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STATE LEGISLATIVE CHANGES

June 2017 Update

Alabama

New-Hire Procedures—Effective July 1, 2017, franchisors aren't considered to be employers of franchisees or their employees or independent contractors, except as provided in voluntary agreements entered into between franchisors and the federal Department of Labor.

http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2017RS/PrintFiles/HB390-enr.pdf

Arizona

Workers' Compensation—Effective for injuries and illnesses that occur in 2018, the maximum monthly benefit for permanent total disability claims is $3,083.95.

California

Income Tax Withholding—Effective July 1 through Dec. 31, 2017, the interest rate on tax underpayments remains at 4 percent.

Equal Employment Opportunity—Effective July 1, 2017, new regulations clarify and expand the gender identity discrimination provisions related to sex and gender and gender identity and gender expression.

Sex Discrimination

Employers can't discriminate based on sex or gender, unless a permissible defense applies. They also can't discriminate based on perceived sex or gender, and can't discriminate based on an association with a person who belongs or is perceived to belong to this protected class. *Sex* includes pregnancy, childbirth, breast-feeding, or related medical conditions; gender, gender identity, or gender expression; and (effective July 1, 2017) a third party's perception of these traits. *Gender* means sex and includes gender identity and gender expression.

The following situations don't justify employers' use of the bona fide occupational qualification (BFOQ) defense:

- a correlation between persons of one sex and physical agility or strength;
- a correlation between persons of one sex and height;
- customer preferences for employees of one sex;
- the need to provide separate facilities for employees of one sex;
- effective July 1, 2017, the fact that a person is transgender or gender nonconforming or that the person's assigned sex at birth is different from the sex required for the job; or
- the fact that persons of one sex traditionally have been hired to perform a particular type of job.

Personal privacy considerations can justify the BFOQ defense only when:

- a job requires an employee to observe other persons in a state of nudity or to conduct body searches;
- it would be offensive to prevailing social standards to have a person of the opposite sex (effective July 1, 2017, a different sex) present; and
- it is harmful to the mental or physical welfare of the person being observed or searched to have a person of the opposite sex (effective July 1, 2017, a different sex) present.

Employers must assign job duties and make other reasonable accommodations in ways that minimize the number of jobs for which sex is a BFOQ.

Sex discrimination includes discrimination based on pregnancy, childbirth, breast-feeding, or related medical conditions; discrimination based on gender identity or gender expression; sexual or gender harassment; and harassment based on pregnancy, childbirth, or related medical conditions. The sex discrimination prohibitions don't affect employers' right to use veteran status as a factor in employee selection or to give special consideration to Vietnam-era veterans. They also don't affect bona fide retirement, pension, employee benefit, or insurance plan terms or conditions that follow customary and reasonable or actuarially sound underwriting practices.

Appearance standards: Employers can't refuse to allow employees to wear pants based on their sex, although the California Fair Employment and Housing Council can exempt employers from this prohibition for good cause. Employers can require employees in a particular occupation to wear a uniform and can require employees to wear a costume while they are portraying a specific character or dramatic role. Employers can maintain physical appearance, grooming, or dress standards; however, these standards are unlawful if they discriminate based on sex and significantly burden employees.

Compensation and benefits: Employers can't base any compensation on employees' sex, unless required or permitted by regulation. They can provide or pay for childcare services for employees who are responsible for the care of their minor children.

Employers can't condition the availability of fringe benefits on employees' sex. They also can't condition fringe benefits on employees' status as a head of household, principal wage earner, or secondary wage earner if this practice discriminates against employees of one sex. Fringe benefit plans can't require contributions or set basic benefit amounts that differ for similarly situated male and female employees (effective July 1, 2017, similarly situated employees based on their sex), unless these differences are required by state law. Pension or retirement plans can't set different optional or compulsory retirement ages based on employees' sex.

Selection: Unless a permissible defense applies, employers can't discriminate based on sex in recruiting and can't refuse to provide, accept, and consider job applications from persons of one sex. Employers can't ask about applicants' sex on job applications or pre-employment questionnaires, unless this question is based on a permissible defense or asked for recordkeeping purposes; however, they can record employees' sex for nondiscriminatory personnel purposes. Employers also can't ask applicants questions about childbearing, pregnancy, birth control, or familial responsibilities, unless these questions are related to specific, relevant working conditions. Employers can't refuse to hire female applicants because they are of childbearing age.

Unless a permissible defense applies, employers can't (until July 1, 2017) classify jobs as "male" or "female," (effective July 1, 2017) designate jobs exclusively for employees of one sex, maintain separate lines of progression or separate seniority lists based on sex, or use selection criteria based on sex stereotypes. They also can't assign job duties based on sex stereotypes. *Sex stereotypes* include

assumptions about a person's appearance or behavior; effective July 1, 2017, gender roles, expression, or identity; and ability or inability to perform certain kinds of work based on myths, social expectations, or generalizations about the person's sex. If employers consider paid work experience in selection or assignment decisions, they also must consider unpaid or volunteer work experience. Employers must provide equal hiring, promotion, and progression opportunities to all qualified employees, although they can use mobility programs to increase the promotion potential of underrepresented groups.

Physical standards: Employers can't use physical agility or strength tests, unless they are administered pursuant to a permissible defense. If employers use these tests, they must give employees and applicants an opportunity to show that they have the required agility or strength to perform the job. Unless a permissible defense applies, employers can't use height or weight standards that discriminate against one sex and can't use separate height or weight standards for males and females.

Work conditions: If work conditions pose a greater danger to health, safety, or reproductive functions for employees and applicants of one sex than those of the opposite sex (effective July 1, 2017, than those of another sex) working under the same conditions, employers must make reasonable accommodations for employees and applicants at higher risk. Specifically, employers must transfer employees to a less hazardous or strenuous job for the period of greater danger, upon their request, or modify work conditions to eliminate this danger. Employers aren't required to make these accommodations, however, if they can show that the accommodations would cause them undue hardship. Employers can require employees and applicants to provide a physician's certification of their higher risk. The existence of higher risk doesn't justify a BFOQ defense or discrimination based on sex.

Employers can't discriminate based on sex in the provision of rest periods, support services, or facilities. Employers must provide employees of both sexes (effective July 1, 2017, employees of any sex) with equal access to comparable, adequate toilet facilities (effective July 1, 2017, equal access to comparable, safe, and adequate facilities), and can't use this requirement to justify discriminatory employment decisions.

Colorado

Distracted Driving—Effective June 1, 2017, employees who send text messages while driving can be subject to imprisonment if their actions result in another person's injury or death.

Group Health Plans

—**E**ffective May 25, 2017, insured group health plan coverage is revised for alcohol misuse screening and counseling, biologically based mental illnesses, chemical abuse and dependence, and court-ordered mental health services.

—Effective Sept. 1, 2017, group health plan issuers can't require plan participants to undergo prescription drug step therapy.

—Effective Jan. 1, 2019, insured group health plans must reimburse participating providers or in-network entities that dispense certain prescription contraceptives that are intended to last for specified periods of time. Plans must provide coverage for contraception in the same manner as any other covered conditions, diseases, injuries, or sicknesses.

—Effective Jan. 1, 2019, unless a referendum petition against this mandate is filed within 90 days after final adjournment of the Colorado General Assembly, and the mandate isn't approved at the November 2018 general election, plans must reimburse participating providers or in-network entities that dispense prescription contraceptives intended to last for a:

- three-month period for the first dispensing of contraceptives to plan participants; and
- 12-month period or through the end of plan participants' plan coverage, whichever is shorter, for any subsequent dispensing of the same contraceptives regardless of whether plan participants are plan enrollees at the time of the first dispensing.

Plans also must reimburse participating providers or in-network entities that dispense prescribed vaginal contraceptive rings intended to last for a three-month period.

Prescription contraceptives means medically acceptable oral drugs, contraceptive patches, or rings used to prevent pregnancy that require a prescription and are covered under plans' terms.

Dispensing entities means prescription drug outlets, pharmacies, or other facilities registered by the Colorado Board of Pharmacy.

Pay Discrimination—Until Aug. 9, 2017, the wage disclosure provisions don't apply to employers that are exempt from the National Labor Relations Act.

Fair employment practices law: Employers can't require employees to refrain from disclosing their wages as a condition of employment. Employers also can't discharge, discipline, discriminate against, coerce, intimidate, threaten or interfere with employees because they ask about, disclose, compare or otherwise discuss their wages. In addition, employers can't require employees to sign waivers or other documents that could deny them the right to disclose their wage information. However, employers can take these actions if permitted by federal law.

Health Benefit Mandates—

Effective Jan. 1, 2019, insured group health plans must reimburse participating providers and in-network entities that dispense certain prescription contraceptives that are intended to last for specified periods of time.

Plans must provide coverage for contraception in the same manner as any other covered conditions, diseases, injuries, or sicknesses.

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Plans also must reimburse participating providers or in-network entities that dispense prescribed vaginal contraceptive rings intended to last for a three-month period.
Prescription contraceptives means medically acceptable oral drugs, contraceptive patches, or rings used to prevent pregnancy that require a prescription and are covered under plans' terms.

Dispensing entities means prescription drug outlets, pharmacies, or other facilities registered by the Colorado Board of Pharmacy.

Workers' Compensation

Effective for injuries and illnesses that occur from July 1, 2017, to June 30, 2018, the maximum weekly benefit for permanent total disability, temporary total disability, temporary partial disability, and survivors' claims is $948.15.

Delaware

Health Benefit Mandates

—Effective for insured group health benefit plans issued or renewed on or after Jan. 1, 2018, coverage for alcohol and drug dependencies and serious mental illnesses is revised. Plans that provide coverage for prescription drugs must provide coverage for immediate access, without prior authorization, to a five-day supply of certain prescribed medications to treat these dependencies and illnesses if emergency conditions exist.

Alcoholism/drug abuse/biologically based mental illness: Plans must provide coverage for alcohol and drug dependencies and serious mental illnesses, for which diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including the following biologically based mental conditions:

- anorexia nervosa,
- bipolar disorder,
- bulimia nervosa,
- delusional disorder,
- major depressive disorder,
- obsessive-compulsive disorder,
- panic disorder,
- schizophrenia, and
- schizoaffective disorder.

Plans can't place greater financial burden on plan participants who obtain services in connection with diagnosis and treatment of alcohol and drug dependencies and serious mental illnesses than for covered services in connection with diagnosis and treatment of any other diseases or illnesses, including:

- coinsurance,
- copayments,
- deductibles,
- durational limits,
- limits in coverage for prescription medicines,
- limits in length of inpatient stays,
- limits in number of visits, or
- monetary limits.

Effective for group health benefit plans issued or renewed on or after Jan. 1, 2018, coverage for alcohol and drug dependencies and serious mental illnesses must include:

- inpatient coverage for diagnosis and treatment of alcohol and drug dependencies, and
- unlimited medically necessary treatment for alcohol and drug dependencies provided in residential settings as required by the federal Mental Health Parity and Addiction Equity Act of 2008.

Alcohol and drug dependencies means substance abuse disorders or chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances.

Serious mental illnesses means the following biologically based mental illnesses for which diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- anorexia nervosa,
- bipolar disorder,
- bulimia nervosa,
- delusional disorder,
- major depressive disorder,
- obsessive-compulsive disorder,
- panic disorder,
- schizophrenia, and
- schizoaffective disorder.

Issuers can't impose precertification, prior authorization, preadmission screening, or referral requirements for diagnosis and medically necessary treatment, including in-patient treatment of alcohol and drug dependencies.

Issuers can't require concurrent utilization review during the first 14 days of inpatient admissions to facilities approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, so long as inpatient facilities notify issuers within 48 hours after plan participants are admitted about participants' admission and initial treatment plan.

Facilities must perform daily clinical reviews of plan participants, including periodic consultations with issuers to ensure facilities are using evidence-based and peer reviewed clinical review tools used by issuers and designated by the American Society of Addiction Medicine or, if applicable, any state-specific ASAM criteria that is age appropriate to ensure plan participants' inpatient treatment is medically necessary.

Utilization review of treatment for alcohol and drug dependencies and serious mental illnesses can include review of all services provided during inpatient treatment, including all services provided during the first 14 days of inpatient treatment. However, issuers can't deny coverage during the initial 14 days unless treatment isn't medically necessary because inpatient treatment was contrary to evidence-based and peer reviewed clinical review tools used by issuers and designated by the ASAM or, if applicable, any state-specific ASAM criteria.

Treatment parity: Insurers that offer group health plans to employers that have more than 50 employees on at least 50 percent of working days during the preceding calendar quarter must comply with federal law pertaining to parity in mental health and substance use disorder benefits.

Plans that provide medical/surgical benefits and mental health or substance use disorder benefits can't impose annual or lifetime dollar limits on mental health and substance use disorder benefits that are more restrictive than limits imposed on medical/surgical benefits. If plans provide medical/surgical benefits and mental health or substance use disorder benefits:

- financial requirements and treatment limitations that apply to mental health benefits can't be more restrictive than predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- financial requirements and treatment limitations that apply to substance use disorder benefits can't be more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;
- mental health or substance use disorder benefits can't be subject to separate cost-sharing requirements or treatment limitations that apply only to such benefits;

- plans must provide for out of network mental health benefits if such plans provide for out of network medical/surgical benefits; and
- plans must provide for out of network substance use disorder benefits if such plans provide for out of network medical/surgical benefits.

If plans can demonstrate that compliance with mental health or substance use disorder treatment parity increases plan claims by at least two percent in the first year and one percent in subsequent years, such plans can request an exemption from treatment parity requirements.

District of Columbia

Minimum Wage—Effective July 1, 2017, the minimum wage increases to $12.50 an hour ($3.33 an hour for tipped employees).

Florida

Emergency Response Leave—Effective July 1, 2017, employers must allow eligible employees to take up to 15 days of leave annually to participate in Civil Air Patrol trainings or missions.

http://www.flsenate.gov/Session/Bill/2017/370/BillText/er/PDF

Iowa

Health Insurance Marketplace—Effective June 12, 2017, Iowa intends to seek a waiver from certain requirements under the federal Patient Protection and Affordable Care Act.

Specifically, Iowa intends to require insurance issuers to offer a single, standardized plan for the 2018 plan year, provide age and income based premium subsidies for individuals who purchase the standardized plan, and increase reimbursements to insurance issuers for individual claims that exceed $100,000 annually.

Kansas

Income Tax Withholding—On June 28, 2017, the Kansas Department of Revenue released its 2017 withholding tables.

Effective July 1, 2017, the supplemental withholding rate increases to 5 percent.

Starting with tax year 2017 forms filed in 2018, employers must file state copies of Form W-2 by Jan 31.

Maine

Health Benefit Mandates—Effective on or about Sept. 19, 2017, health benefit insurance plan issuers and pharmacy benefit managers can't impose copayments or other charges that exceed prescription drug claim costs.

Issuers or pharmacy benefit managers can't impose copayments or other charges that exceed prescription drugs' claim costs. Issuers or pharmacy benefit mangers can't penalize pharmacy providers that provide plan participants with information relating to their out-of-pocket costs, the clinical efficacy of prescription drugs, or alternative medications.

Income Tax Withholding—Starting with tax year 2017 forms filed in 2018, employers must file state copies of Form W-2 by Jan. 31. However, the Feb. 28 annual reconciliation deadline for Form W-3ME

remains unchanged, a spokesman for the Maine Department of Administrative Financial Services told Bloomberg BNA in a June 20 email.

Minimum Wage—Effective Jan. 1, 2018, the tip credit is restored and set at half the state's minimum hourly wage.

The tip credit that allows employers to count employees' tips toward their wages is restored, and employers may consider tips as part of the wages of service employees, as long as the tip credit does not exceed half of the state's minimum hourly wage; however, from Jan. 1, 2017, to Dec. 31, 2017, the minimum hourly cash wage paid directly to tipped service employees must be at least $5.

Workers' Compensation—Effective for injuries and illnesses that occur from July 1, 2017, to June 30, 2018, the maximum weekly benefit for total disability, partial disability and survivors' claims is $804.40.

Maryland

Health Benefit Mandates

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after May 25, 2017, plans that provide coverage for substance use disorder benefits or prescription drugs can't require prior authorization for certain abuse-deterrent drugs used to treat opioid use disorders.

—*Effective for all policies, contracts, and health benefit plans issued, delivered, or renewed in Maryland on or after May 25, 2017*, plans that provide coverage for substance use disorder benefits or prescription drugs can't require prior authorization for prescription drugs that:

- are used to treat opioid use disorders; and
- contain methadone, buprenorphine, or naltrexone.

—Effective June 1, 2017, certain insured group health plan requirements regarding coverage for treatment of mental illnesses, emotional disorders, and drug and alcohol misuse are revised.

—Effective until June 1, 2017, plans (excluding small employer grandfathered health plans) must provide the following coverage for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse if, in the professional judgment of plan participants' health-care providers, mental illnesses, emotional disorders, or drug and alcohol abuse is treatable and treatment is medically necessary:

- inpatient benefits for services provided in licensed or certified facilities, including hospital inpatient benefits;
- partial hospitalization benefits; and
- outpatient benefits, including all office visits and psychological and neuropsychological testing for diagnostic purposes.

Partial hospitalization benefits means providing medically directed intensive or intermediate short-term treatment to plan participants in licensed or certified facilities or programs for mental illness, emotional disorders, and drug abuse or alcohol abuse for a period of less than 24 hours but more than four hours in a day.

Insurers, plans, and HMOs can't charge copayments for methadone treatments that are greater than 50 percent of the daily cost for methadone maintenance treatment.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after July 1, 2017, plans can't deny coverage for medically necessary behavioral health-care

services provided by participating providers to plan participants who are students solely because these services are provided at public schools or through school-based health centers.

Behavioral health counseling services means prevention, intervention, and treatment services for social-emotional, psychological, behavioral, and physical health of students, including mental health and substance abuse disorders.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after Oct. 1, 2017, plan provisions regarding coverage for health-care services appropriately delivered through telehealth are revised to include counseling for substance use disorders.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after Oct. 1, 2017, plans can't apply step therapy or fail-first protocols to prescription drugs used to treat plan participants who have stage four advanced metastatic cancer if such use meets certain conditions.

- consistent with FDA-approved indications or the National Comprehensive Cancer Network Drugs & Biologics Compendium's indications for the treatment of stage four advanced metastatic cancer, and
- supported by peer-reviewed medical literature.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after Jan. 1, 2018, plan provisions regarding coverage for breast cancer screenings are revised to include digital tomosynthesis under certain conditions.

Effective for all policies, contracts, and health benefit plans issued, delivered, or renewed in Maryland on or after Jan. 1, 2018, plans that provide hospital, medical, or surgical benefits must provide coverage for breast cancer screenings in accordance with the most recent guidelines issued by the American Cancer Society. Coverage must include digital tomosynthesis if plan participants' treating physician determines that digital tomosynthesis is medically appropriate and necessary.

Digital tomosynthesis means radiologic procedures that involve obtaining projection images over stationary breasts to produce cross-sectional, digital, three-dimensional breast images.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after Jan. 1, 2018, plans that provide coverage for prescription drugs can require prior authorization for opioid antagonists if they are included in plan formularies and the plans provide coverage for at least one opioid antagonist without prior authorization.

—Effective for insured group health benefit plans issued, delivered, or renewed in Maryland on or after Jan. 1, 2019, plans that provide coverage for prescription drugs and devices must allow and apply prorated, daily copayments or coinsurance to partial supplies of prescription drugs dispensed by in-network pharmacies under certain conditions.

Plans that provide coverage for prescription drugs and devices must allow and apply prorated, daily copayments or coinsurance to partial supplies of prescription drugs dispensed by in-network pharmacies if:

- prescribers or pharmacists determine that dispensing partial prescription drug supplies is in plan participants' best interests,
- prescription drugs are anticipated to be required for more than three months,
- plan participants request or agree to partial prescription drug supplies for purposes of synchronizing their prescription drugs,
- prescription drugs aren't Schedule II controlled dangerous substances, and

- supply and dispensing of prescription drugs meets all prior authorization and utilization management requirements specific to prescription drugs at the time requests are made to synchronize plan participants' prescription drugs.

Plans can't deny payment of benefits to in-network pharmacies for covered prescription drugs solely because only partial prescription drug supplies were dispensed and must allow in-network pharmacies to override any denial codes indicating that prescription drugs are being refilled too soon.

Plans can't use payment structures that use prorated dispensing fees for partial prescription drugs supplies and must pay in-network pharmacies full dispensing fees for dispensing partial supplies for purposes of synchronizing participants' prescriptions regardless of any:

- prorated coinsurance or copayments charged to plan participants, or
- fees paid to pharmacies for synchronizing plan participants' prescriptions.

Minimum Wage—Effective July 1, 2017, the minimum wage increases to $9.25 and hour ($5.62 for tipped employees).

Michigan

Income Tax Withholding— Effective July 1 through Dec. 31, 2017, the interest rate on tax underpayments is 4.7 percent.

Minnesota

Income Tax Withholding—Beginning with tax year 2017 forms filed in 2018, employers must file state copies of Form W-2 by Jan. 31.

Workers' Compensation—Effective for injuries and illnesses that occur from Oct. 1, 2017, to Sept. 30, 2018, the maximum weekly benefit for permanent total disability and temporary total disability claims is $1,061.82.

Mississippi

Equal Employment Opportunity

On June 22, 2017, a federal appeals court ruled that Mississippi's "religious freedom" law can be implemented and enforced (*Barber v. Bryant*, 5th Cir., No. 16-60477, 6/22/17). The law, which originally was scheduled to take effect July 1, 2016, allows certain employers to establish sex-specific standards or policies on employee dress or grooming and access to restrooms or locker rooms based on a sincerely held religious belief or moral conviction that "male" or "female" refers to a person's biological sex at the time of birth.

Overview

Mississippi doesn't have an equal employment opportunity law that applies generally to private employers. However, certain private employers are covered by applicable federal law governing equal employment opportunity.

Coverage

Employers are covered by the appearance discrimination and employment condition provisions if they are sole proprietorships, closely held companies, or other closely held entities operating with a sincerely held religious belief or moral conviction that "male" or "female" refers to a person's biological sex at the time of birth. The provisions also apply to their owners, officers, managers, employees, and

volunteers. [*Note:* On June 30, 2016, a federal district court ruled that the "religious freedom" law enacting these provisions is unconstitutional and blocked Mississippi from implementing or enforcing the law. On June 22, 2017, a federal appeals court ruled that the law can be implemented and enforced. The provisions originally were scheduled to take effect July 1, 2016 (*Barber v. Bryant*, 5th Cir., No. 16-60477, 6/22/17 and 2016 BL 213560, S.D. Miss., No. 3:16-cv-00417, 6/30/16).]

This summary is restricted to private employers and general coverage of anti-discrimination laws and regulations; it doesn't include occupation- or industry- specific legal requirements.

Types of Prohibited Discrimination

Mississippi doesn't have an equal employment opportunity law that applies generally to private employers. However, certain private employers are covered by applicable federal law governing equal employment opportunity.

Appearance Discrimination

Employers can establish sex-specific standards or policies on employee dress or grooming based on a sincerely held religious belief or moral conviction that "male" or "female" refers to a person's biological sex at the time of birth. Employers and their owners, officers, managers, employees, and volunteers can't be penalized by Mississippi state or local governments or sued under Mississippi state or local laws for establishing these standards or policies.

Employment Conditions

Employers can establish sex-specific standards or policies on access to restrooms, locker rooms, or other intimate settings based on a sincerely held religious belief or moral conviction that "male" or "female" refers to a person's biological sex at the time of birth. Employers and their owners, officers, managers, employees, and volunteers can't be penalized by Mississippi state or local governments or sued under Mississippi state or local laws for establishing these standards or policies.

Missouri

Workers' Compensation—Effective for injuries and illnesses that occur from July 1, 2017, to June 30, 2018, the standard maximum weekly benefit for permanent total disability, temporary total disability, temporary partial disability, and survivors' claims is $923.0. The maximum weekly benefit for permanent partial disability claims is $483.48.

Montana

Workers' Compensation—Effective for injuries and illnesses that occur from July 1, 2017, to June 30, 2018, the maximum weekly benefit for permanent total disability, temporary total disability, and survivors' claims for is $768. The maximum weekly benefit for permanent partial disability claims is $384.

Nevada

Noncompetition Agreements—Effective June 3, 2017, the parameters for executing and enforcing noncompetition agreements are revised.

Except under certain circumstances, Nevada's statutes prohibit contracts or agreements that restrain trade or commerce. State law generally forbids employers from willfully doing anything to prevent an individual from obtaining a job once an employee has left the employer.

A noncompetition covenant can't restrict a former employee from providing services to a former customer or client if:

- the former employee didn't solicit the former customer or client;
- the former customer or client voluntarily chose to leave and seek services from the former employee; and
- the former employee is otherwise complying with the limitations in the noncompete covenant as to time, geographical area, and scope of restrained activity.

Employers can negotiate, execute, and enforce noncompetition agreements that prohibit employees from disclosing trade secrets, business methods, lists of customers, secret formulas or processes, and confidential information obtained during the course of employment.

Any noncompetition agreement must be supported by valuable consideration and include only restrictions that are appropriate in relation to the valuable consideration supporting the covenant. Noncompete covenants must be reasonable in both scope and duration, not impose any restraint greater than is required for the protection of the employer, and not impose undue hardship on the employee.

If the termination of employment is the result of a reduction in force, reorganization, or similar restructuring, a noncompetition agreement is only enforceable during the period in which the employer is paying the employee's salary, benefits, or equivalent compensation, including severance pay.

Pay Discrimination—Effective June 3, 2017, employers can't discriminate against employees because they ask about, discuss, or voluntarily disclose their wages or other employees' wages.

This prohibition doesn't apply to employees who have access to other employees' wage information as part of their essential job functions if they disclose this information to anyone who doesn't have such access, unless this disclosure is ordered by the Nevada labor commissioner's office or a court.

Pregnancy Discrimination—Effective Oct. 1, 2017, employers must provide reasonable accommodations to female employees and applicants upon request for pregnancy, childbirth, or related medical conditions, unless these accommodations would impose undue hardship. Employers also must post a notice about employee rights and provide the notice to new employees and to existing employees who become pregnant. In addition, effective June 2, 2017, employers must notify existing employees about the rights that take effect Oct. 1, 2017.

https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5177/Text

Health Benefit Mandates

Effective July 1, 2017, insured group health plan coverage for autism spectrum disorders is revised.

Plans (including MCOs) must provide coverage for diagnosis and screening of autism spectrum disorders for children younger than age 18, or until age 22 if enrolled in high school (doesn't apply to nonprofit hospital, medical, and dental corporations).

Plans can require that autism spectrum disorder treatment be identified in a treatment plan and include medically necessary:

- behavioral therapy,
- habilitative or rehabilitative care,
- prescription care,
- psychiatric care,
- psychological care, or

- therapeutic care.

Behavioral therapy means interactive therapy derived from evidence-based research, including:

- discrete trial training,
- early intensive behavioral intervention,
- intensive intervention programs,
- pivotal response training, and
- verbal behavior.

Plans can limit annual coverage for applied behavior analysis treatment to the actuarial equivalent of $72,000. Applied behavioral analysis means design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Plans that apply coinsurance, copayments, deductibles, and any other general exclusions or limitations must apply these cost-sharing provisions and any other general exclusions or limitations at the same levels that apply to other medical services or prescription drugs. Plans can't limit the number of provider visits for autism spectrum disorder treatments.

Plans that provide coverage for outpatient care can't:

- apply higher coinsurance, copayments, or deductibles, or require longer waiting periods for coverage for outpatient care related to autism spectrum disorders than is applied or required for other covered outpatient care services; or
- refuse to issue or cancel coverage solely because plan participants are diagnosed with or receive treatment for autism spectrum disorders.

Issuers can request copies of and review treatment plans.

Effective until July 1, 2017, autism spectrum disorders means neurobiological medical conditions, including:

- Asperger's disorder,
- autistic disorder, and
- pervasive developmental disorder not otherwise specified.

Issuers aren't required to provide reimbursement to early intervention agencies or schools for services delivered through early intervention or school services.

Effective July 1, 2017, autism spectrum disorders means conditions that meet diagnostic criteria for autism spectrum disorders in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the edition in effect at the time of diagnosis or determination.
Issuers aren't required to provide reimbursement to schools for services delivered through school services.

Effective Jan. 1, 2018, insured group health plan provisions regarding coverage for health-care services performed by counselors are revised. In addition, plans that provide coverage for alcohol or drug abuse or mental health treatment must make payments directly to health-care providers performing such treatments if providers meet certain conditions.

Effective until Jan. 1, 2018, plans that provide coverage for treatment of illnesses that are within the scope of practice of the following licensed professionals must reimburse plan participants for treatment provided by:

- clinical alcohol and drug abuse counselors,
- clinical professional counselors, and
- marriage and family therapists.

Effective Jan. 1, 2018, plans that provide coverage for treatment of illnesses that are within the scope of practice of licensed clinical alcohol and drug abuse counselors must reimburse plan participants for treatment provided by clinical alcohol and drug abuse counselors unless clinical alcohol and drug abuse counselors are out-of-network providers who must be reimbursed directly pursuant to an assignment of benefits.

In addition, plans that provide coverage for treatment of illnesses that are within the scope of practice of the following licensed professionals must reimburse plan participants for treatment provided by:

- clinical professional counselors, and
- marriage and family therapists.

Plans that provide coverage for health-care services using networks of providers under contract with issuers must permit plan participants to continue to obtain health care from specific providers if:

- plan participants are actively undergoing medically necessary courses of treatment, and
- healthcare providers and plan participants agree that continuity of care is desirable.

Effective Jan. 1, 2018, plans that provide coverage for treatment relating solely to alcohol abuse, drug abuse, or mental health must make payments directly to health-care providers that perform treatments if providers:

- are out-of-network, and
- obtain and deliver written assignments of benefits to issuers or their authorized representatives, including third-party administrators.

Effective for plans that are delivered, issued for delivery, or renewed on or after Jan. 1, 2018, plans must provide coverage for depression screenings.
Issuers must ensure depression screenings are available to plan participants from in-network health-care providers.

Issuers can't:

- require plan participants to pay higher coinsurance, copayments, or deductibles, or require longer waiting periods or impose other conditions on coverage for depression screenings;
- refuse to issue or cancel coverage solely because plan participants use or could possibly use benefits related to depression screenings;
- offer or pay plan participants material inducements or provide financial incentives to discourage plan participants from using benefits related to depression screenings;
- penalize health-care providers who provide depression screenings, including, without limitation, reducing providers' reimbursements;
- offer or pay health-care providers material inducements, bonuses, or other financial incentives to deny, reduce, withhold, limit, or delay access to depression screenings; or
- impose any other restrictions or delays on plan participants' access to such benefits.

Issuers can use medical management techniques, including, without limitation, any available clinical evidence, to determine treatment frequency relating to depression screenings or types of health-care providers to provide treatments. Medical management techniques means practices used to control costs or plan participants' usage of health-care services or prescription drugs, including step therapy, prior authorization, or categorizing drugs and devices based on cost, type, or method of administration.

Treatment parity: Issuers that provide coverage for mental health or substance use disorders must comply with treatment parity provisions of the federal Mental Health Parity Act and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

Military Leave—Effective July 1, 2017, employers can't discharge employees who are members of another state's National Guard for participating in protected activities or because they are ordered to active service or duty by that state. Under certain conditions, employees can sue employers for violating the retaliation prohibition, which also covers employees who are Nevada National Guard members. In addition, the penalties/remedies for these violations are revised.

Overview

Employers can't discharge employees who are National Guard members because they assemble for training, participate in field training or active duty, or otherwise meet as required or because they are ordered to active service or duty.

Coverage

Public and private employers are covered by the retaliation prohibition.

This summary is restricted to private employers.

Retaliation Prohibition

Employers can't discharge employees who are members of the Nevada National Guard because they:

- assemble for training, participate in field training or active duty, or otherwise meet as required by Nev. Rev. Stat. § 412.118; or
- are ordered to active service or duty pursuant to Nev. Rev. Stat. §§ 412.122 or 412.124.
- Effective July 1, 2017, employers can't discharge employees who are members of another state's National Guard, but are employed in Nevada, because they:
- assemble for training, participate in field training or active duty, or otherwise meet as required by that other state's law; or
- are ordered to active service or duty pursuant to that other state's law.

Administration/Enforcement

The Nevada Department of Business and Industry's Office of the Labor Commissioner enforces the retaliation prohibition and employers that violate the prohibition also are subject to criminal prosecution. If employees believe they were discharged in violation of the prohibition, they can request a hearing before the office (within 60 days after receiving a termination notice) to determine whether they were unlawfully discharged. Effective July 1, 2017, if the office doesn't determine that employees were discharged in violation of the prohibition, employees can (within 120 days after receiving a termination notice) sue employers for violating the prohibition.

Penalties/Remedies

The Nevada labor commissioner's office can order employers that violate the retaliation prohibition to:

- pay a fine of up to $5,000 for each violation;
- until July 1, 2017, reinstate employees to their position;
- effective July 1, 2017, reinstate employees to the position they would have held if they hadn't been unlawfully discharged;
- until July 1, 2017, restore employees' seniority and benefits;
- effective July 1, 2017, restore seniority and benefits that employees would have attained if they hadn't been unlawfully discharged; and
- pay employees all wages and benefits lost as a result of their unlawful discharge.

Effective July 1, 2017, employers that are sued can be ordered to comply with these and other remedies and pay reasonable attorneys' fees and costs.

Employers that violate the retaliation prohibition also are guilty of a misdemeanor.

Unemployment Insurance—Effective for 2018, the taxable wage base is $30,500.

New Hampshire

Unemployment Insurance—Effective July 1, 2017, through Sept. 30, 2017, tax rates for experienced employers range from 0.1 percent to 1.7 percent for those with a positive rating and from 3.3 percent to 7.5 percent for those with a negative rating. The tax rate for new employers is 1.7 percent.

New Mexico

Military Leave—Effective July 1, 2017, the military leave provisions are expanded to cover employees who are called to serve on active duty in the National Guard for any state or U.S. territory. In addition, employees returning from military leave are subject to revised eligibility requirements for re-employment and new notification requirements.

Until July 1, 2017, employees are eligible for military leave if they are employed in a permanent position and are called to serve on active duty in the U.S. armed forces, Organized Reserves, or National Guard. Effective July 1, 2017, employees are eligible for military leave if they are employed in a permanent position and are called to serve on active duty in the U.S. armed forces or Organized Reserves or the National Guard for New Mexico or another state or U.S. territory.

This summary is restricted to private employers.

Until July 1, 2017, employers must reinstate eligible employees returning from military leave to their position or another position with similar seniority, status, and pay, unless employers' circumstances have changed in ways that make reinstatement impossible or unreasonable. Specifically, employers must reinstate eligible employees who:

- are honorably discharged or released from active duty to complete their remaining service in a reserve component, are entitled to a certificate of service, or are officers who terminate their service without dishonor;
- are still qualified to perform the duties of their position; and
- apply for re-employment within 90 days after their release from training and service or from hospitalization continuing for up to one year after discharge.

Effective July 1, 2017, employers must reinstate eligible employees returning from military leave to their position or another position with similar seniority, status, and pay, unless employers' circumstances

have changed in ways that make reinstatement impossible or unreasonable. Specifically, employers must reinstate eligible employees who:

- gave employers advance written or verbal notice of their obligation or intention to perform service in the uniformed services, unless this notice is precluded by military necessity or is otherwise impossible or unreasonable;
- are honorably discharged or released from active duty to complete their remaining service in a reserve component, are entitled to a certificate of service, or terminate their service without dishonor;
- haven't taken more than a total of five years of leave to serve in the uniformed services;
- are still qualified to perform the duties of their position; and
- apply for re-employment within 90 days after their release from training and service or from hospitalization and convalescence continuing for up to two years after discharge.

Upon reinstatement, employers:

- must treat reinstated employees as if they were on furlough or a leave of absence during their service in the U.S. armed forces;
- must restore reinstated employees' seniority;
- must allow reinstated employees to participate in employer-offered insurance or other benefits pursuant to established rules and practices (for employees on furlough or a leave of absence) that were in effect at the time they entered service in the U.S. armed forces; and
- can't discharge reinstated employees from their position without cause for one year.

Effective July 1, 2017, employees must give employers advance written or verbal notice of their obligation or intention to perform service in the uniformed services, unless this notice is precluded by military necessity or is otherwise impossible or unreasonable. If employees fail to comply with this requirement, employers aren't required to reinstate them upon their return from military leave.

New York

Income Tax Withholding—Effective July 1 through Sept. 30, 2017, the interest rate on tax underpayments remains at 7.5 percent.

Temporary Disability Insurance

—Starting July 1, 2017, employers can initiate wage deductions for New York's paid family leave tax. Starting Jan. 1, 2018, employers must make these deductions or pay the premium costs for this leave. The state has determined the taxable wage base and tax rate for the paid family leave tax from July 1, 2017, through June 30, 2018.

Effective July 1, 2017, employers may start deducting employees' wages for the state's paid family-leave tax. However, effective from July 1, 2017, to Dec. 31, 2017, employers are not required to deduct employees' wages for the state's paid family-leave tax, but employers may choose to do so.

Effective Jan. 1, 2018, employers must either deduct paid family-leave tax from employees' wages or pay the cost of paid family-leave premiums themselves instead of deducting employees' wages. If an employer chooses to forego deductions from employees' wages, the amount the employer would pay for a period would equal the total amount of paid family-leave tax that would have been deducted from its employees' wages for the period.

Taxable wages: The taxable wage base for New York's paid family-leave tax is a maximum taxable amount for each week instead of each year.

The standard weekly taxable wage base upon which the paid family-leave tax may be assessed is the applicable state average weekly wage. For each taxable period from July 1 to June 30 of the next year, the applicable state average weekly wage is the state average weekly wage for the last full calendar year that ended before that July 1.

However, if an employee's total wage for a particular week was less than the standard weekly taxable wage base, the taxable wage base applicable to that employee for that week is the employee's total wage for that week.

Effective from July 1, 2017, to June 30, 2018, the taxable wage base for assessment of New York's paid family-leave tax on an employee is, for each week during this period, the lesser of the employee's total wage for that week or the applicable state average weekly wage of $1,305.92.

Tax rate: The rate of the paid family-leave tax is subject to adjustment. Proceeds from the tax may fund an employer's self-insured paid family-leave program or a third-party paid family-leave program. The tax generally must be deducted from each employee's wages, although employers may choose to forego deductions from employees' wages and instead pay premiums equal to the amounts that would have been deducted.

Effective from July 1, 2017, to June 30, 2018, the rate of the paid family-leave tax on employees is 0.126 percent.

Workers' Compensation—Effective for injuries and illnesses that occur from July 1, 2017, to June 30, 2018, the maximum weekly benefit for total disability, partial disability and survivors' claims for is $870.61.

North Carolina

Health Benefit Mandates—Effective for insured health benefit plans issued, renewed, or amended on or after Oct. 1, 2017, plans must provide coverage for services performed by licensed occupational therapists if these services are within their scope and are covered by the plans.

Plans must provide coverage for services performed by the following health-care providers if providers are licensed, services are within providers' scope of services, and services are covered by plans:

- advanced practice registered nurses,
- clinical social workers,
- chiropractors,
- dentists,
- fee-based practicing pastoral counselors,
- licensed hearing aid specialists,
- *effective for health benefit contracts issued, renewed, or amended on or after Oct. 1, 2017*, licensed occupational therapists,
- licensed professional counselors,
- marriage and family therapists,
- optometrists,
- pharmacists,
- physical therapists,
- physician assistants,
- podiatrists,
- psychologists, and
- substance abuse professionals.

Obstetricians and Gynecologists

Plans must permit female plan participants who are age 13 or older to have direct access to health-care services provided by participating obstetricians and gynecologists without requiring prior authorizations.

Pediatricians

Plans that use networks of contracting health-care providers must permit plan participants to choose in-network pediatricians as primary care providers for children under age 18.

Standing Referrals

Plans that don't allow direct access to all in-plan specialists and subspecialists must have written policies and procedures by which plan participants can receive extended or standing referrals to in-plan specialists for up to 12 months. Insurers must permit plan participants who have serious or chronic degenerative, disabling, or life-threatening diseases or conditions, which require specialized medical care, to select specialists who have expertise in treating such diseases or conditions as their primary care physicians, and such physicians must be responsible for and capable of providing and coordinating plan participants' primary and specialty care.

Plans aren't required to permit plan participants to choose particular specialists as primary care physicians if it is determined that participants' care can't be appropriately coordinated by that specialist.

State Institutions

Plans that provide benefits for hospital or physician charges must provide coverage for services provided by licensed North Carolina tax-supported institutions, such as community mental health centers and other health clinics that are certified Medicaid providers. Coverage must include benefits for treatment of alcoholism and drug or chemical dependency, cerebral palsy, mental and nervous diseases or disorders, mental retardation, orthopedic and crippling disabilities, and respiratory illnesses on a basis that is no less favorable than coverage for services provided by private institutions.

Income Tax Withholding—Effective July 1 through Dec. 31, 2017, the interest rate on tax underpayments remains at 5 percent.

North Dakota

Workplace Smoking

Effective July 1, 2017, employers can request signs from the North Dakota Department of Health to comply with the mandatory poster provisions in workplaces where smoking is prohibited.

If employers, owners, operators, managers, or other persons control workplaces or public places where smoking is prohibited, they must clearly and conspicuously post:

- no-smoking signs or the international no-smoking symbols in these places; and
- a sign, at every entrance to these places, stating that smoking is prohibited.

Until July 1, 2017, these signs can be requested from the North Dakota Tobacco Prevention and Control Executive Committee. Effective July 1, 2017, these signs can be requested from the North Dakota Department of Health.

Oregon

Labor Relations—Effective June 14, 2017, employers and unions can enter into and apply agreements that require union membership as a condition of employment, as permitted by federal law.

https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB1040/Enrolled

Minimum Wage—Effective July 1, 2017, the standard minimum wage rate is $10.25 an hour, the Portland metro minimum wage is $11.25 an hour, and the rate for nonurban counties is $10 an hour.

Rhode Island

Temporary Disability Insurance—Effective for benefit years starting from July 2, 2017, to June 30, 2018, the maximum weekly benefit for covered employees who do not claim dependents is $831.

Texas

Health Benefit Mandates—Effective Jan. 1, 2018, insured group health plan provisions regarding coverage for healthcare services delivered through telemedicine are revised.

Telemedicine medical services means healthcare services provided by physicians licensed in Texas or healthcare professionals acting under the delegation and supervision of physicians licensed in Texas and acting within the scope of physicians' or professionals' license to plan participants who are at different physical locations than physicians or professionals by using telecommunications or information technology.

Telehealth services means health services other than telemedicine medical services provided by healthcare professionals who are certified, licensed, or otherwise entitled to practice in Texas and acting within the scope of professionals' license, certification, or entitlement to plan participants who are at different physical locations than health-care professionals by using telecommunications or information technology.

Store and forward technology means technology that stores and transmits or grants access to plan participants' clinical information for review by health-care professionals located at different physical locations than plan participants.

Effective until Jan. 1, 2018, plans can't exclude telemedicine medical services or telehealth services from coverage solely because services aren't provided through face-to-face consultations (doesn't apply to consumer choice plans or small employer plans).

Plans can apply coinsurance, copayments, and deductibles to telemedicine medical services or telehealth services so long as coinsurance, copayments, and deductibles don't exceed coinsurance, copayments, and deductibles that apply to comparable medical services provided through face-to-face consultations.

Effective Jan. 1, 2018, plans can't exclude healthcare services or procedures provided by preferred or contracted healthcare professionals to plan participants though telemedicine medical services or telehealth services from coverage solely because services or procedures aren't provided through in-person consultations if such services are otherwise covered by plans (doesn't apply to consumer choice plans or small employer plans).

Plans can apply coinsurance, copayments, and deductibles to covered healthcare services or procedures provided by preferred or contracted healthcare professionals to plan participants through telemedicine medical services or telehealth services so long as coinsurance, copayments, and

deductibles don't exceed coinsurance, copayments, and deductibles that apply to covered medical services or procedures provided through in-person consultations.

Plans aren't required to provide coverage for telemedicine medical services or telehealth services provided only through synchronous or asynchronous audio interactions, including audio-only telephone conversations, text only e-mails, or fax transmissions.

Issuers must adopt and display their policies and payment practices for telemedicine medical services and telehealth services prominently on their websites. Issuers don't have to display negotiated contract payment rates for health-care professionals who contract with issuers to provide telemedicine medical services or telehealth services.

—Effective for insured health benefit plans delivered, issued for delivery, or renewed on or after Jan. 1, 2018, plan issuers that require step therapy protocols before providing prescription drug coverage must establish, implement, and administer step therapy protocols in accordance with certain clinical review criteria.

Health benefit plan issuers that require step therapy protocols before providing prescription drug coverage must establish, implement, and administer step therapy protocols in accordance with clinical review criteria readily available to the healthcare industry. Step therapy protocol means issuers require plan participants to use certain prescription drugs, other than prescription drugs recommended by participants' healthcare providers, or take prescription drugs in a certain order before plans provide coverage for recommended prescription drugs.

Issuers must consider the needs of atypical populations and diagnoses when establishing clinical review criteria. Clinical review criteria:

- must consider generally accepted clinical practice guidelines that meet the following characteristics: are developed and endorsed by a multidisciplinary expert panel; based on high-quality studies, research and medical practice; created by an explicit and transparent process that minimizes bias and conflicts of interest; explains relationships between treatment options and outcomes; rates quality of evidence used to support recommendations; considers relevant subgroups and preferences; and are updated at appropriate intervals after new evidence, research, and treatments are reviewed; or
- in the absence of readily available clinical practice guidelines, can be based on peer-reviewed publications developed by independent experts, including physicians who have expertise applicable to relevant health conditions.

Conflicts of interests must be managed by a multidisciplinary expert panel that includes physicians and, as necessary, other health-care providers who develop and endorse clinical practice guidelines (doesn't apply to expert panels or committees, including pharmacy and therapeutics committees, established by issuers or pharmacy benefit managers to provide advice relating to drugs and formularies). Expert panels must manage conflicts by:

- requiring all members who are responsible for writing or reviewing guidelines to disclose any potential conflicts of interest, including conflicts of interest that involve insurers, health benefit plan issuers, or pharmaceutical manufacturers, and recuse themselves from situations in which conflicts of interest exist;
- using methodologists to help writing groups provide objectivity in data analysis and ranking evidence by creating evidence tables and facilitating consensus; and
- offering opportunities for public reviews and comments.

Health benefit plan issuers must permit plan participants and prescribing health-care practitioners to request step therapy protocol exceptions through a user-friendly process that is readily accessible in plans' formulary documents.

Prescribing providers can submit written requests for step therapy protocol exceptions on plan participants' behalf using the standard form prescribed by the Texas Insurance Commissioner.

Plans must grant written requests for step-therapy protocol exceptions submitted by prescribing health-care providers if requests include prescribing providers' written statements along with supporting documentation that states:

- drugs required under step therapy protocols meet the following characteristics: are contraindicated; likely to cause adverse reactions or physical or mental harm to participants; and expected to be ineffective based on participants' known clinical characteristics and prescription drugs regimens' known characteristics;
- participants previously discontinued using prescription drugs in the same pharmacologic class or with same mechanism of action as required drugs while covered under the current plan or under another plan because drugs weren't effective, had diminished effects, or because of an adverse event;
- drugs required under step therapy protocols aren't in plan participants' best interest based on clinical appropriateness because participants' use of drugs is expected to cause significant barriers to participants' adherence to or compliance with participants' plan of care, worsen participants' comorbid conditions, or decrease participants' ability to achieve or maintain reasonable functional ability when performing daily activities; or
- drugs subject to step therapy protocols were prescribed for participants' conditions, participants received benefits for drugs under the current plan or under another plan, participants are stable on the drugs, and changing participants' prescription drug regimen as required by step therapy protocols would likely be ineffective or cause harm based on participants' known clinical characteristics and prescription drug regimens' known characteristics.

Step therapy protocol exception requests are considered to be granted if they aren't denied within 72 hours after plans receive requests. However, if health-care providers reasonably believe that a denial of a request makes plan participants' death or serious harm probable, requests are considered granted if plans don't deny requests within 24 hours after plans receive requests.

—Effective May 23, 2017, Texas intends to seek a waiver of certain health benefit plan coverage requirements for small employer health benefit plans under the federal Affordable Care Act, including requirements pertaining to plans' actuarial value and related levels of plan coverage.

Vermont

Income Tax Withholding—On June 13, Vermont enacted a law that conforms the state to the Internal Revenue Code in effect for tax year 2016.

Unemployment Insurance

Effective July 1, 2017, through June 30, 2018, tax rates for experienced employers range from 1.1 percent to 7.7 percent and tax rates for new employers range from 1 percent to 6.4 percent.

Starting with health-care contributions due for fourth quarter 2017 in relation to Vermont's unemployment insurance program, the state's Department of Taxes administers the processing of these contributions and reports detailing the contributions, both of which are due by the 25th day of the month after a quarter ends.

Health care contribution reporting: Employers use Form HC-1, Health Care Contribution Worksheet, to calculate amounts for line 16 on Form C-101, which indicates an employer's number of nonexempt full-time equivalent employees considered to be uncovered regarding health insurance, and for line 17, which indicates total health care contributions payable to the state Department of Labor.

Effective starting with contributions due for the fourth quarter of 2017, data regarding health care contributions are to be electronically reported to the state Department of Taxes with a new or modified quarterly form that the department is to release by the end of 2017 and the form for a quarter is due by the 25th day of the month following the reported quarter.

To determine the number of uncovered full-time equivalent employees to be reported on line 16, employers are required to total the number of hours uncovered employees worked during pay periods in the applicable quarter, then divide the total by 520. Four uncovered full-time equivalent employees can be exempted from the total reported on line 16. Hours worked by seasonal and part-time employees are not included in total hours worked for the purposes of calculations for line 16 if their employer offers to pay a portion of health care costs for all full-time employees.

Effective through contributions due for the third quarter of 2017, health care contributions are payable to the state Department of Labor with Form C-101 and are due 30 days after the last day of the quarter for which they are being paid. Effective starting with contributions due for the fourth quarter of 2017, health care contributions are payable to the state Department of Taxes and are due 25 days after the last day of the quarter for which they are being paid.

Electronic filing: Employers with up to 250 employees are required to submit Form C-101 using the Vermont Internet Tax and Wage System (VITWS), which is an online portal.

Employers with more than 250 employees and third-party administrators reporting for more than 250 employees are required to file unemployment tax and wage data with the Large Employer Reporting System/Third-Party Portal. To use and gain access to the system, employers must complete and submit Form C-29A, Large Employer Quarterly C-101 Wage & Contribution Report On-Line Application. Third-party administrators must submit a Third Party Quarterly C-101 Wage & Contribution Report On-Line Application to use and gain access to the Large Employer Reporting System/Third-Party Portal.

Payment options: Employers with up to 250 employees can pay unemployment tax and health care contributions mandated by the state's unemployment law with ACH debit or paper checks. Employers with more than 250 employees can pay with ACH credit, ACH debit or paper checks.

Third-party administrators generally can pay with ACH credit, ACH debit or paper checks. However, the tax associated with a report filed through the Vermont Internet Tax and Wage System by a third-party administrator on behalf of an employer cannot be paid with ACH credit.

Employers that file reports with the Vermont Internet Tax and Wage System can pay unemployment tax and health care contributions mandated by the state's unemployment law with ACH debit transactions established through that portal.

Change/correction reports: Any employer that sells its business must give the state 10 days' notice before the transfer of the property becomes final, and must file all contribution and wage reports due. The state will issue such employers a certificate showing that such reports have been filed. This certificate must be furnished to the purchaser, or it becomes liable for any unpaid contributions, interest or penalties of the selling employer.

Employers that think they overpaid unemployment insurance taxes for a quarter can file amended copies of Form C-101, Employer's Quarterly Wage & Contribution Report, with the Vermont Labor

Department. To amend the report, employers can write correct amounts next to those previously reported.

If the department determines an unemployment insurance tax overpayment was made, the overpayment can be credited toward payments due for a future quarter.

Employers also can request that the overpayment be refunded by check if the overpayment was made more than two years beforehand or if the overpayment cannot be fully applied over the two-year-period following the date it was made. All check refund requests must be in writing and should include a signature by an authorized individual representing the employer.

Separation reports: If employers are sent a Request for Separation Data (Form B-8F) to provide details about how individuals separated from employment with their most recent employer, or a Wage and Separation Data Request (Form B-70W) to provide wage information regarding individuals claiming eligibility for benefits, employers should send responses to the forms to the department by the due date specified on the forms to avoid unnecessary benefits charges to their unemployment accounts.

Employers that fail to respond to separation notices in a timely manner are not relieved of charges to their accounts for benefits paid to claimants, unless the department determines that the employers' failure to comply was because of an unavoidable accident or mistake.

Employers and third-party administrators can use the State Information Data Exchange System (SIDES) to electronically receive and respond to benefits-eligibility information requests from the Vermont Department of Labor. Employers and third-party administrators that expect to receive benefits-eligibility information requests regarding more than 30 former employees each week can use UI SIDES, a version of SIDES that involves upgrades to computer systems. Employers and third-party administrators that expect to receive benefits-eligibility information requests regarding up to 30 former employees each week can use SIDES E-Response, a version of SIDES that involves using an online portal to receive and respond to the requests.

Vermont uses UI SIDES and SIDES E-Response to send and receive responses to separation information requests, which ask for information about how individuals claiming benefits ended work with an employer.

Information on signing up to receive and respond to benefits-eligibility information requests through SIDES is available in Payroll Administration Guide's State Information Data Exchange System chapter.

In the case of mass separation that involves 20 percent of the employer's workers, 50 percent of the workers within a department, or at least 25 workers, employers must file a mass separation notice with the state within 24 hours.

For unemployment because of a labor dispute, employers should provide a notice to the state that includes the approximate number of workers affected.

Multiple worksite reports: Employers engaged in more than one type of business activity in Vermont or operating in more than one location are required to file a Multiple Worksite Report with the quarterly contribution and wage reports.

Distracted Driving—Effective July 1, 2017, employees who drive as part of their job duties can have points assessed against their driving record for any unlawful use of portable electronic devices while driving, regardless of the location or nature of these violations.

Workers' Compensation—Effective from July 1, 2017, to June 30, 2018, the maximum weekly benefits for total disability claims are $1,281 for workers who were injured or became ill after June 30, 1986, and $854 for workers who were injured or became ill before July 1, 1986.

Virginia

Income Tax Withholding—The interest rate on tax underpayments is 6 percent.

Washington

Unemployment Insurance—Effective for 2018, the taxable wage base is $47,300.

West Virginia

Emergency Response Leave—Effective July 1, 2017, employers must allow eligible employees to take up to 10 days of leave per calendar year to train for emergency missions conducted by the West Virginia Civil Air Patrol, and up to 30 days of leave per calendar to respond to these missions.

Workers' Compensation—Effective for injuries and illnesses occurring July 1, 2017, through June 30, 2018, the maximum weekly benefit for permanent total disability, temporary total disability, and survivors' benefit claims is $783.59. The maximum weekly benefit for permanent partial disability claims is $548.51.