Roundup of selected state developments, fourth-quarter 2022

February 17, 2023

In this article

Legislative activity dropped during the final quarter of 2022, but regulators remained busy, particularly implementing paid leave laws. In Colorado and Oregon, contributions to paid family and medical leave (PFML) programs started on Jan. 1, 2023. Other states announced their 2023 PFML rates, and new leave-related laws passed in Michigan, New York and Washington, DC. Vermont announced a voluntary PFML program, due to take effect this year. COVID-19 leave mandates continued to wind down. A few states — including California, Delaware and Pennsylvania — enacted new health insurance mandates. Philadelphia now requires some employers to provide commuter benefits, while Massachusetts changed its monthly limits on commuter benefits to match federal limits.

Leave Laws

Colorado and Oregon finalized rules for PFML programs starting this year, while several other states simply updated their rates for 2023. Michigan enacted a tax incentive for employers to offer paid adoption leave. New York passed a leave anti-discrimination measure. Vermont initiated a voluntary PFML program, similar to one in New Hampshire. For more details on the New Hampshire program, see Roundup of selected state health developments, third-quarter 2022 (Nov. 4, 2022).

California

California has announced its 2023 State Disability Insurance (SDI) and Paid Family Leave (PFL) rates. The taxable wage base is $153,164, up from $145,600 in 2022. The employee contribution rate, which includes both SDI and PFL, drops from 1.1% to 0.9% in 2023, up to the taxable wage base. The 2023 maximum weekly benefit is $1,620, up from $1,540 in 2022. Benefits are payable at 60% or 70% of the employee's average weekly wage (AWW), depending on the greatest quarterly base-period earnings above or below 1/3 of the state's average quarterly wage rate.

Colorado

Colorado's Family and Medical Leave Insurance (FAMLI) Division adopted final PFML rules related to coordination of benefits (including employer-provided paid leave and short-term disability (STD)/long-term disability (LTD) plans), private plans, premiums and local government participation (the last two rules amended prior final rules). Premium collection under the FAMLI Act started on Jan. 1, 2023. Benefits start in 2024.

Here are highlights of the coordination-of-benefits rules:

- Employees eligible for workers' compensation or unemployment insurance are not entitled to FAMLI leave for the same absence.
- FAMLI leave runs concurrently with leave under the federal Family and Medical Leave Act (FMLA) and the state's Family Care Act.

Employers can require FAMLI leave to run concurrently with insured (but not self-funded) STD or LTD leave and offset STD/LTD benefits with FAMLI benefits. Whether self-funded STD or LTD benefits can be offset by FAMLI benefits is unclear. The regulations appear to limit the offset option to insured plans and prohibit all other employer-provided leave from offsetting FAMLI benefits.

- Employers cannot require the use of accrued paid leave (e.g., vacation, paid time off (PTO), or paid sick, personal or parental leave) before or concurrently with FAMLI leave. An employee may begin using accrued paid leave before accessing FAMLI benefits. Both the employer and employee must agree to supplement FAMLI benefits with accrued paid leave once FAMLI has started. The combined benefit may not exceed the employee's AWW. The employer and employee also may agree to the use of nonaccrued paid leave, subject to the above restrictions. However, an employer may not require the use of employer-provided paid parental leave to supplement FAMLI benefits.

Here are highlights of the private plan rules:

- The FAMLI Division has provided a self-insured private plan template and related resources.
- The initial application fee drops from $1,200 in the proposed rule to $500 in the final rule, with an annual administration fee starting in 2025.
- Employers must attest that their claim forms are no more onerous than those under the state's plan.
- Private plan reporting frequency changed from annually to quarterly for the first three years, then annually for later years.
- Private plan approvals are good for eight years (vs. two years in the draft rules), but employers must submit attestations every November, starting in 2024.

The changes in the amended premium rules primarily relate to wage calculations for elective leave coverage of self-employed persons and employees of nonparticipating local government employers.

As a reminder, employers must create an account on the My FAMLI+ Employer site before the first quarterly premiums and wage report are due on April 30. (A one-time, 30-day grace period applies to the first deadline.)

Finally, as of Jan. 1, 2023, Colorado employers had to post the required program notice.

Hawaii

Hawaii has posted Temporary Disability Insurance (TDI) rates for 2023:

- Maximum weekly wage base: $1,318.48, up from $1,200.30 in 2022
- Maximum weekly employee contribution (0.5% of wages): $6.59, up from $6.00 in 2022
- Maximum weekly benefit: $765, up from $697 in 2022

Hawaii does not currently have a PFL mandate.

Massachusetts

Massachusetts has posted its 2023 PFML contribution rates. Starting on Jan. 1, the contribution rate dropped from 0.68% to 0.63% of wages up to the Social Security maximum wage base (Social Security max), which is $160,200 in 2023. Employers with 25 or more Massachusetts employees contribute 0.312% (a drop from 0.336% in 2022), while their employees contribute 0.318% (a drop from 0.344% in 2022). Employers with fewer than 25 workers in the state do not have to contribute but must collect and remit employee contributions.

The 2023 weekly maximum is $1,129.82, up from $1,084.31, per an announcement. Also for 2023, Massachusetts employers have a new poster and notices for employers with 25 or more covered employees and employers with fewer than 25 covered employees.

Michigan

A new Michigan law (2022 Act 207, HB 6070) provides a tax incentive to qualified employers offering paid adoption leave to qualified employees. This tax credit is 50% of wages, capped at $4,000 and 12 weeks for a single adoption leave period.

Qualified employers must have a written policy offering at least two weeks of both paid parental and adoption leave (at a rate of at least 50% of wages) to full-time employees and a proportional amount to part-time employees. Qualified employees must have worked at least a year for the offering employer, and their prior-year compensation must not exceed 60% of the highly compensated employee (HCE) threshold under § 414(q)(1)(B) of the Internal Revenue Code ($135,000 in 2022, $150,000 for 2023). This tax credit applies to tax years starting on or after Jan. 1, 2023.

In addition, the status of Michigan's Earned Paid Sick Leave Act remained uncertain throughout the end of 2022 after a July Court of Claims decision struck down the current law. In late January 2023, however, the state Court of Appeals reversed the lower court's decision, upholding the law as currently written. As a result, the current law remains in effect, unless reversed on appeal or otherwise changed by legislative action. For more details, see Roundup of selected state health developments, third-quarter 2022 (Nov. 4, 2022).

New Jersey

New Jersey has posted contribution rates for its 2023 TDI and family leave insurance (FLI), which together provide PFML benefits in the state. Employee contributions are not required in 2023 for TDI, a drop from 0.14% in 2022. Employee FLI contributions decrease from 0.14% in 2022 to 0.06% in 2023. Employers must collect and remit contributions up to the $156,800 taxable wage base for 2023, an increase from $151,900 in 2022. Eligible employees can qualify for 85% of wages for up to 26 weeks for TDI and up to 12 weeks (or 56 days of intermittent leave) for FLI. The 2023 maximum TDI/FLI weekly benefit rate of $1,025 reflects an increase from $993 in 2022.

New York

A new law (2022 Ch. 604, AB 8092/SB 1958) prohibits adverse actions against employees who take legally protected absences under federal, local or state law. This includes leave under New York's paid disability/medical and family leave, paid sick leave, paid leave for COVID-19 vaccines, and New York City's Earned Safe and Sick Time Act. New York employers with no-fault attendance policies should review those policies, because assessing points or deductions from a time bank when an employee uses a legally protected absence in not permitted. The law will take effect Feb. 19. For more details, see 2023 state paid

family and medical leave contributions and benefits (Feb. 1, 2023) and Roundup: State accrued paid leave mandates (April 29, 2022).

Oregon

Paid Leave Oregon (PLO) changed the method for determining employer size for its PFML insurance (PFMLI) program. Contributions started on Jan. 1, and benefits start on Sept. 3. Employers with fewer than 25 employees do not need to contribute; large employers must contribute 40% of the total rate (initially, 1% of wages up to $132,900). Employer size is determined according to new PLO definitions, methods, and a handy guide and chart.

PFMLI rules previously determined employer size based on the average number of employees on payroll reports over the previous four quarters. Now, employers must determine their size using the average number of employees on the 12th of each month from the previous 12 months. This approach mirrors reporting for unemployment insurance and should provide a more accurate reflection of the true number of employees, particularly for small employers with high turnover.

PLO also published final administrative rules and an appeals process. In particular, the administrative provisions include:

- Updated definition of AWW
- Clarification of notice timing for remote workers (on hire or assignment to remote work)
- Requirement for maintaining health benefits during PFMLI leave
- Updated overpaid benefit rules

Finally, a model notice is available. Employers must post this notice at each worksite and send it electronically or by mail to remote workers. Posting must be in a clearly visible place and in the same language(s) an employer uses for employee communications. The notice is available in 12 languages in the resources section of the PLO website.

Vermont

Vermont has selected The Hartford as administrator of its voluntary FMLI (VT-FMLI) program, which the state will launch in stages starting July 1. This program is a result of a governor's action, not an enacted law. VT-FMLI will provide covered employees 60% wage replacement for six weeks in a 12-month period, capped at the Social Security max. Qualifying events are:

- Birth, adoption, or foster care placement of a child and care for a child within one year after birth
- Care for a family member, including a spouse, civil union partner (under applicable state law), parent, foster child or ward living with an employee
- Employee's serious health condition
- Qualifying exigency related to active military duty

The program's rollout schedule is in three phases:

- July 1: state employees only

- Jan. 1, 2024: private and other governmental employers with two or more employees
- Jan. 1, 2025: eligible individual employees whose employers do not opt in and self-employed individuals

The projected cost for state employees is about $4.50 per week. Additional details are available on The Hartford website.

Washington

Washington has posted its 2023 PFML rates. Contributions rose from 0.6% in 2022 to 0.8% of employee wages up to the Social Security max. Of this amount, employers with 50 or more Washington employees pay 27.24% and employees pay 72.76%, unless an employer opts to pay some or all of the employee contribution. Smaller employers need not contribute. Benefits are calculated at 90% of the employee's AWW up to 50% of the state AWW (updated to $1,586) and 50% of the employee's AWW exceeding 50% of the state's AWW. The 2023 maximum weekly benefit amount is $1,427, up from $1,327 in 2022.

Washington, DC

A Washington, DC, law (2022 Act 24-586) continues the prohibition against reducing insured STD benefits based on estimated or actual benefits received under the district's Universal Paid Leave program. The ban does not apply to an employer's self-funded STD or paid leave benefit plan. The law took effect Dec. 13, 2022 and will expire 225 days later on July 26, 2023.

COVID-19 issues

California's nonemergency COVID-19 prevention regulations for workplaces — discussed further below — replace emergency regulations and remove the requirement to continue pay for excluded workers. In December 2022, the Los Angeles city council voted to end the local state of emergency on Feb. 1, 2023, which means the COVID-19 supplemental paid sick leave requirement ended on Feb. 15. COVID-related supplemental paid leave requirements under California state law and in New York City expired at the end of 2022. Similar requirements expired in the fourth quarter of 2022 in Washington state (Oct. 31) and Washington, DC (Oct. 1). On Feb. 14, 2023, the Long Beach, CA city council approved a resolution that ends the city's supplemental sick leave requirement, effective Feb. 21.

Some jurisdictions still have COVID-19 leave requirements in place, including New York state (through the end of 2023), Los Angeles County and Oakland, CA. For more information, see States, cities tackle COVID-19 paid leave (Feb. 7, 2023).

California

In December 2022, the Occupational Safety and Health Standards Board (OSHSB) approved nonemergency regulations addressing workplace COVID-19 prevention. The new regulations do not require paid leave for workers excluded from the workplace due to COVID-19 infection or close contact with someone who has COVID-19. Instead, employers must provide information about leave benefits available under applicable laws, employer policies or contracts. The rules took effect Feb. 3, 2023, and will remain in effect for two years (three years for recordkeeping provisions).

Highlights include:

- **Workplace.** Employers must provide a safe and health workplace and have a written COVID-19 injury and illness prevention program.
- **Testing.** Employers must make tests available at no cost during paid time for all employees in "close contact" to an infected employee.
- **Close contact.** This term means being within six feet of an infected employee for a total of 15 or more minutes in a 24-hour period in the same indoor space that exceeds 400,000 cubic feet per floor. For smaller indoor spaces, the six-foot proximity requirement does not apply. Areas (including bathrooms and offices) separated by floor-to-ceiling walls are considered distinct indoor spaces.

More information is available on Cal/OSHA's COVID-19 prevention resources page.

Insurance

State legislatures and agencies wrapped up the year with several insurance laws affecting group health plans, particularly in New York. In addition, a Massachusetts ballot initiative created a medical loss ratio (MLR) program for dental insurance.

California

California's Miles Hall Lifeline and Suicide Prevention Act (2022 Ch. 747, AB 988) creates a 988 suicide and crisis lifeline telephone system for emergency suicidal, mental health and substance use disorder crises. Among other things, insured plans and healthcare service plans (including HMOs) must cover medically necessary behavioral health crisis services provided by a 988 center or mobile crisis team. Enrollees need pay no more than in-network cost-sharing amount for both in-network and out-of-network providers. What amounts plans must pay providers is unclear. AB 988 took effect on Sept. 29, 2022.

This law does not apply to self-funded plans, dental or vision plans, or MediCal. California insurance law does not apply on an extraterritorial basis to fully insured plans situsued in another state, as long as both an employer's principal place of business and the majority of employees are outside of the state.

Colorado

Colorado's Division of Insurance published a final regulation requiring COVID-19 vaccine coverage (without cost sharing) for fully insured individual, small group, large group, student health and managed care plans. During the federally declared COVID-19 public health emergency (expected to expire May 11), the state's no-cost coverage requirement extends to out-of-network providers, who must be reimbursed at reasonable rates. Self-funded plans and fully insured plans issued in other states are exempt from the state regulation, which took effect Jan. 14.

Delaware

Two Delaware laws impose new requirements on certain plans subject to state insurance law. First, a law (2022 Ch. 522, SB 267) requires fully insured plans, health service corporations and HMOs to apply prescription drug cost-sharing assistance toward the deductible and out-of-pocket maximum. If this will result in ineligibility for a health savings account (HSA), the requirement to accumulate cost-sharing assistance toward the deductible does not apply before the minimum high-deductible health plan (HDHP) deductible (for items other than

preventive care) has been met. The law applies to insurers and pharmacy benefit managers. The law will take effect for plan years starting in 2024.

Second, another law (2022 Ch. 521, SB 316) imposes a $35 monthly cost-sharing limit on diabetes equipment and supplies for individual and group insured plans and the state's health plan. This cap does not apply to accident-only, specified-disease, hospital indemnity, Medicare supplemental, long-term care, disability income or other limited-benefit health insurance policies. The law exempts HDHPs to the extent the mandate would jeopardize HSA eligibility. Diabetes equipment and supplies include glucometers, strips, syringes and insulin pump supplies. The law will take effect April 23.

Massachusetts

A Massachusetts initiative — passed by voters last November — implements a MLR program for fully insured dental plans sitused in the state, similar to the MLR program for health insurers under the federal Affordable Care Act (ACA). The MLR threshold will be 83%. The MLR standard generally means that insurers must spend at least 83% of premium dollars on patient care. Insurers missing this standard must refund the excess premium proportionally to covered individuals and covered groups. A refund is also required if the insurer increases rates by more than the dental services Consumer Price Index or has a contribution to surplus exceeding 1.9%.

This law does not apply to self-funded dental plans. However, the regular reports of third-party administrators (TPAs) administering self-funded plans must include data on those plans in an appendix.

The state MLR requirement for insured dental plans will take effect for plan years starting in 2024.

New Jersey

New Jersey's Department of Banking and Insurance announced that fully insured health plans sitused in the state must cover abortion services without exceptions. State insurance law currently is silent on such coverage, and insurers may limit abortion to cases when the pregnancy resulted from rape or incest or endangers the woman's life. The current action results from a study authorized by the 2022 Freedom of Reproductive Choice Act, which also recognizes the right of certain religious employers to request an exclusion if coverage conflicts with *bona fide* religious beliefs and practices.

After approval in December 2022, the new regulations took effect Jan. 1, 2023, for individual and small-group market plans. The rule-making process for large-group market plans should end sometime this year, with an undetermined effective date once the rules become final.

These rules do not apply to self-funded plans.

New York

In a year-end flurry of activity, New York Gov. Kathy Hochul signed seven bills into law affecting health insurance benefits. Here is a summary:

- **Rx 30-day supply (2022 Ch. 793, AB 7469).** Fully insured plans offering Rx coverage must cover an immediate additional 30-day supply of a prescription drug during a state disaster emergency. The law applies to policies issued, renewed or amended on or after Dec. 28, 2022.

- **Rx cost-sharing assistance (2022 Ch. 736, AB 1741).** Fully insured plans offering Rx coverage must apply third-party payments or financial assistance for prescription drugs made on behalf of an insured individual to the deductible, out-of-pocket maximum and any cost-sharing requirement. If compliance would

result in HSA ineligibility, application to the deductible occurs only after the minimum HDHP deductible (for items other than preventive care) has been met. The law applies to policies issued, renewed or amended on or after Jan. 1, 2023.

- **Opioid treatment coverage (2022 Ch. 734, AB 372).** Fully insured plans may not impose a copayment for an opioid treatment program. The measure does not appear to make an exception for HSA-eligible HDHPs. This law applies to policies issued, renewed or amended on or after Jan. 1, 2023.

- **Colorectal cancer coverage (2022 Ch. 739, AB 2085).** Fully insured plans must cover colorectal cancer early-detection screening exams and laboratory tests in accordance with the American Cancer Society guidelines, without any cost sharing. Insured plan also must provide an annual notice of such coverage and screening guidelines. (Colorectal cancer screening is a preventive health service under ACA rules for adults ages 45–75.) This law applies to policies issued, renewed or amended on or after Dec. 23, 2022.

- **HIV coverage (2022 Ch. 721, AB 807).** Fully insured plans offering Rx coverage must cover pre-exposure prophylaxis (PrEP) for HIV prevention and post-exposure prophylaxis (PEP) to treat HIV infection. (ACA rules classify PrEP, but not PEP, as a preventive health service.) This law took effect Dec. 21, 2022.

- **Balance-billing prohibition on facility fees (2022 Ch. 764, SB 2521).** Hospitals and healthcare providers may not seek patient payment for a facility fee that insurance doesn't cover unless the patient receives notice of the fee before receiving services. This law will take effect June 21, 2023.

- **Required disclosures (2022 Ch. 826, SB 4620).** For covered prescription drugs, fully insured plans and PBMs must furnish on request patient-specific eligibility information, cost and benefit data, cost-sharing information, lower-cost alternatives, and utilization-management requirements to enrollees, their healthcare providers, or a third party of the enrollee's choosing. This law will take effect June 28, 2023.

The first five laws above apply only insured plans issued in New York and do not apply to fully insured plans issued elsewhere or self-funded plans.

Oklahoma

As directed by a 2022 law (2022 Ch. 312, SB 1413), the Oklahoma Insurance Department (OID) has posted several resources related to the federal Mental Health Parity and Addiction Equity Act (MHPAEA). The OID resource page includes:

- Reporting templates and instructions for nonquantitative treatment limitations, which are incorporated by reference into the state mental health parity law, and quantitative treatment limitations

- Mental health parity documents from insurers like Aetna, Cigna, the Health Care Service Corp. (also known as BlueCross BlueShield of Oklahoma) and United Healthcare

Self-funded plans and their TPAs are not subject to the Oklahoma mental health parity law, but most self-funded plans are subject to the MHPAEA.

Pennsylvania

Amendments to the state insurance law impose new requirements on fully insured and managed care plans. The first (2022 Act 146, SB 225) includes these requirements:

- An internal complaint process for enrollees

- Prior-authorization review procedures
- Appeal processes for an administrative denial related to prior authorization and for a complaint
- A provider portal
- Step-therapy criteria, including a process for exception requests
- Medication-assisted treatment requirements for opioid use disorders, including coverage without prior authorization
- Other participant protections mirroring ACA external review requirements

Most provisions will take effect Jan. 1, 2024. Insurers and managed care plans must have the provider portals functioning by July 1, 2024, and must develop training and provider support for portal use within six months thereafter. Providers will have to use the portals for preauthorization requests 18 months after establishing the portal.

The second law (2022 Act 162, SB 1201) requires fully insured plans and HMOs to cover prescription eye-drop refills within a specified time, depending on whether the prescription is for a 30-, 60- or 90-day supply. The law generally took effect for policies filed on or after Jan. 2, 2023.

Neither law applies to self-funded plans.

Commuter benefits

Massachusetts changed its limits on commuter benefits, retroactive to Jan. 1, 2022. A Philadelphia ordinance now requires covered employers to offer commuter benefits. For more details on federal, state and local commuter benefit laws, see Transportation plans offer valued benefits but pose compliance issues (Jan. 25, 2023).

Massachusetts

In years past, Massachusetts had commuter benefit tax limits different from similar federal limits. The reason was that the state's tax system conformed to the Internal Revenue Code (IRC) in effect on Jan. 1, 2005. For example, Technical Information Release (TIR) 21-12 set the state's original 2022 limits at $285 for parking and $150 for combined transit pass and commuter highway vehicle transportation benefits. The federal 2022 limits (based on IRC § 132(f)) were $280 for each of these benefits.

However, a recent TIR — interpreting Section 30 of the official 2023 budget enacted in July 2022 — confirmed that retroactive to Jan. 1, 2022, state transportation benefit limits now mirror federal limits. As a result, Massachusetts employers should confirm their state limits match the federal limits ($300 for each type of benefit in 2023).

Philadelphia

Effective Dec. 31, 2022, the city's commuter benefit ordinance applies to employers with at least 50 covered employees. A covered employee is anyone who worked at least 30 hours per week within city limits for the same employer in the past 12 months. Covered employers must offer an employee commuter transit benefit program under IRC § 132(f).

While Philadelphia did not provide significant guidance on the mandate, the nearby Delaware Valley Regional Planning Commission has a one-page summary and a resource page. Daily penalties range from $150 to $300.

Other benefit-related issues

Arizona, Oregon and South Dakota passed ballot initiatives in November related to medical debt, affordable health coverage and Medicaid expansion, respectively. California reported on prescription drug cost transparency. Delaware and Michigan passed telehealth laws. A Washington report estimated its long-term services and supports (LTSS) program, which will start this July, should remain solvent almost until the end of the 21st century. Washington also issued a report on the viability of a universal healthcare program.

Arizona

In Arizona, Proposition 209 passed in the November elections. This new law addresses medical debt, reducing the allowable interest rate from 10% to 3%, increasing a debtor's home protection value from $250,000 to $400,000 and decreasing disposable income subject to debt collection from 25% to 10%. The measure will take effect Jan. 1, 2024.

California

A prescription drug cost transparency report, released late last year by the Department of Managed Health Care (DMHC), shows drug spending increased by 22% ($2.1 billion) over the five years from 2017 to 2021. Key findings for 2021 include:

- Drug spending by health plans exceeded $10.8 billion, an increase of almost $700 million (6.6%) over the prior year but far less than the $5.2 billion increase to $62.3 billion (9.2%) in medical costs.
- Prescription drugs accounted for over 13.3% of health plan spending.
- Overall, total health plan premiums increased by 2.2% from 2020.
- For the first time, COVID-19 vaccines were on the top-25 lists of the drugs most frequently prescribed, most costly and with the highest year-over-year increase in total spending. While the federal government covered vaccine costs in most situations, health plans incurred administrative costs.
- Specialty drugs accounted for only 1.6% of all drugs dispensed but almost 63% of annual drug spending.
- Generic drugs accounted for almost 90% of all drugs prescribed but less than 17% of annual drug spending.

California law requires DMHC to issue this annual report, using data provided by insured managed care plans in the commercial market.

Delaware

Delaware enacted a new law (2022 Ch. 484, HB 334) allowing out-of-state healthcare providers to deliver services by telehealth, but only if a provider-patient relationship has been established under existing law. Provider-patient relationships may occur either in person or through telehealth, subject to certain conditions.

This law applies to covered services within the state, regardless of whether a group health plan is fully insured or self-funded. The law took effect on Oct. 21, 2022.

Michigan

Two laws enacted in late December — 2022 Pub. Acts 254 and 255 — make Michigan the latest member of the Psychology Interjurisdictional Compact (PSYPACT), an interstate compact between states, facilitating the practice of mental health services across state lines. Licensed healthcare providers can apply to practice telepsychology and/or conduct temporary in-person, face-to-face sessions in PSYPACT states, depending on the certificate issued. Approximately, two-third of states (and Washington, DC) are PSYPACT members.

These laws will take effect March 31, 2023.

Oregon

An Oregon ballot measure, Measure 111 — approved by voters last November — ensures affordable healthcare access as a state constitutional right. Oregon is the first state to do so. This measure is short on specifics but may be a precursor to a state-run universal healthcare program. So far in 2023, legislators have not introduced any related bills.

South Dakota

In South Dakota, Constitutional Amendment D — passed last November — expands Medicaid eligibility to adults ages 18 to 65 earning up to 138% of the federal poverty level. This provision effectuates a state option under the ACA's Medicaid expansion program. The measure will take effect July 1.

Washington

LTSS report. In October 2022, a Milliman actuarial report estimated that a state fund used to finance the state's LTSS program should remain solvent through June 30, 2098. Employee contributions set at 0.58% of pay will start on July 1, 2023. Beginning July 1, 2026, the program will provide a maximum long-term care benefit of $36,500 (adjusted for inflation). For more details, see Washington changes long-term care law (April 13, 2022).

Universal healthcare. In other news, Washington's Universal Health Care Commission — established under a 2021 law (WA Rev. Code § 41.05.840) — issued a baseline report in November 2022. The commission set out a preliminary infrastructure for a universal health system. The report described two alternative primary models, both of which would cover all state residents, along with a third supplemental model:

- **Model A.** This state-administered program has projected costs of $58.9 billion, with savings of $2.5 billion in the first year and $5.6 billion annually thereafter.
- **Model B.** This insurer-administered program has projected costs of $60.6 billion, with savings of $738 million in the first year and unspecified savings annually thereafter.
- **Model C.** This focused program would provide access to coverage for state residents who lack a federally recognized immigration status and cannot buy coverage. Year-one cost estimates are $617 millio