and Human Services (HHS).

Individual coverage mandate

The federal individual health coverage mandate currently carries no penalty, and its validity is facing a court challenge. However, five states and Washington, DC, require residents to maintain minimum health coverage or face tax consequences. Three of these jurisdictions — Massachusetts, New Jersey, and Washington, DC — require plan sponsors to submit coverage reports to local tax authorities this year. Vermont requires only individual reporting, not employer reporting. California and Rhode Island have posted guidance for residents who must maintain coverage beginning in 2020, but won't require employer reports until 2021. In addition, Massachusetts has amended its coverage standards for 2020, and Washington, DC has posted regulations outlining minimum essential coverage (MEC) requirements.

California

California tax regulators posted a notice outlining the state's individual health insurance mandate, which took effect Jan. 1, 2020. The notice explains residents' obligation to maintain MEC, potential penalties, exemptions and available financial assistance. The Franchise Tax Board is also seeking input from employers, tax professionals, software services providers, payroll companies and insurers on implementing the mandate. Employer reporting is set to begin in 2021.

Massachusetts

Massachusetts regulators finalized new minimum creditable coverage (MCC) regulations, effective Jan. 1, 2020. Changes include indexing the state's maximum annual deductibles by using the ACA's premium adjustment percentage (42 USC § 18022(c)(4)); clarifying the criteria for health arrangements provided by religious organizations to satisfy MCC for their members; tying the out-of-pocket maximums (OOPMs) to the annually adjusted amounts for health savings accounts (HSAs) (26 USC § 223(c)(2)(A)(ii)); and making technical changes to clarify terms and enhance readability. Additional changes apply to ConnectorCare (956 Mass. Code Regs. 12.00) individual and small-group coverage.

New Jersey

New Jersey updated employer-reporting guidance for its individual health coverage mandate. Starting with the 2019 tax year, the state's Health Insurance Market Preservation Act requires third-party reporting to verify residents' health coverage. Under the New Jersey law, employers and all other MEC providers must send by March 2, 2020, the appropriate IRS Form 1095 verifying health coverage to each primary enrollee provided MEC in 2019 and file required information with the state's Division of Taxation on or before March 31, 2020.

The state isn't providing the same deadline and penalty relief granted by federal regulators and has no plans to offer filing extensions. Filers (or their representatives) must register and use the Tax Division's Secure Electronic Bulk Filing option — the same system that employers use to e-file W-2 payroll forms with the state. New Jersey will not accept mailed forms. Out-of-state employers that employ even one New Jersey resident have the same filing obligations as in-state businesses.

Rhode Island

Rhode Island's health coverage mandate requires state residents to have MEC beginning Jan. 1, 2020. According to a recent notice by the state's Division of Taxation, qualifying health coverage includes coverage provided through an employer; purchased directly from a health insurance carrier or through HealthSource RI, the state's health exchange; or supplied by Medicare or Medicaid.

Failure to have coverage in 2020 could result in a Rhode Island personal income tax penalty. However, proposed amendments to the state's health benefit exchange rules would exempt members of certain religious sects from the penalty. The state hasn't issued any guidance on employer reporting set to begin in 2021.

Washington, DC

The District of Columbia has proposed individual shared-responsibility regulations outlining residents' obligation to maintain health insurance, what qualifies as MEC and penalties for noncompliance. Individuals can have MEC through a government program, an eligible employer-sponsored plan (other than an excepted-benefit plan), an individual insurance plan or a grandfathered health plan. The

proposal also describes how wellness incentives and employer contributions to health reimbursement arrangements (HRAs) and cafeteria plans affect affordability. An individual is exempt from penalties if the available coverage is unaffordable. The proposed rules don't address employer reporting.

Prescription drugs

Prescription drug prices continued to gain attention in the fourth quarter of 2019. At the federal and state levels, importing drugs from Canada received consideration. States also persisted in pursuing ways to regulate PBMs.

Importation

Efforts to import less expensive drugs moved forward with a proposed Food and Drug Administration (FDA) rule that would allow a state to work with federal regulators to establish a program. Vermont and Florida have submitted importation proposals to the FDA. Separate draft guidance would allow manufacturers to obtain a national drug code for an FDA-approved drug originally intended for a foreign country's market. This would "provide [manufacturers] an additional avenue" to sell drugs at a lower cost in the US market.

State importation

States and certain other nonfederal governmental entities could submit proposals to import prescription drugs for FDA review and authorization under newly proposed rules. Amended federal regulations would allow importation of certain prescription drugs from Canada. An importation program could be cosponsored by a pharmacist, a wholesaler or another jurisdiction. FDA approval would require evidence that the importation program will significantly reduce costs for American consumers without creating any risk to public health and safety. Comments on the proposal are due by March 7, 2020.

Vermont and Florida

Vermont has submitted to HHS a concept paper for the state's wholesale prescription drug importation program. Preliminary projections estimate Vermont's proposed program to import drugs from Canada would generate $5 million in annual savings. State regulators expect to pass these savings along to consumers through health plans via lowered premiums, deductibles and copays. Regulators plan to submit a formal application to HHS as soon as July 1, 2020.

Vermont's importation proposal differs from Florida's concept paper, submitted last August, that would have narrower payer participation. Florida's legislation would import drugs only for consumers served by public payers, including the state's agencies and Medicaid program. Vermont's program would encompass consumers with commercial health plans in the state, with possible expansion to public payers.

PBMs

An Arkansas law restricting PBM rates will undergo US Supreme Court review. Illinois joined a growing list of states regulating PBMs. However, New York's governor vetoed similar legislation, citing potential conflict with federal laws.

Arkansas

The US Supreme Court will hear a case to determine whether ERISA preempts Arkansas' regulation of the rates at which PBMs reimburse pharmacies (*Rutledge v. Pharm. Care Mgmt. Assoc.*, 891 F.3d 1109 (2018)). The case centers on an Arkansas law (2015 PA 900) setting generic drug reimbursements by PBMs at least equal to the pharmacy's invoice amount paid to the wholesaler for the drug inventory. The law also mandates that PBMs use updated "maximum allowable cost" lists and gives pharmacies a "decline-to-dispense" option when a particular transaction would cause them to lose money.

An industry association representing PBMs sued, and the 8th Circuit agreed with the group's preemption claims, striking down the state law. The US solicitor general's amicus brief, submitted on request from the high court, says the Arkansas statute does not make "reference to" nor have an impermissible "connection with" ERISA plans. The brief argues that the Arkansas law regulates only the relationship between PBMs and pharmacies — not ERISA plans or their relationships with PBMs, pharmacies or plan participants.

Illinois

Beginning July 1, 2020, PBMs must be licensed to operate in Illinois. Recent legislation (PA 101-0452) sets requirements for PBM contracts with health insurers and pharmacies, including pricing, reimbursement, disclosure and appeals. The measure bans gag clauses, according to the governor's press release, and grants plan sponsors certain disclosure and annual audit rights. An insured health plan must apply any third-party payments, financial assistance, discounts, product vouchers or any other reduction in out-of-pocket expenses for prescription drugs toward a covered patient's cost-sharing responsibility (essentially banning copay accumulator programs). The law's insurance provisions don't apply to self-insured ERISA plans.

New York

Citing potential preemption by ERISA and Medicare Part D, Gov. Andrew Cuomo vetoed legislation (SB 6531) that would have required a New York license for PBMs to operate in the state beginning Jan. 1, 2021. The governor also raised concerns about the administrative costs of state oversight and the possibility of additional scrutiny from federal regulators. The measure would have set standards on PBMs' financial disclosures; pass-through of certain monetary receipts; conflicts of interest; and deceptive, anti-competitive and unfair claims practices. The bill also addressed PBM contract provisions with pharmacies, including maximum allowable cost reimbursements.

Insurance

Action on insurance laws in the fourth quarter of 2019 addressed "surprise" balance-billing, prescription drug and mental health coverage, reproductive health, and AHPs. State insurance laws don't generally apply to self-insured ERISA plans.

Balance-billing

While Congress debates legislation to curb surprise medical bills from out-of-network (OON) healthcare providers, states have continued to address the issue in insured plans. Missouri and New Jersey regulators outlined arbitration and disclosure obligations under existing surprise billing laws. New York and Ohio focused on new laws.

Missouri

A new Missouri health insurance regulation outlines binding arbitration procedures for disputes arising from claims for unanticipated OON care (Mo. Code Regs. tit. 20, § 400-14.100). The new rule sets out the criteria for approved arbitrators under the state's surprise billing law (Mo. Rev. Stat. § 376.690).

Under the law, the health carrier must offer reasonable reimbursement to an OON healthcare professional for services provided at an in-network facility where a patient sought emergency medical treatment. If the health plan and provider can't agree to a reimbursement amount after 60 days of negotiations, the dispute will be resolved through arbitration, and the patient will only be billed any in-network cost-sharing amount.

The new rule outlines how carriers and providers can initiate arbitration and describes arbitrator qualifications and application procedures. The guidance notes that the state's Department of Insurance will publish on its website a list of entities approved for arbitration services, but doesn't specify timing.

New Jersey

New Jersey's proposed surprise billing rules set out healthcare provider and health plan disclosure obligations, claim-handling steps, and time limits for processing charges inadvertently incurred for OON services at an in-network facility and for OON emergency or urgent care. The proposal, which builds on a 2018 Department of Banking and Insurance Bulletin (18-14), also outlines procedures for negotiating payment disputes and initiating and participating in arbitration.

A self-funded plan may opt to be subject to the claim-processing and arbitration provisions of the surprise billing law (NJ Stat. Ann. § 16:2SS-1 to -20). Health plan administrators would have to file information quarterly on behalf of self-funded plans that elect to follow the law's OON balance-billing standards and participate in out-of-network arbitration. Self-funded health plans opting to participate must provide notice to the state if they later terminate participation. New Jersey residents enrolled in a self-insured group health plan that doesn't opt in can still initiate arbitration through the state program.

New York

New York legislation (2019 Ch. 375) that restricts balance-billing for hospital inpatient services after an emergency room visit took effect when signed Oct. 17 by the governor. Under the new law, patients' out-of-pocket cost for in-patient, follow-up care received from a OON hospital or healthcare provider after an emergency cannot exceed what they would have paid for in-network care. New York insurers must pay a "reasonable" amount for the service. Payment disputes are subject to the state's dispute resolution system. The new provisions modify the surprise billing protections in place since 2015 to include OON inpatient care after an emergency room visit and to exempt hospitals that primarily serve uninsured and Medicaid populations.

Ohio

Recently introduced legislation (HB 388) would prohibit balance-billing patients who receive unanticipated OON care in Ohio. The protections would extend to emergency services and other situations when an individual didn't have the ability to request care from an individual in-network provider. Covered individuals would be billed only the in-network plan cost-sharing, while the insurer would have to pay the OON provider and the healthcare facility the highest of:

- The in-network negotiated price for the services (or median price, if prices vary)
- The usual, customary and reasonable amount
- The amount that would be paid under Medicare Part A or B

A healthcare provider or facility could request to negotiate a reimbursement amount different from the price set by the legislation. If no agreement is reached within 30 days, the dispute would go to arbitration.

Texas

The Texas Department of Insurance (DOI) has set up a surprise medical bills website to implement legislation (2019 Ch. 1342, SB 1264) that applies to health services provided on or after Jan. 1, 2020. Recent updates to the website include a waiver form for individuals who choose to seek treatment from an OON healthcare provider and related waiver rules. Patients can waive the state's balance-billing protections only if they have a choice between an in-network or an OON provider. Balance-billing protections can't be waived in an emergency or when an out-of-network doctor is assigned to a case, such as when an anesthesiologist is assigned to a surgery.

The DOI also hosts another website that explains how to file complaints and seek mediation for surprise medical bills and offers a healthcare costs consumer information guide. The Texas surprise billing protections apply to state-regulated insurance plans — including some out-of-state insured plans covering Texas residents — and coverage through the state employee or teacher retirement systems.

Prescription drug costs and coverage

Prescription drug costs and availability remain a priority in state-regulated insurance plans. California will facilitate prescription-free HIV prevention medication. Illinois has set a cost-sharing limit on insulin.

California

California pharmacists may qualify to dispense antiretroviral drugs to prevent AIDS/HIV without a prescription, if certain conditions are met under a new law (2019 Ch. 532, SB 159). Health insurers and HMOs must cover the cost of at least one therapeutically equivalent version of the preexposure prophylaxis (PrEP) drug, without prior authorization or step therapy. Required coverage of PrEP is limited to a 60-day supply per patient once every two years, unless prescribed by an authorized healthcare provider. An insurer (and any contracting PBM) can't prohibit contracting pharmacists from dispensing PrEP or post-exposure prophylaxis drugs if certain conditions are satisfied.

Illinois

An Illinois bill (SB 667) to limit insulin copayments to $100 received legislative approval, and Gov. JB Pritzker has said he will sign it into law. The law applies to HMOs, individual and group health insurance policies, and state and local self-insured governmental health plans issued or renewed in the state on or after Jan. 1, 2021. The $100 cap applies for a 30-day insulin supply, regardless of quantity or type. Regulators will annually adjust the cap relative to changes in the medical care component of the Bureau of Labor Statistics' Consumer Price Index. The legislation is similar to a Colorado law enacted earlier in 2019.

Mental health

Two states took action on insurance coverage for mental health and substance abuse treatment. Connecticut legislators set parity requirements for nonquantitative treatment limits in insured health plans. New York health insurance regulators outlined expanded coverage requirements for substance use disorder (SUD) treatments.

Connecticut

Connecticut legislation (PA 19-159) now requires parity in the nonquantitative treatment limitations imposed on medical/surgical (med/surg) benefits and mental health/substance use disorder (MH/SUD) benefits. The law applies to Connecticut insured policies issue or renewed on or after Jan. 1, 2020. Beginning March 1, 2021, the plans also must annually report all nonquantitative treatment limitations applied to med/surg and MH/SUD benefits, the criteria used to assess medical necessity, and an analysis of processes used in developing and applying medical-necessity criteria and nonquantitative treatment limitations. The insurance carrier also must demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

New York

Circular Letter No. 13 (2019) provides guidance on New York's law (2019 Ch. 57) that expands MH/SUD coverage for insurance policies and contracts issued or renewed in the state on or after Jan. 1, 2020. The new provisions prohibit insurers from requiring preauthorization or performing concurrent utilization review during the first 14 days of inpatient MH treatment for an individual under 18 years old. In addition, insurers can't perform concurrent utilization review during the first 28 days — up from 14 days under prior law — of inpatient SUD treatment, as long as the facility notifies the insurer and submits a treatment plan within two business days of admission. The law also prohibits concurrent review during the first four weeks (up to 28 visits) — an increase from two weeks — of outpatient SUD treatment provided by certain New York facilities.

Other changes in the law update utilization-review standards for MH treatments; cap cost-sharing for outpatient SUD treatment under large-group plans and outpatient MH treatment (regardless of plan size) to the amount imposed for a primary care office visit; and expand SUD prescription drug access. On request from any insured, prospective insured or in-network provider, a plan must disclose the criteria used in medical-necessity determinations for inpatient and outpatient SUD treatment, as well as its most recent comparative analysis of the plan's compliance with the federal MHPAEA.

Reproductive health

Reproductive health continues to draw attention as state lawmakers remain apprehensive about the fate of related federal regulations and patient protections. In the fourth quarter, Delaware regulators outlined contraceptive coverage and cost-sharing requirements for insured plans. New Jersey added a fertility-preservation mandate similar to laws in other states.

Delaware

A Delaware insurance bulletin (No. 112) reminds insurers to comply with a 2018 contraceptive mandate (Ch. 323) requiring coverage of all FDA-approved contraceptive drugs, devices and other products with no cost-sharing for the participant. The law also requires insurers to cover emergency contraceptives without a prescription, dispense up to 12 months' birth control at one time and cover post-partum insertion of long-acting reversible contraceptives.

The plan may impose cost-sharing for contraceptives if at least one therapeutic equivalent is available without cost-sharing. However, if the healthcare provider recommends a particular FDA-approved contraceptive based on a medical determination for a particular patient, no cost-sharing may apply — regardless of whether the contraceptive has a therapeutic equivalent. The bulletin took effect when issued Dec. 5, 2019.

New Jersey

New Jersey insured plans will have to cover certain fertility-preservation procedures under legislation (2019 Ch. 306, SB 2133) signed Jan. 13, 2020 by the governor and effective for plans issued or renewed after April 12, 2020. The law requires plans to cover standard fertility-preservation services when a medically necessary treatment may directly or indirectly cause infertility. The mandate applies to fertility impairment caused by surgery, radiation, chemotherapy, or other medical treatments or processes that affect reproductive organs or are likely to have the side effect of "iatrogenic" infertility. The same copayments, deductibles and benefit limits imposed for other medical or surgical benefits under the plan can apply to fertility-preservation services.

Association health plans

As the Trump administration's AHP rules face a continuing challenge in the courts, several states have taken positions on these plans for their own residents. A federal court struck down a portion of the federal regulations, known as Pathway 2, but left standing the Pathway 1 rules allowing bona fide associations to form AHPs to avoid small group rates and restrictions (*New York v. US Dep't of Labor*, No. 18-1747 (D.D.C. March 28, 2019). The case is currently on appeal. Three states — Arizona, Florida and North Carolina — have passed laws allowing groups to establish Pathway 2 AHPs, despite the court decision invalidating that part of the federal rules. California regulators have announced the state won't allow AHPs authorized by the federal rules, regardless of the case's outcome.

Arizona, Florida and North Carolina

New state laws allow small employers to form Pathway 2 AHPs in Arizona, Florida and North Carolina. However, all three measures rely on the 2018 AHP rules struck down in 2019. Other states are considering whether to enact similar legislation, although some — like Virginia — may reject efforts to allow Pathway 2 AHPs. Unless the court's decision is overturned on appeal, the future of state laws citing the now-invalid federal regulations is uncertain.

California

With the exception of certain grandfathered "guaranteed associations," group coverage through an AHP or any other association coverage may not be sold in California to individuals or small employers, according to regulatory guidance (APL 19-024) from the Department of Managed Health Care (DMHC). Large-group coverage likewise may not be sold to small employers through multiple employer welfare arrangements (MEWAs), AHPs, voluntary employees' beneficiary associations (VEBAs) or any similar arrangements.

Existing large-group health plans sold to small employers (including sole proprietors) through associations must be phased out. The DMHC guidance says regardless of the outcome of litigation, the now-invalidated federal rule allowing sole proprietors and small groups to form AHPs doesn't apply in California.

California requires insurers to rate sole proprietors as individuals and small employers (up to 100 employees) as small groups, even if they receive coverage through an association. This means that plans in California can't take advantage of either Pathway 1 or 2 under the federal AHP rules. Beginning July 1, 2020, plans must discontinue renewing existing large-group contracts for small employers. No such plan can operate in California on or after July 1, 2021.

Paid leave

California and Hawaii announced their 2020 rates for short-term disability and paid family leave. Colorado's family and medical leave insurance (FAMLI) task force posted preliminary recommendations for a possible paid leave program. Nevada provided guidance for its new paid time-off accrual law. Washington, DC, published paid leave notices and posters for employers to display at worksites.

California

California updated contribution and benefit amounts for its short-term disability insurance (SDI) and paid family leave (PFL) program. The combined contribution paid by employees beginning in 2020 will remain at 1% of pay, but the maximum annual contribution will be $1,229.09. Employers don't contribute to the state program, but must collect and remit employee contributions along with unemployment insurance charges. Weekly benefits depend on the employee's highest quarterly earnings in base period. For qualified leave that begins on or after Jan. 1, 2020, the maximum weekly benefit is $1,300.

Colorado

Colorado's FAMLI task force has begun developing recommendations for a paid family and medical leave (PFML) program in the state. Members met Dec. 17 to vote on aspects of the proposed program. Agreed-upon sections include:

- Purposes of family leave (to bond with new child, care for ill family members, handle family matters related to military service) and medical leave (for employee disability, domestic violence, sexual assault, stalking or organ donation)
- Benefit calculations and maximum amounts tied to the state's average weekly wage
- Funding entirely by employee contributions
- A private plan option
- Coordination with other leave
- Definition of family member
- Administration by the state's Department of Labor and Employment

Areas lacking consensus include the duration of leave and job protections. The task force sent its final PFML recommendations to the legislature on Jan. 8, 2020. The legislative timeline (2019 Ch. 352) calls for establishing a paid family and medical leave program by July 1, 2020, with funding beginning in 2023 and benefits becoming available in 2024.

Hawaii

Hawaii has set its 2020 Temporary Disability Insurance weekly wage base at $1,119.44, up from $1,088.08 in 2019. The law permits employee contributions of up to half the premium or, if less, 0.5% of the weekly wage base, with a maximum weekly contribution of $5.60. The 2020 maximum weekly benefit for leave beginning in 2020 is $650, an increase from $632 in 2019. All employers with one or more employees working in Hawaii must purchase coverage from an authorized insurer or obtain regulatory approval for a self-insured plan.

Nevada

The Nevada Labor Commissioner issued two advisory opinions that provide highlights of the state's paid leave accrual law (SB 312), which took effect Jan. 1, 2020. Under the law, every private employer with 50 or more employees working in Nevada must provide paid leave that accrues at a minimum of 0.01923 leave hours for each hour of work performed. An employee is eligible to use leave once employed 90 days.

The guidance confirms that only employees working in Nevada are counted when determining the 50-employee threshold. Part-time employees are included, but temporary and seasonal workers aren't. Employers already providing leave that matches or exceeds the required accrual as part of a contract, policy, collective bargaining agreement or other agreement — including an employee handbook — are exempt from the law. The guidance also discusses front-loading, payout, employee acknowledgments and calculation of pay rates.

Washington, DC

Washington, DC's Office of Paid Family Leave (OPFL) has published the notice to employees that employer must conspicuously display by Feb. 1, 2020, with other labor law posters at each DC worksite. Employers also must provide the notice in electronic or print form to all DC employees at least once between Feb. 1, 2020, and Feb. 1, 2021, and at least once a year thereafter. After Feb. 1, 2020, employers must give the notice to all new hires and any employee requesting leave for a qualifying event.

Other benefit-related developments

A mix of other benefit-related developments emerged in the fourth quarter. California posted guidance on its controversial law that reclassifies certain independent contractors as employees, effective Jan. 1, 2020. Massachusetts required certain employers to report health plan information to state regulators. Massachusetts also announced state tax limits for employee transit benefits. In Michigan, a motor vehicle insurance law revised coordination of benefits with health plans.

California

Two California websites hosted by the Employment Development Department (EDD) and Labor & Workforce Development Agency (LWD) explain the criteria for classifying workers as employees vs. independent contractors. As of Jan. 1, 2020, employers in California may have to reclassify some independent contractors as employees under a new law (2019 Ch. 296). However, certain sectors and occupations remain exempt, while others remain subject to a separate multifactor test.

For wage and benefit purposes, workers are presumed to be employees rather than independent contractors, unless the hiring entity can show the working relationship meets three conditions known as the "ABC" test: (a) The hiring entity does not exercise control and direction over the performance of the work; (b) the work performed is outside the hiring entity's usual business; and (c) the worker is customarily engaged in an independently established trade, occupation or business of the same nature as the work performed. LWD FAQs provide more detail on determining worker status under the law.

Massachusetts

HIRD

Employers with six or more Massachusetts employees had until Dec. 15, 2019, to complete and submit the state's Health Insurance Responsibility Disclosure (HIRD) form through MassTaxConnect. Penalties for failure to comply could total $1,000–$5,000 per violation. Information in the HIRD report helps the state identify residents with access to employer-sponsored health coverage who may qualify for the MassHealth Premium Assistance Program.

Tax exclusion for commuter benefits

Massachusetts guidance (TIR 19-16) sets 2020 state tax limits for parking and transit benefits. For taxable years beginning in 2020, monthly exclusion amounts are $270 for employer-provided parking and $140 for combined transit pass and commuter highway vehicle transportation benefits. The $140 cap differs from the federal limit of $270 for mass transit or commuter vehicle benefits.

Massachusetts tax law (MA Gen. Laws ch. 62 §1) generally follows the federal tax code in effect on Jan. 1, 2005, with targeted updates. As a result, most federal tax changes enacted since 2005 — including the 2015 change to Internal Revenue Code § 132(f) — don't automatically flow through to the state. The state didn't update its tax code to mirror the federal change allowing the same exclusion amount for all types of commuter benefits. Employers with Massachusetts employees receiving mass transit and/or commuter vehicle benefits must include any amount exceeding $140 per month as taxable income at the state level.

Michigan

Employers with employees residing in Michigan may want to revisit their health plans' coordination-of-benefits provisions for medical expenses related to motor vehicle accidents. Beginning July 1, 2020, legislation (2019 PAs 21 and 22) revises the state's no-fault automobile insurance law in a way that could increase health plans' exposure to costs resulting from motor vehicle accidents. To reduce auto insurance premium rates, Michigan's amended no-fault automobile insurance law will no longer require drivers to purchase unlimited personal insurance protection covering medical costs resulting from motor vehicle injuries. The change may raise self-insured group health plans' exposure to claims related to automobile accidents in the state.

Related resources

State coverage initiatives

Non-Mercer resources

- 2019 Ch. 206, HB 1004 (CO Legislature, May 17, 2019)
- Draft Report for Colorado's State Coverage Option (CO Insurance Division, Oct. 7, 2019)
- Section 1332 Innovation Waivers (CMS)
- Connect for Health Colorado
- Section 1332 Innovation Waiver Application (GA Governor's Office, Dec. 23, 2019)
- Georgia 1115 Medicaid Waiver Application (GA Department of Community Health, Dec. 23, 2019)

Mercer Law & Policy resources

- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)

Individual coverage mandate

Non-Mercer resources

- *Texas v. United States*, No. 19-10011 (5th Circuit, Dec. 18, 2019)
- California Healthcare Mandate (CA Franchise Tax Board, Jan. 2, 2020)
- Proposed Individual Shared-Responsibility Payment Rules (DC Register, Oct. 18, 2019)

- 956 Mass. Code Regs.5.00 (MA Health Insurance Connector Authority, Nov. 13, 2019)
- 956 Mass. Code Regs. 12.00 (MA Health Insurance Connector Authority, Nov. 13, 2019)
- Notice of Proposed Rulemaking — Shared-Responsibility Payment (MA Health Insurance Connector Authority, Nov. 13, 2019)
- ConnectorCare (MA Health Insurance Connector Authority)
- Updated Guidance for Health Coverage Filings (NJ Division of Taxation, Dec. 13, 2019)
- Health Insurance Market Preservation Act (NJ Treasury Department, Nov. 15, 2019)
- Notice 2019-63 (IRS, Dec. 2, 2019)
- Health Coverage Mandate and Open Enrollment Notice (RI Division of Taxation, Nov. 1, 2019)
- HealthSource RI
- Proposed HealthSource RI Regulations (RI Department of Administration, Oct. 18, 2019)

Mercer Law & Policy resources

- Latest ACA case: Appeals court rules individual mandate unconstitutional (Dec. 19, 2019)
- ACA individual statement deadline and good-faith relief extended again (Dec. 4, 2019)
- Massachusetts employers need to gear up for health plan reporting (Oct. 1, 2019)
- DC details employer reporting for individual health coverage mandate (Aug. 20, 2019)
- California individual health coverage mandate includes employer reporting (July 16, 2019)
- New Jersey posts update on health-coverage reports due in 2020 (April 16, 2019)

Other Mercer resources

- Grab some ibuprofen: State mandates may create reporting headaches (June 20, 2018)

Prescription drugs

Non-Mercer resources

- Proposed Regulations on Importation of Prescription Drugs (Federal Register, Dec. 23, 2019)
- Draft Guidance: Importation of Certain Food and Drug Administration-Approved Human Prescription Drugs, Including Biological Products (Federal Register, Dec. 23, 2019)
- Vermont's Canadian Wholesale Importation Program for Prescription Drugs Concept Paper (National Academy for State Health Policy, October 2019)
- Update on Wholesale Prescription Drug Importation Program (VT Agency of Human Services, Oct. 1, 2019)
- Florida's Canadian Prescription Drug Importation Concept Paper (FL Agency for Health Care Administration, Aug. 20, 2019)
- 2019 Ch. 99, HB 19 (FL Legislature, June 11, 2019)
- Amicus brief in *Rutledge v. Pharm. Care Mgmt. Assoc.*, No. 18-540 (US, filed Dec. 4, 2019)
- *Rutledge v. Pharm. Care Mgmt. Assoc.*, 891 F.3d 1109 (2018)
- 2015 PA 900 (AR General Assembly, April 1, 2015)
- PA 101-0452, HB 465 (IL General Assembly, Aug. 23, 2019)
- Press release (IL Governor's Office, Aug. 26, 2019)
- SB 6531 (NY Senate, Dec. 26, 2019)

Mercer Law & Policy resources

- Roundup of selected state health developments — third-quarter 2019 (Oct. 28, 2019)
- US Supreme Court declines to hear Maryland drug-pricing case (March 1, 2019)

Insurance

Non-Mercer resources

- Mo. Code Regs. Ann. tit. 20, § 400-14.100 (MO Secretary of State, Oct. 31, 2019)

- Mo. Rev. Stat. § 376.690 (MO Revisor of Statutes, Aug. 28, 2019)
- Missouri Insurance Department
- Out-of-Network Consumer Protections (NJ Department of Banking and Insurance)
- Payment Arbitration Process (NJ Department of Banking and Insurance)
- Bulletin No. 18-14 (NJ Department of Banking and Insurance, Nov. 20, 2018)
- 2018 Ch. 32 (NJ Legislature, June 1, 2018)
- 2019 Ch. 375 (NY Legislature, Oct. 17, 2019)
- Press release on protecting patients from excessive hospital emergency room charges (NY Governor's Office, Oct. 17, 2019)
- Surprise Medical Bills (NY Department of Financial Services)
- HB 388 (OH Legislature, Nov. 5, 2019)
- Protecting Consumers From Surprise Medical Bills (TX Insurance Department)
- 2019 Ch. 1342, SB 1264 (TX Legislature, June 14, 2019)
- Surprise Medical Bills Consumer Website (TX Insurance Department)
- Texas Healthcare Costs Consumer Information Guide (TX Insurance Department)
- 2019 Ch. 532, SB 159 (CA Legislature, Oct. 7, 2019)
- Final Recommendation: Prevention of HIV Infection: Preexposure Prophylaxis (US Preventive Services Task Force, June 2019)
- Blog: Ending the HIV Epidemic: A Plan for America (HHS, Feb. 15, 2019)
- SB 667 (IL General Assembly, Nov. 14, 2019)
- Press release on legislation to cap insulin costs (IL Governor's Office, Nov. 14, 2019)
- Affordable Care Act Implementation FAQs, Part 39, MH/SUD Parity Implementation and the 21st Century Cures Act (DOL/HHS/IRS, Sept. 5, 2019)

- Mental Health Parity and Addiction Equity Act
- 2019 PA 159 (CT General Assembly, July 8, 2019)
- Circular Letter No. 13 (NY Insurance Department , Dec. 20, 2019)
- 2019 Ch. 57, SB 1507 (NY Legislature, April 12, 2019)
- Bulletin No. 112 (DE Insurance Department, Dec. 5, 2019)
- 2018 Ch. 323, SB 151 (DE General Assembly, July 11, 2018)
- 2019 Ch. 306, SB 2133 (NJ Legislature, Dec. 16, 2019)
- 2019 Ch. 194, SB 1085 (AZ Legislature, May 8, 2019)
- 2019 Ch. 129, SSB 322 (FL State Library and Archives, June 25, 2019)
- 2019 Ch. 202, SB 86 (NC General Assembly, Aug. 26, 2019)
- 29 CFR § 2510.3-5 (US Government Publishing Office)
- *New York v. US Dep't of Labor*, No. 18-1747 (D.D.C. March 28, 2019)
- Veto statement on HB 1661, HB 2443 and SB 1689 (VA Governor's Office, May 2, 2019)
- All Plan Letter 19-024 — Association Health Plans (CA Department of Managed Health Care, Dec. 9, 2019)

Mercer Law & Policy resources

- Mental health parity FAQs address nonquantitative limits, disclosure (Dec. 17, 2019)
- Roundup of selected state health developments — third-quarter 2019 (Oct. 28, 2019)
- More states approve Pathway 2 association health plans (Oct. 21, 2019)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)
- Litigation, legislation leave AHP guidance in flux (May 2, 2019)
- Final association health plan rule offers new options for employers (Nov. 8, 2018)

Paid leave

Non-Mercer resources

- California State Disability Insurance Contribution Rates and Benefit Amounts (CA Employment Development Department)
- California Disability Insurance and Paid Family Leave Benefits (CA Employment Development Department)
- Colorado Paid Family and Medical Leave Implementation Task Force
- FAMLI Task Force Scorecard (CO Paid Family and Medical Leave Implementation Task Force, Dec. 16, 2019)
- Votes, final recommendations and assignments from Dec. 17 FAMLI meeting (CO Paid Family and Medical Leave Implementation Task Force, Dec. 17, 2019)
- 2020 Maximum Weekly Wage Base and Maximum Weekly Benefit Amount (HI Department of Labor and Industrial Relations, Dec. 1, 2019)
- Insurance Carriers Authorized To Write TDI Policies in Hawaii (HI Department of Labor and Industrial Relations, Sept. 16, 2019)
- Advisory Opinions (NV Labor Commissioner's Office, Oct. 4 and 10, 2019)
- 2019 Ch. 592, SB 312 (NV Legislature, June 13, 2019)
- Notice to Employees (DC Department of Employment Services, Dec. 16, 2019)

Mercer Law & Policy resources

- ME, NV accrued paid leave mandates expand state sick leave law totals — state chart included (July 1, 2019)
- Employers need to prepare now for Washington, DC's universal paid leave (June 11, 2019)
- 2019 state-mandated short-term disability contributions and benefits (Jan. 31, 2019)

Other Mercer resources

- Life, Absence & Disability

Other benefit-related developments

Non-Mercer resources

- AB 5 — Employment Status (CA Employment Development Department)
- Employment Status Portal and AB 5 FAQs (CA Labor & Workforce Development Agency)
- 2019 Ch. 296, AB 5 (CA Legislature, Sept. 19, 2019)
- HIRD FAQs (MA Revenue Department)
- MassTaxConnect (MA Revenue Department)
- Technical Information Release 19-16 (MA Revenue Department, Nov. 25, 2019)
- Mass. Gen. Laws ch. 62, §1 (MA General Court)
- Notice 2016-6 (IRS, Jan. 11, 2016)
- 2019 PA 21, SB 1 (MI Legislature, June 11, 2019)
- 2019 PA 22, HB 4397 (MI Legislature, June 11, 2019)

Mercer Law & Policy resources

- Michigan's automobile insurance reforms may cost group health plans (Nov. 13, 2019)
- Massachusetts employers' health coverage insurance reports due by Dec. 15 (Nov. 13, 2019)
- Some independent contractors in California will become employees (Sept. 26, 2019)

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