Revised date: 8/10/26

2026 Summer National Meeting
Columbus, Ohio

REGULATORY FRAMEWORK (B) TASK FORCE
Thursday, August 13, 2026
1:00 – 2:00 p.m.
Hilton Tower 402—Robinson Ballroom AB—Level 5

ROLL CALL

NAIC Member	Representative	State/Territory
Marie Grant, Chair	Marie Grant	Maryland
Erin K. Hunter, Vice Chair	Joylynn Fix	West Virginia
Mark Fowler	Sanjeev Chaudhuri	Alabama
Heather Carpenter	Jeanne Murray	Alaska
Peter M. Fuimaono	Elizabeth Perri	American Samoa
Charles Bassett	Fausto Burruel	Arizona
Michael Conway	Debra Judy/Lila Cummings	Colorado
Joshua Hershman	Tricia Davé	Connecticut
Trinidad Navarro	Jessica R. Luff	Delaware
Karima M. Woods	Howard Liebers	District of Columbia
Michael Yaworsky	Alexis Bakofsky	Florida
John F. King	John F. King	Georgia
Dean L. Cameron	Dean L. Cameron	Idaho
Ann Gillespie	Ann Gillespie	Illinois
Holly W. Lambert	Alex Peck	Indiana
Doug Ommen	Andria Seip	Iowa
Vicki Schmidt	Julie Holmes	Kansas
Sharon P. Clark	Shaun Orme	Kentucky
Michael T. Caljouw	Christopher Joyce	Massachusetts
Julia Dreier	Julia Dreier	Minnesota
Angela L. Nelson	Melissa Panettiere	Missouri
Eric Dunning	Martin Swanson	Nebraska
Ned Gaines	Ned Gaines	Nevada
Susan Ochs	Susan Ochs	New Jersey
Remedio C. Mafnas	Remedio C. Mafnas	Northern Mariana Islands
Judith L. French	Laura Miller	Ohio
Glen Mulready	Mike Rhoads	Oklahoma
TK Keen	TK Keen	Oregon
Michael Humphreys	Richard L. Hendrickson	Pennsylvania

Larry D. Deiter	Jill Kruger	South Dakota
Amanda Crawford	Rachel Bowden	Texas
Jon Pike	Tanji J. Northrup	Utah
Scott A. White	Julie Blauvelt	Virginia
Patty Kuderer	Ingrid Ulrey/Todd Lovshin	Washington
Nathan Houdek	Coral Manning	Wisconsin

NAIC Committee Support: Jolie H. Matthews/Jennifer R. Cook/Joe Touschner

AGENDA

1. Consider Adoption of its June 29 and Spring National Meeting Minutes —*Commissioner Marie Grant (MD)* — Attachment One, Attachment Two

2. Consider Adoption of the Reports of its Working Groups —*Commissioner Marie Grant (MD)*
   A. Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—*Andria Seip (IA)*
   B. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group—*Chrystal Bartuska (ND)*
   C. Prescription Drug Coverage (B) Working Group—*Joylynn Fix (WV)*

3. Consider Adoption of the *Guidance Document – ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws—Andria Seip (IA)*

4. Hear an Update from the Robert Wood Johnson Foundation (RWJF) on Individual Coverage Health Reimbursement Arrangements (ICHRAs)—*Katherine Hempstead (RWJF)*

5. Hear 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—*Peter Nelson (CCIIO) and Jeff Wu (CCIIO)*

6. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Marie Grant (MD)*

7. Adjournment

Agenda Item #1

Consider Adoption of its June 29 and Spring National Meeting Minutes
—Commissioner Marie Grant (MD)

Draft: 7/21/26

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

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

1. Discussed Industry Progress on its PA Reform Initiative

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

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

A. Reducing the Scope of PA

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

B. Improved Continuity of Care Plan Transitions

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

C. Enhanced Communication Efforts

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

D. Additional PA Reforms

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

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

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

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

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

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

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

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

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

Draft Pending Adoption

Draft: 3/30/26

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

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

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

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

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

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

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

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

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

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

B. MHPAEA (B) Working Group

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

C. Prescription Drug Coverage (B) Working Group

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

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

3. Heard an Update on Recently Enacted Federal PBM Legislation

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

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

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

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

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

4. Adopted the *State Flexibility White Paper*

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

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

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

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

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

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

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

Agenda Item #2

Consider Adoption of its Working Group Reports—*Commissioner Marie Grant (MD)*

- *Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group—Andria Seip (IA)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group —Chrystal Bartuska (ND)*
- *Prescription Drug Coverage (B) Working Group—Joylynn Fix (WV)*

2026 Summer National Meeting
Columbus, Ohio

JOINT MEETING OF THE PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP AND THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP
Wednesday, August 12, 2026
11:45 a.m. – 12:45 p.m.

Meeting Summary Report

The Prescription Drug Coverage (B) Working Group met Aug. 12, 2026, in joint session with the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group. During this meeting, the Working Groups:

1. Adopted the Prescription Drug Coverage (B) Working Group's Spring National Meeting minutes (*see NAIC Proceedings – Spring 2026, Regulatory Framework (B) Task Force, Attachment Two*).

2. Adopted the MHPAEA (B) Working Group's April 2 minutes. During this meeting, the Working Group took the following action:
   A. Discussed its work plan for the year with a focus on tracking state parity laws, resources, and enforcement activity.
   B. Heard a presentation on the use of a template to collect information on insurers' prior authorization policies and practices.

3. Reported that the MHPAEA (B) Working Group met July 9 in regulator-to-regulator session, pursuant to paragraph 8 (strategic planning issues relating to federal legislative and regulatory matters) of the NAIC Policy Statement on Open Meetings. During this meeting, the Working Group took the following action:
   A. Discussed a survey of states to collect information on mental health parity laws, resources, and enforcement activity.

4. 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.

Agenda Item #3

Consider Adoption of the Guidance Document – ERISA Preemption and State Pharmacy Benefit Manager (PBM) Laws—*Andria Seip (IA)*

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 TBD
Adopted by the Health Insurance and Managed Care (B) Committee TBD

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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

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[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]

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[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]

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[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

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[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

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[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]

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[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

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[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

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[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

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?.[illegible].F¡Supp¡9d.[illegible].(S¡D¡.Iowa.868[illegible])

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¡?7❸9.F0th.808.(❷th.Cir¡.868❷)

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 an Update from the Robert Wood Johnson Foundation (RWJF) on Individual Coverage Health Reimbursement Arrangements (ICHRAs)—*Katherine Hempstead (RWJF)*

ICHRA: Where are we today?

Presentation to the NAIC Regulatory Framework Task Force

August 13, 2026

Katherine Hempstead

Senior Policy Officer

rwjf robert wood johnson foundation

Overview

- ICHRA stats
  - Size//Growth
  - Geography
  - Demographics
- ICHRA today
  - Marketing
  - Typical contributions
  - Off exchange
- Perspectives on ICHRA
  - The ICHRA-verse
  - Employers
  - Policymakers
- Scenarios
  - Growth forecasts
  - Micro versus Macro
  - What’s needed for scale?
  - What could go wrong?

Overview

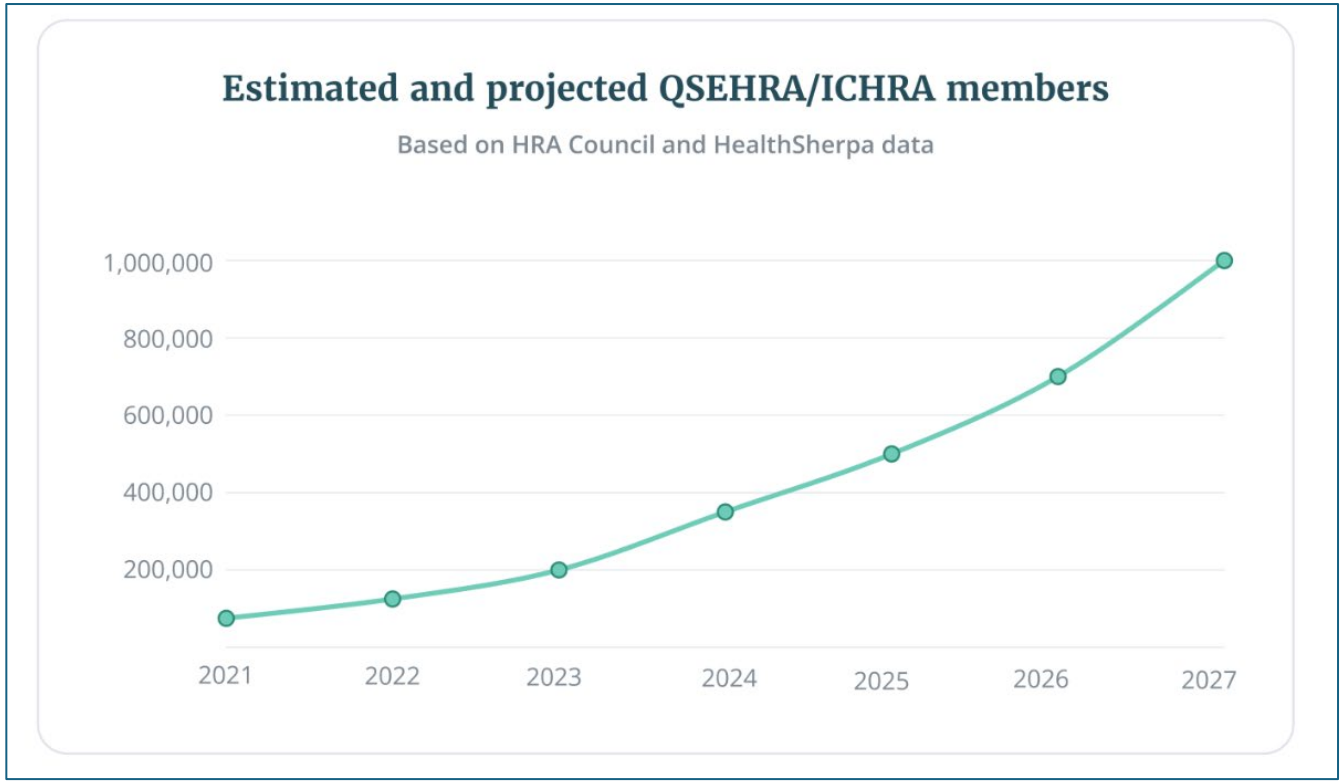
1. Size and growth
2. ICHRA today
3. Perspectives
4. Future Scenarios

1. Size and growth

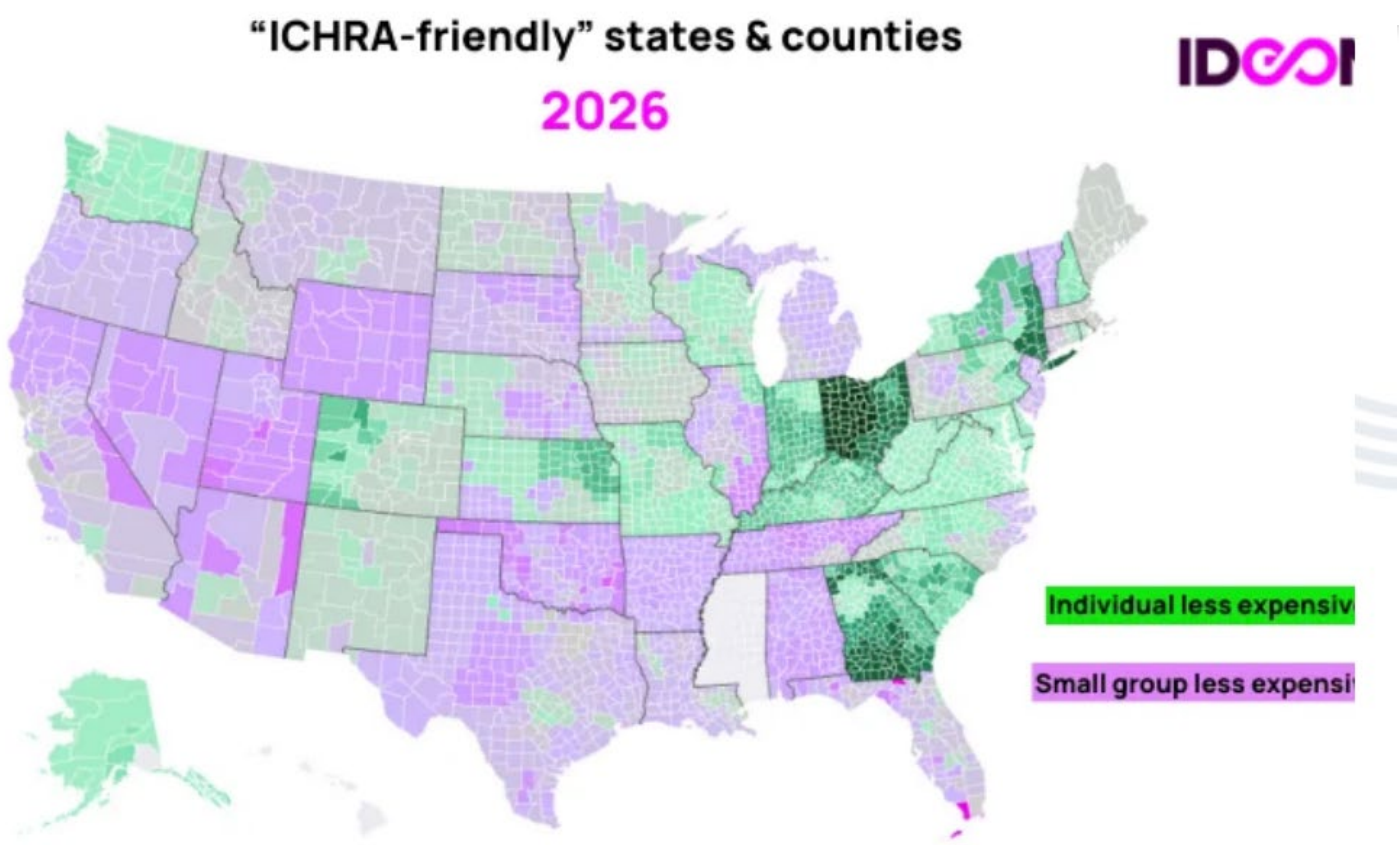
Big projections in 2019: 800,000 employers and 11 million employees

Where are we now? Recent growth has been more rapid

- New data from HealthSherpa: 650,000 – 1.25m employees and dependents
- 58% growth since beginning of the year
- HRA Council: 20,000 employees, > .5m people
- But huge information problem
- Data generally comes from industry
- ICHRA enrollment hard to measure



Geography



2025 → 2026 market snapshot

Number of states where the lowest-cost individual plans ≤ small-group, by metal level:

- 🥉 Bronze: 30 → 25
- 🥈 Silver: 21 → 18
- 🥇 Gold: 21 → 17

- But map doesn't line up that well with enrollment patterns.
- Big ICHRA states are Florida, Texas, Indiana
- Comparative stats deterioriated since 2025, but ICHRA grew.
- ICHRA enrollees somewhat younger than individual market average (70%<45 YO, versus 57% overall)

All 50 States Show HRA Growth with Varying Underlying Factors

The increasing volume and richness of geographic data shared by HRAC data providers each year now offers deep state-level insights. Select notable trends at the state level are provided below. Further insights appear in the supplemental *State Momentum* report also issued within this report's month of publication.

CA State with the most employers
The most populous state also has the largest number of headquarters for employers who have adopted ICHRA and QSEHRA.

States with the most eligible employees
In that order, the states with the most employees eligible for their employers' offer of an ICHRA and QSEHRA.

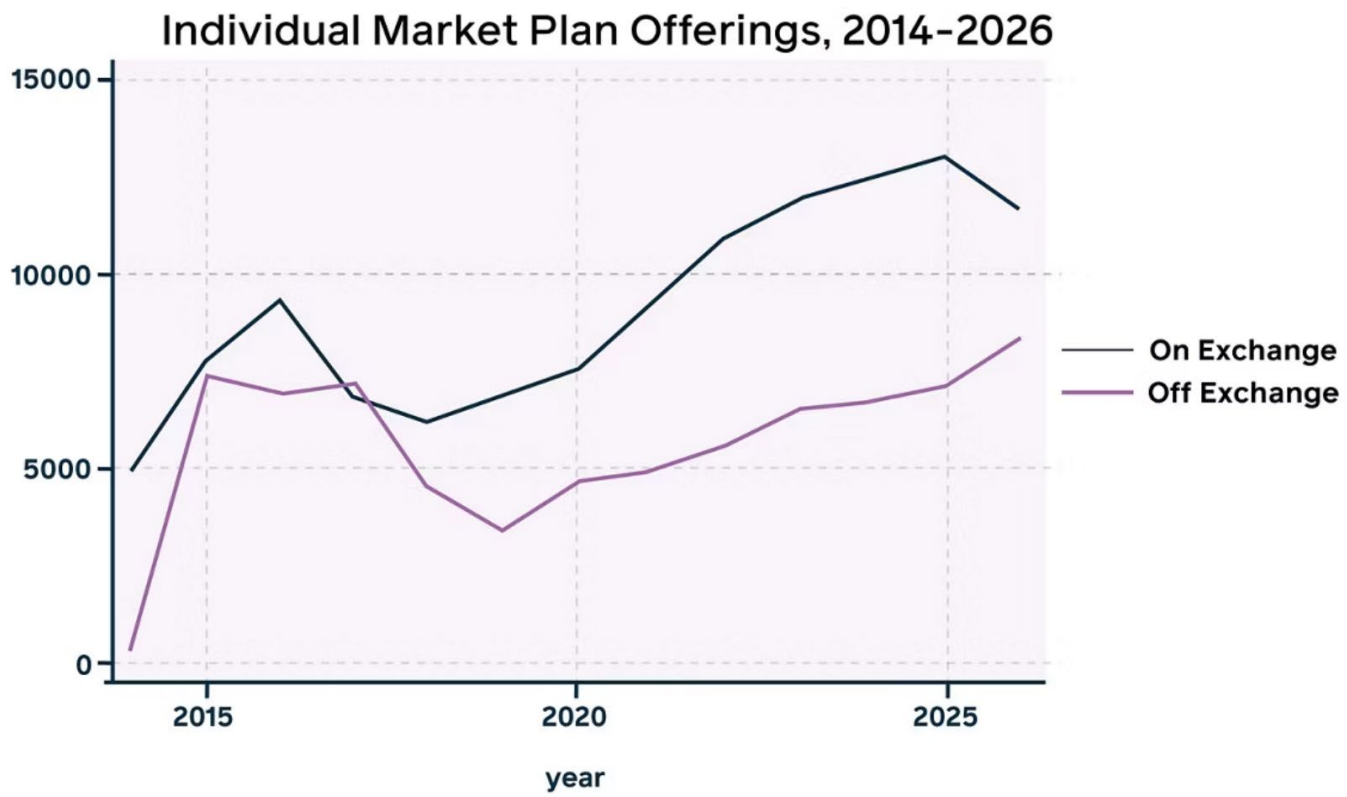
The highest Y-o-Y increase in employer adoption
With HRA Council data showing a 655% increase in the number of eligible employees between 2025 and 2026, mostly due to ICHRA growth, the state legislature is studying the potential for ICHRA to cover state employees and is considering several related bills including tax credits.

Examples of ICHRA-friendly ACA landscapes.
States with reinsurance, multiple insurers in the individual marketplace, strong coverage takeup, and significantly growing ICHRA adoption rates.

Council Members get
ss to interactive adoption
enrollment trends maps
d on our latest data each
Consider joining to access
powerful resources.

Small But Mighty States for ICHRA Growth
Smaller population states with strong ICHRA growth. In 2026, MS passed ICHRA tax credits for small businesses and NH introduced tax credit legislation.

2. ICHRA Today
About 80% of ICHRA enrollment is off-exchange



Source: HIX Compare

Marketplace Pulse: If You Build it, Will They Come?—Off-Exchange Offerings Explode in 2026

- Off-exchange offerings increased significantly in 2026
- Many insurers added plans designed for ICHRA
- @ 20% of off-ex plans are PPOs, vs. @ 5% on-market plans.
- About 50% of ICHRA enrollment in “non-mirrored” off-ex plans

Average monthly employer contributions

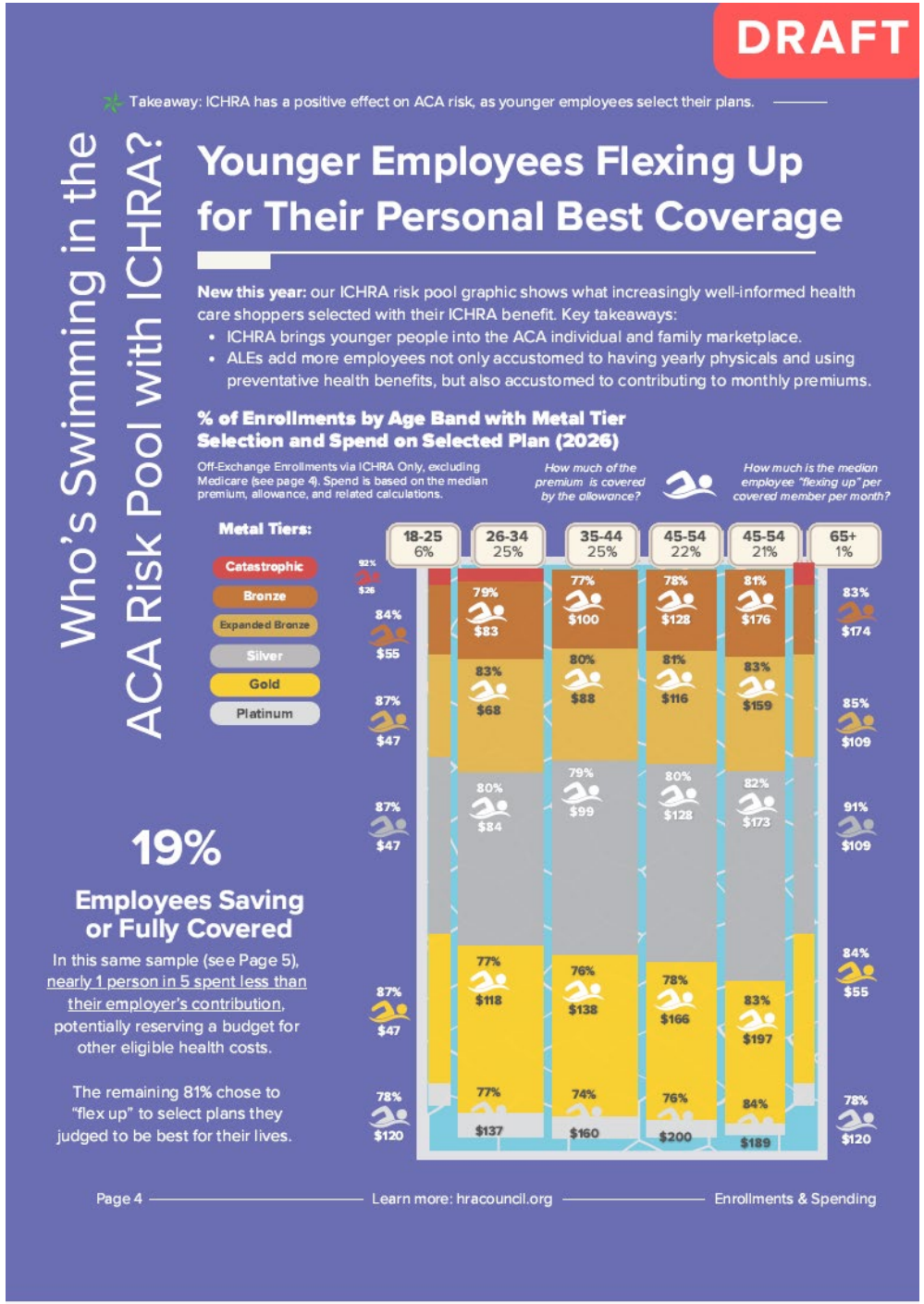
- Individual: $440-$700
- State variation
- Family coverage varies
- Source: Remodel Health –

“largest vendor-specific data set”

Remodel health® Products Solutions Industries Resources

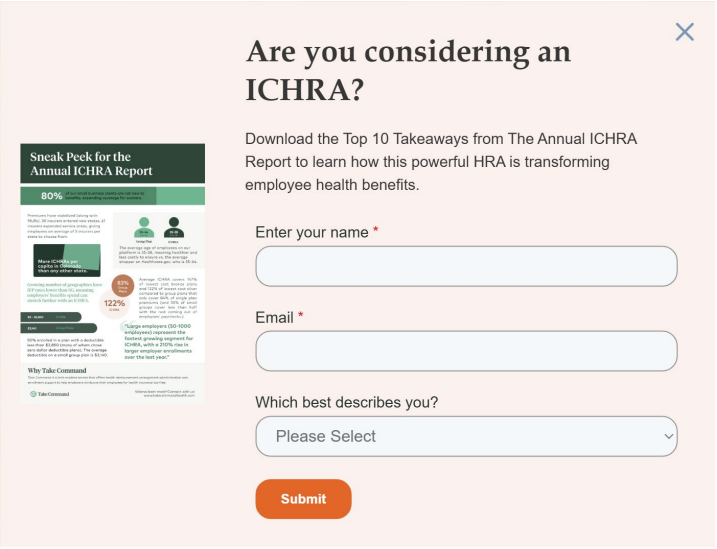
Arts, Entertainment, and Recreation	$553	$666	$794	$812
Automotive	$441	$602	$756	$805
Business Services	$553	$703	$753	$921
Construction	$535	$748	$957	$1,029
Education	$612	$830	$1,024	$1,190
Farming and Agriculture	$688	$900	$965	$1,067
Financial Services	$604	$888	$1,009	$1,148
Food & Hospitality	$471	$601	$662	$737
Government	$699	$871	$1,933	$1,913
Healthcare	$579	$739	$829	$963

From HRA report.
Median contribution: $457
Median premium: $567
Median ‘flex up’: $105
19% of employees are fully covered



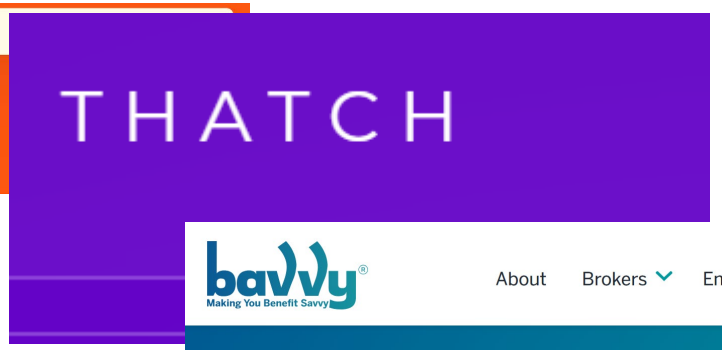
ICHRA Marketing

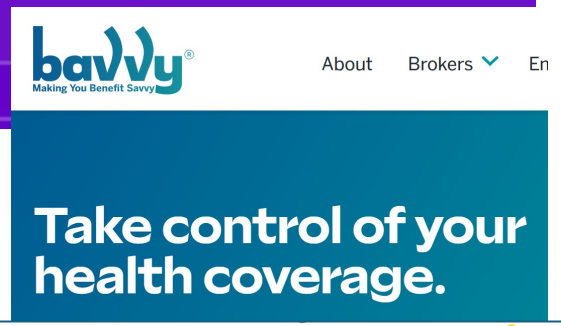
- Marketed by:
  - Platform companies – Peoplekeep, etc. (# increased from 31 to 52)
  - Large brokerage firms too (WTW, Aon)
  - Some insurers (OSCAR and Centene)
  - Platforms often partner with brokers
- Marketed to (mostly small) employers:
  - Antidote to high premium increases
  - Promise of predictability
  - Framed as “401k of health benefits”
  - Choice for employees, but this is secondary



3. Perspectives

- The “ICHRA-verse”
  - ICHRA platforms (Take Command, Thatch, Zorro, etc.)
  - Larger benefits platforms (Gravie, SureCo)
  - Investors and large brokers (Morgan Health, WTW)
  - Some insurers – OSCAR and Centene
- Fairly big tent, but some issues
  - Lumpers versus splitters
  - “Account focus” versus comprehensive coverage
  - OSCAR’s “Lucie”
  - HRA Alliance is major trade association



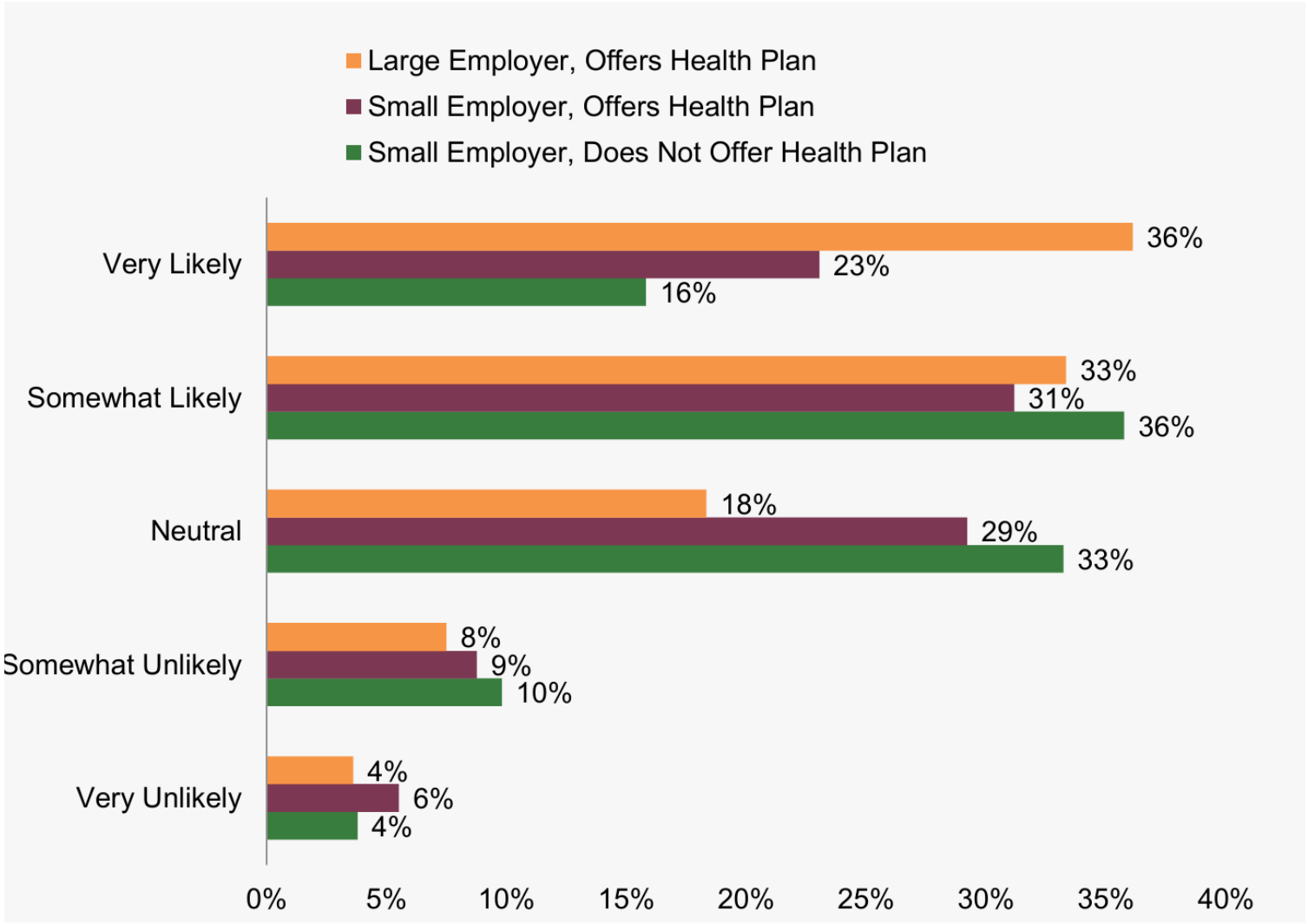


Employer perspectives

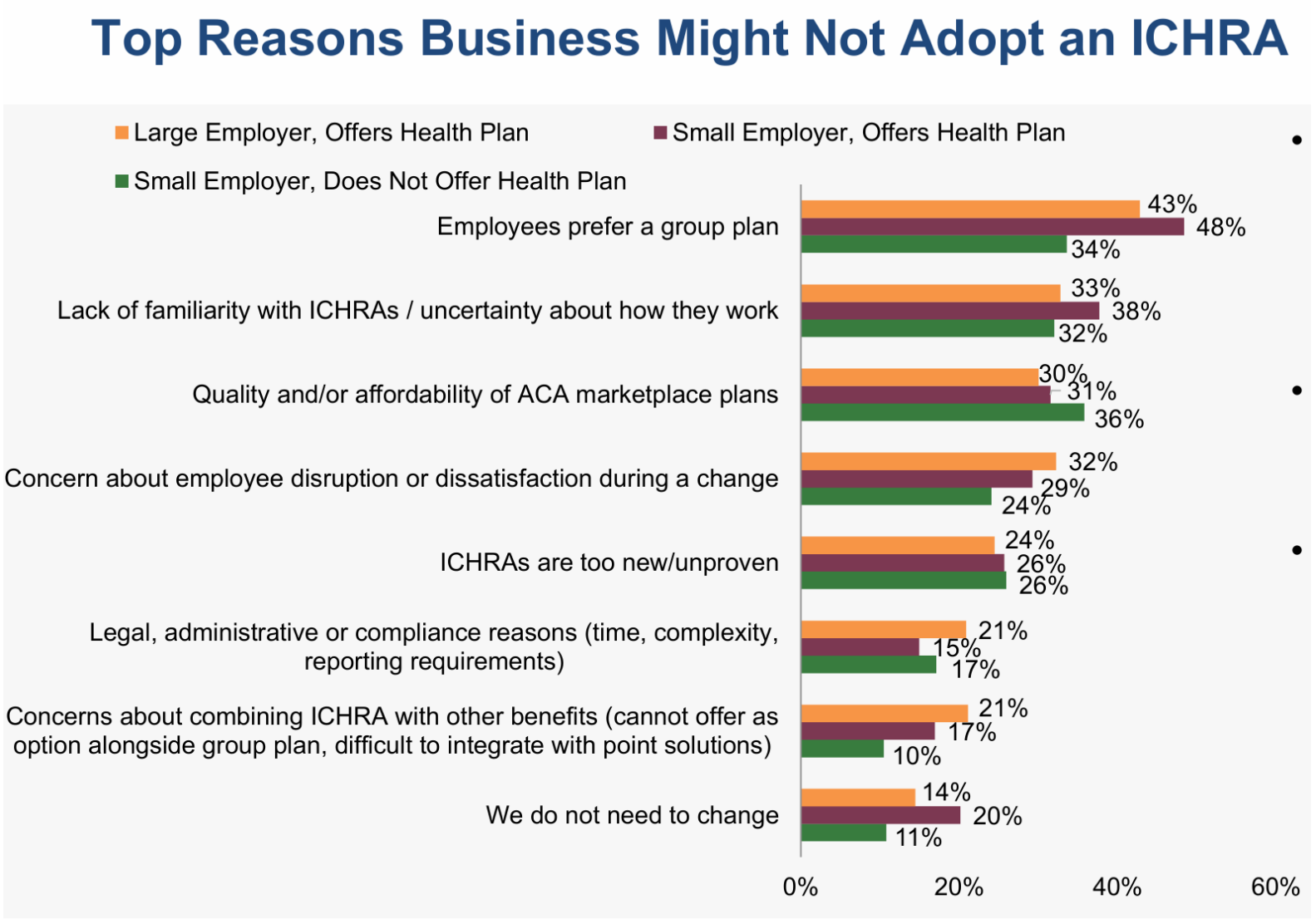
Survey Sponsors

- Recent survey – Morgan-EBRI
- Surveyed about 1000 employers
- Caveats
- Interest higher among larger employers
- Pros: Flexibility of benefits, choice, affordability
- Cons: Marketplace concerns, employee preferences
- Want ICHRA to be like group lan
- Open to policy changes that would combine tax credits with employer contributions

Likelihood of adopting ICHRA in next 1-2 years



Top concerns about ICHRA



Other perspectives

- Policymaker
  - State tax credits
  - NCOIL ICHRA Model Act
  - Congress: Codification attempts
  - CMS/CCIIO
- Employer organizations
- Labor/Employees
- Opposition?
- What are barriers to bipartisan support ?

Scenarios

- What's next?
  - Growth forecasts:
  - SR: Doubling every year for at least next few years
  - MR: 15% of ESI over the next 5-10 years - @ 20m
- Micro versus Macro versions
  - Niche option for small employers OR revolution in coverage ecosystem?
  - Whole is greater than the sum of its parts
  - What is needed to reach scale?
  - What could go wrong?

Thank you!

khempstead@rwjf.org

Agenda Item #5

Hear 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—*Peter Nelson (CCIIO) and Jeff Wu (CCIIO)*

Agenda Item #6

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Marie Grant (MD)