Regulatory Framework (B) Task Force

Regulatory Framework (B) Task Force August 13, 2026, Minutes

- Regulatory Framework (B) Task Force June 29, 2026, Minutes (Attachment One)
- Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group August 13, 2026, Minutes (Attachment Two)
  - Revised Draft Guidance Document – ERISA Preemption and State PBM Laws July 22, 2026, Minutes (Attachment Two-A)
  - Revised Draft Guidance Document: ERISA Preemption and State PBM Laws May 18, 2026, Minutes (Attachment Two-B)
    - Guidance Document – ERISA Preemption and State PBM Laws (Attachment Two-B1)
- Prescription Drug Coverage (B) Working Group and the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group August 12, 2026, Minutes (Attachment Three)
  - Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group April 2, 2026, Minutes (Attachment Three-A)

Draft Pending Adoption

Draft: 8/17/26

Regulatory Framework (B) Task Force
Columbus, Ohio
August 13, 2026

The Regulatory Framework (B) Task Force met in Columbus, OH, Aug. 13, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Erin K. Hunter, Vice Chair, and Joylynn Fix (WV); Heather Carpenter represented by Sarah Bailey (AK); Mark Fowler represented by Kelli Littlejohn Newman (AL); Charles Bassett represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy (CO); Joshua Hershman represented by Tricia Davé (CT); Karima M. Woods represented by Howard Liebers and Tina Ching (DC); Trinidad Navarro represented by Jessica R. Luff (DE); John F. King represented by Paula Shamburger (GA); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Josh Carlson and Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Angela L. Nelson (MO); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); Ned Gaines represented by Diana Branciforte (NV); Judith L. French represented by Kristin Cly (OH); Glen Mulready represented by Rebecca Ross (OK); TK Keen represented by Cassie Soucy (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Fairbanks and Julie Blauvelt (VA); Patty Kuderer represented by Ingrid Ulrey (WA); and Nathan Houdek represented by Darcy Paskey and Jamie Adams (WI). Also participating was: Chrystal Bartuska (ND).

1. Adopted its June 29 and Spring National Meeting Minutes

The Task Force met June 29. During this meeting, the Task Force heard an update from the Blue Cross Blue Shield Association (BCBSA), AHIP, and a panel of plan representatives on the progress related to the industry's prior authorization (PA) reform initiative announced last year. The Task Force plans to hold a follow-up meeting on Aug. 31 to hear presentations on the issue from other stakeholders and hold a question-and-answer (Q&A) session.

Hohl made a motion, seconded by Swanson, to adopt the Task Force's June 29 minutes (Attachment One) and March 24 minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

Prior to asking for a motion to adopt the Task Force's working group reports, Commissioner Grant said that in adopting the report of the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, the Task Force is not adopting the *Guidance Document—ERISA Preemption and State PBM Laws* (Guidance Document). The Task Force will consider its adoption as the next meeting agenda item.

Hohl made a motion, seconded by Commissioner Hunter, to adopt the reports of the ERISA and Alternative Health Coverage (B) Working Group (Attachment Two); and the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and the Prescription Drug Coverage (B) Working Group, which met in joint session Aug. 12 (Attachment Three). The motion passed unanimously.

3. Adopted the Guidance Document

Seip said the ERISA and Alternative Health Coverage (B) Working Group adopted the Guidance Document during its July 22 meeting. She said the purpose of the Guidance Document is to provide information to state department of insurance (DOI) regulators and other state government officials related to ERISA preemption of state pharmacy benefit manager (PBM) laws. The Guidance Document considers the different types of state PBM laws and how appellate courts have applied the reasoning of the U.S. Supreme Court case *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, to those laws. Seip said the Guidance Document does not analyze cases that were still being litigated as of July 22, which is the date the ERISA and Alternative Health Coverage (B) Working Group adopted the it. She noted, however, that recognizing the ongoing legal activity in this area, the Guidance Document includes an addendum summarizing ongoing cases involving ERISA preemption of state PBM laws.

Swanson made a motion, seconded by Hohl, to adopt the *Guidance Document—ERISA Preemption and State PBM Laws* (*see NAIC Proceedings – Summer 2026, Health Insurance and Managed Care (B) Committee, Attachment Four*). The motion passed unanimously.

4. Heard an Update from the RWJF on ICHRAs

Katherine Hempstead (Robert Wood Johnson Foundation—RWJF) updated the Task Force on individual coverage health reimbursement arrangements (ICHRAs). She said that while there has been rapid growth in ICHRA plan enrollment recently, it remains below the initial projections made in 2019. She also discussed the difficulty in tracking enrollment due to the lack of comprehensive data. Hempstead explained that about 80% of ICHRA plan enrollment is off the Affordable Care Act (ACA) exchange (ACA exchange), with a significant increase in ICHRA-tailored plan offerings in 2026. She said ICHRA plans are marketed by platform companies such as PeopleKeep. In addition, some insurers, such as Oscar, also market them. Hempstead said ICHRAs are being offered and marketed to mostly small employers: 1) as an antidote to high premium increases; 2) a promise of predictability; and 3) as the "401k of health benefits." She discussed the key findings of a July 2026 survey of about 1,000 employers conducted by the Employee Benefit Research Institute (EBRI) in partnership with Morgan Health. In assessing interest in ICHRAs, the survey's key findings indicate that just over one-third of evaluated employers are looking at ICHRAs. Companies with 100 or more workers show the highest interest, with 62% saying they are likely to adopt an ICHRA within two years. However, the study's key findings also found caveats to employer adoption, such as cost, plan quality, and network adequacy. Hempstead said that policy support for ICHRAs exists from both state and federal regulators, but labor unions remain skeptical. She noted that the "ICHRA-haters" have faded. Looking to the future, Hempstead said that at the macro-level, there is the potential for ICHRAs to reshape the coverage ecosystem, but risks remain if the individual market weakens.

Commissioner Grant asked if Hempstead had any recommendations or thoughts about how state insurance regulators can obtain a better understanding of the number of employers enrolling in ICHRAs for their employees. Hempstead reiterated the difficulty in obtaining the data. She said that because most ICHRA enrollments are off the ACA exchange, it makes it more difficult. Hempstead said she believes that the federal Centers for Medicare & Medicaid (CMS) is trying to measure this as part of ACA enrollment, but right now, she does not have any recommendations to offer, even though it is an important issue.

Commissioner Humphreys noted the difficulty in obtaining ICHRA plan enrollment data. He said, however, that when the Pennsylvania DOI asked insurers for enrollment data, the data they provided was pretty accurate based on what it had obtained from HealthSherpa. HealthSherpa is an official enhanced direct enrollment (EDE) partner with the federal government for the ACA exchanges. He asked Hempstead about administrative fees charged for operating an ICHRA platform because he was told by a provider group in western Pennsylvania that the fees that if they enrolled in an ICHRA plan, the fees they could see could be as high as $43 per member per month (PMPM). Commissioner Humphreys said that in contrast, Pennsylvania's ACA exchange user fee would be $11 to $13

PMPM. Hempstead said that the potential higher administrative fee costs for ICHRA plans are not surprising to her, given some of the complexities inherent with these types of plans.

5. Heard an Update from the CCIIO on EHBs Activities and the Pre-Enrollment Verification Process

Jeff Wu (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Task Force on upcoming changes mandated by a provision in the One Big Beautiful Bill Act (OBBBA) H.R. 1, requiring pre-verification of eligibility for financial assistance before enrollment. He discussed the CMS' work in developing regulations implementing this requirement, including introducing a new concept of a pre-open enrollment verification period to help spread workload and improve timing.

Wu also discussed the status of the state essential health benefits (EHB) benchmark plan review process. He said the EHB benchmark plan review process remains paused while the review and stakeholder engagement continue. He noted that the CMS recently issued a request for information (RFI) titled *Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard* to obtain and engage stakeholders on the topic. Wu said there is no timeline for when the review process will resume. He also discussed the defrayal policy, which the CMS is enforcing more strictly than in the past. He noted, however, that the CMS is willing to work with the states on mandate clarifications. Wu discussed the CCIIO's priorities, which include fraud prevention, price transparency, and continued support for ICHRA innovation. He also mentioned that the CMS is working to resolve issues related to the stay of certain provisions of the 2027 Notice of Benefit and Payment Parameters (NBPP) Final Rule pursuant to *City of Columbus v. Kennedy*, *et al.* (Columbus II) No. 1:26-cv-02215.

Swanson asked Wu whether the CMS is truly wedded to enforcing the defrayal requirements outlined in the ACA rather than to its prior enforcement approach. Wu confirmed that the CMS is serious about enforcing the requirements as outlined in the law. Burruel asked Wu the purpose of the language regarding the defrayal requirement, which applies regardless of whether the benefit is embedded in the state's EHB benchmark plan. He discussed Arizona's previous actions and approach on the subject. Burruel said that with this new language, Arizona's legislature and its governor are concerned that the CMS will find that in clarifying some of its coverages, which are already embedded in its EHB benchmark plan, Arizona will be subject to the defrayal requirement. Wu agreed with Burruel that state EHB benchmark plans are broad, which complicates determining whether any updates and/or clarifications related to them would be subject to the defrayal requirement. He reiterated that the CMS is willing to work with the states on clarifying mandates as related to the defrayal requirements.

Commissioner Grant asked Wu if he had a timeline for when the CMS would promulgate the regulations implementing the pre-verification of eligibility for the financial assistance provision. Wu explained that it will not be a tri-agency regulation, with the CMS, the U.S. Department of Labor (DOL), and the Internal Revenue Service (IRS) all involved in its promulgation. However, because of some of the tax elements involved in developing the rule, which complicate it, he said the CMS currently has no specific timeline, but it is working as quickly as possible.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

Draft: 7/21/26

Regulatory Framework (B) Task Force
Virtual Meeting
June 29, 2026

The Regulatory Framework (B) Task Force met June 29, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Allan L. McVey, Vice Chair, represented by Tim Sigman (WV); Heather Carpenter represented by Jeanne Murray (AK); Charles Bassett (AZ); Michael Conway represented by Debra Judy (CO); Joshua Hershman represented by Tricia Davé (CT); Karima M. Woods represented by Howard Liebers (DC); Trinidad Navarro represented by Jessica R. Luff (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); John F. King represented by Garrison Bennett and Paula Shamburger (GA); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by William Coon (ID); Ann Gilespie represented by Emily Downs and Michelle Baldock (IL); Holly W. Lambert represented by Teresa Tetrick (IN); Vicki Schmidt represented by Kenneth Scott (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Cara Libman (MA); Grace Arnold represented by Julia Dreier (MN); Angela L. Nelson (MO); Eric Dunning represented by Martin Swanson (NE); Susan Ochs (NJ); Ned Gaines represented by Jack Childress (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready and Mike Rhoads (OK); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Lisa Harmon (SD); Amanda Crawford represented by Debra Diaz-Lara and Rachel Bowden (TX); Jon Pike represented by Heidi Clausen (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Delika Steele (WA); and Nathan Houdek represented by Coral Manning (WI).

1. Discussed Industry Progress on its PA Reform Initiative

Jeanette Thornton (AHIP), David Merritt (Blue Cross and Blue Shield Association—BCBSA), and key representatives from major health insurance plans, including Aetna, Blue Shield of California, Cigna, Elevance Health, , and Highmark, provided updates on their commitments to reform the prior authorization (PA) process. These commitments aim to reduce administrative friction, improve patient and provider experiences, and ensure appropriate care. The plans have made progress in reducing the scope of services requiring PA, improving communication, and supporting continuity of care. Merritt highlighted an 11% reduction in PA requests this year, equating to 6.5 million fewer requests. Thornton emphasized that all nonapproved PA requests for clinical reasons continue to be reviewed by medical professionals.

Thornton guided the discussion among the plan representatives, which centered on significant progress made since the commitments were announced over a year ago, including those commitments to: 1) reduce the scope of services requiring PA; 2) improve continuity of care during plan transitions; and 3) enhance communication efforts to make PA decisions clearer and more actionable for members and providers.

A. Reducing the Scope of PA

In reducing the scope of PA, the plans discussed how they have actively reviewed and reduced the list of services requiring PA to minimize unnecessary administrative burden. This reduction targets services with predictable outcomes or those supported by clear clinical guidelines, aiming to focus PA where it adds clinical value. Dr. Stanley Crittenden (Cigna) reported that Cigna removed 375 tests and procedures from its PA list in 2025, reducing PA volume by 15%. Catherine Gaffigan (Elevance Health) shared that Elevance Health has reduced by 12% the number of medical codes requiring PA over three years, focusing on durable medical equipment and sleep medicine. Frank Caporusso (Blue Shield of California) described a data-driven approach to remove services consistently approved and supported by clinical guidelines.

B. Improved Continuity of Care Plan Transitions

The plans discussed how they have implemented processes to ensure that patients with active PAs maintain access to care during insurance plan transitions. This includes honoring prior approvals for a 90-day transition period to avoid treatment disruptions. Katerina Guerraz (Aetna) explained Aetna's practice of honoring PAs across commercial, Medicare, and Medicaid lines during member transitions. Crittenden noted Cigna's efforts to evaluate new members' needs and honor prior plan commitments to ensure seamless care continuity. The plans also discussed how they have enhanced tracking and reporting of continuity-of-care efforts, with thousands of PA requests processed under this protocol.

C. Enhanced Communication Efforts

The plans also discussed their efforts to improve the clarity and accessibility of PA communications to members and providers, which include using plain language, personalized explanations, and clear guidance on appeals and next steps. Gaffigan described how Elevance Health has redesigned its member communications to be clearer and more action-oriented, along with enhanced customer service training. Crittenden highlighted Cigna's digital tools, including a PA digital tracker and provider portal with real-time status updates and automated frequently asked questions (FAQ).

D. Additional PA Reforms

The plans also discussed additional PA reforms they are working toward for 2027, such as advancing real-time electronic PA to speed decisions and reduce administrative errors. They are working to achieve 80% real-time electronic PA approvals by 2027, leveraging new federal standards and technology to reduce manual processes such as phone and fax submissions. Gaffigan said that more than two-thirds of Elevance's electronic PA approvals are already processed in real time, with ongoing efforts to digitize further. Caporusso discussed Blue Shield of California's modernized interoperable platform, which uses coverage requirements discovery, automated rules engines, and Fast Healthcare Interoperability Resources (FHIR)-based application programming interfaces (APIs) to streamline PA. As part of this initiative, the plans are collaborating with providers and electronic health record vendors to implement these technologies and improve data exchange.

The plans are also making efforts toward standardization to unify PA questions and documentation across the top 70 procedures nationally, with pilot implementations planned to ensure provider workflow compatibility. The plans also discussed provider engagement challenges, especially for smaller and behavioral health providers, emphasizing education, multiple electronic submission options, and provider support teams. They also discussed the role of artificial intelligence (AI) in automating approvals, with a consensus that human clinical review remains critical to ensure safety and appropriateness. Throughout the meeting, Merritt, Thornton, and the plan representative panelists acknowledged the complexity of the PA process and the importance of ongoing collaboration among industry, providers, state insurance regulators, and technology partners.

Rhoads asked how the PA reform progress just discussed is resonating with physicians and other health care providers. In other words, how is industry communicating this progress to stakeholders, and what is the level of engagement? Guerraz discussed Aetna's approach, including holding meetings with providers in their networks about the PA process and using scorecards to help ensure that both the plan and the providers have the same level of understanding about what is expected. Merritt added that before industry even rolled out its commitments on PA reform last year, they briefed stakeholders, such as the American Medical Association (AMA), the American Hospital Association (AHA), and the Federation of American Hospitals (FAH), about their initiative

and have continued to update them on their progress. Caporusso said that Blue Shield of California has incorporated into its staff workflows the need and the requirement to communicate with its providers.

Manning asked about plan efforts to ensure that those providers still using the fax, phone, and other less advanced technologies can access and use the modernized platforms to submit PA requests. Commissioner Grant said she has heard that providers have had issues with submitting PA requests electronically. As such, related to Manning's question, she would like to know what industry is doing to work with providers to get them up to speed and educate them on submitting electronic PA requests. Gaffigan noted that it is up to providers whether they submit their PA requests electronically. She said Elevance Health has provider relationship account managers who work with network providers to identify opportunities to reduce PA administrative burdens and speed up PA request turnaround times. Gaffigan said those efforts also help encourage providers to use the electronic PA process. Guerraz said that in working more closely with providers over the past few years, Aetna found that some providers did not realize they were still submitting PA requests by fax. Because they were using a computer to submit the requests, they thought they were submitting them electronically. Given this, Aetna has stepped up its efforts to host provider events and visit provider offices to educate them on these processes.

Commissioner Grant said Noah Isserman (AHA) had posted a question in the chat asking whether the reductions in PA volume highlighted during this meeting as a key metric of success under the industry commitments are being offset by a shift to other forms of utilization management (UM). He also asked what safeguards or monitoring approaches should be in place to assess the net effect on providers and patients. Specifically, he asked how stakeholders can distinguish between genuine burden reduction versus potential reclassification or "back-end" UM activities that may not be captured in PA metrics alone. Commissioner Grant asked whether BCBSA, AHIP, or any of the plan panelists wanted to discuss how they are viewing these commitments in the context of all UM plan activities. Thornton explained that the focus of today's meeting was on improving and streamlining the PA process. However, she said that industry and all the plans involved in the initiative genuinely want providers and other stakeholders to have positive experiences as part of all these UM processes, and as such, they are open to future conversations about it.

Commissioner Grant noted that Joylynn Fix (WV), the Task Force's vice chair, could not attend the meeting due to a conflict. She said, however, that Fix had a question she wanted to present on her behalf on whether PA for a particular service is necessary if AI is signing off on a certain number of approvals for the service and in real time. Caporusso discussed Blue Shield of California's approach, which could ultimately eliminate PA requirements for that service in that situation. Crittenden said Cigna takes a similar approach to Blue Shield of California, along with backend checks with human clinicians in the feedback loop.

Commissioner Grant said that because the Task Force ran out of time for additional questions and because other stakeholders want an opportunity to provide their perspective on the topic, she anticipates the Task Force holding a follow-up meeting sometime after the Summer National Meeting to continue the discussion.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

Draft: 8/14/26

Employee Retirement Income Security Act (ERISA)
and Alternative Health Coverage (B) Working Group
Columbus, Ohio
August 13, 2026

The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Columbus, OH, Aug. 13, 2026. The following Working Group members participated: Andria Seip, Chair (IA); Sara Farris, Vice-Chair (AR); Debra Judy and Lila Cummings (CO); Weston Trexler (ID); Craig Van Aalst and Julie Holmes (KS); Shaun Orme (KY); Frank Opelka (LA); Mary Kwei (MD); Teresa Kroll (MO); Robert Croom (NC); Chrystal Bartuska (ND); Martin Swanson (NE); Alexia Emmermann (NV); Laura Miller (OH); Jill Kruger (SD); Tanji J. Northrup (UT); Mary Ashby Brown and Julie Fairbanks (VA); Sofia Pasarow (WA); Coral Manning (WI); and Joylynn Fix (WV).

1. Adopted its July 22, May 18, and Spring National Meeting Minutes

The Working Group met July 22 and May 18. During these meetings, it took the following action: 1) reviewed drafts and changes made to the *Guidance Document—ERISA Preemption and State PBM Laws* based on comments received; and 2) adopted the final draft of the document.

Swanson made a motion, seconded by Bartuska, to adopt the Working Group's July 22 (Attachment Two-A), May 18 (Attachment Two-B), and March 24 (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment One)* minutes.

2. Discussed Next Steps for a Guidance Document on Level-Funded Plans

Seip said the Working Group has formed a drafting group of state insurance regulators to begin work on drafting a guidance document addressing level-funded plans. The drafting group has had an initial meeting and plans to begin biweekly meetings to draft a document, building on a preliminary document drafted by the former chair of the Working Group, Robert Wake (ME), prior to his retirement this past January.

3. Discussed its Next Steps

Seip reminded the Working Group that the *Guidance Document—ERISA Preemption and State PBM Laws* will be considered for adoption by the Regulatory Framework (B) Task Force at its meeting later today. If it is adopted, the Health Insurance and Managed Care (B) Committee will consider it for adoption, where it will become a final document of the Committee. Further adoption by NAIC full membership is not planned.

Having no further business, the ERISA and Alternative Health Coverage (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 3 (specific companies, entities, or individuals) and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to discuss details of ongoing investigations, how to coordinate information sharing, and next steps regarding these entities.

Draft: 8/3/26

Employee Retirement Income Security Act (ERISA) and
Alternative Health Coverage (B) Working Group
Virtual Meeting
July 22, 2026

The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group of the Regulatory Framework (B) Task Force met July 22, 2026. The following Working Group members participated: Andria Seip, Chair (IA); Sara Farris, Vice Chair (AR); Yada Horace (AL); Sophie Thomas (CO); Mike Milnes (FL); Weston Trexler (ID); Shaun Orme (KY); Mary Kwei (MD); Amy Hoyt and Melissa Panettiere (MO); Robert Croom (NC); Crystal Bartuska (ND); Martin Swanson (NE); Jack Childress (NV); Laura Miller (OH); Andy Schallhorn (OK); Jill Kruger (SD); Shelley Wiseman (UT); Mary Ashby Brown (VA); Delika Steele (WA); and Lauren Van Buren (WI).

1. Adopted the Revised Draft *Guidance Document – ERISA Preemption and State PBM Laws*

Seip explained that she and Farris participated in a drafting group that included state insurance regulators from Alabama, Massachusetts, Missouri, Nebraska, North Dakota, Virginia, and West Virginia. The group had been meeting biweekly to revise the May 11 draft of the *Guidance Document—ERISA Preemption and State PBM Laws* (Guidance Document) based on comments received during the comment period ending July 17. Seip walked through the revised draft Guidance Document dated July 8, 2026. Seip explained the revisions and the rationale for the changes, as well as explaining why certain suggestions were not included.

Seip reiterated that the purpose of the Guidance Document is to provide guidance to state regulators as they or their legislatures consider pharmacy benefit manager (PBM) legislation. It is helpful for regulators to understand how courts have interpreted state PBM laws and whether there is an intersection with ERISA. Seip explained the difficulty with finalizing a document while the courts are actively litigating. Since the last draft, cases still subject to judicial review have been added in an addendum.

Seip reviewed the revisions and explained that most of the changes to the document were technical, cleanup-type changes. Seip explained that some language suggestions were offered for the section "ERISA Preemption." The current language was retained because it mirrors the NAIC *Health and Welfare Plans under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook).

Seip said there were some additional language suggestions offered in the "Lessons for States" section that were not incorporated into the draft. One comment suggested that laws with an option for self-funded plans to voluntarily participate in a state's regulatory structure would likely be unenforceable. The drafting group disagreed and did not add such language. Another suggestion was to add language from a 1997 U.S. Supreme Court case describing when a state law has an impermissible "connection with" an ERISA plan. The reference was not added because the current language quotes the U.S. Supreme Court in *Rutledge v. Pharmaceutical Care Management Association (PCMA),* and a detailed analysis of the "connection with" phrase can be found in the ERISA Handbook, which is repeatedly referenced in the Guidance Document. Seip said a comment suggested that this section could benefit from additional emphasis on the fact that this area of law is evolving as new cases are decided. This point is made throughout the paper, and additional language in this section was considered unnecessary.

Seip explained that the chart of categories of state laws at issue in *Rutledge v. PCMA*, *PCMA v. Wehbi*, and *PCMA v. Mulready* was updated to clarify that the citations in the chart are to the state laws that were at issue at the time the case was litigated and may have been amended since the cases were decided.

Seip summarized the revisions that were made to the addendum. The addendum is intended to assist states in this rapidly evolving environment where cases are rapidly progressing through the legal process, and new cases are being filed. The addendum lists ongoing cases in alphabetical order and provides a brief summary. Seip said a comment was received suggesting that the summary of the *Iowa Association of Business and Industry v. Ommen* should list not only the provisions that were enjoined but also those that were not. The drafting group decided not to include this level of detail in the addendum summaries, as it is readily available in the decision. *PCMA v. Bonta* was removed from the addendum because the court had not yet taken any action in the case. The case of *Flowers v. Caremark PCS Health* was added to the addendum.

Carl Schmid (HIV+Hepatitis Policy Institute) asked whether there were plans to keep this document updated on a consistent basis. He also reiterated his opinion that state laws that were not preempted in court cases should be listed, as this information is important for state insurance regulators and legislators to review as they consider new laws. Seip said that her priority is to finish this version of the Guidance Document and that the issue of potential updates is best left for a later time once pending cases are finalized. She said the Working Group will consider how best to address this issue, whether through updates to this document or something else. She said the Working Group will consider this issue in the context of the Working Group's charges going forward.

Swanson made a motion, seconded by Farris, to adopt the revised Draft *Guidance Document—ERISA Preemption and State PBM Laws (see NAIC Proceedings, Summer 2026, Health Insurance and Managed Care (B) Committee, Attachment Four).* The motion passed unanimously.

2. Discussed its Next Steps

Seip said that this draft will be considered for adoption by the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee at their respective meetings at the upcoming Summer National Meeting.

Following the Summer National Meeting, a regulator-only drafting group plans to begin drafting a guidance document on level-funded plans. Level-funded plans are an increasingly popular arrangement typically sold to small employers that involves self-funding with a fixed amount (level-funded) stop loss policy. State insurance regulators who are interested in participating in the drafting group should contact Jennifer Cook (NAIC).

Having no further business, the ERISA and Alternative Health Coverage (B) Working Group adjourned.

Draft: 6/18/26

Employee Retirement Income Security Act (ERISA) and
Alternative Health Coverage (B) Working Group
Virtual Meeting
May 18, 2026

The Employee Retirement Income Security Act (ERISA) and the Alternative Health Coverage (B) Working Group of the Regulatory Framework (B) Task Force met May 18, 2026. The following Working Group members participated: Andria Seip, Chair (IA); Sara Farris, Vice Chair (AR); Yada Horace (AL); Kim Williams (CO); Howard Liebers (DC); Alexis Bakofsky (FL); Shannon Hohl and Weston Trexler (ID); Craig Van Aalst and Julie Holmes (KS); Shaun Orme (KY); Mary Kwei (MD); Melissa Panettiere (MO); Robert Croom (NC); Ross Hartley (ND); Maggie Reinert (NE); Alexia Emmermann (NV); Laura Miller (OH); Andy Schallhorn (OK); Travis Jordan and Frank Marnell (SD); Shelley Wiseman (UT); Mary Ashby Brown and Stephen Hogge (VA); Sarah Smith (WI); and Michael Malone (WV).

1. Reviewed the Revised Draft *Guidance Document: ERISA Preemption and State PBM Laws*

Seip explained that she and Farris participated in a drafting group that included state insurance regulators from Alabama, Massachusetts, Missouri, Nebraska, North Dakota, Virginia, and West Virginia. The group had been meeting biweekly to revise the Feb. 2 draft of the *Guidance Document: ERISA Preemption and State PBM Laws* (Guidance Document) based on comments received during the comment period ending March 3. Seip walked through the revised draft (Attachment Two-B1), explaining the revisions and the rationale for the changes the drafting group made, as well as explaining why certain suggestions were not included.

Seip reiterated that the purpose of the Guidance Document is to provide guidance to state regulators as they or their legislatures consider pharmacy benefit manager (PBM) legislation. It is helpful for regulators to understand how courts have interpreted state PBM laws and whether there is an intersection with ERISA.

A. Comments on the Scope and Introduction

Seip said that there were several comments made regarding the scope of the Guidance Document. The first addition was to include the following on the top of the first page: “Disclaimer: The information in the paper is current as of [insert publication date].” Additional explanatory language was added to the introduction to clarify that this document addresses issues only from the Supreme Court case *Rutledge v. PCMA* and procedurally final cases post-*Rutledge*. Pending cases and cases eligible for appeal are not included. For example, the Fourth Circuit reached a decision in *McKee Foods Corporation v. BFP Inc.* This case is not included in the paper because it is still subject to appeal to the Supreme Court. Commenters also suggested aligning this paper with the NAIC *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook). The draft was revised to reference the ERISA Handbook in the introduction and in several places throughout.

Several comments suggested adding policy pros and cons, as well as policy arguments related to PBMs and PBM oversight. The paper focuses on the court's legal analysis rather than matters that might be considered opinions, so the revised draft did not incorporate opinion-type suggestions. The revised draft does reference the PBM law in effect when *Rutledge* was decided, in recognition that the law has changed since then. There were comments made suggesting changes to the sentence in the paper that said, “Per *Rutledge,* ERISA does not preempt state regulations that 'merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.’” This phrase is a key part of the *Rutledge* holding that is especially

relevant to states assessing potential or current legislation. The revised Guidance Document retained this sentence unchanged.

B. Comments on ERISA Preemption

Several comments were submitted emphasizing the importance of describing the ERISA preemption tests. In response to those comments, a reference to the ERISA Handbook was included that contains a fulsome explanation of ERISA preemption and state law, as well as clarifying that ERISA's "saving" and "deemer" clauses were not considered in the cases analyzed in this Guidance Document.

C. Comments on Cases Addressing ERISA Preemption Analysis of State PBM Laws

Comments were submitted suggesting the inclusion of the Supreme Court case *Gobeille v. Liberty Mutual*. The revised draft added a footnote explaining that *Gobeille* is not a PBM case but an ERISA preemption case that regulators may want to familiarize themselves with and included a citation to the ERISA Handbook.

The revised draft incorporated suggested comments in the analysis of *Pharmaceutical Care Management Association v. Wehbi*. The revised draft clarifies the two tests used to determine whether a law "relates to" an ERISA plan such that it is preempted: does the law make "reference to" an ERISA plan or have an impermissible "connection with" an ERISA plan.

The revised draft included suggested language in the *Pharmaceutical Care Management Association v. Mulready* analysis clarifying that the Medicare Part D preemption issue is outside the scope of this Guidance Document.

Seip explained that the revised Guidance Document includes an "Addendum" of ongoing cases. Many comments were received about pending litigation. The Working Group acknowledges that this is an ongoing issue and aims to make it as useful as possible. This issue will have to be revisited as cases conclude, and this Guidance Document will need to be revised to stay current. In recognition of the PBM litigation that is currently ongoing, brief summaries of ongoing cases have been added to the addendum.

D. Comments on Lessons for States

The revised draft incorporated comments received regarding the importance of considering the full preemption test, including the saving clause, and added a sentence in a footnote pointing out that the United States, in its amicus brief to the Tenth Circuit in the *Mulready* case, took the position that the PBM law at issue was saved from preemption as a law that regulates insurance. The Tenth Circuit did not consider the saving clause because, in its view, the state failed to preserve the argument at the district court.

In the section on "Principles to Apply," the revised Guidance Document did not incorporate the suggestion to limit the section to an analysis of fully insured plans. Many states' laws apply to all PBMs, regardless of whether they work with fully insured or self-funded plans.

E. Addendum of Pending Cases

Seip explained that this latest draft includes brief summaries of pending cases addressing ERISA preemption of state PBM laws. While the main part of the paper does not analyze pending cases, the Working Group wanted to flag cases ongoing at the time of publication for monitoring.

Carl Schmid (HIV+Hepatitis Policy Institute) said that consumer representatives will plan to review this draft and submit comments. He spoke in support of adding an addendum on pending cases but noted that the Iowa case summary listed only the provisions that were enjoined and suggested also listing those that were not. Similarly, the summary of the California PBM case highlights the Pharmaceutical Care Management Association (PCMA) arguments, but not the California Attorney General's arguments from their brief.

2. Discussed its Next Steps

Seip said that this draft is exposed for a 30-day public comment period ending June 18. Comments should be emailed to Jennifer Cook (NAIC). Commenters are encouraged to provide suggested language and to keep comments within the scope of the document.

Having no further business, the ERISA and Alternative Health Coverage (B) Working Group adjourned.

Comments are requested by email to jcook@naic.org by close of business June 18, 2026

DRAFT 5-11-26

Disclaimer: The information in the paper is current as of [insert publication date.]

GUIDANCE DOCUMENT – ERISA PREEMPTION AND STATE PBM LAWS

OUTLINE

I. Introduction

This document providesguidance related to ERISA preemption by undertaking an analysis of the different types of state PBM laws[1] and considering how appellate courts have applied the reasoning in *Rutledge* to those laws.[2] Per the Disclaimer above, this document is current as of DATE and therefore, does not discuss pending litigation in this area.[3] Additionally, the NAIC *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* provides a more comprehensive overview of ERISA preemption and its impact on state efforts to regulate ERISA plans.

Pharmacy benefit managers (PBMs)[4] play a significant role in the provision of health care in the U.S. PBMs negotiate and contract with pharmacies on reimbursement and pharmacy network terms. PBMs design, negotiate, implement, and manage formulary designs for prescription drugs, including negotiating rebates and drug coverage terms with pharmaceutical manufacturers. Insurance companies and employer groups contract with PBMs for the design and implementation of preferred and non-preferred pharmacy networks,

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[1] The National Conference of State Legislatures publishes policy reports on various topics. The report titled "State Policy Options and Pharmacy Benefit Managers" places state PBM laws into categories and includes a state-by-state list of laws by category. See, https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers.

[2] Note that *PCMA v. Rowe,* 429 F.3d 294 (1st Cir. 2005) and *PCMA v. District of Columbia,* 613 F.3d 1085 (D.C. Cir. 2010) predate the *Rutledge* decision and are outside the scope of this paper. Additionally, *McKee Foods Corporation v. BFP Inc., et al*, (6th Cir. 2026)

[3] Court cases, including the recently decided *McKee Foods Corporation v. BFP Inc., et al*, (6th Cir. 2026) will not be included in this paper until they are procedurally final and no longer subject to additional judicial review.

[4] The alternative form "pharmacy benefits managers" is used in many publications and statutes.

metric-based payment arrangements, and formulary design elements (drug coverage, out-of-pocket responsibilities for patients and utilization management protocols). PBMs engage in the negotiation and financial transactions between pharmaceutical manufacturers, health plans, and pharmacies.[5]
In connection with their regulatory authority over health care, including the practice of pharmacy and the business of insurance, states have enacted laws regulating PBMs. However, these laws interact in complex ways with a variety of federal laws (Medicare, Medicaid, Employee Retirement Income Security Act of 1974) that might also apply, depending on the type of benefit plan that the PBM is managing. This has created the opportunity for a variety of different federal preemption challenges, which complicate the ability of states to address important health policy issues affecting their citizens.

This guidance document deals specifically with questions about preemption of state PBM laws under the Employee Retirement Income Security Act of 1974 (ERISA), which regulates employee benefit plans. It does not address potential preemption by other federal laws such as those governing the Medicare Part D prescription drug program.

The leading Supreme Court case on this subject is *Rutledge v. PCMA,* decided in 2020, which held that an Arkansas PBM law, Act 900 of 2015, was not preempted by ERISA.[6] Per Rutledge, ERISA does not preempt state regulations that "merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."[7] However, *Rutledge* did not conclusively resolve all questions about the permissible scope of state PBM regulation, so there continue to be disputes over how the principles analyzed in *Rutledge* apply to PBM laws that include different types of provisions. There have been two recent ERISA preemption decisions by federal Courts of Appeals that reached opposing conclusions. The Eighth Circuit upheld North Dakota's law[8] while the Tenth Circuit struck down parts of Oklahoma's law[9].

II. ERISA Preemption

The Employee Retirement Income Security Act of 1974 is a complex and comprehensive statute that federalizes the law of employee benefits. ERISA establishes a comprehensive regulatory framework for employee pension benefit plans and also preempts most state laws relating to private-sector "employee

[5] NAIC Health Insurance and Managed Care (B) Committee, *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation*, 2023, https://content.naic.org/sites/default/files/committee_related_documents/PBM%2520White%2520Paper%2520Draft%2520Adopted%2520B%2520Committee%252011-2-23_0.pdf

[6] *Rutledge v. Pharmaceutical Care Management Ass'n,* 592 U.S. 80 (2020). The case was only appealed to the United States Supreme Court on the issue of ERISA preemption. The Court did not opine on the Eight Circuit's finding that Act 900 was preempted by Medicare Part D.

[7] *Rutledge at 88.*

[8] *Pharmaceutical Care Management Ass'n v. Wehbi, 18 F.4th 956 (8th Cir. 2021).*

[9] *Pharmaceutical Care Management Ass'n v. Mulready, 78 F. 4th 1183 (10th Cir. 2023)*

welfare benefit plans,"[11] a broad category that includes nearly all employer-sponsored and union-sponsored health plans. However, ERISA does not preempt state insurance law.[12] ERISA's "saving clause" for any state law that "regulates insurance"[13] gives states broad authority to regulate PBMs administering state regulated insurance policies, including fully-insured employee health plans.[14]

ERISA's saving clause does not entirely foreclose the possibility of preemption challenges to insurance-specific PBM laws. The "saving clause" is limited by ERISA's "deemer clause," which prohibits states from "deeming" an employee benefit plan to be an insurer as means to assert state authority to regulate the employee benefit plan .

The focus of recent preemption litigation has been state laws that apply broadly to the PBM industry, including with respect to PBMs acting on behalf of self-insured, ERISA-covered plans. Many states have chosen to address PBM issues through pharmacy regulation rather than insurance regulation because the majority of consumers do not get their medications through state-regulated insurance policies. In particular, almost 2/3 of people with coverage through their employer are covered by self-insured health plans not regulated by state insurance law.[15]

At a high level, when a state contemplates applying a particular regulatory measure to PBMs contracted with self-insured employers, the question policymakers must consider is whether that measure is a permissible exercise of the state's general powers to regulate PBMs, or whether it encroaches on the exclusive federal power to regulate the employer's health benefit plan. Under ERISA, if a state PBM law "may now or hereafter relate to any employee benefit plan" and is not a law "which regulates insurance," that law is preempted.[16]

As the case law discussed below illustrates, it is not a simple task to decide whether a particular provision of state law "relates", within the meaning of ERISA, to a state-regulated PBM or to its self-insured, federally-protected client. It should be noted that, in the cases below, the courts decisions did not consider the "saving clause" or "deemer clause."

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[11] Government employee plans are exempt from ERISA. ERISA § 4(b)(1), *codified at* 29 U.S.C. § 1003(b)(1).

[12] As mentioned in this paper's introduction, consult the NAIC publication *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* for a more comprehensive treatment of ERISA preemption and state law.

[13] ERISA § 514(b)(2)(A), *codified at* 29 U.S.C. § 1144(b)(2)(A).

[14] The terms "fully-insured employee health plan" and "employer group health insurance policy" are often used interchangeably, and as a practical matter they are functionally identical. However, strictly speaking, the policy is issued by an insurance company, while the fully-insured plan is established by the employer when it buys the policy. This is what the Supreme Court was referring to in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985), when it explained that the structure of ERISA "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." In other words, by directly regulating the insurer and the insurance policy, the state indirectly regulates the employer that buys the insurance.

[15] https://www.kff.org/health-costs/2024-employer-health-benefits-survey/#e3efa8b3-48d2-458b-a2f7-c4d5add1983b--h-section-10-plan-funding.

[16] ERISA §§ 514(a) & (b)(2)(A), *codified at* 29 U.S.C. §§ 1144(a) & (b)(2)(A).

III. CASES ADDRESSING ERISA PREEMPTION ANALYSIS OF STATE PBM LAWS

Rutledge

To consider the potential impact of ERISA on state PBM laws, it is logical to begin with an analysis of the Supreme Court's *Rutledge* opinion. In *Rutledge*, the Court upheld an Arkansas law, Act 900 of 2015, which requires PBMs to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. To accomplish this, Act 900 mandates that PBMs: 1) keep their Minimum Acquisition Cost (MAC) pricing lists current with wholesale drug price increases;[17] 2) establish an appeal process for pharmacies to challenge PBM MAC pricing lists;[18] 3) increase pharmacy reimbursement rates to cover pharmacy acquisition costs;[19] and 4) allow the pharmacy to adjust any claims[20] affected by the pharmacy's inability to get the drug at a lower price from its usual wholesaler. Act 900 also includes a fifth provision allowing the pharmacy to refuse to fill a prescription if the PBM reimbursement to the pharmacy is less than the pharmacy paid for the drug.

The Court reviewed each of these provisions in the Arkansas law and concluded that they did not "relate to" ERISA plans and were not preempted. The Court explained that in order to impermissibly "relate to" an ERISA plan, the state law must have a "connection with" or make a "reference to" ERISA plans.[21]

To analyze whether Act 900 had an impermissible "connection with" ERISA plans, after providing some general background on the objectives of ERISA,[22] the Court contrasted three prior cases in which it held laws to be preempted on that ground, stating that ERISA is "primarily concerned with preempting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits" as in *Shaw v. Delta Air Lines,*[23] or "by binding plan administrators to specific rules for determining beneficiary status," as in *Egelhoff.*[24] In addition, there can be an impermissible connection if "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage," citing *Gobeille v. Liberty Mutual,*[25] invalidating a Vermont law establishing an all-payer health

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17 Act 900 of 2015.

18 *Id.*

19 *Id.*

20 *Id.*

21 *Rutledge*, 592 U.S 80 at 86.

22 *Id.* The Court progressed through its prior jurisprudence by: 1) considering "ERISA's objectives as a guide as to what state laws would survive" (*California Div of Labor Standards Enforcement v. Dillingham Constr. , N.A., Inc,* 519 US 316, 325 (1997)); 2) identifying the objective of ERISA as ensuring the security of employer sponsored benefits "by mandating certain oversight systems and other standard procedures." (*Gobeille*, 577 U.S. 312, 320-321 (2016)); and 3) explaining that Congress, in pursuit of the security of employer sponsored plans, "sought to ensure that plan and plan sponsors would be subject to a uniform body of benefits laws," thereby minimizing the administrative and financial burden of complying with different benefit requirements in multiple jurisdictions. (*Ingersoll-Rand Co. v. McClendon*, 498 US 133, 142 (1990)).

23 *Id.* at 86-87.

24 *Id.* at 87.

25 *Id.*

claim database and including third-party administrators and self-insurers among the entities subject to mandatory reporting.[26] In summary:

> As a shorthand for these considerations, this Court asks whether a state law "governs a central matter of plan administration or interferes with nationally uniform plan administration." If it does, it is preempted.[27]

However, the Court observed:

> Crucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs.[28]

The Court discussed each of PCMA's contentions that provisions in Act 900 interfered with central matters of plan administration and impermissibly affected plan design. The Court, in addressing each provision, concluded that the provisions at issue, "do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies…."[29] stating that "ERISA does not preempt a state law that merely increases costs . . . even if plans decide to limit benefits or charge plan members higher rates as a result."[30] The opinion concludes: "In sum, Act 900 amounts to cost regulation that does not bear an impermissible connection with or reference to ERISA."

Finally, the Court determined that there was no impermissible "reference to" ERISA plans. Citing *Gobeille,* the Court stated that a law refers to ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."[31] Applying this reasoning to Act 900, the Court explained that the law does not "refer to" ERISA. It held that the Arkansas law

> …does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.[32]

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[26] While not a PBM case, regulators may want to review the summary of the *Gobeille* case in the NAIC *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation, p 32.*

[27] *Id.*

[28] *Id.*

[29] *Id.* at 89, noting in footnote 2 that PCMA does not suggest that Act 900's enforcement mechanisms overlap with "fundamental components of ERISA's regulation of plan administration." *Gobeille*, 577 U. S. at 323.

[30] *Id.* at 91.

[31] *Id.* at 88.

[32] Id. at 88-89.

Instead, the Court likened Act 900 to the New York law at issue in *Travelers,*[33] a landmark 1995 case limiting the reach of ERISA's "relate to" clause. That law had imposed surcharges on most hospital bills but not bills for patients who were covered by Medicaid or by nonprofit insurers that offered coverage to all applicants regardless of health status. The law was held not to refer to ERISA plans because the surcharge applied without regard to whether coverage was secured by an ERISA plan or not.[34]

Cases Post-*Rutledge*

Since the *Rutledge* decision, lower courts have applied the holding and reasoning espoused in *Rutledge* to resolve ERISA preemption challenges to the myriad PBM laws that have been passed in the states.[35] The results have been complicated. Two PBM cases in particular – *Mulready* and *Wehbi* – have risen to the circuit courts and reached opposite conclusions regarding whether ERISA preempted the laws at issue. While the laws being challenged in these cases regulate PBMs, they each include different provisions that were not specifically litigated in *Rutledge*. They cover some of the same topics, (transparency and pharmacy reimbursement), but the North Dakota Law at issue in *Wehbi* includes additional provisions related to pharmacy practices. The Oklahoma law also addresses pharmacy networks. *Mulready* petitioned the Supreme Court for a Writ of Certiorari citing the circuit conflict in these two cases. The Court denied Cert on June 30, 2025, leaving the *Mulready* decision binding law in the 10th Circuit.

Wehbi

The United States Court of Appeals for the Eighth Circuit analyzed North Dakota's PBM laws on remand after the Supreme Court directed the Eighth Circuit to reconsider its decision in light of the reasoning in *Rutledge*. The Eighth Circuit had initially determined that ERISA preempted the contested provisions of Act 900, in 19-02.1-16.1 and 16.2, however, on remand, they reversed their decision and held that the laws were not preempted under ERISA.

Like the Supreme Court in *Rutledge*, the Eighth Circuit Court held that whether a state law "relates to" ERISA plans by analyzing whether there is an impermissible "connection with" or "reference to" ERISA plans.

Considering whether a law has an impermissible "reference to" an ERISA plan, the Court looked to whether the law "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation."[36] In the case of North Dakota's PBM laws, they did not make "reference to" ERISA plans because the law applies to PBMs regardless of who they contract with. The Eighth Circuit Court

[33] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, (1995)*.

[34] "…Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage. Act 900 is therefore analogous to the law in *Travelers*, which did not refer to ERISA plans because it imposed surcharges 'regardless of whether the commercial coverage [was] ultimately secured by an ERISA plan, private purchase, or otherwise.' 514 U. S., at 656 (footnote omitted)." *Rutledge*, 592 U.S. 80, 89.

[35] All 50 states have laws regulating PBMs. https://www.ncsl.org/health/prescription-drug-legislation-database

[36] *Wehbi,* 18 F.4th 956 at 969.

followed the decision in Rutledge and held that the "existence of ERISA plans is essential to a law's operation only if the law cannot apply to an non-ERISA plan."[37]

In assessing whether the law has a "connection with" ERISA, the Eighth Circuit reasoned that

> A state law has an impermissible 'connection with' ERISA plans if and only if (1) it 'governs . . . a central matter of plan administration'; (2) it 'interferes with nationally uniform plan administration'; or (3) 'acute, albeit indirect, economic effects' of the law 'force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'[38]

The Eighth Circuit, quoting *Rutledge,* stated that "the mere fact that a state law 'affects an ERISA plan or causes some disuniformity in plan administration'" does not mean the law meets the "connection with" standard, "especially…if the law merely affects costs.'"[39] The Eighth Circuit further clarified its focus stating that ERISA pre-emption is "primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status."[40]

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The Court in *Wehbi* held that the challenged provisions of the North Dakota law did not meet the "connection-with" standard, and therefore, was not preempted under ERISA. The Court reasoned that certain provisions were not preempted because they were "merely *authorizing* pharmacies to do certain things." Those provisions were:

- Section 16.1(5): disclose certain information to the plan sponsor;
- Section 16.1(7): provide relevant information to a patient;
- Section 16.1(8): mail or deliver drugs to a patient as an ancillary service;
- Section 16.1(9): charge shipping and handling fees to patients requesting prescriptions to be mailed or delivered;[42]

The Eighth Circuit says that "These provisions affect PBMs only insofar as they prevent PBMs from preventing pharmacies/pharmacists from engaging in these practices. This constitutes at most, a regulation of a noncentral 'matter of plan administration' with *de minimis* economic effects and impact on the uniformity of plan administration across states."[43] The *Wehbi* court draws a distinction between allowing pharmacies to

[37] Id. at 969.
[38] 18 F.4th 956 at 968.
[39] *Id.*
[40] *Id.*
[42] *Id.* at 968.
[43] *Id.*

decline to dispense a prescription if the reimbursement is too low and "requiring payment of specific benefits."[44]

The Court explained that Sections 16.1(11) and 16.2(4) of the North Dakota law also did not meet the "connection-with" standard because they "merely limit the accreditation requirements that a PBM may impose on pharmacies as a condition for participation in its network."[45] The Court said sections 16.1(10) and 16.2(2) also did not meet the "connection-with" standard because these provisions merely "require PBMs to disclose basic information to pharmacies and plan sponsors upon request."[46] The Court explained that section 16.2(3), which prohibits a PBM from having "an ownership interest in a patient assistance program and a mail order specialty pharmacy," did not reach the pre-emption threshold because compliance with the law was the responsibility of the PBM, and therefore, the PBM (and not the law) was responsible for any effect on ERISA plans' beneficiaries.[47]

Mulready

The United States Court of Appeals for the Tenth Circuit reversed the District Court for the Western District of Oklahoma, holding that ERISA preempted Oklahoma's PBM law. The decision also addressed a Medicare Part D preemption claim, which is beyond the scope of this paper. Oklahoma enacted legislation in 2019 to "establish minimum and uniform access to a provider and standards and prohibitions on restrictions of a patient's right to choose a pharmacy provider."[48]

The Tenth Circuit focused on laws that have a "connection with" an ERISA plan (as opposed to laws that "refer to" an ERISA plan) so as to be preempted under the "relates to" language of ERISA. The Supreme Court in *Rutledge* relied on the "shorthand inquiry" it recited in *Gobeille*: "Does the state law 'govern a central matter of plan administration or interfere with national uniform plan administration'," [49] while also clarifying that "ERISA does not preempt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."[50]

The Tenth Circuit divided the provisions of the law under review into two categories[51]: 1) "network restrictions," which includes access standards;[52] discount prohibition;[53] and any willing provider provision[54]; and 2) "integrity and quality restriction," which is the probation provision that prohibits "PBMs from denying, limiting or terminating a pharmacy's contract because one of its pharmacists is on probation" with the state

[44] *Id.*
[45] *Id.*
[46] *Id.* at 968-969.
[47] *Id.* at 969.
[48] Okla. Stat. tit. 36, § 6959 (2019).
[49] *Gobeille*, 577 U.S. at 320.
[50] *Rutledge*, 592 U.S. 80, 88.
[51] *Mulready,* 78 F.4th 1183 at 1196.
[52] Okla.Stat. tit. 36 § 6961 (a)-(B) (2019).
[53] Okla.Stat. tit. 36 § 6963.
[54] Okla.Stat. tit. 36 § 6962 (B)(4).

pharmacy board.[55] The Tenth Circuit analyzed whether the provisions "govern[] a central matter of plan administration" or "interfere[] with nationally uniform plan administration" so as to be preempted. Emphasizing the importance of uniformity under ERISA, the Tenth Circuit stated that "ERISA's promise of uniformity is vitally important for employers, who "have large leeway to design . . . . plans as they see fit."[56] The Tenth Circuit concluded in regard to the "network restrictions" "[e]ach provision either directs or forbids an element of plan structure or benefit design" which is a "central matter of plan administration" and therefore preempted under ERISA.[57] Additionally, the Court held the "integrity and quality restriction" provision is preempted under ERISA as it acts similar to the network restrictions, "dictating which pharmacies must be included in a plan's PBM network."[58]

As applied to the Oklahoma laws, the Tenth Circuit explains that even though Oklahoma's law regulates PBMs, not plans, Supreme Court precedent has held that state laws can relate to ERISA plans even if they regulate only third parties, citing *Metropolitan Life*[59] and *Rush Prudential HMO, Inc. v. Moran*.[60]

Mulready petitioned the United State Supreme Court for a Writ of Certiorari, citing a conflict between the Eighth and Tenth Circuit decisions. Amicus briefs were filed by numerous parties. Of note is the brief for the United States arguing that the petition for a Writ of Certiorari should be denied. In the brief, the U.S. argued that the decision in *Mulready* did not conflict with the Supreme Court's decision in *Rutledge* or with the Eighth Circuit's decision in *Wehbi*. The brief argued that:

> The Tenth Circuit faithfully adhered to this Court's precedent, and the Eighth Circuit's decision in *Wehbi* does not necessarily indicate any divergence of approach to ERISA preemption. In addition, this case would be a suboptimal vehicle for addressing ERISA preemption because neither the Tenth Circuit nor the district court addressed whether the challenged provisions of the Oklahoma law are exempt from preemption in some applications under ERISA's savings and deemer clauses.[61]

The Supreme Court denied the Writ of Certiorari in *Mulready* on June 30, 2025.

IV. LESSONS FOR STATES

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[55] Okla.Stat. tit. 36 § 6962 (B)(5);

[56] *Mulready,* 78 F.4th 1183 at 1193.

[57] *Id.* at 1198.

[58] *Id.* at 1203.

[59] *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 734 (1985).

[60] *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359 (2002).

[61] Brief for the United States as Amicus Curiae, p. 10, *Pharmaceutical Care Management Ass'n*, v, *Mulready,* No.23-1213, *cert. denied*. In its amicus brief to the Tenth Circuit, The U.S. took the position that the law was saved in its entirety as applied to PBMs serving both fully insured and self-funded ERISA plans. The Tenth Circuit did not address this issue because, in its view, the State failed to preserve this argument.

As a threshold matter, states should look to recent court decisions for guidance as to how federal courts will apply ERISA's preemption provisions to a particular state's law. While decisions of the U.S. Supreme Court constitute binding authority, variations in state laws must be carefully considered in any analysis. While appellate decisions can serve as persuasive authority, they are only binding on states within that circuit court's jurisdiction. This is especially true with respect to questions of ERISA's preemption of state PBM laws since the *Rutledge* decision.

As the beginning of this paper notes, PBMs play a critical role in the current health care ecosystem, and as a result, states have an interest in regulating their activities for the benefit of consumers. Every state has enacted PBM legislation, and the scope and focus of those laws differ. Also, states continue to consider enacting new PBM legislation to address PBM practices as the market evolves.[62]

When states evaluate existing PBM statutes or contemplate new legislative measures, it is important to carefully consider both the entities to which the legislation will apply and the content and focus of its specific provisions. For new legislation, make sure severability language is included.

[62] *See*, NAIC Health Insurance and Managed Care (B) Committee, *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* at 28

Principles to apply to the question of whether ERISA may preempt the state law at issue:

Step 1 – To whom does the law apply?

a. **State laws as applied to PBM contracts with insurers issuing individual health coverage regulated by the state.** These applications will not raise ERISA preemption concerns because they do not apply to ERISA covered health plans.

b. **State laws limited to PBM contracts with state-regulated insurers who may be issuing both individual health coverage and fully insured ERISA plans.** These laws are likely to fall under ERISA's "saving clause" as state laws that "regulate insurance" and therefore would not be preempted under ERISA. It bears repeating that there have not been any challenges to insurance-specific PBM laws; the focus of recent preemption litigation has been state laws that apply broadly to the PBM industry.

c. **State laws that apply to PBM contracts both for state regulated insurance and for other state-regulated health plans.** Only private employers are protected by ERISA's deemer clause when they self-insure. In addition to individual plans and fully-insured employer plans, ERISA gives states broad authority to regulate self-insured plans maintained by state and local governments and by other public employers such as state universities. However, to the extent a state law regulating non-Federal governmental plans prevents the application of a Federal law, the state law would be preempted.

   Likewise, state Medicaid plans and other publicly funded benefit programs are outside the scope of ERISA. Though states will need to ensure that any Medicaid PBM requirements are consistent with federal Medicaid law and any relevant terms and conditions of the federally-approved state Medicaid plan. Medicare plans are also outside the scope of ERISA, but are subject to Medicare preemption as they are governed by federal law and regulated by CMS.[63]

d. **State laws that apply to all PBM contracts regardless of the type of health plan involved.** Insofar as the law applies to contracts with self-insured private employers (directly or through a third-party administrator), it is necessary to analyze the specifics of these laws to determine if they improperly "relate to" an ERISA plan so as to be preempted.

e. **State laws mandating requirements for PBM contracts with state-regulated fully insured health plans, with an opportunity for self-funded group health plans to voluntarily participate ("opt-in") in**

[63] 42 U.S.C. § 1395 et seq. Additionally, because federal employee health benefit plans (FEHBP) are not subject to state regulation, they are not discussed in this paper.

state regulatory structure.[64] Including an opt-in for self-funded plans should not, in and of itself, cause the law to be preempted under ERISA, but this specific question has not been litigated.[65]

Step 2 – If a state law applies to contracts between PBMs and ERISA plans (either fully insured or self-funded), states should consider the content and focus of the specific provisions in the state PBM law and the analysis in the chart that follows:

a. Does the state law "relate to" an ERISA plan – Shorthand inquiry asks whether the law makes "reference to" or has a "connection with" an ERISA plan.

b. A state law "makes reference" to an ERISA plan if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."[66]

c. The law will have a "connection with" a state law if it 'govern(s) a **central matter of plan administration or interfere(s) with nationally uniform plan administration**.'"[67] That test is satisfied when, for example, a state law "require[s] providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits," or when state law "bind[s] plan administrators to specific rules for determining beneficiary status."[68]

d. In contrast, state laws "that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage" are not preempted.[69] "[N]ot every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection" and "[t]hat is especially so when a law merely affects costs."[70]

It is important to recognize that the application of Supreme Court decisions leaves considerable room for interpretation. As evidenced in the chart below, there are inconsistencies in how each circuit understood what is a "central matter of plan administration." In Wehbi, the Court determined that ERISA did not preempt the provision in North Dakota's statute prohibiting PBMs from imposing accreditation or recertification standards that exceed those required by state or federal licensure. This provision may arguably pertain to

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[64] Washington state law authorizes self-funded group health plans to opt into their PBM law beginning January 1, 2026. See RCW 48.200.330. This approach has been incorporated into state balance billing protections in several states. In Washington state, over 300 self-funded group health plans have opted into the Balance Billing Protection Act. To give an opportunity for local and governmental self-funded group health plans to opt in, whether or not governed by or exempt from ERISA, see RCW 48.49.130.

[65] The Supreme Court made clear in *Gobeille* that more than mentioning an ERISA plan is required create a "reference to" ERISA such that the law "relates to" an ERISA plan and is preempted. (*See infra* p.12 n. 49)

[66] *Gobeille*, 577 U.S. at 319–320

[67] *Rutledge*, 592 U.S. at 87.

[68] *Id. at 86-87*.

[69] *Id.* at 88.

[70] *Id.* at 87

pharmacy network development or maintenance. Conversely, in Mulready, the Court adopted a broader perspective, classifying network development and maintenance provisions as central matters of plan administration subject to ERISA preemption. Legal challenges to state PBM regulations continue, and varying court interpretations are expected.

Laws at issue in Rutledge, Wehbi and Mulready

CATEGORIES OF STATE LAW	UPHELD (SCOTUS)	UPHELD (8th Cir. Court of Appeals)	**NOT** UPHELD (10th Cir. Court of Appeals)
PBM PAYMENT TO PHARMACIES			
Requires PBMs to reimburse pharmacies at a price equal to or higher than the pharmacy's wholesale cost.	Rutledge (Act 900) of 2015		
Pharmacies may refuse to sell a drug if the PBM's reimbursement rate is lower than its acquisition cost.	Rutledge: Act 900 of 2015		
If a consumer pays a copayment, it is retained by pharmacy; cannot be 'clawed back' by PBM.		*Wehbi (19-02.1-16.1(4))	
PBM OVERSIGHT OF PHARMACY OPERATIONS			
PBM may not collect a fee from a pharmacy if the pharmacy's performance scores or metrics fall within the criteria identified by the electronic quality improvement platform for plans and pharmacies or other unbiased nationally recognized entity aiding in improving pharmacy performance measures.		*Wehbi (19-02.1-16.1(3))	
PBM is limited to applying a fee to the professional dispensing fee outlined in the pharmacy contract.		*Wehbi (19-02.1-16.1(3))	
PBM may not impose a fee relating to performance metrics on the cost of goods sold by a pharmacy.		*Wehbi (19-02.1-16.1(3))	
PBM may not prohibit a pharmacy from disclosing certain health information to the plan sponsor or patient.		Wehbi (19-02.1-16.1(5))	
Gag Orders prohibited: PBM may not prevent a pharmacy from providing relevant drug pricing & efficacy information to a patient.		Wehbi (19-02.1-16.1(7))	
PBM may not prevent mail or delivery of drugs to a patient as a pharmacy's ancillary service.		Wehbi (19-02.1-16.1(8))	
PBM may not prevent a pharmacy from charging shipping and handling fees to patients requesting prescriptions to be mailed or delivered.		Wehbi (19-02.1-16.1(9))	
PBM may be required to provide pharmacists information about each pharmacy network established or administered by a PBM.		Wehbi (19-02.1-16.1(10))	

PBM may not require accreditation or recertification requirements that are more stringent than federal & state licensure requirements (*for network participation*).		Wehbi (19-02.1-16.1(11) & *16.2(4))*	
PBM may not prohibit pharmacy from dispensing any drug allowed under its license.		*Wehbi (19-02.1-16.2(5))	
AWP Provision. Any willing pharmacy that is already in the PBM/plan's network must be allowed to be part of a preferred network if it is willing to accept the contractual terms.			Mulready: Okla. Stat. tit. 36, § 6962(B)(4) (2019).
Probation Prohibition: PBM may not deny or terminate a pharmacy license based on the license status of a pharmacy employee (being on probation with the State Pharmacy Board).			Mulready: Okla. Stat. tit. 36, § 6962(B)(5) (2019).
TRANSPARENCY IN PBM OPERATIONS			
PBMs must timely update their MAC lists when drug wholesale prices increase.	Rutledge: Ark. Code Ann. §17–92–507(c)(2)		
PBMs must have an appeal procedure for pharmacies to challenge MAC reimbursement rates.	Rutledge:Act 900 of 2015		
PBM may not charge or hold a pharmacy responsible for fees that it does not disclose to the pharmacy.		*Wehbi (19-02.1-16.1(2))	
Disclosing Spread Pricing: If requested, a PBM (or third-party payer) that has an ownership interest in a pharmacy, must disclose the difference between PBM's pharmacy payments and what is charged to the plan.		Wehbi (19-02.1-16.2(2))	
If a patient pays a copayment, PBM may not redact the adjudicated cost paid.		*Wehbi (19-02.1-16.1(4))	
A PBM may not have ownership interest in a patient assistance program or mail order specialty pharmacy unless it agrees to NOT participate in a transaction that would benefit the PBM.		Wehbi (19-02.1-16.2(3))	
Access Standards: PBM must meet certain network adequacy requirements for retail pharmacies (that do not include mail order pharmacies).			Mulready: Okla. Stat. tit. 36, § 6961((A)-(B) (2019).
Discount Prohibition: A PBM shall not use any discounts in cost-sharing or a reduction in copay for individuals to receive prescription drugs from an individual's choice of in-network pharmacy.			Mulready: Okla. Stat. tit. 36, § 6963(E) (2019).

* PCMA at appeal withdrew its claims that ERISA preempts section 16.1(2), section 16.1(3), the challenged portions of section 16.1(4), and section 16.2(5).

Citations are to statutes as codified at the time they were litigated and these statutory provisions may have been amended since the Courts' decisions were rendered:

Rutledge (SCOTUS): Arkansas State law at: Act 900 of 2015

Wehbi (8th Circuit): North Dakota State law at: https://ndlegis.gov/cencode/t19c02-1.pdf

Mulready (10th Circuit): Oklahoma State law (Patient's Right to Pharmacy Choice Act) at: https://law.justia.com/codes/oklahoma/2019/title-36/section-36-6958/

Addendum of pending cases and cases subject to additional judicial review:

***Central States, et al. v. McClain, et al.*, Seventh Circuit Court of Appeals, Case No. 25-2727**
U.S. District Court in the Northen District of Illinois, Eastern Division, 1:25-cv-03938; 2025 WL 2522621

Plaintiffs sued the Arkansas Insurance Commissioner and alleged that the following provisions of Rule 128, codified at 23 CAR pt 148, are preempted by ERISA.

1. Fair and Reasonable Pharmacy Reimbursements: requires health benefit plans and healthcare payors that have Arkansas covered lives to submit pharmacy compensation and claims information (the "Reporting Requirement") to the Arkansas Insurance Commissioner, who determines if payments to Arkansas pharmacists and pharmacies are fair and reasonable.
2. The Dispensing Fee Requirement: If compensation is not determined to be fair and reasonable, the Commissioner can require the plan to pay an additional pharmacy dispensing fee to ensure that the plan offers an adequate network of pharmacy providers.

The District Court ruled that Rule 128 does not contain an impermissible "reference to" ERISA plans, because the plaintiffs failed to plead that Rule 128 exclusively acts on ERISA plans. In addition, the Court found that the existence of an ERISA plan was not essential to the Rule's operation.

The Court also denied Plaintiffs' argument that Rule 128 has an "impermissible connection" to ERISA plans. It held that the Reporting Requirement was incidental to its stated purpose of regulating dispensing fees, and the Dispensing Requirement regulated costs, per *Rutledge*, and was not preempted.

Plaintiffs appealed to the Seventh Circuit, which held oral arguments on April 14th, 2026.

***Express Scripts Inc. et al. v. Richmond et al.*, Case No. 4:25-cv-00520 (E.D. Ark. filed May 29, 2025)**

On April 16, 2025, Arkansas enacted Act 624 prohibiting PBMs from acquiring, owning or operating retail or mail-order pharmacies in the state. The Act was challenged by several PBMs and PCMA in the U.S. District Court for the Eastern District of Arkansas. The Plaintiffs alleged that Act 624 was unconstitutional and preempted under the Medicare Part D, TRICARE and ERISA. Plaintiffs filed motions for preliminary injunction to enjoin the Act from taking effect pending the resolution of the litigation.

On July 28, 2025, the U.S. District Court for the Eastern District of Arkansas granted the motions for preliminary injunction based on the Commerce Clause and TRICARE preemption claims. The Court denied the motions for preliminary injunction based on the Privileges and Immunities Clause, Bill of Attainder Clause, Takings Clause, Equal Protection Clause, Medicare Part D preemption; and ERISA preemption claims.

In its order, the Court addressed the ERISA preemption claim and stated Act 624 does not "relate to" an ERISA plan, such that it is preempted. The Act does not make a "reference to" ERISA nor does it have an impermissible "connection with" an ERISA plan because the Act "does not regulate PBMs in their capacity as employee benefit plan administrators. Rather, it merely regulates the requirements for obtaining a retail

pharmacy license." Citing the *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*[71]., the Court reasoned that Act 624 would affect an ERISA plan's shopping decisions but would "merely be an indirect economic influence and would not bind plan administrators to any particular choice." The Arkansas State Board of Pharmacy has appealed the preliminary injunction before the Eight Circuit.

Iowa Association of Business and Industry v. Ommen, 799 F.Supp.3d 795 (2025)

This case is on appeal with the final ruling expected from the United States Court of Appeals for the Eighth Circuit. The case temporarily blocked 11 provisions of Iowa's PBM reform law (SF 383) that conflict with federal ERISA law and the First Amendment. The following provisions are enjoined as preempted by ERISA:

1. Prohibiting a PBM from discriminating against pharmacies acting within the scope of their license;
2. Any-willing-provider standards;
3. Prohibiting a PBM from unreasonably designating a drug as a specialty drug;
4. Anti-steering provision including prohibiting a PBM from offering incentives for use of mail-order pharmacies or requiring higher cost-sharing provisions at some pharmacies;
5. Allowing any amount paid by a consumer to apply to the consumer's deductible;
6. Requiring mandatory contract terms and supersession provisions; and
7. Providing a private right of action for 'injured' consumers or pharmacies.

The following provisions are enjoined as violative of the First Amendment:

1. Anti-referral provision and
2. Compelled disclosure requirements.

Finally, the following provisions are enjoined as inseverable from the above-mentioned invalid provisions:

1. Supersession over contrary contract terms and
2. Dispensing fee provision that cannot survive without the anti-discrimination framework.

McKee Foods Corporation v. BFP Inc., 173 F4th 242 (6th Cir. 2026)

On April 7, 2026, the United States Court of Appeals for the Sixth Circuit ruled that the following portions of the Tennessee (TN) PBM law have an impermissible connection with ERISA and are therefore preempted:

1. Any Willing Provider provisions:
    a. Prohibits a covered entity from denying a pharmacy the right to participate in a plan under the same terms and conditions as other participating pharmacies and
    b. PBMs cannot prohibit a consumer from receiving services as the pharmacy of their choice.
2. Incentive (aka Steering) provisions:
    a. Prohibits covered entities from requiring higher out-of-pocket costs to consumers at certain pharmacies and
    b. Prohibits PBMs from offering lower costs to consumers when they utilize PBM owned pharmacies.

This case may be appealed to the U.S. Supreme Court.

[71] 514 U.S. 645, 659–60 (1995)

Pharmaceutical Care Management Association v. Robert Bonta, et al., 2:26-cv-0012 (C.D. Ca). January 2, 2026

Pharmaceutical Care Management Association (PCMA) filed a lawsuit challenging part of a recently enacted California law, SB 41, that imposes a fiduciary duty on PBMs in their actions with self-insured employer plan clients. PCMA argues the provision is preempted by ERISA because the law "relates to" ERISA plans.

As amended, California's Business and Professions Code § 4441(c)(2) states:

A pharmacy benefit manager has a fiduciary duty to a self-insured employer plan that includes a duty to be fair and truthful toward the client, to act in the client's best interests, to avoid conflicts of interest, and to perform its duties with care, skill, prudence, and diligence.

PCMA argues that, because the law applies specifically to self-insured plans, the law has an impermissible "reference to" ERISA plans. PCMA seeks to have § 4441(c)(2) declared to be preempted by ERISA and to permanently enjoin the defendants from implementing or enforcing the provision.

Draft: 8/17/26

Prescription Drug Coverage (B) Working Group
and the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Columbus, Ohio
August 12, 2026

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Columbus, OH, Aug. 12, 2026, in joint session with the MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force. The following Prescription Drug Coverage (B) Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Tricia Davé (CT); Tina Ching (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Chris Heisler (IL); Craig Van Aalst (KS); Shaun Orme (KY); Frank Opelka (LA); Joe Stoddard (MI); Brogan Dinolfo and Teresa Kroll (MO); Matthew Eberhardt (MT); Robert Croom (NC); Michael Muldoon, Maggie Reinert, and Cheryl Wolff (NE); Jesse O'Brien (OR); Richard L. Hendrickson (PA); Jud Jones (TN); Tanji J. Northrup (UT); Sofia Pasarow (WA); Darcy Paskey (WI); and Lauren White (WY). Also participating were: Lila Cummings and Debra Judy (CO); Kevin P. Beagan (MA); and Jill Kruger (SD). The following MHPAEA (B) Working Group members participated: Chrystal Bartuska, Chair (ND); Michelle Heaton, Vice Chair (NH); Crystal Phelps (AR); Leanette Henagan (AZ); Lila Cummings and Debra Judy (CO); Kurt Swan (CT); Tina Ching (DC); Elizabeth Nunes and Simone Edmonson (GA); Andria Seip (IA); Chris Heisler (IL); Mary Kwei (MD); David Dachs (MT); Robert Croom (NC); Jack Childress (NV); Tony Bonofiglio (OH); Ashely Scott (OK); Richard L. Hendrickson (PA); Renee Boyce (SC); Jill Kruger (SD); Daniel McAdams (TX); Tanji J. Northrup (UT); Julie Fairbanks (VA); Sofia Pasarow (WA); Darcy Paskey (WI); Joylynn Fix (WV); and Jill Reinking and Lauren White (WY). Also participating was: Molly Nollette (AK).

1. Adopted the Prescription Drug Coverage (B) Working Group's Spring National Meeting Minutes

Hohl made a motion, seconded by Seip, to adopt the Working Group's March 23 minutes *(see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment Two)* minutes. The motion passed unanimously.

2. Adopted the MHPAEA (B) Working Group's April 2 Minutes

The MHPAEA (B) Working Group met April 2, 2026. During this meeting, the Working Group took the following action: 1) discussed its work plan, and 2) heard an update on the use of prior authorization templates.

Kruger made a motion, seconded by Scott, to adopt the Working Group's April 2 minutes (Attachment Three- A). The motion passed unanimously.

3. Heard Presentations on Insurance Coverage of Medications to Treat Substance Use Disorders

Dr. Marcus Bachhuber (Center for Evidence-Based Policy) and Dr. Matthew Sankey (The INS Companies) presented on insurance coverage of medications to treat substance use disorders. Bachhuber defined substance use disorders and said they are characterized by continued use despite consequences, persistent desire to cut down, tolerance, and withdrawal. He said substance use disorder shares many characteristics with other chronic medical illnesses. He said patient values, preferences, and prior experiences drive medication selection.

Bachhuber described three drugs used to treat opioid use disorder: methadone, buprenorphine, and naltrexone. He characterized treatment with medication as effective and lifesaving and said any medication is superior to treatment without medication. He said there is no one best option among the drugs; they are delivered in different

settings for different patients. He described additional medications that are used as opioid reversal agents or to treat opioid withdrawal.

Bachhuber listed the prescription drugs used to treat alcohol use disorder and tobacco use disorder. He shared statistics on the success of different treatments for tobacco use disorder, which showed the highest success rates with drug treatments. He said the use of drugs in treating substance use disorder is not optional, extra, or ancillary, but a core method of treatment.

Bachhuber cited several common issues with the placement of these drugs on insurance formularies. He said plans place the medications on high tiers, lack coverage for some forms, require prior authorization, or cover them through medical rather than pharmacy benefits. He provided examples of how confusion over medical versus pharmacy benefits can lead to treatment delays and patient harm.

Bachhuber cited resources from the Center for Evidence-Based Policy and other sources for state insurance regulators.

Sankey presented issues with formulary development, medical vs. pharmacy benefits, parity analysis, and utilization management techniques related to medications to treat substance use disorders. He described how health plan formularies are developed by pharmacy benefit managers (PBMs) at the national level and may not be appropriately adjusted for state benefit mandates. He provided examples of drugs that may be covered by either a medical benefit or a pharmacy benefit and questioned whether consumers or prescribers have enough information to understand this distinction. He described formulary tiering, prior authorization, step therapy, and quantity limits as practices that may raise parity concerns.

Sankey provided examples of parity findings related to medications to treat substance use disorders. He said buprenorphine lock out limitations, substance use disorder medications not being considered maintenance drugs, inappropriate quantity limits on buprenorphine/naloxone and buprenorphine, and naloxone product limitations were examples of parity problems.

Sankey described some of the issues with the transition of naloxone from a prescription drug to an over-the-counter (OTC) medicine. He said some health plans lack coverage for OTC items, and some have higher copays when a state lacks tiering or cost-sharing mandates.

Sankey provided tips for state insurance regulators' review of health plan formularies. He recommended obtaining a list of RxNorm Concept Unique Identifiers (RxCUIs), running the formulary tools from the federal Centers for Medicare & Medicaid Services (CMS), and developing a list of RxCUIs that require further review, with attention to tiering, prior authorization, and copays. He suggested focusing on new medications and making a checklist of RxCUIs.

Sankey suggested that states could implement ongoing compliance checks for formularies because formularies can change during the year.

Bartuska asked about differences between providers' recommendations for patients and what insurers decide will be covered. She asked how guidelines from the American Society of Addiction Medicine (ASAM) relate to such differences and whether insurance companies deviate from ASAM recommendations. Bachhuber said ASAM guidance is one of the standards used. He said ASAM suggests open access to treatment, but this may not be a realistic position. He said some drugs have similar efficacy but massive cost differences. He said it is reasonable to prefer a lower cost treatment, though this approach can be taken to an extreme. He said unnecessary utilization

controls have largely been removed, and those that remain focus on choosing lower-cost treatments among those with similar efficacy. He said ASAM levels of care provide clear guidance, though insurers and providers may have different interpretations based on the same information. Sankey added that ASAM guidelines were published in 2020 and may not capture newer medications.

Jones asked why medical providers may be hesitant to purchase medications and bill for them through the medical benefit when they are dispensed. Bachhuber said the main issue is matching purchases with the volume of treatments the clinic will administer. The medications have expiration dates and refrigeration requirements, so clinics do not want to purchase medications that may not be used.

4. Discussed Other Matters

Bartuska described the MHPAEA (B) Working Group's efforts to survey states on their parity activities. She said a survey instrument was developed and distributed to states. She said the Working Group continues to collect responses, which include information on state laws and regulations, use of reporting templates, and enforcement activities. She said the Working Group met in regulator-to-regulator session to discuss the survey. She said the Working Group plans to release the full results to state insurance regulators and a summary of responses to interested parties. She asked that states submit responses to NAIC committee support by Aug. 31.

Having no further business, the Prescription Drug Coverage (B) Working Group and the MHPAEA (B) Working Group adjourned.

Draft: 4/15/26

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Virtual Meeting
April 2, 2026

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met April 2, 2026. The following Working Group members participated: Chrystal Bartuska, Chair (ND); Michelle Heaton, Vice Chair (NH); Molly Nollette (AK); Crystal Phelps (AR); Gio Espinosa and Leanette Henagan (AZ); Kayte Fisher (CA); Kurt Swan (CT); Andria Seip (IA); Chris Heisler (IL); Mary Kwei (MD); Candace Gergen (MN); David Dachs (MT); Ted Hamby (NC); Ralph Boeckman (NJ); Viara Ianakieva and Jessica Sanchez (NM); Tom Sargent (NV); Tony Bonofiglio (OH); Ashley Scott (OK); Lindsi Swartz (PA); Glynda Daniels (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Brant Lyons (VA); Karen Brooks (WA); Barbara Belling (WI); Joylynn Fix (WV); and Tana Howard (WY).

1. Discussed its Work Plan

Bartuska asked for input on how the Working Group should structure its work for the year. She reviewed the Working Group's discussions during 2025, including the recognition that states have different capacities to enforce mental health parity laws. She suggested that 2026 work could include compiling a tracking document that shows activity by state and the resources they use, such as reporting templates, to help regulators understand what is happening across states.

Fix agreed that a tracking document would be helpful, particularly for identifying states at a level similar to her own. Fisher said that California would find such a document useful as it expands enforcement into new areas, such as network adequacy.

Bartuska updated the Working Group on the Employee Retirement Income Security Act (ERISA) Industry Committee lawsuit against the 2024 federal final parity rule. She said court filings indicate that the federal government will propose a revised rule by the end of 2026. She said the Working Group will track further updates. Fisher said California has a bill moving through its legislature to codify provisions of the 2024 rule into state law. Heaton said it would be important for the Working Group to identify changes between any new rule and the 2024 rule, as well as any divergence among states on enforcement.

Bartuska outlined a potential work product of adapting a template for insurers to report their use of quantitative treatment limits (QTLs). She asked the group whether a newly adapted template from the Working Group would be more useful than an existing state template, like the Pennsylvania QTL template used by several states. Sanchez said New Mexico uses a sample template. She said a new template may not be useful, but the opportunity to look at what other states use would be helpful. Bartuska said a state-tracking document would help identify which states have templates that could be useful to review. Belling agreed and asked whether states that use QTL templates hear industry concerns about their use. Swartz said Pennsylvania has had great success with its template, though not all insurers use it. She said the use of the template has led insurers to remove treatment limits to ensure parity compliance. She said a summary page would be a useful addition to Pennsylvania's template.

Bartuska asked whether the Working Group should develop recommendations on how the NAIC can best support future mental health parity work. She said the Working Group would continue and asked whether it would be useful for the Working Group to refer the matter to the Market Regulation and Consumer Affairs (D) Committee, since parity enforcement is a market conduct issue. She asked whether education and training materials would be helpful. Fix observed that work related to pharmacy benefit managers (PBMs) is divided between the Health

Insurance and Managed Care (B) Committee and the Market Regulation and Consumer Affairs (D) Committee, and the split has worked well. Heaton said work to compile information on state parity activity may help identify where needs are.

Lauren Finke (The Kennedy Forum) summarized a letter NAIC consumer representatives sent to members of the Working Group. She said the key request was to update the Working Group's charges to include developing a model bulletin to reaffirm insurers' obligations under MHPAEA and to outline expectations regarding comparative analyses. She recommended consumer-facing work to share information on utilization management practices, potentially working with the Consumer Information (B) Working Group.

J.P. Wieske (Monument Advocacy) asked the Working Group to help the insurance industry understand the rules they need to comply with and to encourage consistency in the rules. He said the industry expects to comply with the rules once they are made clearer.

2. Heard an Update on the Use of Prior Authorization Templates

Heaton presented on New Hampshire's use of reporting templates for prior authorization as a non-quantitative treatment limit (NQTL). She said the Northeast Zone states met in a Mental Health Parity Symposium in January 2025. She said ensuring compliance with mental health parity is a top priority of Commissioner Bettencourt. She said the symposium allowed states to discuss what is working and what is not in parity enforcement.

She said there is great potential for cross-state collaboration on parity because the rules stem from a federal law. She said the Northeast Zone participants decided a common template would help streamline rules and data collection for insurers. She said many states worked together to develop the prior authorization template by the summer of 2025. She said states approach parity slightly differently, with some collecting information as part of form filings and others during market conduct exams.

Heaton said New Hampshire wanted the template to be comprehensive and detailed because past parity reporting was too vague. She said a template needs to address all the information needed to answer the exam questions, so regulators understand that completing the template can be a heavy lift for insurers. She said New Hampshire's template is robust and includes instructions, a narrative, and data. She said the instructions indicate whether information should be entered into the narrative or the data sections. She described the responses expected in the narrative section and the elements expected in the data section.

Heaton said the current federal rules are good instructions to follow, even if the federal government is not enforcing them at the moment. She said the template is being used by New Hampshire and some other states and is still being refined. She said New Hampshire expects to publicly post its template soon.

Heaton said the template allows the collection of information regarding factors and evidentiary standards, processes, and comparisons of prior authorization practices as written and in operation. She said the template uses the data elements to demonstrate parity in the plan's operations. Insurers are expected to comment on any comparisons flagged by the data template as unfavorable for mental health or substance use services.

Heaton outlined the common issues insurers encounter when completing the templates. She said no insurer passed the review on its first attempt to complete the template. She said regulators provided feedback and allowed two additional submissions. She said the data template has been difficult for insurers to fill out properly. She said insurers tried to reorganize the template, but such changes are not workable. She said the weighing and ordering of decision factors, as well as vague definitions, were problem areas. She said insurers did not adequately explain the cost factors, and that the analyses they provided were often neither meaningful nor conclusive.

Heaton identified best practices for insurers in completing NQTL templates. She said insurers should read the instructions carefully, designate one person to fill out the template, complete it in order, and provide meaningful analysis. She said an advantage of the template is that it is comprehensive, but a drawback is that it is only applicable to one NQTL.

Having no further business, the MHPAEA (B) Working Group adjourned.

