REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force March 24, 2026, Minutes
- Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group March 24, 2026, Minutes (Attachment One)
  - Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group Feb. 26, 2026, Minutes (Attachment One-A)
    - ERISA Preemption and State PBM Laws Guidance Paper (Attachment One-A1)
- Prescription Drug Coverage (B) Working Group March 23, 2026, Minutes (Attachment Two)
  - Prescription Drug Coverage (B) Working Group Dec. 15, 2025, Minutes (Attachment Two-A)
- State Flexibility White Paper Adopted by the Task Force (Attachment Three)

Draft Pending Adoption

Draft: 3/30/26

Regulatory Framework (B) Task Force
San Diego, California
March 24, 2026

The Regulatory Framework (B) Task Force met in San Diego, CA, March 24, 2026. The following Task Force members participated: Marie Grant, Chair (MD); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Jeanne Murray (AK); Mark Fowler represented by Kelli Littlejohn Newman (AL); Charles Bassett represented by Fausto Burruel and Gio Espinosa (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 Susan Jennette (DE); Michael Yaworsky represented by Alexis Bakofsky (FL); John F. King (GA); Doug Ommen represented by Andria Seip and Paula T. Wallin (IA); Dean L. Cameron and Shannon Hohl (ID); Ann Gilespie represented by Shannon McNally and Matthew Pickett (IL); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig Van Aalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Angela L. Nelson represented by Melissa Panettiere and Amy Hoyt (MO); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); Susan Ochs represented by Michael Fahncke (NJ); Ned Gaines (NV); Judith L. French represented by Kristin Cly (OH); Glen Mulready represented by Andy Schallhorn (OK); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys represented by Richard L. Hendrickson (PA); Larry D. Deiter represented by Jill Kruger (SD); Amanda Crawford represented by Rachel Bowden and Latif Almanzan (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer and Rocky Patterson (WA); and Nathan Houdek represented by Jamie Adams (WI). Also participating were: Rebecca DeLaSalle (LA); Marti Hooper (ME); and Chrystal Bartuska (ND).

1. Adopted its Feb. 13, 2026, and 2025 Fall National Meeting Minutes

The Task Force met Feb. 13, 2026, in joint session with the Health Insurance and Managed Care (B) Committee. During this meeting, the Task Force and Committee adopted the Task Force's revised 2026 charges, which included adding a new charge taken from the former Health Innovations (B) Working Group to "gather and share information, best practices, experience, and data to inform and support state flexibility options through the Affordable Care Act (ACA) and other health insurance-related policy initiatives." The revisions also change the name of the Employee Retirement Income Security Act (ERISA) (B) Working Group to the ERISA and Alternative Health Care Coverage (B) Working Group to reflect its new charge taken from the Task Force's charges to "monitor, analyze, and report, as necessary, developments related to excepted benefit coverage, short-term, limited-duration (STLD) coverage, health care sharing ministry (HCSM) coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage."

Kruger made a motion, seconded by Schallhorn, to adopt the Task Force and Committee's Feb. 13, 2026, joint minutes (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee, Attachment Two*) and Dec. 10, 2025, minutes (*see NAIC Proceedings – Fall 2025, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Received Status Updates and Adopted the Reports of its Working Groups

A. ERISA and Alternative Health Care Coverage (B) Working Group

Seip said the ERISA and Alternative Health Care Coverage (B) Working Group met March 24. She said during this meeting, the Working Group adopted its Feb. 26 minutes. Seip said the Working Group also discussed the comments received on the initial draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit*

Manager (PBM) Laws and next steps in developing a revised draft based on those comments. Seip said the Working Group also discussed its planned work on guidance related to level-funded plans, which is a Health Insurance and Managed Care (B) Committee priority assigned to the Working Group last year. She said that last year, she, NAIC committee support, and the former Working Group chair, Robert Wake (ME), developed an outline for the proposed guidance document. She said that prior to his retirement from the Maine Bureau of Insurance earlier this year, Wake developed a rough draft of the proposed guidance document. Seip said the Working Group decided to form a drafting group to develop an initial draft based on Wake's rough draft.

Seip said the Working Group also discussed its potential work related to its new charge to monitor, analyze, and report, as necessary, developments related to excepted benefit coverage; STLD coverage; health care sharing ministry (HCSM) coverage; and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage. She said the Working Group received suggestions related to this charge from Working Group members, interested regulators, and interested parties. The Working Group asked stakeholders to submit any additional suggestions by April 30.

B. MHPAEA (B) Working Group

Bartuska said the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group has not yet met this year, but it plans to meet April 2. She said the Working Group is gathering feedback from stakeholders on what specific activities and projects the Working Group should tackle this year. Bartuska said one potential project being considered is developing a list and/or catalog of state activities and work related to MHPAEA implementation. She said the Working Group is also considering creating or adapting the current quantitative treatment limitations (QTL) template. Bartuska said the Working Group also hopes to make recommendations on how the NAIC can support the states in their MHPAEA compliance work moving forward, which could include referrals to other NAIC groups, such as those under the Market Regulation and Consumer Affairs (D) Committee and supporting the NAIC's Education and Training team in developing MHPAEA content to assist state insurance regulators in their mental health parity compliance and enforcement efforts.

C. Prescription Drug Coverage (B) Working Group

Fix said the Prescription Drug Coverage (B) Working Group met March 23. During this meeting, the Working Group heard a presentation from the NAIC consumer representatives on prescription drug formularies and the need for more transparency to ensure consumers have access to the drugs they need. The Working Group also heard a presentation from the Alabama Department of Insurance (DOI) on the prescription drug claim ecosystem. Fix said the discussions resulting from these presentations illustrate the need for the Working Group to perform more work in these areas, particularly around utilization review, which could lead the Working Group to develop a guidance document outlining best practices. Fix said the Working Group also plans to hold a joint meeting with the MHPAEA (B) Working Group to discuss concerns with substance use disorder (SUD) drugs and formulary concerns related to those drugs. The Working Group also adopted its Dec. 15, 2025, minutes.

Swanson made a motion, seconded by Commissioner King, to adopt the reports of the ERISA and Alternative Health Coverage (B) Working Group (Attachment One); MHPAEA (B) Working Group; and Prescription Drug Coverage (B) Working Group (Attachment Two). The motion passed unanimously.

3. Heard an Update on Recently Enacted Federal PBM Legislation

Joe Touschner (NAIC) updated the Task Force on the recently enacted federal PBM legislation. He said that as part of the Consolidated Appropriations Act of 2026 (2026 CAA), on Feb. 3, Congress passed a package of PBM reforms. Touschner said the reforms center on rebate pass-through, increased transparency, standardized reporting, and expanded federal oversight. For the commercial market, both fully insured and self-insured group plans, the

changes are effective for plan years after August 2028. He said the changes in the law for Medicare Part D plans mirror its requirements for the commercial market, except for provisions to strengthen the "any willing pharmacy" (AWP) requirements. The changes for the Medicare Part D plans are effective beginning Jan. 1, 2028.

Director Cameron asked about the federal law's changes to the AWP requirements and whether those requirements are like many states' AWP laws. Touschner said the AWP provision is specific to Medicare Part D plans and has been in the Medicare Part D program law for a long time. Under the AWP requirements, Medicare Part D plans must allow any pharmacy to participate in a plan's or PBM's network if the pharmacy agrees to accept a plan's standard terms and conditions. Those terms must be "reasonable and relevant" to the pharmacy services provided. Touschner said the federal law strengthens the AWP requirements by directing the federal Centers for Medicare & Medicaid Services (CMS) to establish standards defining "reasonable and relevant." This change is meant to address an issue that arises when PBMs that manage pharmacy networks offer pharmacies requesting to participate in a PBM's network the PBM's standard contract and reimbursement terms, and those standard contract and reimbursement terms do not align with the pharmacy's specific business model.

Director Cameron asked about the consequences of a PBM's failure to offer "reasonable and relevant" contract terms to a pharmacy. Touschner said that under the 2026 CAA, CMS will create a process that allows pharmacies to submit allegations of PBM noncompliance with the AWP contract standards. He said Medicare Part D plan sponsors that fail to offer contracts consistent with CMS-established standards will face civil monetary penalties. Commissioner King asked Touschner what it meant as far as increased oversight from the U.S. Department of Health and Human Services (HHS) regarding the AWP requirements. He expressed concern given the history of federal oversight over certain programs. Touschner said there are some specifics in the legislation, which he would be happy to provide to the Task Force following the meeting. He noted, however, that he anticipates additional details will be provided in any federal regulations implementing the law.

Commissioner Grant asked about the impact of the federal law's PBM provisions, particularly as related to PBM transparency, on existing state PBM laws noting that at least a majority of the states have PBM transparency laws. She asked if the NAIC has prepared a comparison chart or something similar. Touschner said that, like the discussion on the federal PBM law during the Pharmacy Benefit Management (D) Working Group's March 23 meeting, there is the potential for those provisions to impact the states' abilities to enforce their existing PBM laws if there is some overlap in the provisions. He said the NAIC Legal Division is looking to prepare such a document. Touschner noted that the federal PBM law's PBM reporting requirements for group health plans require PBMs to report to the plan, and for Medicare Part D plans to report to the federal government. He said this could ease any conflicts and overlap between the federal PBM law and state PBM laws.

4. Adopted the *State Flexibility White Paper*

Commissioner Grant said that last year, the Health Insurance and Managed Care (B) Committee gave the former Health Innovations (B) Working Group the task to develop a white paper on state flexibilities under the ACA's Sections 1331, 1332, and 1333. She said the Working Group developed an initial white paper draft last December 2025 and exposed it for a public comment period ending Feb. 2, 2026. The Working Group received six comment letters. Based on the comments received, the Working Group developed a revised draft.

Commissioner Grant said that earlier this year, the Health Insurance and Managed Care (B) Committee renamed the Health Innovations (B) Working Group and transferred its work to develop the white paper to the Task Force. She said the Task Force's NAIC committee support distributed the revised draft and posted it on the Task Force's website prior to this meeting. The revised draft is also included in the Task Force's meeting materials. She asked for comments from Task Force members.

Commissioner King expressed support for the white paper. He stressed the importance of states using the flexibility provided in the ACA. Commissioner King discussed how Georgia took advantage of such flexibility in developing a state-based marketplace (SBM), which has been successful in keeping Georgians insured even without subsidies. Director Cameron said he generally also supports the white paper; however, he had concerns with one sentence in the reinsurance section under the consumer coverage impacts section, which states "[c]onsumers who are eligible for premium tax credits may not always see direct benefit from a reinsurance program." Director Cameron expressed concern that the language may be too broad and not apply to every state. Commissioner Grant said there has been a lot of discussion about that language. To address his concerns, she suggested adding "depending on the structure of the program" at the end of the sentence.

Commissioner Grant asked for comments from interested regulators. There were no comments. She asked for comments from interested parties. Claire Heyison (Center on Budget and Policy Priorities—CBPP), speaking on behalf of the NAIC consumer representatives, expressed support for the white paper and appreciation for the Working Group and Task Force's open and deliberative process in developing it. She suggested adding "depending on the extent to which the reinsurance program reduces gross premiums" to the sentence as an alternative to Commissioner Grant's suggested language. The Task Force revised the sentence to add "depending on the structure and scope of the program."

Director Cameron made a motion, seconded by Seip, to adopt the *State Flexibility White Paper* (Attachment Three). The motion passed, with Arizona abstaining.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2026 Spring Meeting/RFTF 3-24-26 MtgMin.docx

Draft: 4/1/26

Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group
San Diego, California
March 24, 2026

The ERISA and Alternative Health Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in San Diego, CA, March 24, 2026. The following Working Group members participated: Andria Seip, Chair (IA); Sara Farris, Vice Chair (AR); Kelli Littlejohn Newman (AL); Debra Judy (CO); Alexis Bakofsy (FL); Weston Trexler, Shannon Hohl, and Randy Pipal (ID); Julie Holmes (KS); Shaun Orme (KY); Mary Kwei (MD); Robert Croom (NC); Chrystal Bartuska (ND); Martin Swanson (NE); Alexia Emmermann (NV); Kristin Cly (OH); Andy Schallhorn (OK); Jill Kruger (SD); Tanji J. Northrup (UT); Julie Blauvelt and Mary Ashby Brown (VA); Sofia Pasarow (WA); Sarah Smith and Lauren Van Buren (WI); and Joylynn Fix (WV). Also participating were: Michelle Heaton (NH); and Rachel Bowden (TX).

1. Adopted its Feb. 26 Minutes

Seip said the Working Group met Feb. 26. During this meeting, the Working Group took the following action: 1) discussed its name change and new charge; 2) heard preliminary feedback on the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws*; and 3) discussed next steps, which would likely involve discussing comments received on the guidance document at the Spring National Meeting.

Trexler made a motion, seconded by Farris, to adopt the Working Group's Feb. 26 minutes (Attachment One-A). The motion passed unanimously.

2. Discussed Comments Received on the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws*

Seip said the Working Group received four comment letters on the guidance document, which were posted on the Working Group's web page. The National Community Pharmacists Association (NACP), Pharmaceutical Care Management Association (PCMA), NAIC consumer representatives, and AHIP all submitted comment letters. Seip said the comments were detailed and will take some time to review.

Seip explained that the drafting group that produced the draft guidance document has been meeting bi-weekly since 2025, most recently on March 16. At that meeting, the drafting group discussed what would be the best approach to address the comments. Given the length and complexity of the comments, the Working Group expressed its willingness to continue to meet to review the comments and prepare a second draft for further discussion. Seip said the Working Group was committed to a transparent process and to explaining revisions to the draft relative to the comments received in an open meeting, in addition to another public comment period on the revised draft. Seip asked if there were any questions or concerns about having the drafting group revise the draft guidance document.

Newman asked whether any additional regulators could participate in the drafting group. She said she is a pharmacist and the new senior director of pharmacy benefit management (PBM) compliance with the Alabama Department of Insurance (DOI) and expressed her interest in joining the drafting group. Seip said Newman was welcome to join the drafting group.

Chris Petersen (PCMA) said the proposed approach to revising the guidance document makes sense given that the issues in it are too complicated to discuss in a large group setting. Petersen offered to make PCMA's ERISA counsel available to the drafting group to answer any questions about the PCMA comment letter.

Seip said that during its March 16 call, the drafting group discussed some of the big-picture issues raised in the comment letter. First, several comment letters asked about the guidance document's relationship with the NAIC's *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook). Seip explained that the ERISA Handbook is a treatment of settled law, while the guidance document is focused on an issue that is in flux. At present, these issues are not suitable for inclusion in the ERISA Handbook; however, they may be considered for addition in the future as circumstances change. The drafting group did agree, however, that the guidance document should make reference to the ERISA Handbook for its more fulsome treatment of certain issues, like general ERISA preemption and summaries of Supreme Court of the United States (SCOTUS) cases.

Another big-picture issue raised in the comment letters was the inclusion of policy or opinion-type language regarding PBMs. The Working Group is endeavoring to develop a fact-based document and does not plan to opine in this document about whether something is good or bad from a policy perspective. As a result, the drafting group does not plan to make those kinds of changes to the draft.

Lastly, some comment letters mentioned pending litigation. Seip said that she is aware of a few states with pending PBM litigation, including Iowa. The drafting group does not plan to include live cases or controversies in the guidance document. Heaton suggested sharing a list of ongoing cases so people can track them and know which states to contact if litigation arises. Seip said the drafting group is considering how to do that.

3. Discussed its Next Steps

Seip stated that she wanted to discuss the Working Group's new charge for 2026 and some of the projects that it plans to work on next. Last year, the Regulatory Framework (B) Task Force asked the Working Group to look at level-funded plans. The Working Group heard a presentation on level-funded plans from the National Association of Benefits and Insurance Professionals (NABIP) at the 2025 Summer National Meeting and started to draft an outline. The former chair of this Working Group, Robert Wake (ME), filled in the outline and created a rough draft of a paper on level-funded plans. Seip asked for volunteers to form another drafting group to review Wake's rough draft and develop a draft paper that the Working Group can expose for public comment.

Saip said the Working Group's new charge in 2026 is to "monitor, analyze, and report, as necessary, developments related to excepted benefits coverage, short-term, limited-duration (STLD) coverage, health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage." Seip said she would like to know what the most useful thing would be to focus on under this charge. She mentioned that one idea would be to develop a repository of state laws for some of these alternative coverages. For example, laws addressing STLD plans vary from state to state. Seip said that a common criticism of STLD plans is that they are "junk plans." However, Iowa requires that STLD plans include certain benefits, like prescription drug coverage and mental health and substance use disorder (MH/SUD) coverage, as well as limits on the maximum out-of-pocket coverage that can be charged. While they are allowed to be underwritten, STLD plans must comply with certain mandated benefits and some consumer protections. Seip stated that while they are not a substitute for major medical coverage, she does not consider STLD plans to be junk plans in Iowa.

Seip asked whether states are interested in a resource showing how states are addressing the increasing number of alternative coverages, such as hospital indemnity and accidental death benefits. Hohl said that Idaho would like to contribute to a repository of state laws and see what other states are doing in the areas outlined in the charge. Kwei asked whether the idea was to look only at state laws or also at enforcement actions regarding misleading marketing. Seip said that the Working Group is collecting ideas. No decisions have been made. Swanson said that the plans may not be junk, but the way they are marketed and sold may be inappropriate, so that they turn out to be junk for the purpose for which consumers are buying them. Swanson said he could see a benefit to collecting laws governing alternative plans as well as laws around the sale and enforcement actions.

Van Buren said Wisconsin is seeing hundreds of enforcement actions and has been pursuing actions aggressively, agent by agent and consumer by consumer. She said that Wisconsin appreciates the Working Group's efforts to address these issues and is closely monitoring any proposed solutions. Swanson said that he remembered that the NAIC, at some point in the recent past, started cataloging state laws on STLD plans, so there is already a starting point. Jennifer Cook (NAIC) confirmed that that is true. Swanson also mentioned a list of health care sharing ministries (HCSMs) and suggested including farm bureaus in any efforts. Swanson said he is very interested in what other states are doing relative to HCSMs. He said the Nebraska DOI does not have jurisdiction and sends complaints to the attorney general's (AG's) office. The AG then has to inform them that they are out of luck because there is no contractual obligation to pay. Swanson said he would like to see what other states are doing in the area and whether they know of any ministries acting outside the scope of the Affordable Care Act (ACA). He also said he is seeing more sharing plans that are not religious in nature.

Bartuska said she is interested in a repository of information on STLD plans and accident and sickness plans, as well as excepted benefits. She said North Dakota recently denied quite a few carve-out type plans that it does not feel fall under excepted benefits; however, other states have approved them. Heaton supported what Bartuska was saying and said she would support guidance around excepted benefits and STLD plans. She said that as changes at the federal level increase the pressure for alternative plans, it becomes increasingly important for states to confirm they are making the correct analysis of the filings and are consistent with other states. Bowden said it would be helpful for the repository of state laws and rules on alternative plans to identify differences in interpretations along the lines that Bartuska mentioned. One example might be which states allow reference-based pricing style plans to qualify as fixed-indemnity plans.

Hohl suggested starting with a chart of state laws on the coverages included in the Working Group's charge, building on the information the NAIC has collected already. Once it has enough information, it can identify states that may be doing things differently or better and could have a series of short presentations from a few states. She said she knows Idaho is doing a few things differently, and it might be beneficial to hear from a few states regarding what is working well in their markets.

Swanson mentioned that the Working Group will likely want to get the U.S. Department of Labor (DOL) involved in some of these conversations about alternative arrangements, especially level-funded plans, to better understand the insurance regulator's role and what the DOL might be doing.

Lucy Culp (Blood Cancer United) suggested that the Working Group look at the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#170) and the *Model Regulation to Implement the Supplementary and Short-Term Health Insurance Minimum Standards Model Act* (#171). While the models are not perfect, they represent the collaboration, negotiation, and hard work that went into thinking about how to best balance the needs of different types of consumers with the needs of industry and seem to address the plans listed

in the charge. Culp suggested that the repository of laws could reflect the states that have adopted Models #170 and #171.

Culp encouraged regulators to keep preexisting conditions in mind and consider options for people who cannot pass medical underwriting. Culp also encouraged regulators to think about how to understand where consumers are turning for health care coverage since the expiration of the federal tax credits, whether through a data call or other method. She stated that the NAIC consumer representatives are interested in partnering to obtain more information.

Petersen agreed with Culp that Model #170 and Model #171 are good places to start to assemble a repository of state laws. He stated that Model #170, Model #171, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provide a definition of what a fixed indemnity plan is and what a hospital indemnity plan looks like. He also agreed with Swanson that one of the problems with alternative coverages is not how the products are designed, but how they are marketed and what they are called once a product has been approved. He said regulators need to be mindful of not only what is in the product but also of how it is being presented to the public. Van Buren said it would be helpful if companies were more aggressive in terminations for cause when agents market products improperly.

Seip asked Working Group members, interested regulators, and interested parties to email Cook by April 30 with any ideas for addressing the Working Group's new charge.

4. Discussed Other Matters

Seip said there seems to be a resurgence of "creative" activity in how plans are being designed and marketed as more people search for affordable health coverage options. The Working Group anticipates holding some regulator-to-regulator meetings this spring, looking into unauthorized activity that has come to regulators' attention and falls under paragraph 2 (pending investigations) and paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings.

The Working Group also plans to work in collaboration with the Improper Marketing of Health Insurance (D) Working Group. The Working Groups plan to meet April 2 in joint regulator-to-regulator session, pursuant to paragraph 2 (pending investigations) and paragraph 3 (specific companies, entities, or individuals) of the NAIC Policy Statement on Open Meetings, to discuss an issue that impacts both Working Groups.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B Cmte/National Meetings/2026 Spring National Meeting/RFTF/EAHCWG Minutes.docx

Draft: 3/16/26

Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group
Virtual Meeting
February 26, 2026

The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group of the Health Insurance and Managed Care (B) Committee met Feb 26, 2026. The following Working Group members participated: Andria Seip, Chair (IA); Kelli Littlejohn Newman (AL); Sara Farris (AR); Alexis Bakofsky (FL); Weston Trexler (ID); Craig Van Aalst and Julie Holmes (KS); Shaun Orme (KY); Frank Opelka (LA); Mary Kwei (MD); Jeana Thomas and Melissa Panettiere (MO); Chrystal Bartuska (ND); Michael Anderson (NE); Jeremy Christensen (NV); Laura Miller (OH); Andy Schallhorn (OK); Jill Kruger (SD); Tanji J. Northrup (UT); Gregory Lee (VA); and Sarah Smith (WI).

1. Discussed its Name Change and Charges

Seip introduced herself as the new chair of the Working Group. Seip was vice chair of the Working Group last year, and with the retirement of the previous chair, Robert Wake (ME), she agreed to chair the Working Group. She asked anyone interested in being vice chair to contact Jennifer Cook (NAIC).

Seip explained that the Working Group has been renamed the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group. The new name reflects the inclusion of a new charge: to "monitor, analyze, and report, as necessary, developments related to excepted benefits coverage, short-term, limited-duration (STLD) coverage, health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage." The Working Group's remaining charges remain unchanged, and it plans to maintain its focus on ERISA-related issues and to continue last year's projects. In addition to completing the *Guidance Document: ERISA Preemption and State PBM Laws*, the Working Group anticipates drafting a paper discussing level-funded plans.

2. Received Preliminary Feedback on the *Draft Guidance Document: ERISA Preemption and State PBM Laws*

Seip shared background on the development of the draft *Guidance Document: ERISA Preemption and State PBM Laws* (Attachment One-A1). Last year, there was a priority to examine ERISA preemption and state pharmacy benefit manager (PBM) laws. That priority was delegated to the ERISA (B) Working Group by the Regulatory Framework (B) Task Force. A drafting group started meeting bi-weekly following the 2025 Summer National Meeting. The draft being discussed was released on Feb. 2 for a public comment period ending March 3. Today's meeting was intentionally scheduled before the March 3 comment deadline, allowing participants to hear each other's input prior to submitting written feedback.

The purpose of the guidance document, as the title suggests, is to provide guidance about ERISA preemption and state PBM laws. The guidance document could be helpful to state regulators or legislators as they consider PBM oversight legislation. The guidance document provides an overview of developments in other states and the types of legal challenges that have arisen. This document is only current as of its publication date, as this area is rapidly changing and legal challenges are ongoing. Seip said the Working Group plans to consider updating this document as the legal landscape shifts.

Chris Petersen (Arbor Strategies) spoke on behalf of the Pharmaceutical Care Management Association (PCMA). He said PCMA would submit detailed comments and plans, suggesting that the guidance document reference the existing language in the NAIC publication *Health and Welfare Plans Under the Employee Retirement Income*

Security Act: Guidelines for State and Federal Regulation (ERISA Handbook), so that they can be read as a whole. The PCMA will also be seeking a fuller listing of federal jurisprudence and hopes to share examples of other court cases to include. Leanne Gassaway (AHIP) said she thought that this guidance document was intended to be a chapter in the ERISA Handbook. Seip explained that the ERISA Handbook focuses on settled law, while the guidance document addresses an issue that is very much in flux. She welcomed feedback on how to reference the ERISA Handbook in the guidance document and on how to ensure consistency.

Carl Schmid (HIV+Hepatitis Policy Institute) spoke on behalf of NAIC Consumer Representatives who plan to offer written comments, suggesting that, in addition to describing PBMs and their functions, they want to add the ways PBMs negatively impact the drug pricing ecosystem, which is one of the reasons states want to regulate them. He said the consumer representatives plan to suggest language addressing rebating, which results in PBMs favoring higher-cost drugs over lower-cost ones, the lack of transparency in PBM financial transactions, and the lack of competition among PBMs. He said the consumer representatives think the guidance document should note that PBMs are fighting state legislative efforts to regulate them, arguing for federal preemption. Schmid said they will also be offering some language edits, but generally think the draft lays out what the U.S. Supreme Court has said very well, along with the appellate decisions and the conclusion that there will continue to be litigation filed.

Robert T. Smith (Katten Muchin Rosenman LLP), speaking on behalf of the National Community Pharmacist Association (NCPA), said the NCPA will be submitting written comments. The NCPA will suggest including two appellate court decisions decided before the U.S. Supreme Court's *Rutledge v. PCMA* decision in 2020: *PCMA v. Rowe* and *PCMA v. District of Columbia*. Those cases created a circuit split over whether states have the authority to impose fiduciary duties on PBMs. The First Circuit in Rowe held that states have the authority to impose fiduciary duties on PBMs, and the DC Circuit reached the opposite conclusion. There is some meritorious discussion in Rowe regarding whether PBM regulation implicates ERISA in the first instance. The Supreme Court did not have to address the issue in Rutledge because it was obvious that cost regulation does not implicate ERISA, leaving the issue open. Additionally, Smith said he thinks it makes sense to include the amicus brief of the United States in Mulready at the 10th Circuit level. The United States took the position in Mulready that certain state laws, as applied to PBMs, may be saved as laws that regulate insurance within the meaning of ERISA's saving clause, with respect to both fully insured and self-funded ERISA plans. Under this reasoning, PCMA's preemption claims would be saved from ERISA preemption. The 10th Circuit did not address the saving clause issue because it deemed it waived, but those arguments are percolating up in the courts and have been raised in the Iowa case heading to the Eighth Circuit. He said that informing regulators about these pending arguments is important.

Kris Hathaway (AHIP) said AHIP would be submitting written comments and agreed that adding more context by including other cases would be beneficial.

3. Discussed its Next Steps

Seip reiterated that written comments should be submitted by the March 3 deadline. She suggested that comments should be as specific and detailed as possible. Seip also welcomed comments on the relationship between the ERISA Handbook and the guidance document. Seip explained that the volume and scope of the comments would dictate the Working Group's next steps and whether the drafting group could revise the draft prior to the Fall National Meeting. Either way, she anticipates a productive discussion at the Working Group's meeting at the Fall National Meeting.

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 March 3, 2026.

DRAFT 2/2/26

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

GUIDANCE DOCUMENT – ERISA PREEMPTION AND STATE PBM LAWS

OUTLINE

I. Introduction
II. ERISA Preemption
III. Cases Addressing ERISA Preemption Analysis of State PBM Laws
- ***Rutledge***
- ***Wehbi***
- ***Mulready***

IV. Lessons for States
- **Principles to apply to the question of whether ERISA may preempt the state law at issue**
- **Laws at issue in Rutledge, Wehbi and Mulready – Chart**

I. Introduction

Pharmacy benefit managers (PBMs)[1] 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, 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.[2]

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.

[1] The alternative form "pharmacy benefits managers" is used in many publications and statutes.
[2] 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

This guidance paper 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 was not preempted by ERISA.[3] 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. 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[4] while the Tenth Circuit struck down parts of Oklahoma's law[5].

This paper provides some guidance related to ERISA preemption by undertaking an analysis of the different types of state PBM laws and considering how appellate courts have applied the reasoning in *Rutledge* to those laws.[6]

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 welfare benefit plans,"[7] a broad category that includes nearly all employer-sponsored and union-sponsored health plans. However, ERISA does not preempt state insurance law. ERISA's "saving clause" for any state law that "regulates insurance"[8] gives states broad authority to regulate PBMs administering state regulated insurance policies, including fully-insured employee health plans.[9]

---

[3] *Rutledge v. Pharmaceutical Care Management Ass'n,* 592 U.S. 80 (2020). The Court also held that the law was not preempted as applied to Medicare Part D plans.

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

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

[6] 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.

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

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

[9] 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.

Although ERISA's saving clause does not entirely foreclose the possibility of preemption challenges to insurance-specific PBM laws, the focus of recent preemption litigation has been state laws that apply broadly to the PBM industry. 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.[10]

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 the pharmaceutical industry, 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.[11]

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.

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, 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;[12] 2) establish an appeal process for pharmacies to challenge PBM MAC pricing lists;[13] 3) increase pharmacy reimbursement rates to cover pharmacy acquisition costs;[14] and 4) allow the pharmacy to adjust any claims[15] 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.[16]

---

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

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

[12] Ark. Code Ann. §17-92-507(c)(2) (Supp. 2019).

[13] Ark. Code Ann. §17-92-507(c)(4)(A)(i)(b) (Supp. 2019)

[14] Ark. Code Ann. §17-92-507(c)(4)(C)(i)(b)

[15] Ark. Code Ann. §17-92-507(c)(4)(C)(iii).

[16] *Rutledge*, 592 U.S 80 at 86.

To analyze whether Act 900 had an impermissible "connection with" ERISA plans, after providing some general background on the objectives of ERISA,[17] 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,*[18] or "by binding plan administrators to specific rules for determining beneficiary status," as in *Egelhoff.*[19] 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,*[20] invalidating a Vermont law establishing an all-payer health claim database and including third-party administrators and self-insurers among the entities subject to mandatory reporting. 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.[21]

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.[22]

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…."[23] 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."[24] The opinion concludes: "In sum, Act 900 amounts to cost regulation that does not bear an impermissible connection with or reference to ERISA."

---

[17] *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)).

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

[19] *Id.* at 87.

[20] *Id.*

[21] *Id.*

[22] *Id.*

[23] *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.

[24] *Id.* at 91.

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."[25] 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.[26]

Instead, the Court likened Act 900 to the New York law at issue in *Travelers,*[27] 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.[28]

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.[29] 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

[25] *Id.* at 88.

[26] Id. at 88-89.

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

[28] "…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.

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

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 applied reasoning from *Gobeille* to determine 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."[30] 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 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.'[31]

The Eighth Circuit, quoting *Rutledge,* softened the emphasis on uniformity in the "connection with" analysis saying, "the mere fact that a state law 'affects an ERISA plan or causes some disuniformity in plan administration'" does not mean the law meets this standard, "especially…if the law merely affects costs.'"[32] 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."[33]

The Eighth Circuit did not find any "reference to" ERISA plans because the law applies to PBMs regardless of who they have a contract with. The Eighth Circuit Court following the decision in Rutledge, holding that the "existence of ERISA plans is essential to a law's operation only if the law cannot apply to a non-ERISA plan."[34]

The Court in *Wehbi* also held that the challenged provisions of the North Dakota law did not meet the "connection-with" standard, and therefore, were 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;

[30] *Wehbi,* 18 F.4th 956 at 969.
[31] 18 F.4th 956 at 968.
[32] *Id.*
[33] *Id.*
[34] *Id.* at 969.

- Section 16.1(9): charge shipping and handling fees to patients requesting prescriptions to be mailed or delivered;[35]

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."[36] The *Wehbi* court draws a distinction between allowing pharmacies to decline to dispense a prescription if the reimbursement is too low and "requiring payment of specific benefits."[37]

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."[38] 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."[39] 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.[40]

Mulready

The United States Court of Appeals for the Tenth Circuit reversed the District Court for the Western District of Oklahoma, holding that ERISA and Medicare Part D preempted Oklahoma's PBM law. 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."[41]

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'," [42] 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."[43]

[35] *Id.*at 968.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id*. at 968-969.
[40] *Id.* at 969.
[41] Okla. Stat. tit. 36, § 6959 (2019).
[42] *Gobeille*, 577 U.S. at 320.
[43] *Rutledge*, 592 U.S. 80, 88.

The Tenth Circuit divided the provisions of the law under review into two categories[44]: 1) "network restrictions," which includes access standards;[45] discount prohibition;[46] and any willing provider provision[47]; 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 pharmacy board.[48] 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."[49] 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.[50] 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."[51]

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*[52] and *Rush Prudential HMO, Inc. v. Moran*.[53]

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.[54]

---

[44] *Mulready,* 78 F.4th 1183 at 1196.
[45] Okla.Stat. tit. 36 § 6961 (a)-(B) (2019).
[46] Okla.Stat. tit. 36 § 6963.
[47] Okla.Stat. tit. 36 § 6962 (B)(4).
[48] Okla.Stat. tit. 36 § 6962 (B)(5);
[49] *Mulready,* 78 F.4th 1183 at 1193.
[50] *Id.* at 1198.
[51] *Id.* at 1203.
[52] *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 734 (1985).
[53] *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359 (2002).
[54] Brief for the United States as Amicus Curiae, p. 10, *Pharmaceutical Care Management Ass'n*, v, *Mulready,* No.23-1213, *cert. denied*.

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

IV. LESSONS FOR STATES

As a threshold matter, states should recognize that it is not possible to predict with any degree of certainty 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.[55]

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.

[55] *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.

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 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 state regulatory structure.**[56] Including an opt-in for self-funded plans should not, in and of itself, cause the law to be preempted under ERISA.[57]

[56] 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.

[57] 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)

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."[58]

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**.'"[59] 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."[60]

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.[61] "[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."[62]

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 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.

[58] *Gobeille*, 577 U.S. at 319–320
[59] *Rutledge*, 592 U.S. at 87.
[60] *Id. at 86-87*.
[61] *Id.* at 88.
[62] *Id.* at 87

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)		
Pharmacies may refuse to sell a drug if the PBM's reimbursement rate is lower than its acquisition cost.	Rutledge: Ark.Code Ann. §17–92–507(e)		
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) & 7❷8(0))	
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).
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).
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: Ark. Code Ann. §17–92–507(c)(4)(A)(i)(b)		
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).

Discount Prohibition: A PBM shall not using 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).

*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).

Rutledge (SCOTUS): Arkansas State law at: A.C.A sec. 17-92-507

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:

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2026 Spring Meeting/RFTF/ERISA Preemption and State PBM Laws Guidance Paper.docx

Draft: 3/31/26

Prescription Drug Coverage (B) Working Group
San Diego, California
March 23, 2026

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in San Diego, CA, March 23, 2026. The following Working Group members participated: Joylynn Fix, Chair, and Allan L. McVey (WV); Ashley Scott, Vice Chair (OK); Sarah S. Bailey and Kayla Erickson (AK); Kelli Littlejohn Newman (AL); Tolanda McNeal (AZ); Tricia Davé (CT); Howard Liebers (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Matthew Pickett and Chris Heisler (IL); Craig Van Aalst (KS); Shaun Orme and Daniel McIlwain (KY); Frank Opelka (LA); Joe Stoddard (MI); Norman Barrett and T.J. Patton (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Cheryl Wolff, Martin Swanson, and Maggie Reinert (NE); Ralph Boeckman and Erin Porter (NJ); Sahar M. Hassanin and Krystal Bartholomew (NM); Sylvia Lawson and Gail A. Ross (NY); Sarah Young (OR); Michael Humphreys, Lindsi Swartz, and Richard L. Hendrickson (PA); Glory Montalvo (PR); Jud Jones (TN); Tanji J. Northrup and Shelley Wiseman (UT); Sofia Pasarow (WA); Lori Luder (WI); and Lauren White (WY). Also participating were: Lila Cummings and Debra Judy (CO); Kevin P. Beagan (MA); Robert L. Carey and Marti Hooper (ME); Mike Chaney (MS); Chrystal Bartuska (ND); Tony Bonofiglio (OH); and Jill Kruger (SD).

1. Adopted its Dec. 15, 2025, and 2025 Fall National Meeting Minutes

The Working Group met Dec. 15, 2025. During this meeting, the Working Group took the following action: 1) heard a presentation from the Pharmaceutical Research and Manufacturers of America (PhRMA) on the 340B Drug Pricing Program and anticipated changes beginning Jan. 1, 2026.

Van Aalst made a motion, seconded by Seip, to adopt the Working Group's Dec. 15, 2025 (Attachment Two-A), and Dec. 9, 2025 *(see NAIC Proceedings – Fall 2025, Regulatory Framework (B) Task Force, Attachment Four)* minutes. The motion passed unanimously.

2. Heard Presentations on Prescription Drug Formularies, Consumer Protections, and State Enforcement

Wayne Turner (National Health Law Program—NHeLP) and Carl Schmid (HIV+Hepatitis Policy Institute) presented on prescription drug formularies, consumer protections, and state enforcement. Turner discussed the importance of insurer compliance with the Affordable Care Act's (ACA's) nondiscrimination drug formulary requirements. He discussed ways state insurance regulators can help to ensure there is no such discrimination by bringing greater transparency to: 1) Pharmacy & Therapeutics (P&T) committees to ensure comprehensive, up-to-date formularies; 2) exceptions processes to access non-formulary drugs; 3) independent review of drug denials; and 4) up-to-date formulary information, including tiering structure and access restrictions. To further ensure consumers have access to necessary prescription drugs, Turner also suggested that state insurance regulators more closely monitor P&T committees, particularly their members, meetings, minutes, and conflict-of-interest disclosure requirements. He also suggested that state insurance regulators review the data on standard and expedited exceptions process requests and monitor drug exceptions processes to determine if there is a high use of the exceptions process, which could be a sign that the formulary is inadequate.

Schmid said that, generally, plans are following the ACA requirements with respect to non-discriminatory drug formulary designs. However, there are a few outliers, particularly related to drug formulary designs involving HIV medications. He discussed a few examples. Schmid said federal and state insurance regulators can prevent such

discriminatory designs by: 1) fully reviewing plans for drug coverage; 2) fully reviewing plans for drug tier placement; 3) ensuring all prescription drugs are part of the essential health benefits (EHB) benchmark plan; 4) ensuring plan documents are clear and transparent; and 5) responding to consumer complaints.

3. Heard a Presentation on the Prescription Drug Claim Ecosystem

Newman provided an overview of the prescription drug claim ecosystem. She described the distribution and reimbursement system for patient-administered, outpatient generic drugs with a discount card. Newman also described a typical prescription drug transaction between the entities involved in the drug distribution system—the pharmaceutical manufacturer, the wholesaler, the pharmacy benefit manager (PBM), the pharmacy, and the health plan—and how reimbursement works when a discount card is used or is not used.

Newman discussed copay assistance programs, which include manufacturer copay cards and coupons; state pharmaceutical assistance programs (SPAPs); drug discount cards, such as GoodRx and Single Care; patient assistance programs (PAPs); and retail pharmacy savings clubs. She also discussed copay accumulators, what they are, and how they work. Additionally, she discussed copay maximizers and the federal regulatory history related to copay accumulators. She explained that prior to September 2023, the U.S. Department of Health and Human Services (HHS) allowed plans at its discretion to count or not count any copay assistance a consumer receives toward the consumer's annual cost-sharing requirements. In September 2023, the HHS rule permitting this was struck down, and requirements related to copay assistance reverted to a previous HHS rule, the 2020 Notice of Benefit and Payment Parameters rule, which requires plans to count copay assistance toward a consumer's annual cost-sharing requirements except when the assistance is for a brand-name drug with an available generic drug. Newman provided a case study example of a situation involving copay accumulators, illustrating how complex and confusing they can be for consumers.

Newman said her presentation illustrates the complexity of the prescription drug distribution and reimbursement system. She urged state insurance regulators to remain aware because it is always changing. She also highlighted the importance of transparency and patient advocacy.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/Prescription Drug Coverage Working Group/PDCWG MtgMin 3-23-26.docx

Draft: 2/2/26

Prescription Drug Coverage (B) Working Group
Virtual Meeting
December 15, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met Dec. 15, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Sarah S. Bailey (AK); Dusty Smith (AL); Lena Bahar and Michael Shanahan (CT); Howard Liebers (DC); Mike Milnes (FL); Johanna Nagel (IA); Shannon Hohl (ID); Matthew Pickett (IL); Craig VanAalst (KS); Daniel McIlwain (KY); Frank Opelka (LA); Renee Campbell (MI); Norman Barrett (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Eric Dunning and Cheryl Wolff (NE); Erin Porter and Ralph Boeckman (NJ); Sahar M. Hassanin (NM); Sylvia Lawson and Gail A. Ross (NY); Keith Turner (OR); Lindsi Swartz (PA); Jud Jones (TN); Tanji J. Northrup (UT); Jennifer Kreitler (WA); Lori Luder (WI); and Tana Howard (WY). Also participating was: Grant Lindman (IN).

1. Heard a Presentation from PhRMA on the 340B Drug Pricing Program and Anticipated Changes Beginning Jan. 1, 2026

Jessica Lynch (Pharmaceutical Research and Manufacturers of America—PhRMA) provided an overview of the 340B Drug Pricing Program (Program) and anticipated changes to it beginning Jan. 1, 2026. She said the Program is an outpatient drug program administered by the federal government intended to help vulnerable patients gain better access to medicines at certain qualifying hospitals and clinics. She said that when the U.S. Congress (Congress) established the Program, it envisioned it as a small safety net program requiring drug manufacturers to sell medicines at a reduced price to covered entities—certain qualifying hospitals (e.g., Disproportionate Share Hospitals [DSHs], children's and rural hospitals) and safety-net clinics (e.g., community health centers)—known as grantees who Congress envisioned would use the money saved to help patients.

Lynch discussed how sales under the Program have skyrocketed over the years and what is driving the growth. She explained that the Program is currently the second-largest prescription drug program administered by the federal government, behind only Medicare Part D. She explained how the Program drives up costs for employers, states, and consumers. Lynch discussed the Program's lack of transparency and state actions taken, such as in Hawaii, Indiana, Maryland, and Minnesota, to increase transparency.

Lynch discussed congressional investigations and efforts to reform the Program. She said the Health Resources and Services Administration (HRSA) 340B Rebate Pilot set to start Jan. 1, 2026, is a first step toward increasing transparency and Program integrity. She described the components of the rebate pilot, explaining that the HRSA approved rebate model plans for all eligible manufacturers. Approved plans for nine drugs have a Jan. 1, 2026, effective date, and one has an April 1, 2026, effective date. She noted, however, that the American Hospital Association (AHA), along with four hospital systems, filed suit in Maine on Dec. 1 to block the pilot.

Matt Walker (Walker & Stevens) asked Lynch to explain the Program's duplicate discount prohibition, which he said confuses many people, particularly as it relates to Medicaid. Lynch said the Program's duplicate discount prohibition forbids drug manufacturers from giving both a 340B discount and a Medicaid rebate for the same drug. Covered entities, such as hospitals, must prevent this by either using 340B drugs for Medicaid fee-for-service (FFS) patients or buying drugs for them through other means. She said that some estimates put the cost of duplicate discounts at between $3 and $5 billion a year, which drug manufacturers pay even though they are not federally required to and are prohibited from doing so under federal law. Lynch said she knows state Medicaid departments are working diligently to address this issue, but in the commercial market, it is less clear whether drug manufacturers are paying duplicate discounts.

Lindman asked how the rebate pilot will work with sub-ceiling pricing arrangements. Lynch said the rebate pilot is meant to be separate from any sub-ceiling prices. She said the goal of the rebate pilot is, in part, to eliminate duplicate discounts because drug manufacturers will have so much more access to claims data and, as such, the state will receive either the rebate or the discount, but not both.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PDCWG/PDCWG MtgMin 12-15-25.docx

Adopted by the Regulatory Framework (B) Task Force, March 24, 2026

State Flexibility White Paper

Compiled by the NAIC Health Innovations (B) Working Group (2025) and the Regulatory Framework (B) Task Force (2026)

Contents

Introduction: State and federal roles in regulating health insurance 2
Section 1331 Basic Health Programs 3
Population eligible 4
Summary of federal statute, regulations, and guidance 4
State experiences 5
Minnesota 5
New York 7
Oregon 8
District of Columbia 8
Considerations for consumers, states, and insurance markets 8
Consumer coverage impacts 9
State considerations 9
Section 1332 State Innovations Waivers 12
Summary of statutes, regulations, and guidance 12
Guardrails and the limitations they introduce 12
Funding and applications 13
State experiences 13
Reinsurance waivers and related state choices 14
Other Approved 1332 Waivers 15
Waivers Applied for But Not Approved 16
Considerations for consumers, states, and insurance markets 18
Reinsurance 18
Other waiver types 19

Section 1333 Health Care Choice Compacts 19
Background 19
Summary of statute and 2019 request for information 19
Considerations for consumers, states, and insurance markets 23
Potential areas of regulation impacted by HCC compact 23
Pros and cons for states 23
Discussion, including combining state flexibilities 25
Conclusion 26

Introduction: State and federal roles in regulating health insurance

State insurance regulators have primary responsibility for regulating insurance in the United States, including health insurance. While the Supremacy clause of the Constitution assures that federal law takes precedence over state laws, Congress has recognized and validated states' roles in regulating insurance within specific markets. The McCarran-Ferguson Act of 1945 protects state authority to regulate the business of insurance. Generally, federal law preempts state insurance laws when the state law would prevent the application of a federal law.

Nonetheless, both states and Congress have taken steps to regulate health insurance. States generally supervise solvency, review health insurers' rates and the content of policies, and establish consumer protections for individual and group health insurance markets. Congress reserved for federal regulators the role of regulating self-funded employer health plans through the Employee Retirement Income Security Act of 1974 and the Medicare Modernization Act (MMA) limited the authority of states to oversee Medicare Advantage plans to only.

Over time, federal laws have added requirements for health insurers related to information privacy, availability of coverage, surprise billing, and some benefit mandates, among others.

In 2010, the passage of the Affordable Care Act (ACA) introduced extensive new federal regulations for individual health insurance markets. While maintaining markets in each state, the ACA established requirements in each state's market related to risk pools, enrollment periods, coverage tiers, benefits, and consumer protections. It also created Marketplaces for

consumers with coverage supported by federal premium tax credits (PTCs) for eligible individuals.

While the ACA's reforms apply nationwide, Congress also provided mechanisms in the law for states to alter how the ACA functions on a state-by-state basis. The state flexibility sections of the ACA allow for states, individually or working together, to change how coverage is delivered or waive requirements of the law entirely, as long as the states meet specified criteria. These criteria, often referred to as "guardrails" aim to assure that state flexibility maintains comparable levels of affordability, comprehensiveness, and breadth of coverage as the ACA makes available while not increasing costs to the federal government. Under two of the flexibility sections, states can access federal funding that would otherwise be used for ACA coverage in the state.

Section 1331 of the ACA allows states to contract directly with health plans to cover some individuals who would otherwise qualify for Marketplace coverage. Section 1332 includes broad authority to waive portions of the ACA as long as states meet the guardrails established in the Section. Section 1333 provides a process for states to enter into multistate compacts in order to allow the sale of individual insurance products in multiple states. This paper reviews each of these three sections, summarizing state experiences and offering considerations for states as well as potential recommendations to allow for greater flexibility to improve coverage options within states.

Section 1331 Basic Health Programs

Section 1331 of the Affordable Care Act allows states to create a Basic Health Program (BHP), a health benefits coverage program for low-income residents who would otherwise be eligible for subsidized coverage through the Health Insurance Marketplace. The Basic Health Program gives states the ability to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and Children's Health Insurance Program (CHIP) levels.[1] While state legislation is not explicitly required by Section 1331, a state may need to pass a state law to establish authority to operate a Basic Health Program.

Benefits under a Basic Health Program are required by the ACA to include at least the ten essential health benefits specified in the Affordable Care Act. The monthly premium

[1] Center for Medicare and Medicaid Services, *Basic Health Program,* https://www.medicaid.gov/basic-health-program, accessed September 28, 2025.

charged to eligible individuals must not exceed what an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace and additional limits apply to cost-sharing. A state that operates a Basic Health Program receives federal funding equal to 95 percent of the amount of the premium tax credits that would have otherwise been provided to (or on behalf of) eligible individuals if these individuals enrolled in QHPs through the Marketplace.[2] This amount may cover the costs of a state program, but depending on state circumstances and implementation choices, some additional state funding may be necessary.

Population eligible

Through the Basic Health Program, states can provide coverage to individuals who are citizens or lawfully present non-citizens, who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133 percent and 200 percent of the federal poverty level (FPL). People who are lawfully present non-citizens who have income that does not exceed 133 percent of FPL but who are unable to qualify for Medicaid due to their non-citizen status, are also eligible to enroll.[3] However, lawfully present non-citizens with incomes below 100 percent of FPL are no longer eligible for premium tax credits beginning in 2026. And many other lawfully present non-citizens—all but those designated "eligible aliens"—will no longer be eligible for premium tax credits beginning in 2027. As a result, federal BHP funding will no longer be available to states for these populations.

Summary of federal statute, regulations, and guidance

Section 1331 of the ACA outlines the requirements for the Basic Health Program. Regulations finalized by HHS in 2014[4] further define the program, while subsequent regulation and guidance have refined the methods for calculating federal payments to states to support their programs.[5]

The law describes how the state contracts with health plans to cover eligible enrollees and the amount of federal payments. The ACA requires a competitive process to select the contracting health plans and provides several factors for consideration in making the contract awards. The statute lays out the process for the Secretary to determine the amount

[2] Id. States also receive 95% of any payments the federal government would have made for cost-sharing reductions if the individuals were enrolled in Qualified Health Plans.

[3] Id.

[4] 42 CFR Part 600 and 45 CFR Part 144

[5] See https://www.medicaid.gov/basic-health-program

of federal funding for a state program, which includes 95% of the federal payments for premium tax credits and cost-sharing reductions that would otherwise go to Basic Health enrollees. The law also defines who is eligible for enrollment in Basic Health coverage and requires that BHP enrollees pay no more in premiums than they would for the second lowest cost silver plan in their states' marketplaces and no more in cost-sharing than would be applicable in a gold or platinum plan, depending on income.

The final regulation establishes a Basic Health Program Blueprint which states must develop and submit to HHS for certification. The Blueprint defines how the state will operate its Basic Health Program. The rule establishes eligibility and enrollment standards and enrollee financial responsibilities. It requires states to offer at least two plan choices to enrollees, except where it is not feasible to do so.

The 2014 rule set up the initial funding formula for BHPs. Because the amount of funding is tied to premium tax credits and cost-sharing reductions (CSRs), changes to state or federal policy since 2014 that alter PTC or CSR payments have affected the funding available to states with BHPs. The end of federal payments to insurers for CSRs in 2017 eliminated the CSR portion of Basic Health funding. The enhanced premium tax credits authorized in 2021-2025 significantly increased BHP funding for states before the enhanced credits expired. In 2023, HHS established a reinsurance factor in determining BHP funding—this allows states to maintain BHP funding even when they operate a reinsurance program that lowers silver plan premiums and thus PTCs.

State experiences

The experience of the states that have adopted BHPs under the ACA can help guide those that are considering the option. Effective in 2015, Minnesota and New York converted state coverage options that pre-existed the ACA to BHPs, grandfathering in certain provisions. New York in 2024 converted its BHP to a Section 1332 waiver, but has since reverted it back to a BHP, which is discussed further below. Oregon launched a new BHP in July 2024 and the District of Columbia established a new BHP in 2026.

Minnesota

MinnesotaCare offers comprehensive and affordable health insurance coverage for Minnesota children, parents, and adults without children. MinnesotaCare was established as a state-run program in 1992 to provide coverage for children and parents who were not eligible for Medicaid but still required financial assistance with health coverage.

In 2015, Minnesota became the first state to take up the Basic Health Program option, sunsetting its Section 1115 Medicaid waiver and converting coverage to the Section 1331

option. In the first full fiscal year that the program was operational, federal funding covered 70% of MinnesotaCare's costs[6].

MinnesotaCare covers adults ages 19-64 with incomes between 134-200% FPL who don't have access to other types of insurance, and legal immigrants including children in families with income from 0-200% of FPL who are otherwise not eligible for Medicaid.[7]

MinnesotaCare provides coverage to people who don't have access to employer-sponsored insurance and today continues to require that enrollees have no such access[8].

In 2024, MinnesotaCare covered 101,900 Minnesotans on average each month, about 60% of them adults without children, and the remainder families with children[9].

MinnesotaCare is administered by the Minnesota Department of Human Services, which is also the state's Medicaid agency. In compliance with BHP regulations, MinnesotaCare is administered through managed care, as was its predecessor state program. Rates paid to providers in the program mirror the rates paid in the state's Medicaid program (Minnesota Statutes 256L.11 Subd. 1). MinnesotaCare's benefit set mimics Minnesota's Medicaid benefits including things like behavioral health care, eyeglasses, and dental coverage, but excluding benefits such as waivered services and coverage for long-term care. MinnesotaCare lowered premiums from a maximum payment of $80 to $28 per month due to increased federal funding available from enhanced premium tax credits.

When MinnesotaCare was established, so too was the Health Care Access Fund (HCAF), a state account that receives revenue from a statewide tax on hospitals and other providers. The provider tax, then set at 2% of gross receipts, provided additional funding for MinnesotaCare and included providers and a premium tax on HMOs. The tax rate and base have varied over the years, but it remains a funding source for the non-federal share of BHP costs.

---

[6] Minnesota Management and Budget. "BHP Trust Fund - February 2025 Forecast." 2025. https://mn.gov/dhs/assets/BHP_Trust_Fund_Feb25_tcm1053-671717.pdf.

[7] Minnesota Department of Human Services. "Minnesota Health Care Programs Eligibility Policy Manual." 2025. https://hcopub.dhs.state.mn.us/epm/3.htm.

[8] Id.

[9] Minnesota Department of Human Services, Reports and Forecasts Division. "February 2025 Forecast." 2025. https://mn.gov/dhs/assets/forecastDHS_202502_tcm1053-671523.pdf.

In SFY2024, federal funds covered about 87% of the state's MinnesotaCare costs. That is expected to change over the next four federal fiscal years, with a projection of federal funds covering 75% of costs in SFY29[10].

New York

New York's Essential Plan provides low cost coverage to New Yorkers with income above Medicaid limits and those ineligible for Medicaid due to Medicaid's five year bar for immigrants. Prior to the ACA, New York covered individuals with income up to 150% of the FPL and lawful immigrants not eligible for Medicaid in the state's Family Health Plus program. The Basic Health Program allowed the state to access federal funds to cover those previously served by Family Health Plus as well as a wider set of eligible enrollees. New York has expanded eligibility and shifted funding mechanisms in recent years to maintain affordable coverage for New Yorkers and respond to federal funding limits.

The Essential Plan covers New Yorkers under age 65, not eligible for Medicaid and CHIP, without an affordable offer of coverage, up to an income limit of 250% of FPL (increased from 200% in 2024). The plan charged premiums of $20 per month to enrollees above 150% of FPL until 2021, when it eliminated all premiums. There are no deductibles and limited cost-sharing only for individuals over 150% of FPL.

New York's Medicaid agency administers the Essential Plan and contracts with health plans to deliver it, largely overlapping with the health plans that provide Medicaid managed care. Provider payments started somewhat above Medicaid rates and have increased since 2021.

Due to state-specific circumstances, federal funding has covered the cost of New York's BHP and generated a surplus in the state's BHP trust fund. In 2024, New York transitioned its BHP to a Section 1332 waiver. This change allowed the state to raise the Essential Plan's eligibility threshold to 250% of the FPL, offer state subsidies for certain Marketplace enrollees, and provide reimbursement to insurers to adjust for the transition of enrollees between 200% and 250% of FPL out of the Marketplace and into the Essential Plan.

In October 2025, New York submitted a request to CMS to terminate the Section 1332 waiver and return the Essential Plan to a BHP. The state identified federal changes to premium tax credit eligibility for lawful immigrants as the reason for the change, saying associated reductions in waiver pass-through funding would leave the state with unsustainable funding obligations.

[10] Minnesota Management and Budget

Oregon

Oregon launched the Oregon Bridge Plan in 2024. The state sought to maintain coverage gains from the pause in Medicaid eligibility redeterminations during the COVID-19 public health emergency and reduce churn of consumers on and off of Medicaid.

Oregon's BHP covers consumers with income between 138% and 200% of the FPL. The benefits are almost identical to those in Medicaid, covering adult dental benefits in addition to the essential health benefits.

Oregon uses its Medicaid managed care entities to administer the plans and initially uses Medicaid-level provider payment rates. The state plans to reconsider payment rates as funding allows.

The state's actuarial analysis showed that the individual market would remain stable and healthy despite the transition of consumers to the BHP, though consumers with income greater than 200% of FPL would pay more in premiums due to decreased silver loading (see Individual Market Effects below). While Oregon considered several proposals to mitigate the impact of higher individual market premiums, it determined none were feasible.

District of Columbia

The District of Columbia received approval in 2025 to move Medicaid-enrolled adults and caregivers with incomes above 138% of FPL to a Basic Health Program, referred to as the Healthy DC Plan. Through 2025, DC covered childless adults in Medicaid up to 210% of the FPL and parents/caregivers up to 216%.

The Basic Health Program allows DC to access greater federal funds as it makes the Healthy DC Plan available to enrollees up to 200% of FPL. These consumers will pay no premiums or cost-sharing. Consumers with incomes above 200% of FPL will transition to Marketplace plans with premium tax credits.

DC's Health Benefit Exchange (Marketplace) administers the Healthy DC Plan and contracts with three managed care plans to offer coverage, each of which participate in Medicaid managed care.

Considerations for consumers, states, and insurance markets

Basic Health Programs have the potential to impact consumer costs both for those who enroll in the BHP and for Marketplace consumers who do not. BHPs require administration by state agencies and potential investment from the state budget. States evaluating the

establishment of a BHP should weigh a range of considerations to determine the most appropriate choice given state-specific circumstances and priorities.

Consumer coverage impacts

BHPs offer an opportunity to provide moderate-income consumers with coverage that is as or potentially more affordable than they could find through the Marketplace. They also have the potential to ease enrollment and coverage transitions for consumers, particularly those whose income fluctuates between the Medicaid and premium tax credit ranges.

Federal law requires that BHP premiums be no more than consumers would face for a benchmark Marketplace plan with cost-sharing limited to the level of gold and platinum plans. In practice, however, states with BHPs have offered coverage that is substantially more affordable, both in premiums and cost-sharing, than required by the law. DC, New York, and Oregon offer BHP plans with no premiums and no or minimal cost-sharing. Minnesota applies premiums only to consumers with incomes at the higher range of eligibility and cost-sharing lower than Marketplace plans, with some enrollees exempt from cost-sharing.

Enrolling and maintaining enrollment in a BHP is likely to be simpler for consumers than enrollment in a Marketplace plan with premium tax credits. Marketplace enrollment requires selection of a plan, often from dozens of choices at differing metal levels, and reconciliation of premium tax credits at tax time. States have chosen to operate BHPs more like Medicaid managed care, with longer periods of continuous enrollment, limited plan choices, and no reconciliation requirement.

BHP networks and benefits, too, are often more similar to Medicaid than Marketplace plans. When Medicaid managed care entities contract to provide Basic Health coverage, they often use the same networks. Benefits must include essential health benefits, but states may add additional benefits, such as adult dental and vision services.

The establishment of a BHP can also affect affordability for consumers who enroll in Marketplace plans—see the Individual Market Effects section below.

State considerations

Budget

Federal funding under the BHP formula is available to cover a substantial portion of a state's BHP costs. State funding, however, may be necessary to make up any difference between available federal funds and the costs of a BHP. Due to the link between BHP funding and premium tax credits, policy changes that increase PTCs offer states greater BHP funding and

reduce the need for state dollars, while decreased PTCs lower federal support for BHPs and increase state spending.

States have been able to offer more affordable and more robust coverage through BHPs than is available in their Marketplaces by using provider payment rates closer to those used in Medicaid than the commercial rates paid by Marketplace plans. The gap between lower Medicaid rates and higher Marketplace provider payment rates determines how much "room" a state has to increase the generosity of BHP plans relative to Marketplace plans. States with higher provider payments in Marketplace plans, and thus higher Marketplace premiums and PTCs, are more likely to be able to fully fund a BHP with 95% of PTCs that would otherwise be paid on behalf of enrollees. The size of the gap is also determined by a state's choice of provider payment levels in the BHP—states that pay a multiple of their Medicaid rates may need to invest greater state funds to cover BHP costs.

States considering a BHP should plan for the possibility of changes to their BHP funding due to changes in the PTC amounts (and cost-sharing reduction payments, if any) paid in their states. The 2017 federal decision to end cost-sharing reduction payments removed these funds from BHP funding, though the BHP funding formula was subsequently adjusted to account for this change. The enhanced premium tax credits enacted in 2021 increased federal funds for BHPs, but the increase was temporary with the enhanced credits expirng in 2025.

Medicaid and Marketplace roles in implementation

While the eligibility criteria for BHP enrollment mirror those of premium tax credits for Marketplace coverage, many of the potential benefits of a BHP for consumers and states stem from the similarity of BHP coverage with Medicaid. For consumers, Medicaid-like affordability and benefits can make BHP coverage more favorable than Marketplace coverage. For states, using Medicaid as a starting point for provider payment rates, health plan contracting, eligibility determinations, and other program administration can offer efficiencies and cost savings in operating a BHP.

A state contemplating a BHP, then, should consider the extent to which it can align rules between Medicaid and the BHP. Since BHP funding cannot be used for administrative costs, states should consider the resources available to implement the eligibility updates required by administration of a BHP.

BHPs have the potential to ease coverage transitions for consumers whose eligibility shifts between Medicaid, BHP, and Marketplace coverage. This may be most likely to be achieved in a state with a state-based Marketplace, so Medicaid, BHP, and Marketplace systems can

more easily coordinate with each other. Nonetheless, Oregon has implemented a BHP while using the federal platform for Marketplace eligibility.

Individual market effects

States, especially state insurance regulators, should consider the effects of a BHP on a state's market for individual coverage. BHPs serve individuals who would otherwise be eligible for Marketplace coverage and for cost-sharing reduction plan variations since their incomes are between 138% and 200% of the federal poverty level. Covering this population in a BHP removes them from the individual market risk pool and can affect costs and market stability for the remaining risk pool.

One way a BHP alters a state individual market is through muting the effects of silver loading. Through silver loading, insurers add to silver plan premiums the cost of providing enhanced actuarial value plans to lower-income consumers. The higher silver plan premiums raise premium tax credits, making bronze and gold plans more affordable for subsidized consumers (subsidized consumers' costs for silver plans are unchanged since PTCs rise with their premiums). With a BHP, Marketplace plans don't cover individuals with income below 200% of the FPL, the enrollees eligible for silver plan variations with 87% or 94% actuarial value. The silver load in BHP states only needs to account for the 73% actuarial value plans available for consumers with income between 201% and 250% of the FPL. This minimal silver load reduces the affordability boost for bronze and gold plans that would be available in the absence of a BHP. So the BHP reduces affordability for some higher-income Marketplace enrollees at the same time it can provide more generous coverage for those enrolled in the BHP. The size of this effect varies with state circumstances, so states should evaluate the impacts and weigh how the coverage and affordability benefits for lower-income consumers compare to added costs for those with greater incomes.

Covering consumers with income below 200% of FPL in a BHP also reduces the size of the individual market. And if those who become eligible for a BHP are significantly more or less in need of health care services than others in the individual market, the individual risk pool could see improvement or deterioration. A less healthy risk pool could raise premiums for unsubsidized consumers, particularly for those over 400% of FPL do not qualify for subsidies with the expiration of enhanced PTCs. Changes in the size and health status of the risk pool could also lead insurers to reconsider their participation if the market is too small or too risky for their business goals.

Section 1332 State Innovations Waivers

Summary of statutes, regulations, and guidance

Section 1332 of the Affordable Care Act (ACA) allows states the flexibility to pursue innovative approaches to high-quality health care coverage by waiving certain ACA provisions. These waivers, referred to as State Innovation waivers, allow states to adapt coverage options to meet the needs of their states while still retaining the ACA's basic consumer protections. Section 1332 of the ACA provides that "State legislation" must grant the authority to implement the law.[11]

Only certain provisions of the ACA are deemed waivable. They include:

- Requirements for QHPs (42 U.S.C. §§ 18021 – 18024)
- Provisions relating to Exchanges, including requirements for plans, enrollment periods, navigators, and establishing a single risk pool for markets (42 U.S.C. §§ 18031-18033)
- Cost sharing reductions for low-income individuals (42 U.S.C. § 18071);
- Provisions relating to Premium Tax Credits (26 U.S.C. § 36B); and
- The requirement for large employers (that is, employers with more than 50 employees) to provide coverage and accompanying tax penalty if they do not (26 U.S.C. § 4980H).

Provisions that cannot be waived by a 1332 waiver include guaranteed issue requirements, age rating, and prohibitions on use of health status and gender rating.

Guardrails and the limitations they introduce

In order to receive approval from the Department of Health and Human Services (HHS) and the Treasury Department, states must meet four statutory guardrails.

- **Comprehensiveness:** Coverage must be at least as ***comprehensive*** as coverage without the waiver.
- **Affordability:** The state plan must provide coverage and cost-sharing protections as ***affordable*** as coverage available to people absent the waiver.
- **Comparable Number of Insured:** ***The number of people with health coverage must be comparable*** with the waiver in place to without the waiver.

[11] 42 U.S.C. § 18052, available at https://www.law.cornell.edu/uscode/text/42/18052.

- **Deficit-Neutrality:** The waiver must be ***deficit-neutral*** to the federal government over ten years.[12]

The guardrails provide strong, clear guidance to ensure that state reforms meet federal standards and do not result in a race to the bottom. However, when combined, they may also provide limits on the types of innovation that states can pursue under the 1332 waiver option. For example, expanding the number of people covered while maintaining or improving affordability and comprehensiveness is likely to increase expenditures, and thus violate the deficit neutrality guardrail without the addition of state funds. If a waiver satisfies the guardrails, it is subject to HHS and Treasury discretion on whether to approve a state's application.

Funding and applications

States can potentially access federal funds to support their waiver plans. If a waiver's policy changes result in lower federal spending on Marketplace subsidies, the state can generally receive those savings as "pass-through funding." One way to reduce federal subsidy costs is to reduce individual market premiums. Pass-through funding can be used to fund the costs of implementing the waiver, for example reinsurance program payments or a state subsidy program. States must supply their own funds for any waiver costs that exceed their pass-through funding.

To assure compliance with the statutory guardrails and determine accurate pass-through funding amounts, Section 1332 comes with substantial procedural requirements for states. States must complete a detailed application with actuarial analysis demonstrating how the guardrails are maintained. They must commit to ongoing reporting and coordination regarding waiver outcomes and any state policy changes that may affect the waiver.

State experiences

Twenty-one states have applied for and successfully received section 1332 waivers – in fact, some states have multiple waivers. Most states have waivers leveraging federal pass-through funds to support reinsurance programs for individual market stability. A handful of states have sought further market reforms through section 1332 waivers – including Colorado, Washington, Nevada, and New York (New York's waiver and its current status are

[12] See United States of Care, Using 1332 Waivers to Promote Access to Affordable Coverage, updated February 2025, available at: https://unitedstatesofcare.org/wp-content/uploads/2023/05/1332-Chart.pdf.

discussed in more detail above as part of the 1331 Section). However, several states have been denied section 1332 waivers for proposed reforms, or have received determinations that their applications were incomplete.

Reinsurance waivers and related state choices

The most common use of 1332 waivers to date has been to allow operation of state-based reinsurance programs. Through reinsurance, insurers with high-cost enrollees receive payments from the reinsurance program to offset some of their spending for these enrollees. These payments allow for lower base premiums.

As of 2025, 19 states operate state-based reinsurance programs by waiving the single risk pool requirement under section 1312(c)(1) of the ACA to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate.[13] Most states use a claims-based model, where qualifying insurers are reimbursed for a percentage ("coinsurance rate") of an enrollee's claims costs exceeding a specified threshold ("attachment point") and up to a specified ceiling ("reinsurance cap"). Alaska uses a conditions-based model, where insurers are reimbursed for all medical and prescription drug costs of enrollees with one or more of pre-determined high-cost conditions. Idaho uses a hybrid conditions and claims cost-based model for its section 1332 state-based reinsurance program.[14,15]

The scope and impact of a reinsurance program is dependent on the amount of state funding that states use to leverage further federal passthrough of savings. CMS' analysis of the impact of section 1332 state-based reinsurance programs demonstrate high success in the ability of such programs to retain insurers and reduce rates in the individual market.[16]

Reinsurance Example: Colorado

Colorado's approved 1332 waiver consists of two programs that reduce individual market premiums. Program one, the reinsurance program, has operated under a Section 1332

---

[13] CCIO Data Brief on State Innovation Waivers: Section 1332 Waivers, April 2024, available at https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

[14] Maine also used a hybrid program from plan years 2019-2021, *see id*.

[15] Daniel Meuse, Section 1332 Innovation Waivers in the New Federal Paradigm, presentation to NAIC Health Innovations Working Group, April 22, 2025. Another source for further summaries and analysis of state reinsurance waivers is State Health Access Data Assistance Center (SHADAC). Resource: 1332 State Innovation Waivers for State-Based Reinsurance [Internet]. University of Minnesota, Minneapolis (MN) [cited November 8, 2025]. Available from: https://www.shadac.org/publications/1332-state-innovation-waivers.

[16] See https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf.

waiver since 2020. Program two, the Colorado Option program, began implementation in Plan Year 2023 and includes a standardized health insurance plan and required premium reduction targets. Colorado generated $339,125,752 in 1332 waiver pass-through funding in 2025.

Colorado House Bill 19-1168 established the state-based individual market reinsurance program starting in plan year 2020. The reinsurance program uses a tiered payment parameter structure to emphasize savings for certain areas of the state that have historically had the highest rates by paying more toward consumer claims in higher cost areas. For example, Tier 2 (the Eastern Plains) and Tier 3 (the Western Slope) receive higher coinsurance rates to achieve higher premium reductions relative to Tier 1 (the Denver Metro). A claims-based attachment point reimbursement model is used to reimburse issuers annually following the applicable plan benefit year. Colorado's 1332 waiver reinsurance program will have saved Coloradans over $2.1 billion between 2020 and 2025.

Reinsurance Example: Wisconsin

Wisconsin's initial Section 1332 waiver was approved in July, 2018, for January 1, 2019-December 31, 2023. Then, Wisconsin received a 5-year waiver extension that runs January 1, 2024-December 31, 2028. Through its 1332 waiver, Wisconsin operates a reinsurance program called the Wisconsin Healthcare Stability Plan (WIHSP). The goal of WIHSP is to create a stable individual insurance market where consumers have a choice of health plans. It aims to maintain affordability of premiums by reimbursing insurers for a portion of any claims that exceed an attachment point in a given plan year. State law requires the commissioner of insurance to set payment parameters to define the portion of insurer costs that WIHSP reimburses each year by May 15th before the applicable plan year. For plan year 2024, 15 individual market insurers received reinsurance payments. The total budget for WIHSP payments is $265 million per year which is comprised of the federal pass-through and state general funds. The amount of state funding that goes into the WIHSP budget each year varies based upon the level of federal pass-through received. The annual federal pass-through has ranged from $127 million to $229 million with required state funds ranging from $0 to $47 million.

Other Approved 1332 Waivers

In recent years, several states have used 1332 waivers in ways to impact the individual market beyond reinsurance. Colorado's experience is described in more detail below. Other states that have recently sought and received approval for innovations beyond reinsurance include Nevada and Washington.

Colorado Option Program

The Colorado General Assembly passed House Bill 21-1232 in June 2021 to create the Colorado Option program and to allow the state to apply for a 1332 waiver amendment to capture pass-through savings generated from the Colorado Option. The driving principles of the Colorado Option program are to make health insurance in the individual and small group markets more accessible and affordable.

To support these goals, the Colorado Option program creates a standardized health benefit plan offered in the individual and small group markets. Issuers must offer Colorado Option Plans at the bronze, silver, and gold metal levels in all counties where they offer non-Colorado Option plans. Colorado Option plans captured 47% of all enrollments on Colorado's state-based exchange during Plan Year 2025 open enrollment.

Health insurance companies are also required to reduce premiums on Colorado Option plans. These premium rate reduction requirements, which rely on the 1332 waiver authority, are incorporated into "target premiums" each year for issuers. These targets establish the measure, or "trigger", by which a Colorado Option public hearing may be initiated. In cases where issuers fail to meet their targets, the Commissioner of Insurance is authorized to hold a public hearing to investigate the reasons why premiums remain above the targets. These premium rate reduction targets and the associated public hearing process give the Commissioner of Insurance the ability to set a reimbursement rate between an issuer and hospital/health-care provider for Colorado Option plans, which then passes on savings to consumers in the form of lower premiums. Lower premiums generate savings to the federal government in premium tax credits and these savings become pass-through funds for the state.

The Premium Rate Reduction and public hearing process encouraged carriers and hospitals to lower reimbursement rates for Colorado Option plans without the need for formal legal proceedings, and therefore the Commissioner vacated adjudicatory hearings for the Plan Years 2024 through 2026 Premium Rate Reduction processes." [17]

Waivers Applied for But Not Approved

A handful of states have applied for section 1332 waivers that have not been implemented – either due to the state withdrawing the application, the federal government determining

[17] Colorado Division of Insurance, ACA Section 1332 Waiver Reinsurance & Colorado Option Programs, December 12, 2024.

that an application was incomplete or could not be approved, or receiving a suspension of the waiver. Examples of these applications are below.

Georgia

Georgia originally received approval for its 1332 waiver in November 2020 effective for Plan Year 2022. This waiver included a reinsurance program ("Part I") and the Georgia Access Model ("Part II"), which would have replaced the Marketplace in the state with a system under which private entities such as carriers, web-brokers, and agents would provide marketing, outreach, and the front-end shopping experience for consumers.[18] However, the federal administration changed from the Trump Administration to the Biden Administration in January of 2021, and in June 2021, CMS sent correspondence to Georgia requesting updated analyses on Part II of its waiver in light of new federal priorities and guidance. On August 9, 2022, CMS suspended implementation of the Georgia Access Model, citing a lack of compliance with the coverage guardrail that requires that the number of people with health coverage be comparable with the waiver as without the waiver. Georgia subsequently moved to establish Georgia Access as a state-based Marketplace, which was approved in September of 2024.[19]

Iowa

On August 21, 2017, Iowa submitted a 1332 State Innovation Waiver application, known as the Iowa Stopgap Measure, to the U.S Treasury Department and the U.S. Department of Health and Human Services. The Iowa Stopgap Measure was designed to stabilize Iowa's Affordable Care Act (ACA)–compliant individual market through a series of modifications: (1) a requirement that all insurers in the individual market offer a single standard plan, similar to the ACA's silver plan; (2) elimination of CSR subsidies for those with incomes between 200 and 250 percent of the federal poverty level (FPL); (3) a new premium tax credit structure (tax credits would vary by age and income and would be extended to

[18] Fact Sheet – Georgia: State Innovation Waiver under Section 1332 of the PPACA, November 1, 2020, available at https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-/1332-ga-fact-sheet.pdf.

[19] The Centers for Medicare and Medicaid Services greenlights Georgia's transition to a state-based healthcare exchange, Georgia Access

individual market enrollees with incomes above 400 percent of the FPL); and (4) federally funded reinsurance on all annual individual market claims above $100,000.[20]

Iowa submitted additional information to address CMS questions regarding the Measure's compliance with the 1332 guardrails. However, after additional questions and information from CMS regarding the limits of available federal funding, in October of 2017, Iowa's Insurance Department submitted a letter of withdrawal for its 1332 waiver application, indicating that 1332 waivers are not designed to fix the collapsing individual market and that Congress needed to pass legislation to address the circumstances.[21]

Considerations for consumers, states, and insurance markets

Reinsurance

Consumer coverage impacts

State-based reinsurance programs have successfully lowered base premiums, aiding in the affordability of coverage for some consumers, generally those who do not qualify for premium tax credits. At this point, the waivers are relatively straightforward in design, meet the ACA's statutory guardrails, and may improve issuer participation and reduce year to year volatility.

However, premium tax credits insulate many lower income individual market enrollees from base premium costs. Consumers who are eligible for premium tax credits may not always see direct benefit from a reinsurance program, depending on the structure and scope of the program.

Budget

A key consideration for states is how to fund the state share of reinsurance costs. Reinsurance program costs are determined by the program structure and the claims experience of participating insurers, while federal pass-through funds are set by the amount of premium reduction a reinsurance program is expected to achieve. The state is responsible for covering any difference between the program costs and available federal pass-through funds.

---

[20] Nowak, Sarah A., Preethi Rao, Jodi L. Liu, and Christine Eibner, The Effects of Iowa's Proposed Stopgap Measure on Health Insurance Costs and Coverage. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR2228.html.

[21] Letter available at https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/ia-letter-withdraw-1332-waiver.pdf.

The share of costs covered by federal funds varies by state and by year depending on state-specific factors and changes in policy. Federal funds can cover virtually all of a state reinsurance program's costs or less than half. If other factors are held equal, federal funding for reinsurance waivers is larger where a larger share of enrollees received PTCs. Policies that increase premium tax credits due to state residents, such as the enhanced premium tax credits, boost the pass-through funds available to a state. Conversely, a reduction in premium tax credits (except for those resulting from the waiver itself) limits the pass-through funds.

States have chosen different methods for funding their state share of costs. About half of reinsurance programs use assessments on health insurance premiums. Other states use broader premium taxes, general funds, shared responsibility payments (individual mandate penalties), or a mix of these sources.

The continued success of reinsurance waivers depends on stable state and federal financing and clear guidance on future pass-through funding levels.

Other waiver types

States have used the flexibility of section 1332 waivers to make other changes in their health insurance markets. Hawaii was the first state to implement a section 1332 waiver; it replaced the ACA's Small Business Health Options Program (SHOP) with its pre-existing employer coverage program. Colorado (as described above) and Nevada require Marketplace insurers to meet premium reduction targets in addition to their reinsurance programs. Washington offers access to Marketplace coverage regardless of immigration status, without changing eligibility for federal premium tax credits. These uses show that section 1332 can be used for specific state objectives, provided the state meets the guardrails established in federal law.

Section 1333 Health Care Choice Compacts

Background

Summary of statute and 2019 request for information

Section 1333 of the Public Health Service Act, codified at 42 USC §18053, establishes statutory authority for states to create "health care choice compacts" (HCC Compacts)". The law directs HHS/CMS, in consultation with NAIC, to issue regulations for the creation of these compacts. The regulations are required under section 1333 to authorize two or more states to enter into an agreement where a qualified health plan could be sold in the

individual markets of all the states and only be subject to the laws and regulations of the state where the plan is written or issued. Section 1333 clarifies that such health care choice compacts are also subject to the following requirements:

- A state must be **authorized by state law** to enter into a health choice compact;
- A compact must provide coverage that is at least as **comprehensive** as essential health benefits and offered through Marketplaces;
- A compact must provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as **affordable** as those under federal law;
- A compact must provide coverage to at least a **comparable** number of its residents as would be provided under federal law;
- A compact **may not increase the Federal deficit**; and
- A compact **may not weaken state enforcement** of market conduct, unfair trade practices, network adequacy, and consumer protection standards (such as rate review), and disputes arising under the contract of the state where the purchaser resides.

Thus, HCC Compacts under section 1333 must meet similar guardrails to waivers approved under section 1332, with the additional caveat that state consumer protections where the purchaser of insurance resides cannot be weakened. Section 1333 also does not contemplate states receiving pass-through funding, unlike section 1332 waivers.

CMS released a Request for Information on HCC Compacts in March 2019. At that time, NAIC commented that states already have authority to permit sales of non-domiciled plans to their residents and thus, separate federal authority to do so was not needed. The comments noted concern about the risks of market instability if plans were sold across state lines and stated that federally-directed sales of health insurance coverage across state lines would frustrate the ability of state insurance regulators to fulfill one of their central obligations—to provide protection and counsel to insurance consumers in their states. CMS did not at that time follow up with proposed regulations.

On June 30, 2025, CMS sent a letter to NAIC President Jon Godfread seeking input to inform the development of Section 1333 regulations. The NAIC responded in a letter to CMS on October 2, 2025. In that letter, the NAIC emphasized that state regulators value the flexibility available under the Affordable Care Act, which allows state regulators to respond to individual market characteristics that are best managed at the state level. NAIC held that federal regulations that allow states to maintain flexibility in state or compact decision-making will ensure their effectiveness in guiding the development of compacts.

Comparison with other multi-state compact authority

The National Center for Interstate Compacts at the Council of State Governments maintains a database of enacted Interstate Compacts. The database currently contains 271 Interstate Compacts, covering a wide range of policy areas, from setting boundaries between states, to water rights and disaster response among many other areas. The Council notes that benefits of compacts may include the following:[22]

- Providing state-developed solutions to shared and complex policy
- Settling interstate disputes
- Responding to national priorities in consultation or partnership with the federal government
- Helping states maintain sovereignty in matters traditionally reserved for the states
- Creating economies of scale to reduce administrative costs
- Addressing regional issues that affect multiple states

The multi-state compact most familiar to insurance regulators is the Interstate Insurance Product Regulation Commission (IIPRC). IIPRC allows for multi-state approval of annuity, life insurance, disability income, and long-term care insurance products. Each of these are fixed indemnity products that are largely independent of state-specific market considerations. Insurers pay a fixed indemnity payment amount to (or on behalf of) a consumer and the amount of the payment is not tied to the cost or network participation of a service provider. IIPRC describes its history on its website[23]:

> The IIPRC was created and established as a "joint public agency" by Compacting States that enacted the Interstate Insurance Product Regulation Compact (Compact Statute). The Compact Statute delegates to the Commission a limited regulatory function traditionally within state insurance departments, that is, to accept, review, and approve or disapprove individual and group annuity, life insurance, disability income, and long-term care insurance products submitted by insurance companies for use in Compacting States. The Commission adopts Uniform Standards, Rules and filings requirements constituting the exclusive provisions applicable to the content and approval of such products, rates and advertising on behalf the Compacting States.

---

[22] CSG National Center for Interstate Compacts, "Frequently Asked Questions," available at https://compacts.csg.org/faq/.

[23] Interstate Compacts and the Insurance Compact, https://www.insurancecompact.org/about/faq.

> The IIPRC came into existence in March 2004, when it was enacted into law by the first state, Colorado, creating an offer to its sister states and then by the second state Utah, constituting an acceptance of the Compact. Article XIII, Section 2 of the Compact Statute required enactment by twenty-six (26) Compacting States or, alternatively, by States representing greater than forty percent (40%) for the Commission to become operational. Both of these operational thresholds were met in May 2006 and 27 Compacting States held the Commission's inaugural meeting in June 2006. The Commission's product operations commenced in June 2007, when the first product filing was submitted, and was approved in July 2007. As of May 16, 2022, 44 states, the District of Columbia, and Puerto Rico (46 Compact Member Jurisdictions) representing approximately 75% of the nationwide premium volume for asset-based insurance products have adopted over 100 Uniform Standards covering all individual product lines and several employer/employee group products.

In the years following the passage of the Affordable Care Act, an organization called "Competitive Governance Action" proposed a "Health Care Compact."[24] The purpose of the Health Care Compact was to restore "authority and responsibility for health care regulation to the member states."[25] It would allow member states to enact legislation to suspend the operation of all federal laws, rules, regulations and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to the compact. It would also give member states the rights to federal funds in an amount equal to total spending on health care in the member state during federal fiscal year 2010.[26] Nine states[27] adopted legislation authorizing them to enter into the Compact, but no further action to receive Congressional consent or otherwise stand up the compact has taken place.

Section 1333 of the ACA establishes a somewhat different model of compact in that it requires approval by a federal official, the Secretary of Health and Human Services.

---

[24] Health Care Compact, website, available at https://www.healthcarecompact.org/about.html.

[25] CSG National Center for Interstate Compacts, "Health Care Compact." available at https://compacts.csg.org/faq/.

[26] Health Care Compact website, "The Problem & Solution" available at https://www.healthcarecompact.org/about.html

[27] CSG National Center for Interstate Compacts, "Health Care Compact" available at https://compacts.csg.org/faq/.

Considerations for consumers, states, and insurance markets

Potential areas of regulation impacted by HCC compact

HCC Compacts, as outlined in the ACA, are subject to a number of restrictions, including application only to qualified health plans in the individual market. Potential areas of regulation could include mandated benefits (so long as essential health benefits continue to be met), and plan standards, such as plan design (so long as other guardrails continue to be met).

Section 1333 of the ACA also makes clear what state regulatory authority cannot be weakened under such a compact:

- market conduct
- unfair trade practices
- network adequacy
- consumer protection standards (such as rate review), and
- disputes arising under the contract of the state where the purchaser resides.

Additionally, a plan issued under a section 1333 Compact must be licensed in each state or voluntarily submit to each state's regulatory authority. It must also clearly notify consumers that the policy may not be subject to all of the laws of the state where the consumer lives.

Pros and cons for states

Multi-state compacts under Section 1333 could allow a range of market adjustments, from offering the same qualified health plan across multiple states to greater integration of multiple states' markets. While the precise parameters of Section 1333 compacts have not been defined, they could potentially add to market stability, encourage more market participants, and give insurers greater leverage to negotiate better rates.

In its October 2025 consultation letter to CMS, the NAIC noted that state flexibility and input will be paramount in making Section 1333 waivers effective. NAIC cautioned against federal regulations that limit how states work together to harmonize differing rules, how a compact is governed, and how a compact is funded.

Given the extensive federal regulation of qualified health plans under the ACA, states may value greater ability to set QHP standards and certification processes, even without a state-based marketplace. As noted in the NAIC's 2025 letter to CMS, flexibility is very important to states when discussing both section 1332 and section 1333 waivers. Consumer protection is of paramount importance to state insurance regulators, and a key element of

the Section 1333 compact is that plans offered across state lines would continue to be subject to important consumer protection laws in each state in which they are offered.

The potential for state flexibility and increased stability for plans offered in the individual market are some of the more attractive features of a Section 1333 compact. States may be able to minimize the impact of certain federal level policy changes by relying on state or compact-defined standards for qualified health plans, rather than federal standards. However, the extent to which a Section 1333 compact would allow plans to avoid federal standards is uncertain.

States that are part of a Section 1333 compact may be able to work together to develop plans that meet the unique needs of the member states and may be more nimble in responding to threats to the stability of the individual market, like significant network changes. Furthermore, states participating in a Section 1333 compact would also be able to closely coordinate changes to consumer protection and market conduct laws to minimize the impact of state level policy changes on the Section 1333 compact plans.

However, maintaining a nimble and coordinated compact would require an effective and flexible governance structure for the compact itself. An effective compact would require long-range planning and cooperation between governors, state agencies and legislatures. Legislatures in particular may require multi-year lead times in developing new policy. Thus, creating a smoothly functioning compact will require a concentrated, coordinated effort over a several year period, with no funding currently identified to support these efforts.

In contrast with the insurance products reviewed and approved by the IIPRC, health insurance often depends on state-specific factors. Rather than an indemnity model, comprehensive health insurance operates on an expense-incurred model and relies on localized provider contracting and networks. State policymakers may wish to retain more authority over health insurance policy and regulation than they have over the life, disability, and long-term care insurance handled by IIPRC.

The biggest unknown about the Section 1333 compact today is the lack of federal regulations outlining specifics. States would gain greater clarity if CMS defines the scope of flexibility granted, specifies whether the four guardrails shared with Section 1332 will be interpreted the same way, and provides more information on the guardrail on consumer protections. States will also require details about the approval process by CMS, funding, and procedural issues. These outstanding questions are also a significant deterrent to states that may be contemplating a compact under Section 1333.

Discussion, including combining state flexibilities

Each of the provisions discussed above offers states some flexibility to design coverage options that meet their specific needs. Below are potential areas where federal guidance could assist in greater state flexibility aligned with greater opportunities for consumer protection.

Section 1331 Basic Health Programs offer important flexibilities and federal funding opportunities for states to design coverage options that best suit their state needs. However, they may also have adverse impacts on individual markets and on individual market participants above 200% FPL by removing healthier lives from the risk pool in the individual market.

Section 1332 waivers have been used widely to provide individual market stability and in more recent years, have been used to implement innovations that address coverage needs of states. However, consistent interpretation of guardrails is needed, as is greater certainty and transparency surrounding the process for pass-through calculations.

Section 1333 waivers have not yet been implemented. Some have argued that standards for an individual market plan offered through a compact put regulation of state insurance products beyond federal changes and offer insurers, consumers, and regulators greater certainty, stability, and predictability.[28] Others caution that compacts are not likely to increase options, reduce operational complexity for insurers, or reduce premiums. Other issues that would need to be resolved include risk adjustment at the state level.[29] It is also unclear how a section 1333 compact could help stabilize markets without the ability for federal pass-through funds. This raises the question of whether an accompanying 1332 waiver would also be needed for states pursuing such an option. Clear federal guidance is needed on several issues before states can consider further pursuing these compacts.

Pursuing any of these flexibility options, alone or in combination, requires long-range planning and cooperation between governors, state agencies, and legislatures, as well as funding for actuarial modeling and venues for robust stakeholder engagement. Careful

---

[28] *See* "Section 1333 Health Care Choice Compacts: Opportunities for States to improve the individual health insurance market through state compacts under the Affordable Care Act", by Peter J. Nelson, July 2024, available at https://files.americanexperiment.org/wp-content/uploads/2024/07/Health-Care-Choice-Compacts.pdf.

[29] See "A blast from the past: Dusting off ACA Section 1333 Compacts", Stacey Pogue, March 2025, available at https://chir.georgetown.edu/a-blast-from-the-past-dusting-off-aca-section-1333-compacts/.

design is needed to avoid anti-selection and prevent risk pool fragmentation. Federal technical assistance and funding for planning could assist states in taking further advantage of the ACA's state flexibility provisions.

Conclusion

State flexibility under the ACA has already shown success in achieving greater affordability for consumers across many states. The law's flexibility options have the opportunity to play an increased role in maintaining accessible health coverage for consumers as the federal regulatory landscape changes. States are anticipating increased Medicaid disenrollments and future challenges for ACA market risk pools, among other tests for state health insurance regulation. Ever increasing health care costs also continue to drive premiums upward, leading to affordability challenges for individuals and small businesses. Clear and consistent guidance as well as flexibility from the federal government will help states to pursue state innovation options that best meet their coverage needs.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2026 Spring Meeting/State Flexibility Paper Draft Adopted by RFTF 3-24-26.docx

