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Roundup of selected state health developments, first-quarter 2026

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In this article

The first quarter of 2026 was active on the state legislative and regulatory fronts. Maryland finalized paid family and medical leave (PFML) regulations in advance of contributions starting next year. New York and Washington, DC, tweaked their PFML laws. Oregon issued guidance on PFML and paid sick and safe leave (PSSL). Puerto Rico authorized emergency paid leave due to an influenza epidemic. Four states and Washington, DC, addressed vaccines. Florida, Ohio, and Virginia passed significant pharmacy benefit manager (PBM) laws while Maine clarified a prior law through regulations. New Mexico and South Dakota focused on prior authorization. Indiana, New Jersey, and Utah passed insurance mandates. Alabama and New York clarified how insurance mandates affect HSA-qualifying high-deductible health plans (HDHPs). West Virginia concluded three enforcement actions against healthcare entities. Mississippi eased access to association health plans, and a Wyoming law enabled independent contractors to open portable benefit accounts. California issued provider directory rules and fined a carrier for grievance process failures. San Francisco's new methodology for compliance with the Healthy Airport Ordinance (HAO) started.

PFML

Maryland issued final regulations. A New York paid family leave (PFL) law clarified the effective date of a law passed late last year. Oregon guidance implements changes from recently enacted legislation under the Paid Leave Oregon (PLO) program as well as job protections. Washington passed laws targeting contribution rates and federal taxation. Washington, DC, continued its extension of a Universal Paid Leave (UPL) law provision on short-term disability (STD) insurance. For details on PFML laws, see State paid family and medical leave contributions and benefits (February 6, 2026).

Maryland

The final regulations (now in effect) issued by the Family and Medical Leave Insurance (FAMLI) Division varied little from proposed rules published in October. Here are the highlights:

- **Contributions.** Contributions are required for employees performing "qualified employment," which encompasses those covered under the state's unemployment insurance program. Qualified employment also occurs where an employee performs all work within state borders (e.g., on federally owned property); work performed outside Maryland is incidental, temporary, or transitory; or work is performed partly in the state, but the base of operations or place the work is controlled or directed is in the state. The FAMLI Division will consider an employer failing to make payroll deductions as having elected to pay all of the employee portion for each missed pay period.
- **Equivalent private insurance plans.** The rules provide detailed instructions for employers seeking equivalent private insurance plans (EPIPs), including required application fees and timelines. An employer filing a declaration of intent during the submission period (September 1–November 15, 2026) will be exempt from contributing to the PFML fund during the seeding period (January 1–December 31, 2027). Only employers with 50 or more employees can apply for a self-insured EPIP.
- **Claims.** Employees may submit a claim as early as 60 days before leave starts and as late as 60 days after it starts. The rules also cover qualifying events, employer and employee notice requirements, and coordination of benefits.
- **General provisions.** The FAMLI Division is tasked with providing a sizable list of templates and forms.
- **Dispute resolution.** A comprehensive review, reconsideration, and appeals process is available for denied or terminated EPIPs and any FAMLI Division determination related to a claimant.

New York

A 2025 law extended PFML eligibility to certain construction employees under a collective bargaining agreement. The application to construction workers was perfected in 2026 Ch. 72 (SB 8795), effective January 1, 2027 (see also this state FAQ).

Oregon

Here is a summary of the two sets of regulations:

- **PLO changes.** Changes from three laws — SB 913, SB 69, and SB 858 — were incorporated into the PLO regulations. The Oregon Employment Department clarified who may act on behalf of incapacitated or deceased claimants and described the program's actions if a claimant started a leave benefit year under an equivalent plan prior to applying for benefits with the state plan. Also, leave to care for a child is limited to those under age 18 or with a limiting physical impairment. Employees receiving unemployment benefits are ineligible for PLO benefits.
- **Job protections.** The PLO job protection rules were moved from under the Employment Department to under the Bureau of Labor and Industries to comply with SB 69. Job restoration (including any equivalent position within a 50-mile radius for employers with 25 or more employees) is required if an employee was employed at least 90 consecutive calendar days before taking PLO leave. An exception exists if an employee would have been terminated or reassigned but for taking the leave. Benefit restoration must occur upon return to work.

Washington

Here is a summary of the two laws:

- **SB 5292.** Last September, the Employment Security Department (ESD) estimated that the state's PFML fund would be insolvent by 2029, in the red to the tune of $353 million. During the 2026 session, the legislature considered many proposals, but SB 5292 was the only one to become law. It does not alter the rate cap (currently at 1.2%), decrease benefits, or narrow eligibility. Instead, it requires greater actuarial analysis annually and sets a goal of having a four-month reserve by the end of the 2030 collection year. The law will take effect on January 1, 2028.
- **HB 2345.** IRS Rev. Ruling 2025-4 (later updated by Notice 2026-6) clarifies how state PFML contributions and benefits are treated for federal income and employment tax purposes, effective for the 2027 tax year. Generally, medical leave benefits attributable to employee contributions are nontaxable, but those same benefits attributable to required employer contributions are considered wages, subject to employment taxes and reportable on Form W-2. Family leave benefits are included in gross income but are not subject to income or

employment taxes, regardless of how contributions are shared between employers and employees.

Currently, Washington law attributes 55% of medical leave benefits to employer contributions, 45% to employee contributions. For family leave, employees pay 100% of the cost. Under the new law, in 2027, employees will pay 100% of the cost of medical leave, eliminating federal income and employment tax consequences for benefits. The family leave contribution will be split 45%/55% for employees/employers. The overall 2027 contribution rate will be announced by mid-November. Further details are available in an ESD announcement.

For more information on federal taxation of PFML benefits, see IRS clarifies taxation of state and DC PFML contributions, benefits (January 13, 2026).

Washington, DC

The UPL law is the District's paid family and medical leave mandate. A provision prohibiting STD insurance issued in Washington, DC, from offsetting benefits based on an employee's estimated or actual UPL benefits does not apply to STD policies issued outside of Washington, DC. As a result, the DC Council and mayor periodically enact temporary legislation to apply the STD insurance offset prohibition to policies issued elsewhere. Under 2026 Act A26-0260 (B-573), the extraterritorial prohibition was extended to May 14. Further, under 2026 Act A26-0278 (B-574), the expiration date will be extended to 225 days after the mandatory 30-day Congressional review period ends on May 22.

Other types of leave

Oregon finalized PSSL rules on permissible uses. The influenza epidemic in Puerto Rico triggered an emergency paid sick leave law. For details on PSSL laws, see Roundup: State accrued paid leave mandates (July 23, 2025).

Oregon

Changes from SB 1108 were incorporated in the regulations. Specifically, PSSL may be used for blood donation approved or accredited by the American Association of Blood Banks or the American Red Cross.

Puerto Rico

On January 27, Puerto Rico's Department of Health declared influenza as an epidemic and Governor Jenniffer González issued Executive Order 2026-005, formally announcing a state of emergency. This action triggers a 2020 law, which provides up to five paid business days for nonexempt employees (under the Fair Labor Standards Act) who contract, or are suspected of contracting, a disease or illness prompting a state of emergency. Eligible employees must have

exhausted vacation and regular sick leave before using the additional five days of paid leave. The Executive Order will remain in effect for the duration of the emergency.

Rx and vaccines

Colorado, Vermont, Washington, and Washington, DC, made changes to how required vaccines are determined, extending authority beyond the federal Advisory Committee on Immunization Practices (ACIP). New laws in Florida, Ohio, and Virginia imposed restrictions on PBMs. The Maine Bureau of Insurance (MBI) issued regulations clarifying the scope of a 2025 PBM law. A New Mexico law applied insurer prior authorization requirements to PBMs. Three healthcare entities were the subject of enforcement actions in West Virginia.

Colorado

SB 26-032 amends the insurance code (applicable to fully insured plans) to rename a coverage mandate: from vaccines for cervical cancer to vaccines for human papillomavirus. If ACIP no longer recommends the human papillomavirus vaccine, the insurance department is authorized to require coverage as a preventive health service. The board of health's rulemaking authority for adult vaccines must consider input from ACIP and national pediatric, OB/GYN, and physician organizations. The board of health must complete its review of existing rules by October 1. Otherwise, the law took effect on March 27.

Florida

As a result of Ch. 2026-4 (HB 697), PBMs may not engage in these actions:

- Prohibit or restrict a pharmacy from declining to dispense a drug if reimbursement is less than the acquisition cost
- Reimburse a pharmacy less than it reimburses a PBM-affiliated pharmacy

The law makes no distinction between PBMs operating on behalf of fully insured or self-funded ERISA plans. Florida generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

Maine

The spread pricing prohibition in a 2025 law extended to carriers and PBMs. Its applicability was not limited to fully insured plans. As a result, the law potentially applied to PBMs working on behalf of self-funded ERISA plans, raising ERISA preemption concerns. However, Rule 210 (now in effect) provides insight into MBI's enforcement of the law, limiting the spread pricing ban to a "carrier or PBM *under contract with a carrier*…" [emphasis added]. This appears to exclude self-funded ERISA plans, despite the broad statutory definition of a PBM: any "entity that … manages

the prescription drug coverage provided by the carrier, self-insurance plan, or other 3rd-party payer." Rule 210 specifically excludes self-funded multiple employer welfare arrangements, MaineCare (the state's Medicaid program), and the state employee health plan. Rule 210 also confirms that PBMs owe a fiduciary duty to carriers to:

- Act prudently and solely in the best interest of the insurer
- Account for and disclose to the carrier all compensation
- Ensure compliance with all other statutory and regulatory requirements

For background on the law, see Roundup of selected state health developments, second-quarter 2025 (August 5, 2025).

New Mexico

Per 2026 Ch. 47 (SB 20), PBMs must comply with prior authorization rules previously applicable only to insurers. The law also addressed processing delays for PBMs and insurers. Approval of a prior authorization is presumed after three business days (down from seven days). Medical necessity determinations of drugs to treat certain conditions shall be automatically approved within three business days and within 24 hours for certain emergency determinations. With limited exceptions, prior authorizations for a chronic maintenance drug are good for three years.

The law will take effect for plan years starting on or after January 1, 2027. New Mexico generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Ohio

Governor Mike DeWine signed HB 229, which pulls PBM licensing out of the third-party administrator licensing process to create a stand-alone program and, more importantly, enhanced PBM transparency. Given the broad "PBM" definition and lack of clear verbiage limiting application to fully insured plans, the law may apply to PBMs working on behalf of self-funded ERISA plans. A limited self-funded plan exemption exists "[f]or purposes of licensure." Here is a summary:

- At least annually, PBMs must account to the plan sponsor any pricing discounts, rebates, inflationary payments, credits, claw backs, fees, grants, charge backs, reimbursements, or other benefits received by the PBM.
- At least annually, PBMs must give the plan sponsor and insurer a report of premiums, administrative fees, and claim payments.
- PBMs must disclose to the plan sponsor the terms and conditions of any PBM contract with another entity related to PBM services, including a group purchasing organization.

- PBMs must disclose conflict of interest.

The new PBM requirements apply to agreements entered into, amended, or renewed on or after July 1, 2027. Ohio generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state. For a discussion on extraterritoriality, see Beyond state lines: A primer on insurance law extraterritoriality (March 26, 2025).

Oregon

SB 1598, now in effect, addresses nongrandfathered group health plan coverage of vaccines. Previously, fully insured plans had to cover all recommended preventive health services (including vaccines) as determined by the federal Department of Health and Human Services (HHS). Under the new law, HHS recommendations that apply are those that were in effect as of June 30, 2025, as well as vaccines recommended by the state public health officer. Plans must cover a recommended vaccine within 15 business days of publication on the Oregon Health Authority's website.

Oregon generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Vermont

HB 545, now in effect, authorizes the state commissioner of health to issue vaccine recommendations for children and adults. The commissioner must consult with the state immunization advisory council before making recommendation and consider recommendations from ACIP and other relevant organizations. Fully insured plans must cover recommended vaccines without copayments, coinsurance, or deductibles.

Virginia

Governor Abigail Spanberger signed 2026 Ch. 36 (HB 830/SB 669), which prohibits the following PBM activities:

- Charging a pharmacy a fee for electronic claims processing
- Claims reversals, except in limited situations
- Reimbursement reductions via reconciliation, unless agreed to in the PBM-pharmacy contract
- Retroactive claim reductions or denials with limited exceptions (like pharmacy fraud or improper handling)

The law also requires 100% rebate pass-through to the insurer (in order to offset participant cost sharing) or to the participant (at the point of sale). As with existing PBM laws in Virginia, there is an express exemption for "an employee welfare benefit plan as defined in section 3 (1) of [ERISA] that

is self-insured or self-funded." The state corporation commission is also charged with conducting a study on PBM steerage to affiliated pharmacies and report its finding by December 1, 2027.

The law will take effect July 1, 2027. Virginia generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Washington

Under 2026 Pub. Law 13 (HB 2242), now in effect, the state Department of Health's childhood vaccine recommendations must be covered by nongrandfathered, fully insured plans as a preventive health service. This is in addition to the three ACA guidelines that were in effect on June 30, 2025. Washington generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Washington, DC

Act 26-251 (B26-0414), now in effect, allows pharmacists and pharmacy technicians to order and administer vaccines in accordance with the published guidelines and recommended vaccine schedules of ACIP or a competent medical or public health organization designated by the DC Department of Health.

West Virginia

Based on market conduct examinations, the West Virginia Offices of the Insurance Commissioner penalized three healthcare entities for violations of the state's PBM and mental health parity (MHP) laws. The agreed orders include corrective action plans (CAPs). Here is a summary:

- **Express Scripts.** The exam (covering 17 months in 2023-2024) found violations related to: pharmacy audits; affiliated pharmacy payments; reimbursement rates at the National Average Drug Acquisition Cost (known as NADAC), plus a required dispensing fee; 100% rebate pass-through at the point of sale; credentialing; the insulin cost-sharing cap; network adequacy; and designation of certain drugs as specialty. The penalty is $1.5 million.
- **Navitus.** This exam (covering the same time period as Express Scripts) found similar violations related to pharmacy audits, pharmacy reimbursements, and rebate procedures. The penalty is $800,000.
- **Aetna.** This exam (covering all of 2022) discovered: improper dispensing or quantity limitations on certain drugs (including all smoking cessation medications); insufficient pharmacy reimbursements; faulty explanations of benefits for behavioral health claims; and an insufficient comparative analysis for several nonquantitative treatment limitations (known as NQTLs). The penalty is $100,000.

In recent years, West Virginia has passed several PBM laws, most notably a 2022 law that amended the Pharmacy Audit Integrity Act to encompass fully insured and self-funded ERISA plans. See Roundup of selected state health developments, second-quarter 2022 (August 22, 2022).

Insurance

Alabama and New York addressed HSA compatibility with state insurance mandates. California issued regulations related to provider directories for health care service plans, including HMOs. The state also fined an insurer for violations related to its complaint handling. An Indiana law prohibits plans from penalizing a facility or provider for using an out-of-network (OON) provider. New Jersey enacted laws requiring plans to cover menopause treatment and to apply third-party financial assistance to cost sharing for covered healthcare. About half of the states (as well as Puerto Rico and Washington, DC) now have these types of cost-sharing restrictions, designed to prohibit so-called "copay accumulator" programs. South Dakota limited use of prior authorization. A Utah law requires plans covering gender-affirming care to cover reversal treatments.

Alabama

The HSA State-Federal Regulatory Coordination Act (Act 2026-298, SB 170) addressed cost sharing for HDHPs. Specifically, the law directs any cost-sharing requirement to apply only after the statutory deductible in § 223 of the Internal Revenue Code has been satisfied if application would otherwise interfere with HSA eligibility. The law will take effect June 1.

California

The provider directory rules clarify a 2015 law, now in effect, by defining key terms (including what it means for a provider to be "accepting new patients"), addressing telehealth providers, and dictating how and when directories are updated. The plan is responsible for compliance.

The Department of Managed Health Care (DMHC) fined Blue Cross of California $15 million for systemic breakdowns in its complaint process for more than 15 years, dating back to 2008. The insurer must now complete a CAP and hire an auditor to review compliance with state grievance and appeals standards, per a settlement agreement. The CAP requires repeated assessments of the plan's grievance system performance through 2029, with a final third-party auditor report due February 1, 2030. This is at least the fifth time since 2009 that DMHC has penalized Anthem for related issues. Previous fines were just over $9 million.

Indiana

Under SB 189, now in effect, insurers cannot assess an administrative fee or penalty for a facility or provider using an OON provider. Such actions will be subject to penalties issued by the

Department of Insurance. The law also imposes notice requirements on parties initiating an independent dispute resolution claim under the federal No Suprises Act.

Indiana generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

New Jersey

Here is a summary of the two laws:

- **Cost sharing.** As a result of 2025 Ch. 199 (AB 5217), fully insured plans and PBMs (including those working with self-funded plans) must include amounts paid from any third party when calculating payments applicable to the plan's deductible, out-of-pocket maximum, and other cost sharing. The mandate does not apply to Medicaid, the state's health plan or self-funded ERISA plans. The mandate also does not apply to an HDHP until the participant meets the minimum statutory HDHP deductible. The law will take effect for plan or policy years starting on or after April 10.
- **Menopause coverage.** Under the New Jersey Menopause Coverage Act (2025 Pub. Law 200, AB 5278), fully insured plans must cover treatment of perimenopause and menopause and associated symptoms, including but not limited to hormonal and physical therapy, behavioral healthcare services, bone health treatments, counseling, and education. The law will take effect for plan years starting in 2027.

New Jersey generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state.

New York

Under 2026 Ch. 62 (SB 8772), all insurance coverage mandates applicable to individual plans and group and blanket plans apply to HDHPs only after the plan's deductible has been satisfied, if to do otherwise would make a participant HSA-ineligible. Previously, the rule was based on the annually adjusted minimum deductible in § 223 of the Internal Revenue Code and also applied to HDHPs offered with a health reimbursement arrangement. The law will take effect for plan years starting in 2027.

South Dakota

HB 1199 requires fully insured plans to report annually on prior authorization activity and eliminate prior authorizations that are routinely approved. Specifically, plans must eliminate prior authorization where "requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending, to a degree that justifies the plan's administrative costs associated with the prior authorization requirement." While the law does not further define the standard or provide a

bright-line rule, the annual report must include a list of prior authorizations with at least an 80% approval rate. The state division of insurance is charged with publishing these annual reports within 60 days of receipt.

The law will take effect July 1. It does not apply to prescription drug or dental benefits. South Dakota generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state. The law does not affect self-funded ERISA plans.

Utah

Under 2026 Pub. Act 89 (HB 258), if a fully insured plan covers transgender hormonal treatments, it must also cover hormonal treatments to reverse the transition. If the plan covers sex transition surgical procedures, it must also cover surgical procedures necessary to reverse the transition. The law applies to plans renewed or entered into after January 1, 2027.

Utah generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, unless more than 25% of participants reside in Utah. The law does not affect self-funded ERISA plans.

Other benefit-related benefits

Changes to San Francisco's HAO took effect in February. Mississippi passed the Association Self-Funded Health Benefit Plan Coverage Act, aiming to expand coverage options for professional and trade associations. Wyoming established portable benefit accounts for independent contractors.

California — San Francisco

Late last year, San Francisco changed the HAO by providing a third method for covered employers to satisfy the health coverage requirement for covered employees, called the Quality Standards Program (QSP). Previously, covered employers (i.e., subject to the QSP, adopted by the San Francisco Airport (SFO) Commission) could comply with the HAO in two ways:

- Offer qualifying health benefits (requiring employers to offer at no cost self-only medical coverage, which must have an actuarial equivalence of at least 90%)
- Make an annually adjusted contribution to the City Option Program

As of February 26, covered employers can adopt the "Irrevocable Health Care Expenditure" tiered approach and meet minimum spending levels (annually adjusted) based on employees' household size (apparently regardless of whether dependents are actually covered under the plan):

Coverage tier	Minimum spending level
Employee-only	$6.17/hour (capped at $246.80/week)

Coverage tier	Minimum spending level
Employee + one dependent	$12.33/hour (capped at $493.20/week)
Employee + two or more dependents	$17.44/hour (capped at $697.60/week)

Dependents include a spouse and registered domestic partner. Covered employees must work at least 20 hours per week. No minimum hours requirement applies to SFO service employees.

To be considered an Irrevocable Health Care Expenditure, the employer payment cannot be retained, recovered, or returned to the employer. The actuarial value of self-funded ERISA plan coverage qualifies as an Irrevocable Health Care Expenditure.

Starting in 2027, the new tiered approach will be the only available option for HAO compliance. The other two options — offering qualifying health benefits and contributing to the City Option — will no longer be available. For other details on HAO, see San Francisco updates contractor-lessee health plan standards, pay rates (September 5, 2025).

Mississippi

Under SB 2704, members of professional and trade associations located in the state may obtain coverage from self-funded association plans subject to the laws of another state insurance department or the federal government. The plan and the association must have existed for at least three years. Approval by the insurance commission is required. The law will take effect on October 1.

Wyoming

Governor Mike Gordon signed SF 41, which creates portable benefit accounts that independent contractors can use to buy medical, dental, and vision coverage; income replacement insurance; and retirement benefits. A hiring party may contribute to an account without affecting the employment classification (i.e., employee vs. independent contractor) under state law. A hiring party may withhold money from compensation if certain conditions are met. The individual owns the account. The law will take effect on July 1. Wyoming has no state individual income tax.

Last year, Alabama and Tennessee adopted similar measures. For details, see Independent contractors "got a brand new (benefits) bag" (April 24, 2025).

Related resources

Mercer Law & Policy resources

- State paid family and medical leave contributions and benefits (February 6, 2026)

- IRS clarifies taxation of state and DC PFML contributions, benefits (January 13, 2026)
- San Francisco updates contractor-lessee health plan standards, pay rates (September 5, 2025)
- Roundup of selected state health developments, second-quarter 2025 (August 5, 2025)
- Roundup: State accrued paid leave mandates (July 23, 2025)
- Independent contractors "got a brand new (benefits) bag" (April 24, 2025)
- Beyond state lines: A primer on insurance law extraterritoriality (March 26, 2025)
- Roundup of selected state health developments, second-quarter 2022 (August 22, 2022)

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