Revised date: 8/10/26

2026 Summer National Meeting
Columbus, Ohio

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Friday, August 14, 2026
12:15 – 1:30 p.m.
Greater Columbus Convention Center—Battelle Grand Ballroom—Level 3

ROLL CALL

TBD, Chair	TBD	Mike Chaney	Mississippi
John F. King, Vice Chair	Georgia	Ned Gaines	Nevada
Charles Bassett	Arizona	Alice T. Kane	New Mexico
Trinidad Navarro	Delaware	Glen Mulready	Oklahoma
Dean L. Cameron	Idaho	Michael Humphreys	Pennsylvania
Ann Gillespie	Illinois	Jon Pike	Utah
Timothy N. Schott	Maine	Erin K. Hunter	West Virginia
Marie Grant	Maryland		

NAIC Committee Support: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

AGENDA

1. Consider Adoption of its Spring National Meeting Minutes
   —*Commissioner John F. King (GA)*

2. Consider Adoption of the Reports of its Working Groups and Task Forces
   —*Commissioner John F. King (GA)*
   A. Consumer Information (B) Working Group—*T.J. Patton (MN)*
   B. Health Care Affordability and Mitigation (B) Working Group
      —*Kate Harris (CO)*
   C. Health Actuarial (B) Task Force—*Director Anita G. Fox (MI) and Kevin Dyke (MI)*
   D. Regulatory Framework (B) Task Force
      —*Commissioner Marie Grant (MD)*
   E. Senior Issues (B) Task Force—*Commissioner Ned Gaines (NV)*

3. Consider Adoption of the *Guidance Document – ERISA Preemption and State PBM Laws*—*Commissioner Marie Grant (MD)*

4. Hear a Discussion on Prescription Drug Affordability and Access
   —*Mark Cuban (Mark Cuban Cost Plus Drug Company)*

5. Hear a Discussion from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on Affordability and Provisions in the 2027 Notice of Benefit and Payment Parameters (NBPP) Final Rule
   —*Peter Nelson (CCIIO) and Jeff Wu (CCIIO)*

6. Discuss Any Other Matters Brought Before the Committee
   —*Commissioner John F. King (GA)*

7. Adjournment

Agenda Item #1

Consider Adoption of its Spring National Meeting Minutes
—Commissioner John F. King (GA)

Draft Pending Adoption

Revised: 4/7/26

Health Insurance and Managed Care (B) Committee
San Diego, California
March 25, 2026

The Health Insurance and Managed Care (B) Committee met in San Diego, CA, March 25, 2026. The following Committee members participated: Grace Arnold, Chair (MN); John F. King, Vice Chair (GA); Charles Bassett (AZ); Trinidad Navarro represented by Susan Jennette (DE); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Robert L. Carey represented by Marti Hooper (ME); Mike Chaney represented by Bob Williams (MS); Alice T. Kane represented by Viara Ianakieva (NM); Ned Gaines (NV); Glen Mulready represented by Brian Downs (OK); Michael Humphreys (PA); Jon Pike (UT); and Allan L. McVey and Joylynn Fix (WV). Also participating were: Peter M. Fuimaono (AS); Michael Conway (CO); Michael T. Caljouw (MA); Kevin Dyke (MI); Eric Dunning (NE); D.J. Bettencourt (NH); Judith L. French (OH); Scott A. White (VA); and Rocky Patterson (WA).

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

The Committee met Feb. 13, 2026. During this meeting, it took the following action: 1) adopted its revised 2026 charges, which include renaming the Health Innovations (B) Working Group to the Health Care Affordability and Mitigation (B) Working Group.

The Committee also met Feb. 13 in joint session with the Regulatory Framework (B) Task Force. During this meeting, the Committee and Task Force took the following action: 1) adopted the Task Force's revised 2026 charges, which include renaming the Employee Retirement Income Security Act (ERISA) (B) Working Group to the ERISA and Alternative Health Coverage (B) Working Group.

Commissioner McVey made a motion, seconded by Director Gillespie, to adopt the Committee's Feb. 13, 2026 (Attachment One), the joint Committee and Regulatory Framework (B) Task Force Feb. 13, 2026 (Attachment Two), and Dec. 11, 2025 (*see NAIC Proceedings – Fall 2025, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

2. Adopted the Reports of its Working Groups and Task Forces

Director Gillespie made a motion, seconded by Commissioner Pike, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its March 4 minutes (Attachment Three); 2) Health Care Affordability and Mitigation (B) Working Group (Attachment Four); 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force, including its *State Flexibility White Paper* (Attachment Five); and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Heard a Presentation from Bailit Health on Health Insurance Affordability and State Options to Address It

Michael Bailit (Bailit Health) discussed state strategies for addressing the affordability crisis in the commercial health insurance market. He set the stage for the discussion by highlighting the adverse impact of high health care costs on consumers. He said that due to high health care costs, roughly 36% of adults in the U.S. say they have skipped or postponed needed health care in the last year; one in five have not filled a needed prescription. In addition, four in 10 adults report having debt resulting from medical or dental bills. Bailit also discussed health care cost drivers. He said that in 2022, nationally, hospital spending made up nearly half of total health care spending. He also described the growth in health care spending in recent years.

Bailit discussed state strategies for managing rising health care costs and addressing the problem of commercial health care market affordability, including: 1) hospital and prescription drug price caps; 2) enhancing market competition; 3) site-neutral payments and facility fee bans; and 4) limiting consolidation, vertical integration, and/or private equity. Bailit also posed the question of whether the lack of a functioning market for health care is part of the problem and whether health care can work as a market. He noted the following key aspects of the U.S. health care market that explain why it does not or cannot work as a market: 1) provider market consolidation; 2) lack of transparency on cost and quality; and 3) consumers not acting rationally when it comes to health care.

Bailit reviewed specific strategies that a wide array of states have adopted to address the growth in health care costs. He said most address hospital and pharmacy prices. He said data analysis has shown these to have been the primary forces driving up health care spending and commercial premiums for the past decade or more.

Bailit said several states, such as Minnesota, Rhode Island, and Utah, have initiatives to measure annual cost growth across markets, identify care cost drivers, and collaboratively develop strategies and opportunities for improving affordability. He discussed price caps that some states have instituted. Bailit said the states have three options for implementing a price cap: 1) state purchasing authority; 2) insurance regulation; or 3) provider price regulation. He discussed how Indiana and New Mexico instituted hospital price caps to slow the rise in health care costs. Bailit also highlighted Colorado's pharmacy price cap. He said Colorado was the first state to set an upper payment limit on a high-cost drug, which will be effective in 2027.

Bailit next discussed site-neutral payments and facility fee bans. He explained that site-neutral payment policies reduce the prices for certain services delivered within a hospital-owned or affiliated setting and those that can be safely provided in a lower-cost setting. Facility fee bans limit higher prices charged when hospitals acquire physician practices and shift services that were billed at office-based rates to outpatient hospital rates. Bailit provided examples of states using these strategies to manage health care costs. He next discussed price growth caps, which some states have used. A price growth cap limits how much provider payments can grow each year. He said the cap can be linked to an economic indicator, such as Consumer Price Index (CPI) or Gross State Product (GSP) growth. Bailit discussed Connecticut's pharmacy price growth cap, which prohibits any pharmaceutical manufacturer or wholesale distributor from selling a generic drug at a price above the wholesale acquisition cost after adjusting for any increase in the CPI.

Bailit discussed various state strategies to increase competition and address market changes to control rising health care costs. He said that to increase health plan competition, Nevada launched a public option on their state-based exchange (SBE) in January 2026. Bailit also provided examples of various state strategies being used to address market changes, including: 1) increasing transparency through ownership reporting requirements and expanded financial disclosures; 2) strengthening Corporate Practice of Medicine (CPOM) protections to preserve professional autonomy; and 3) addressing anticompetitive contracting practices of dominant insurers with providers, such as all-or-nothing contracting.

Commissioner Grant asked Bailit to discuss hospital rate-setting and global billing, which Maryland has used for years to control hospital costs. Bailit explained that hospital rate-setting was instituted in a number of states, but Maryland's program is the only one that remains. He said research has shown it has been effective in Maryland. He distinguished between hospital rate-setting and hospital global budgets. He said he believes hospital global budgets, particularly if done on a multi-payer basis, hold great attraction and potential in controlling health care costs because they do not involve fee-for-service payment coding games currently happening in the market between insurers and providers, especially if the rate of budget growth is controlled and not subject to market power. Bailit said that although global billing is a hard model to implement, it is worth trying.

Commissioner Caljouw asked Bailit to discuss state experiences with price capping in more detail and how they might be implemented with utilization controls, both in a hospital and pharmaceutical setting. Bailit agreed with

Commissioner Caljouw that if states cap prices, they are not controlling utilization, which creates opportunities for gaming the system. He said one reason the hospital global budget model is attractive is that it can address both price and utilization.

With respect to state experience with price capping and whether it is effective, Bailit said there has been a flurry of state price growth cap activity over the last few years, but the only program that has been in effect long enough to be evaluated is Oregon's. He said Oregon's program applies to state employees and teachers and has been found to have generated state savings. He said a second recent program evaluation found that there was no substantial harm caused to hospitals. Bailit said another related concept, the price growth cap, has been evaluated because Rhode Island has had a commercial price growth cap in place since 2010, and there have been two peer-reviewed published evaluations of it to date. He said both evaluations found that premiums in Rhode Island grew at a much slower rate than in other New England states, resulting in lower premiums and consumer savings.

Fix asked if facility fee bans have been effective in controlling health care costs. Bailit acknowledged the increasing number of states imposing facility fee bans. He said such bans have had some impact on costs, but obviously less impact if fees were addressed more broadly. Bailit said the critical aspect of facility fees for him and whether they will generate any meaningful savings, is limiting facility fees for both on-hospital and off-hospital campus facilities. He explained that a lot of facility fees are for professional offices located on the hospital campus but are not part of the hospital. Therefore, if you exempt facility fee charges on campus, most of the savings are lost. Bailit cited a recently published study of Medicare's limitation on facility fees to support his claim.

Director Bassett asked Bailit whether he had found in his research that fraud is a significant health care cost driver. Bailit said he is not aware of any studies on the issue. He explained that he would distinguish between fraud and gaming the system, which is occurring now between providers and insurers, with providers upcoding or maximizing the number of diagnoses in a claim to increase reimbursement.

Director Cameron asked Bailit about the data analysis he mentioned during his presentation. He asked if Bailit is aware of any studies of utilization trends based on Current Procedural Terminology (CPT) codes. Bailit referenced a few such studies, including the RAND Corporation's examination of hospital prices within the state using claims data that it obtains from insurers, and the Health Care Cost Institute's (HCCI's) collection of claim data from large insurers across the country, which it uses to perform analyses that include a metropolitan area drilled down on pricing utilization.

As a follow-up to Director Bassett's question about fraud, Director Cameron asked Bailit about artificial intelligence (AI) being used in billing practices to bill for health care services that are not provided. He asked if Bailit is aware of any study providing evidence of such actions. Bailit said there is currently a lot being written about hospitals using AI for billing, but he is not aware of it being used for fraudulent purposes.

4. Heard Remarks from CMS on Improving State/Federal Coordination on Issues Related to MA Plans

Alec Aramanda (Centers for Medicare & Medicaid Services—CMS) discussed CMS' state/federal coordination efforts related to Medicare Advantage plans. He first provided an overview of CMS and its priorities, including the number of beneficiaries it serves and its rule-making process. Aramanda said CMS also serves as the lead for management, oversight, budget, and performance issues relating to Part C (Medicare Advantage), Part D (prescription drug plans), and Medicare fee-for-service providers and contractors. He noted that one of CMS's priorities involves its work related to the Make America Healthy Again (MAHA) initiative.

Aramanda discussed CMS' work to move toward more market-based pricing using empirically reliable, auditable information from the commercial sector to help inform Medicare payment rates. He said CMS believes this effort will ultimately put the right kind of downward competitive pressure on pricing and ultimately make sure that the

relative allocation of resources available will show that providers are being adequately compensated for the high-value care that they deliver and patients are receiving the quality of care they deserve. He said that, also in doing this, CMS is looking to address the consolidation going on in the Medicare Advantage market and looking to remove incentives that create arbitrage opportunities that increase costs for patients and taxpayers and do not provide any measurable improvement in the quality of care provided.

Aramanda stated that another CMS priority is its star ratings system, which evaluates Medicare Advantage and Medicare Part D on a one-to-five-star scale, with five stars representing excellent performance. He said the star ratings program helps beneficiaries compare plans based on quality, covering areas like customer service, preventive care, and chronic condition management. High-rated plans (i.e., those with four or more stars) receive financial bonuses. Aramanda also mentioned CMS' work related to prior authorization and partnering with insurers to streamline and modernize the prior authorization process.

Aramanda discussed how unique Medicare is and the services it provides. He stated that a goal CMS shares with state insurance regulators is to ensure Medicare beneficiaries have access to timely, high-quality care close to their homes. He noted that Medicare Advantage is a federally administered program that provides broad federal preemption of state laws related to all aspects of Medicare Advantage plans except Medicare Advantage plan licensing and financial solvency. Aramanda said that CMS has a statutory obligation to ensure there are uniform national rules for Medicare Advantage plans to ensure Medicare Advantage beneficiaries receive consistent protection and high-quality care regardless of where they live. He noted that CMS has a memorandum of understanding (MOU) with each state enabling the sharing and coordination of that information as related to Medicare Advantage plan issues. He also noted CMS' commitment to meeting monthly with the Senior Issues (B) Task Force to enhance this coordination and information sharing.

Commissioner Arnold acknowledged and expressed appreciation for CMS' recent efforts to provide opportunities for information sharing and discuss Medicare Advantage plan issues with state insurance regulators.

Director Cameron asked Aramanda whether CMS has any data or information it could share on how many carriers it has terminated or actions it has taken related to market conduct issues. He said there appears to be a lack of clarity between the roles that states and CMS play when Medicare Advantage plan insurers act inappropriately, do not provide or deny access to seniors being able to enroll in their Medicare Advantage plans, shut down their websites, or hide applications. Aramanda said he does not have that information readily available and would be happy to follow up with the Committee to the extent that CMS can provide it.

5. Heard an Update from the CCIIO on its Recent Activities

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO's recent activities of interest and priorities. He said transparency and innovative plan design are high priorities for the CCIIO. He discussed provisions in the 2027 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) proposed rule to accomplish these priorities. Nelson also noted the CCIIO's continued commitment to reducing waste, fraud, and abuse. He said the CCIIO is actively working more closely with stakeholders, including state insurance regulators, particularly as it relates to agents and brokers, to address the issue. Nelson also touted the provisions in the federal Working Families Tax Cut (WFTC) Act (better known as the One Big Beautiful Bill), which significantly expands health savings account (HSA) utility starting Jan. 1. The key changes include making bronze and catastrophic individual marketplace plans HSA-compatible, allowing tax-free HSA funds for direct primary care (DPC) fees, and increasing flexibility for dependents.

Commissioner Arnold asked about the timing of finalizing the 2027 NBPP proposed rule. Nelson acknowledged the importance of finalizing it as expeditiously as possible. He said the CCIIO is currently reviewing comments received and hopes to finalize the rule as soon as possible.

Commissioner Humphreys stressed support for the CCIIO's efforts to provide greater transparency, which is also an important initiative in Pennsylvania. He asked whether there were any opportunities at the federal level to leverage the enrollee-level external data-gathering environment (EDGE) server to create additional data resources for the states to enhance their transparency efforts.

Jeff Wu (CCIIO) discussed the opportunities and limitations of the EDGE server data, explaining that the state all-payer claims database (APCD) would have more comprehensive data. He discussed the CCIIO's other efforts on transparency and those related to prior authorization.

Commissioner Pike expressed support for the CCCIIO's efforts related to transparency and similar initiatives. He expressed disappointment and frustration, however, with the delays in the essential health benefit (EHB) benchmark plan application process. Nelson said he understood Commissioner Pike's frustration. He said the CCIIO is working to establish a framework for EHB benchmark plans that align with Affordable Care Act (ACA) statutory requirements and hopes to resolve it soon.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2026 Spring National Meeting/Final Minutes/03-Bmin.docx

Agenda Item #2

Consider Adoption of its Working Group and Task Force Reports

—Commissioner John F. King (GA)

Virtual Meeting

CONSUMER INFORMATION (B) WORKING GROUP
July 23, 2026 / April 10, 2026

Summary Report

The Consumer Information (B) Working Group met July 23 and April 10, 2026. During these meetings, the Working Group:

1. Discussed its planned activities for 2026 based on a poll of Working Group members. The poll showed that their top priorities are mental health parity and balance billing protections under the No Surprises Act (NSA). The Working Group decided to complete work on both topics prior to its work on updating the *Frequently Asked Questions about Health Care Reform* in the fall.

2. Discussed and exposed a consumer guide on the NSA for a 7-day public comment period ending July 29. The Working Group plans to conduct an e-vote to approve the guide after the Summer National Meeting.

3. Discussed and exposed a consumer guide on mental health parity for a 7-day public comment period ending July 29.

4. Based on a suggestion from a stakeholder, discussed and decided to add to its list of potential future projects the development of consumer disclosures or guides on health savings accounts (HSAs) following recent legislative changes that expand access to HSAs.

Draft: 7/29/26

Consumer Information (B) Working Group
Virtual Meeting
July 23, 2026

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met July 23, 2026. The following Working Group members participated: T.J. Patton, Chair (MN); David Buono, Vice Chair (PA); Anthony L. Williams (AL); Debra Judy (CO); Patricia Dorn (MD); Jeana Thomas (MO); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan (TN); Shelley Wiseman (UT); Andrew Davis (WA); and Christina Keeley (WI).

1. Discussed a Consumer Guide on the No Surprises Act

Buono led a discussion on a consumer guide developed for the No Surprises Act (NSA). A drafting group consisting of state insurance regulators, consumer representatives, and industry officials completed the draft guide. He said the guide focuses on providing clear, high-level information to consumers about surprise billing protections. The guide aims to be accessible, avoiding insurance jargon, and includes links to existing federal resources and a section for states to add information on their own balance billing protections. He noted that the guide defines surprise billing, explains the protections under the No Surprises Act, and describes which health plans and health services are subject to those protections. He said Brenda J. Cude (Individual Consumer Advocate) reviewed the draft for readability and suggested several edits to the text that were adopted. The Working Group acknowledged the challenge of balancing detail with simplicity and considered allowing more time for review and feedback before adoption.

The Working Group exposed the consumer guide on the NSA for a 7-day public comment period ending July 29, 2026. The Working Group resolved to conduct an e-vote to approve the guide in the coming weeks.

2. Discussed a Consumer Guide on Mental Health Parity

Patton reviewed a concise consumer guide on mental health parity protections written by a second drafting group. The drafting group included state insurance regulators, consumer representatives, and other interested parties. He said the draft guide is designed to be brief, digestible, and user-friendly. He said the drafting group based its work on a document developed by The Carter Center for use in Georgia after the state passed a parity law in 2022.

Patton said the drafting group aimed to highlight key information without overwhelming consumers. He noted the guide explains at a high level that mental health and substance use services are covered by health plans and identifies a number of potential issues consumers should watch for when accessing mental health and substance use services. It includes an area where state departments of insurance may insert their contact information and encourage consumers to reach out.

Some Working Group members expressed concerns about potential confusion regarding cost differences in medications between drugs used to treat mental health conditions and drugs for physical health conditions. Others pointed out that the application of deductibles may lead to higher costs for mental health services even without a parity violation. Patton acknowledged the challenge of simplifying complex topics and welcomed suggestions for improvement.

The Working Group exposed the consumer guide on mental health parity for a 7-day public comment period ending July 29, 2026.

Patton emphasized that both draft guides are intended to be templates for use by state departments of insurance. States are welcome to use or change the templates as they see fit, adding or changing content to make the guides relevant for their states.

3. Discussed Other Matters

Jeff Klein (American Bankers Council) suggested the Working Group consider developing consumer disclosures or guides on health savings accounts (HSAs) following recent legislative changes that expand access to HSAs. The Working Group decided to add the topic to its list of potential future projects.

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

Draft: 4/17/26

Consumer Information (B) Working Group
Virtual Meeting
April 10, 2026

The Consumer Information (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 10, 2026. The following Working Group members participated: T.J. Patton, Chair (MN); David Buono, Vice Chair (PA); Debra Judy (CO); Corbin McGhee (IL); Alex Peck (IN); Patricia Dorn (MD); Margaret Pena (NM); Donna Dorr (OK); Jill Kruger (SD); Jennifer Ramcharan (TN); Shelley Wiseman (UT); Vicki Jones (WV); and Christina Keeley (WI).

1. Discussed its 2026 Projects and Priorities

Patton led a discussion on the Working Group's planned activities for 2026. He said a poll of Working Group members showed that their top priorities are mental health parity and balance billing protections under the No Surprises Act (NSA). He asked whether Working Group members were interested in completing work on one or both of the topics prior to their work on updating the *Frequently Asked Questions about Health Care Reform* in the fall. The Working Group supported developing materials on both topics.

Patton emphasized mental health parity as a top priority and said the Working Group would need to carefully consider how to describe this complex policy area to consumers. Ramcharan noted provider refusal to accept insurance as a major barrier and volunteered to join a drafting group on parity issues. Several other state insurance regulators and interested parties volunteered to participate in the drafting group.

Buono, along with several other members and interested parties, volunteered to participate in an NSA drafting group.

Patton raised the importance of improving the accessibility, readability, and usability of all Working Group materials. He said the Working Group should aim to enhance content delivery beyond static PDFs to reach broader audiences.

Brenda J. Cude (NAIC Consumer Representative) highlighted the distinction between accessibility (i.e., format and delivery) and readability (i.e., content clarity). She recommended that the Working Group finalize the materials' contents before focusing on formatting.

Bonnie Burns (California Health Advocates—CHA) stressed that accessibility includes ease of finding, viewing, and understanding information, especially for people with vision impairments. Harry Ting (Health Care Consumer Advocate) suggested including consumer representative Eric Ellsworth (Consumers' Checkbook/Center for the Study of Services—CSS) in discussions about interactive tools to improve accessibility.

The Working Group agreed to proceed with forming subject matter expert (SME) groups for mental health parity and the NSA, with volunteers identified. Members were encouraged to propose ideas for improving material accessibility and usability ahead of the next meeting.

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

2026 Summer National Meeting
Columbus, Ohio

HEALTH CARE AFFORDABILITY AND MITIGATION (B) WORKING GROUP
Thursday, August 13, 2026
10:15 – 11:15 a.m.

Meeting Summary Report

The Health Care Affordability and Mitigation (B) Working Group met Aug. 13, 2026. During this meeting, the Working Group:

1. Adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee, Attachment Four).*

2. Adopted its June 2, May 5, April 21, and April 7 minutes. During these meetings, the Working Group took the following action:
   A. Discussed its work plan for the year with a focus on developing a series of short issue briefs covering state options for improving the affordability of health care. The Working Group received updates on the work of its drafting groups and compiled a list of potential topics to cover in the issue briefs.
   B. Discussed the *State Options for Reducing Health Insurance Costs* document.
   C. Discussed a list of policy topics to focus on when developing briefs describing state options for addressing health care affordability. The Working Group conducted a poll among its members to identify the top priority affordability options.
   D. Heard presentations from the Georgetown University Center on Health Insurance Reforms (CHIR) and the Health Care Affordability Lab at Yale on drivers of health care costs and strategies for controlling them.

3. Heard a presentation from the Blue Cross and Blue Shield Association (BCBSA) on challenges posed by the independent dispute resolution process under the federal No Surprises Act and recommendations for mitigating them.

4. Heard a presentation from Equality Arlington on limited benefit health plans that consumers may view as alternatives to Marketplace health plans and how the plans affect consumer costs and risks.

5. Solicited input on the draft affordability issue briefs that the Working Group exposed July 13 for a 45-day public comment period ending August 31, 2026.

2026 Summer National Meeting
Columbus, Ohio

HEALTH ACTUARIAL (B) TASK FORCE
Tuesday, August 11, 2026
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Actuarial (B) Task Force met Aug. 11, 2026. During this meeting, the Task Force:

1. Adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Health Actuarial (B) Task Force*).

2. Adopted its April 20 minutes. During this meeting, the Task Force took the following action:
   A. Adopted the incorporation of reference to the health knowledge statements into the Health Annual Statement Instructions as a requirement for actuaries signing the Statement of Actuarial Opinion (SAO) for the health annual statement blank.

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Aug. 5, July 14, and May 27. During its Aug. 5 meeting, the Working Group took the following action:
   A. Adopted its July 14 and May 27 minutes. During these meetings, the Working Group took the following action:
      i. Heard an industry presentation on hybrid life/long-term care insurance (LTCI) product features and pricing.
      ii. Exposed proposed LTCI lapse and mortality tables for a 45-day public comment period ending July 14.

4. Discussed its 2026 work plan.

5. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on the changes to plan year 2027 federal Affordable Care Act (ACA) rate filings due to changes effected by the federal *City of Columbus v. Kennedy II* lawsuit, reporting of cost-sharing reductions (CSRs) for plan year 2027 rates, and a proposed rule to implement statutory limits on health care-related provider taxes.

6. Heard an American Academy of Actuaries (Academy) professionalism update.

7. Heard an update from the Academy Health Practice Council.

2026 Summer National Meeting
Columbus, Ohio

REGULATORY FRAMEWORK (B) TASK FORCE
Thursday, August 13, 2026
1:00 – 2:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met Aug. 13, 2026. During this meeting, the Task Force:

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

2. Adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force*).

3. Adopted the report of the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, which met Aug. 13. During this meeting, the Working Group took the following action:
   A. Adopted its July 22 and May 18 minutes. During these meetings, the Working Group took the following action:
      i. Adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment One*).
      ii. Discussed the comments received on and adopted the draft *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws*.
   B. Discussed its planned work on guidance related to level-funded plans. A regulator-only drafting group plans to begin drafting a guidance document on level-funded plans after the Summer National Meeting. Level-funded plans are an increasingly popular arrangement, typically sold to small employers, that involves self-funding with a fixed-amount (level-funded) stop-loss policy.
   C. Adjourned into regulator-to-regulator session, pursuant to paragraph 2 (pending investigations), paragraph 3 (specific companies, entities, or individuals), and paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings.

4. Adopted the reports of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group and the Prescription Drug Coverage (B) Working Group, which met Aug. 12 in joint session. During this meeting, the Working Groups took the following action:

A. The Prescription Drug Coverage (B) Working Group adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment Two*).
B. The MHPAEA (B) Working Group adopted its April 2 minutes. During this meeting, the Working Group took the following action:
    i. Discussed its planned work for 2026. The Working Group decided that its 2026 work would include compiling a tracking document that shows activity by state and the resources they use, such as reporting templates, to help regulators understand what is happening across states related to MHPAEA implementation and enforcement.
    ii. Heard an update on New Hampshire's use of reporting templates for prior authorization as a nonquantitative treatment limit (NQTL).
C. Heard presentations from the Center for Evidence-Based Policy and The INS Companies on medications to treat substance-use disorders and their coverage by health plans, focusing on coverage delays and state enforcement of parity requirements.

5. Adopted the *Guidance Document: ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws*, which the Health Insurance and Managed Care (B) Committee will consider for adoption during its Aug. 14 meeting.

6. Heard an update from the Robert Wood Johnson Foundation (RWJF) on individual coverage health reimbursement arrangements (ICHRAs).

7. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on its recent activities related to essential health benefits (EHBs) and the pre-enrollment income verification process.

2026 Summer National Meeting
Columbus, Ohio

SENIOR ISSUES (B) TASK FORCE
Thursday, August 13, 2026
7:30 – 8:45 a.m.

Meeting Summary Report

The Senior Issues (B) Task Force met Aug. 13, 2026. During this meeting, the Task Force:

1. Adopted its May 21 minutes. During this meeting, the Task Force took the following action:
   A. Adopted its Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Senior Issues (B) Task Force*)
   B. Discussed the Medigap "Birthday Rule" and Medigap for those under 65

2. Discussed the Task Force's survey on long-term care (LTC) riders on life insurance products and variable plans.

3. Heard a presentation from Envision Benefit Specialists on long-term care insurance (LTCI) riders on life insurance products and variable plans.

4. Heard a presentation from NAIC consumer representatives on health care services migrating from hospitals to outpatient services and the Medigap cost impact.

5. Heard a federal legislative update.

Agenda Item #3

Consider Adoption of the Guidance Document – ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws—*Commissioner Marie Grant (MD)*

Adopted by the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, July 22, 2026
Adopted by the Regulatory Framework (B) Task Force on Aug. 13, 2026
Adopted by the Health Insurance and Managed Care (B) Committee TBD

Disclaimer: The information in the guidance document is current as of July 22, 2026.

GUIDANCE DOCUMENT—ERISA PREEMPTION AND STATE PBM LAWS

OUTLINE

I. Introduction

This document provides guidance on the Employee Retirement Income Security Act (ERISA) preemption of state pharmacy benefit manager (PBM)[1] laws by analyzing the different types of state PBM laws[2] and considering how appellate courts have applied the reasoning in *Rutledge v. Pharmaceutical Care Management Association (PCMA)* to those laws.[3] Per the disclaimer above, this document is current as of July 22, 2026, and, therefore, does not discuss pending litigation in this area.[4] Additionally, the NAIC *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal*

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

[2] 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. Refer to https://www.ncsl.org/health/state-policy-options-and-pharmacy-benefit-managers.

[3] Note, several cases, such as *PCMA v. Rowe,* 429 F.3d 294 (1st Cir. 2005) and *PCMA v. District of Columbia,* 613 F.3d 1085 (D.C. Cir. 2010) were decided before the Supreme Court opinion in *Rutledge* and are outside the scope of this guidance document.

[4] Court cases, including the recently decided *McKee Foods Corporation v. BFP Inc., et al*, (6th Cir. 2026) will not be included in this Guidance Document until they are procedurally final and no longer subject to additional judicial review. However, several pending cases are mentioned in the addendum to this guidance document.

Regulation (ERISA Handbook) provides a more comprehensive overview of ERISA preemption and its impact on state efforts to regulate ERISA plans.

PBMs 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 to design and implement preferred and non-preferred pharmacy networks, metric-based payment arrangements, and formulary design elements (drug coverage, patients' out-of-pocket responsibilities, and utilization management protocols). PBMs engage in negotiations and financial transactions among pharmaceutical manufacturers, health plans, and pharmacies.[5]

In connection with their regulatory authority over health care, including the practice of pharmacy and the business of insurance, states have enacted laws regulating PBMs. However, these laws interact in complex ways with a variety of federal laws (Medicare, Medicaid, and ERISA) that might also apply, depending on the type of benefit plan that the PBM is managing. This has created opportunities for a variety of federal preemption challenges, complicating states' ability to address important health policy issues affecting their citizens.

This guidance document addresses questions about preemption of state PBM laws under ERISA, which regulates employee benefit plans. It does not address potential preemption by other federal laws, such as those governing the Medicare Part D prescription drug program.

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

---

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

[6] *Rutledge v. Pharmaceutical Care Management Ass'n,* 592 U.S. 80 (2020). The case was only appealed to the United States Supreme Court on the issue of ERISA preemption. The court did not opine on the 8th Circuit's finding that Act 900 was preempted by Medicare Part D.

[7] *Rutledge at 88.*

conclusions. The 8th Circuit upheld North Dakota's law,[8] while the 10th Circuit struck down parts of Oklahoma's law.[9]

II. ERISA Preemption

ERISA 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,"[10] a broad category that includes nearly all employer-sponsored and union-sponsored health plans. However, ERISA does not preempt state insurance law.[11] ERISA's "saving clause" for any state law that "regulates insurance"[12] gives states broad authority to regulate PBMs that administer state regulated insurance policies, including fully insured employee health plans.[13]

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

The focus of recent preemption litigation has been on state laws that broadly apply to the PBM industry, including those governing PBMs acting on behalf of self-insured, ERISA-covered plans. Many states have chosen to address PBM issues through pharmacy regulation rather than insurance regulation because most consumers do not get their medications through state-regulated insurance policies. In particular, almost two-thirds of people with coverage through their employer are covered by self-insured health plans that are not regulated by state insurance law.[14]

---

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

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

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

[11] As mentioned in this guidance document's introduction, consult the NAIC ERISA Handbook for a more comprehensive treatment of ERISA preemption and state law.

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

[13] 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.

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

At a high level, when a state contemplates applying a particular regulatory measure to PBMs contracted with self-insured employers, the question policymakers must consider is whether that measure is a permissible exercise of the state's general powers to regulate PBMs, or whether it encroaches on the exclusive federal power to regulate the employer's health benefit plan. Under ERISA, if a state PBM law "may now or hereafter relate to any employee benefit plan" and is not a law "which regulates insurance," that law is preempted.[15]

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

III. CASES ADDRESSING ERISA PREEMPTION ANALYSIS OF STATE PBM LAWS

Rutledge

To consider the potential impact of ERISA on state PBM laws, it is logical to begin with an analysis of the Supreme Court's *Rutledge* opinion. In *Rutledge*, the court upheld an Arkansas law, Act 900 of 2015, which requires PBMs to reimburse pharmacies at a price equal to or higher than the price the pharmacy paid for 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;[16] 2) establish an appeal process for pharmacies to challenge PBM MAC pricing lists;[17] 3) increase pharmacy reimbursement rates to cover pharmacy acquisition costs;[18] and 4) allow the pharmacy to adjust any claims[19] 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.[20]

---

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

[16] Act 900 of 2015.

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] *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,[21] 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,*[22] or "by binding plan administrators to specific rules for determining beneficiary status," as in *Egelhoff*.[23] 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,*[24] 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.[25] 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.[26]

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.[27]

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

---

[21] *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)).

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

[23] *Id.* at 87.

[24] *Id.*

[25] While not a PBM case, regulators may want to review the summary of the *Gobeille* case in the NAIC ERISA Handbook on page 32.

[26] *Id.*

[27] *Id.*

anything more than potential operational inefficiencies...",[28] 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."[29] The opinion concludes: "In sum, Act 900 amounts to cost regulation that does not bear an impermissible connection with or reference to ERISA."

Finally, the court determined that there was no impermissible "reference to" ERISA plans. Citing *Gobeille,* the court stated that a law refers to ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation."[30] 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.[31]

Instead, the court likened Act 900 to the New York law at issue in *Travelers,*[32] a landmark 1995 case limiting the reach of ERISA's "relate to" clause. That law had imposed surcharges on most hospital bills but not on bills for patients covered by Medicaid or 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 regardless of whether coverage was secured by an ERISA plan or not.[33]

Cases Post-*Rutledge*

Since the *Rutledge* decision, lower courts have applied its holding and reasoning to resolve ERISA preemption challenges to myriad PBM laws enacted by states.[34] The results have been complicated. Two PBM cases in particular, *Mulready* and *Wehbi*, have reached opposite

---

[28] *Id.* at 89, noting in footnote 2 that the 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.

[29] *Id.* at 91.

[30] *Id.* at 88.

[31] Id. at 88–89.

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

[33] "...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.

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

conclusions in circuit courts regarding whether ERISA preempted the laws at issue. While the laws 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 8th Circuit analyzed North Dakota's PBM laws on remand after the Supreme Court directed the 8th Circuit to reconsider its decision in light of the reasoning in *Rutledge*. The 8th 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, it reversed its decision and held that the laws were not preempted under ERISA.

Like the Supreme Court in *Rutledge*, the 8th Circuit Court held that whether a state law "relates to" ERISA plans by analyzing whether there is an impermissible "connection with" or "reference to" ERISA plans.

Considering whether a law has an impermissible "reference to" an ERISA plan, the Court looked to whether the law "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation."[35] 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 8th Circuit Court followed the decision in *Rutledge* and held that the "existence of ERISA plans is essential to a law's operation only if the law cannot apply to a non-ERISA plan."[36]

In assessing whether the law has a "connection with" ERISA, the 8th 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.'[37]

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

[36] Id. at 969.

[37] 18 F.4th 956 at 968.

The 8th Circuit, quoting *Rutledge,* stated that "the mere fact that a state law 'affects an ERISA plan or causes some disuniformity in plan administration'" does not mean the law meets the "connection with" standard, "especially… if the law merely affects costs."[38] The 8th 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."[39]

The court in *Wehbi* 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.
- Section 16.1(9): Charge shipping and handling fees to patients requesting prescriptions to be mailed or delivered.[40]

The 8th 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."[41] 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."[42]

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."[43] 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."[44] 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

[38] *Id.*
[39] *Id.*
[40] *Id.*at 968.
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id*. at 968-969.

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.[45]

Mulready

The United States Court of Appeals for the 10th Circuit reversed the District Court for the Western District of Oklahoma, holding that ERISA preempted Oklahoma's PBM law. The decision also addressed a Medicare Part D preemption claim, which is beyond the scope of this guidance document. 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."[46]

The 10th 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'," [47] 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."[48]

The 10th Circuit divided the provisions of the law under review into two categories[49]: 1) "network restrictions," which includes access standards,[50] discount prohibition,[51] and any willing provider provision[52] 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.[53] The 10th 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 10th Circuit stated that "ERISA's promise of uniformity is vitally important for employers, who "have large leeway to design… plans as they see fit."[54] The 10th 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.[55]

---

[45] *Id.* at 969.
[46] Okla. Stat. tit. 36, § 6959 (2019).
[47] *Gobeille*, 577 U.S. at 320.
[48] *Rutledge*, 592 U.S. 80, 88.
[49] *Mulready,* 78 F.4th 1183 at 1196.
[50] Okla.Stat. tit. 36 § 6961 (a)-(B) (2019).
[51] Okla.Stat. tit. 36 § 6963.
[52] Okla.Stat. tit. 36 § 6962 (B)(4).
[53] Okla.Stat. tit. 36 § 6962 (B)(5);
[54] *Mulready,* 78 F.4th 1183 at 1193.
[55] *Id.* at 1198.

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."[56]

As applied to the Oklahoma laws, the 10th 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*[57] and *Rush Prudential HMO, Inc. v. Moran*.[58]

Mulready petitioned the United States Supreme Court for a Writ of Certiorari, citing a conflict between the 8th and 10th 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 8th 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.[59]

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

IV. LESSONS FOR STATES

As a threshold matter, states should look to recent court decisions for guidance on 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

---

[56] *Id.* at 1203.

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

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

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

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 noted at the beginning of this guidance document, 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.[60]

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.

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 been no 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. States will need to ensure that any Medicaid PBM requirements are consistent with federal Medicaid law and any relevant terms and conditions of the

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

federally approved state Medicaid plan. Medicare plans are also outside the scope of ERISA but are subject to Medicare preemption as they are governed by federal law and regulated by the Centers for Medicare & Medicaid Services (CMS).[61]

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 whether they improperly "relate to" an ERISA plan and thus are 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 the state regulatory structure.**[62] Including an opt-in for self-funded plans should not, in and of itself, cause the law to be preempted under ERISA, but this specific question has not been litigated.[63]

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, as well as 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."[64]

c. The law will have an impermissible "connection with" an ERISA-covered plan if it "govern(s) a **central matter of plan administration or interfere(s) with nationally uniform plan administration**."[65] An impermissible connection with a plan also arises when 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

---

[61] 42 U.S.C. § 1395 et seq. Additionally, because federal employee health benefit plans (FEHBP) are not subject to state regulation, they are not discussed in this guidance document.

[62] Washington state law authorizes self-funded group health plans to opt into their PBM law beginning Jan. 1, 2026. Refer to 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, refer to RCW 48.49.130.

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

[64] *Gobeille*, 577 U.S. at 319–320

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

status."[66] The "nature of the effect of the state law on ERISA plans" thus determines whether the state law has an impermissible connection with the ERISA plans.

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.[67] "[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."[68]

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.

[66] *Id. at 86-87*.
[67] *Id.* at 88.
[68] *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 of 2015		
Pharmacies may refuse to sell a drug if the PBM's reimbursement rate is lower than its acquisition cost.	*Rutledge* Act 900 of 2015		
If a consumer pays a copayment, it is retained by the pharmacy. It cannot be "clawed back" by the PBM.		**Wehbi* (19-02.1-16.1(4))	
PBM OVERSIGHT OF PHARMACY OPERATIONS			
A PBM may not collect a fee from a pharmacy if the pharmacy's performance scores or metrics meet the criteria identified by the electronic quality improvement platform for plans and pharmacies or by another unbiased nationally recognized entity that aids in improving pharmacy performance measures.		**Wehbi* (19-02.1-16.1(3))	
A PBM is limited to applying a fee to the professional dispensing fee outlined in the pharmacy contract.		**Wehbi* (19-02.1-16.1(3))	
A PBM may not impose a fee related to performance metrics on the pharmacy's cost of goods.		**Wehbi* (19-02.1-16.1(3))	
A 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 are prohibited. A PBM may not prevent a pharmacy from providing relevant drug pricing and efficacy information to a patient.		*Wehbi* (19-02.1-16.1(7))	
A PBM may not prevent the mailing or delivery of drugs to a patient as a pharmacy's ancillary service.		*Wehbi* (19-02.1-16.1(8))	
A PBM may not prevent a pharmacy from charging shipping and handling fees to patients who request that prescriptions be mailed or delivered.		*Wehbi* (19-02.1-16.1(9))	
A PBM may be required to provide pharmacists with information about each pharmacy network established or administered by a PBM.		*Wehbi* (19-02.1-16.1(10))	
A PBM may not require accreditation or recertification requirements that are more stringent than federal and state licensure requirements (*for network participation*).		*Wehbi* (19-02.1-16.1(11) & *16.2(4))*	

A PBM may not prohibit a pharmacy from dispensing any drug allowed under its license.		*_Wehbi_ (19-02.1-16.2(5))	
Any Willing Pharmacy (AWP) Provision: Any willing pharmacy already in the PBM/plan's network must be permitted to join a preferred network if it agrees to accept the contractual terms.			_Mulready_: Okla. Stat. tit. 36, § 6962(B)(4) (2019).
Probation Prohibition: A PBM may not deny or terminate a pharmacy license based on the license status of a pharmacy employee (being on probation with the state pharmacy board).			_Mulready_: Okla. Stat. tit. 36, § 6962(B)(5) (2019).
TRANSPARENCY IN PBM OPERATIONS			
PBMs must timely update their minimum acquisition cost (MAC) lists when drug wholesale prices increase.	_Rutledge_: Ark. Code Ann. §17–92–507(c)(2)		
PBMs must have an appeal procedure for pharmacies to challenge MAC reimbursement rates.	_Rutledge_ Act 900 of 2015		
A PBM may not charge or hold a pharmacy responsible for fees that they do 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 a PBM's pharmacy payments and what is charged to the plan.		_Wehbi_ (19-02.1-16.2(2))	
If a patient pays a copayment, a 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: A PBM must meet certain network adequacy requirements for retail pharmacies (that do not include mail order pharmacies).			_Mulready_: Okla. Stat. tit. 36, § 6961((A)-(B) (2019).
Discount Prohibition: A PBM shall not use any discounts in cost-sharing or a reduction in copay for individuals to receive prescription drugs from an individual's choice of in-network pharmacy.			_Mulready_: Okla. Stat. tit. 36, § 6963(E) (2019).

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

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

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

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

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

Addendum

The cases in this addendum, listed in alphabetical order, are still active and subject to additional judicial review. At the time of this document's publication, July 22, 2026, the outcomes and judicial findings of these cases remain uncertain. This is not a comprehensive discussion of all issues raised but rather highlights additional cases states may want to monitor where a court has taken action.

***Central States, et al. v. McClain, et al.*, 7th Circuit Court of Appeals, Case No. 25-2727, U.S. District Court in the Northern District of Illinois, Eastern Division, 1:25-cv-03938; 2025 WL 2522621**

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

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

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

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

Plaintiffs appealed to the 7th Circuit, which held oral arguments on April 14, 2026.

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

On April 16, 2025, Arkansas enacted Act 624, prohibiting PBMs from acquiring, owning, or operating retail or mail-order pharmacies in the state. The act was challenged by several

PBMs and the Pharmaceutical Care Management Association (PCMA) in the U.S. District Court for the Eastern District of Arkansas. The plaintiffs alleged that Act 624 was unconstitutional and preempted under the Medicare Part D, TRICARE, and ERISA. The plaintiffs filed motions for a preliminary injunction to enjoin the act from taking effect pending the resolution of the litigation.

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

In its order, the court addressed the ERISA preemption claim and stated that Act 624 does not "relate to" an ERISA plan, such that it is preempted. The act does not make a "reference to" ERISA, nor does it have an impermissible "connection with" an ERISA plan because the Act "does not regulate PBMs in their capacity as employee benefit plan administrators. Rather, it merely regulates the requirements for obtaining a retail pharmacy license." Citing the *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,*[69] the court reasoned that Act 624 would affect an ERISA plan's shopping decisions but would "merely be an indirect economic influence and would not bind plan administrators to any particular choice." The Arkansas State Board of Pharmacy has appealed the preliminary injunction before the 8th Circuit.

***Flowers v. Caremark PCS Health, LLC*, No. 25-3068, — F.4th —-, 2026 WL 1859929 (8th Cir. June 29, 2026)**

The United States Court of Appeals for the 8th Circuit affirmed the judgment of the United States District Court for the Western District of Arkansas dismissing a class action brought by Kevin Flowers, an ERISA plan beneficiary, who alleged that Caremark PCS Health LLC, doing business as CVS Caremark, had been unjustly enriched through violations of two Arkansas statutes.

The Circuit Court affirmed the dismissal of claims involving the "Mail Order Provision" in the Arkansas Code and the "Geographic Coverage Requirements" regulation implementing the "Network Adequacy Provision" in the Arkansas Code.

1. The Mail Order Provision prohibits PBMs from requiring that patients receive prescriptions through home delivery. The court affirmed the dismissal of the claim for failure to present a plausible claim of violation of the law. Caremark required the use

[69] 514 U.S. 645, 659–60 (1995)

of mail-order or CVS retail pharmacies, not just mail-order. The court never reached the issue of ERISA preemption.

2. The Network Adequacy Provision requires PBMs to provide "[a] reasonably adequate and accessible [PBM] network…[with] convenient patient access to pharmacies within a reasonable distance from a patient's residence." The Arkansas Insurance Department promulgated "Geographic Coverage Requirements" defining what is a reasonable and accessible network under the Network Adequacy Provision by establishing specific distance requirements for beneficiary access to pharmacies in urban, suburban, and rural areas.

   The court determined that the "Geographic Coverage Requirements" implementing the "Network Adequacy Provision" were preempted because they "related to" an ERISA plan by having an impermissible "connection with" an ERISA plan and affirmed the dismissal of the plaintiff's claim based on preempted provisions.

   The court specifically stated that they were leaving open the question of whether the Network Adequacy Provision, on its own or implemented through different regulations, would be preempted under ERISA.

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

This case is on appeal, with the final ruling expected from the United States Court of Appeals for the 8th Circuit. The case temporarily blocked 11 provisions of Iowa's PBM reform law (SF 383) that conflict with federal ERISA law and the First Amendment. The following provisions are enjoined as preempted by ERISA:

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

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

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

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

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

While the above provisions were enjoined by the lower court, several provisions included in the Iowa PBM law were not, as the court found them not preempted by ERISA.

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

On April 7, 2026, the United States Court of Appeals for the 6th Circuit ruled that the following portions of the Tennessee PBM law have an impermissible connection with ERISA and are therefore preempted:

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

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

PROJECT HISTORY

GUIDANCE DOCUMENT – ERISA PREEMPTION AND STATE PBM LAWS

1. Purpose, Description of the Project, Date Adopted

This document provides guidance for insurance department regulators and other state government officials related to the Employee Retirement Income Security Act (ERISA) preemption of state pharmacy benefit manager (PBM) laws by analyzing the different types of state PBM laws and considering how appellate courts have applied the reasoning in Rutledge v. Pharmaceutical Care Management Association (PCMA) to those laws. The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group adopted the document July 22, 2026.

2. Relationship to Federal Legislation, If Any

This guidance document analyzes the preemptive effect of ERISA on state PBM laws.

3. Name of Group Responsible for Drafting the Model and States Participating

The ERISA and Alternative Health Coverage (B) Working Group.

4. Project Authorized by What Charge and Date First Given to the Group

In 2023, the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup drafted *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (PBM Guide), which was adopted by the Health Insurance and Managed Care (B) Committee in November 2023. This document contains a section addressing potential ERISA preemption of state PBM laws and cites the 2020 U.S. Supreme Court decision in Rutledge v. PCMA, which held that ERISA did not preempt the Arkansas' PBM laws at issue in that case.

The Rutledge decision did not conclusively resolve all questions about the permissible scope of state PBM regulation. Litigation involving the potential ERISA preemption of state PBM laws is ongoing, and questions remain over how to apply the principles analyzed in Rutledge v. PCMA to PBM laws that include different types of provisions. In 2025, the PBM Guide was updated, and the Regulatory Framework (B) Task Force asked the ERISA (B) Working Group (renamed the ERISA and Alternative Health Coverage (B) Working Group in 2026) to draft a document to help state policymakers in navigate this complex question.

The Working Group drafted this guidance document pursuant to its existing charge to: "Monitor, report and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments."

5. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated. (Attach a list.)

In early 2025, the Working Group chair, Robert Wake (ME), and vice chair, Andria Seip (IA), developed an outline and first draft. Following the 2025 Summer National Meeting, an ERISA and State PBM Laws Drafting Group started meeting. In 2026, the Drafting Group membership included the Working Group chair, Andria Seip; vice chair, Sara Farris (AR); Kelli Littlejohn Newman (AL); Cara Libman (MA); Amy Hoyt (MO); Jamie Struthers (ND); Martin Swanson and Cheryl Wolff (NE); Stephen Hogge (VA); Jane Beyer (WA); and Michael Malone (WV) .

6. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in September 2025, the Drafting Group met every other week. A first draft dated Feb. 2, 2026, was posted to the Working Group's web page and exposed for a 30-day public comment period ending March 3. The Working Group met Feb. 22 to hear oral feedback on the draft to allow interested parties to consider the meeting discussions when finalizing their written feedback by the March 3 deadline. Written comments were submitted by the PCMA, the National Community Pharmacists Association (NCPA), NAIC Consumer Representative Carl Schmid (HIV+Hepatitis Policy Institute), and America's Health Insurance Plans (AHIP) and posted to the Working Group's web page.

The Drafting Group continued to meet every other week to review the comments and revise the draft. The Working Group met May 18 to review the second draft dated May 11 and highlight the revisions made in response to the comments received. The May 11 draft was exposed for a 30-day public comment period ending June 18. The Working Group received written comments on the May 11 draft from AHIP, BlueCross BlueShield Association (BCBSA), and Schmid.

The Drafting Group resumed meeting and revised the draft based on the written comments received. A third draft dated July 9 was posted on the Working Group's web page. The Working Group met July 22, where the revisions were explained, and the Working Group unanimously voted to adopt the Guidance Document.

7. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

The Guidance Document does not analyze cases that were still being litigated as of July 22, the date the ERISA and Alternative Health Coverage (B) Working Group adopted the document. There has been ongoing legal activity in this area, so in recognition of that, an addendum includes a summary of ongoing cases involving ERISA preemption of state PBM laws, limited to situations where there has been some court action. There was interest in continuing to update the document as cases progress and are finalized. The Working Group understands that this document may need to be updated, but until the pending cases are finalized, it cannot offer guidance on when/if changes will be needed. The Working Group will assess this issue as cases are finalized.

Another area of concern for some commenters was that the addendum did not contain a listing of state laws that were not deemed to be preempted. Again, because the cases are not finalized, the Working Group did not add this level of detail to the addendum.

8. List the key provisions of the model (sections considered most essential to state adoption)

Not applicable.

9. Any Other Important Information (e.g., amending an accreditation standard)

No other information.

Agenda Item #4

Hear a Discussion on Prescription Drug Affordability and Access—*Mark Cuban (Mark Cuban Cost Plus Drug Company)*

Agenda Item #5

Hear a Discussion from the Federal Center for Consumer Information and Insurance Oversight (CCIIO) on Affordability and Provisions in the 2027 Notice of Benefit and Payment Parameters (NBPP) Final Rule—*Peter Nelson (CCIIO) and Jeff Wu (CCIIO)*

Agenda Item #6

Discuss Any Other Matters Brought Before the Committee
—Commissioner John F. King (GA)