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Roundup of selected state health developments, second-quarter 2026

By Rich Glass and Katharine Marshall
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In this article

The second quarter of 2026 was very active among the states. Virginia stole the spotlight by passing two major paid leave laws: paid family and medical leave (PFML) and paid sick and safe leave (PSSL). Major pharmacy benefit manager (PBM) laws were passed in several states, including Tennessee where the law was immediately challenged in court. A few states — Alabama, Georgia, and Texas — addressed artificial intelligence (AI) use in benefits. Insurance mandates centered on menopausal coverage, vaccines, and other key topics. California and New Jersey passed Medicaid-funding laws that are expected to directly impact employers. Georgia and Louisiana became the latest states to enact portable benefit accounts for independent contractors.

Paid family and medical leave

Louisiana became the latest state to authorize voluntary PFL insurance. Colorado, Maine, Oregon, Rhode Island, and Washington updated PFML rates. A Massachusetts budget law shifts employer PFML contributions from medical to family leave for tax purposes. Virginia passed a PFML mandate that takes effect in 2028. 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 Paid family and medical leave — snapshots across the US (slide deck) (June 26, 2026), Virginia hits

'back of the net' on PFML; who's next? (June 24, 2026), and State paid family and medical leave contributions and benefits (February 6, 2026).

Colorado

Effective July 1, Colorado announced a 4.8% increase in the state AWW, which in turn increases the maximum PFML benefit. The state AWW changed from $1,534.94 to $1,608.91, and the maximum weekly FAMLI benefit (90% of the state AWW) changed from $1,381.45 to $1,448.02.

Louisiana

As a result of 2026 Act 817 (HB 591), now in effect, life/disability insurers can offer a new line of insurance for PFL through a rider or separate policy. The law is flexible on waiting periods and benefit amounts/offsets, requiring a minimum of two weeks of leave during a 52-week period. Louisiana joins these similarly situated states: Alabama, Arkansas, Florida, Kentucky, South Carolina, Tennessee, Texas, and Virginia.

Maine

The state average weekly wage (AWW) rose by 4.2% to $1,249.12 (up from $1,198.84) for the period of July 1, 2026–June 30, 2027. Maine PFML uses the state AWW in three different ways:

- **Minimum earnings threshold**. Individual must have earned six times the state AWW in their base period to be eligible for benefits.
- **Weekly benefit amount (WBA).** A worker's AWW up to half the state AWW is replaced at 90%, and the AWW above that level is replaced at 66%.
- **Maximum WBA.** It equals 100% of the state AWW.

Claims with an application date and a leave start date after July 1 use the new state AWW.

Massachusetts

Massachusetts is one of a few states specifying the premium contribution allocation between medical and family leave in the PFML program. (Employers with fewer than 25 covered employees do not contribute.) Currently, employees pay 40% of the medical leave contribution and 100% of the family leave contribution.

Effective January 1, 2027, 2026 Ch. 101 (HB 5470) dictates a change in allocation. Employees will pay 100% of the medical leave contribution and 40% of the family leave contribution. The result will not alter the overall contribution split between employer and employee. For further details (including an updated contribution calculator), see this Department of Family and Medical Leave

webpage. As background, Washington made a similar change earlier this year; see Roundup of selected state health developments, first-quarter 2026 (May 1, 2026).

The legislature made the change in response to IRS Revenue Ruling 2025-4 and Notice 2026-6, which state that medical leave benefits attributable to employee contributions are nontaxable while family leave benefits, regardless of attribution, are taxable, starting in 2027. For further details, see IRS clarifies taxation of state and DC PFML contributions, benefits (January 13, 2026).

Oregon

A 3.4% state AWW increase boosted the weekly PFML benefit minimum (from $68.19 to $70.51) and maximum (from $1,636.56 to $1,692.16) for benefit years starting on or after June 28. As a reminder, PLO defines a benefit year as the 52-week (occasionally a 53-week) time frame that begins on the Sunday before a covered employee's first day of PFML.

Rhode Island

Effective July 1, Rhode Island increased by 4.3% the temporary disability insurance (TDI) and caregiver insurance (TCI) maximum weekly benefit from $1,103 to $1,150, with a corresponding increase to the dependent allowance (from $1,489 to $1,552) for employees with five or more dependents. TDI and TCI maximum weekly benefit amounts are calculated using the AWW in covered employment for the previous calendar year. The maximum weekly benefit is set at 85% of the state AWW.

Virginia

Under 2026 Chs. 981/1093 (SB 2/HB 1207), contributions to VA's new PFML program will start on April 1, 2028. Benefits will first become available on December 1, 2028. The Virginia Employment Commission will determine contribution rates. Contributions will be split 50/50 between employer and employee, except that employers with 10 or fewer employees will not have to contribute. The law applies to employers with at least one employee working in Virginia. State and federal (but not local) governmental employers are excluded; so are employers and employees covered by federal railroad unemployment insurance. Self-employed individuals can opt into the program.

PFML can be used to:

- Bond with a child within the first year of birth, adoption, or foster care placement
- Care for the employee or a family member with a serious health condition
- Care for a covered service member — who is next of kin or a family member — with a serious health condition
- Handle matters related to a family member's qualifying military exigency

- Seek safety services for the employee or a family member who is the victim of domestic violence, harassment, sexual assault, or stalking

Maximum duration is 12 weeks per benefit year. "Family member" is defined to include domestic partners, grandparents/grandchildren, and any individual (i) who regularly resides in the employee's home or where the relationship creates an expectation that the employee care for such individual, and (ii) who depends on the employee for care. The benefit amount is 80% of an individual's AWW, capped at 100% of the state AWW. Approved private employer plans (fully insured or self-insured) are permitted (existing law already allows for voluntary PFL insurance).

See Virginia enacts paid family and medical leave mandate (with slide deck) (June 17, 2026).

Washington

The Employment Security Department posted its PFML maximum weekly benefit amount for 2027. PFML benefits are calculated at 90% of an employee's AWW up to 50% of the state AWW plus 50% for AWW over 50% of the state AWW. The prior fiscal year's AWW ($1,919, a 4.9% increase) is used to calculate the next calendar year's PFML maximum weekly benefit amount, which will be $1,727 (2027), up from $1,647 (2026). The minimum weekly benefit amount will stay at $100.

Washington, DC

The UPL law is the District's PFML 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. The latest law is 2026 Act A26-0278 (B-574), which extended the extraterritorial prohibition to January 1, 2027 (see the legislative note).

Other types of leave

Hawaii amended its unpaid family leave law to include qualifying military exigencies. Minnesota's Department of Labor and Industry (DLI) finalized its earned sick and safe time rules. New York City issued final rules for last year's amendments to the Earned Safe and Sick Time Act (ESSTA), now known as the Protected Time Off (PTO) law. Virginia passed a PSSL mandate. For details on PSSL laws, see Roundup: State accrued paid leave mandates (July 23, 2025).

Hawaii

Per 2026 Act 13 (SB 3082), now in effect, eligible employees will be able to take up to four weeks of unpaid family leave for a qualifying military exigency, as defined under federal FMLA regulations. However, differences exist. First, a qualifying military exigency under the Hawaii law extends beyond FMLA to include siblings, grandchildren, and reciprocal beneficiaries (as defined by state

law). Second, Hawaii's law applies to employers with 100 or more employees in at least 20 weeks in the current or prior year; the FMLA threshold is 50. Finally, covered employees must have at least six months of continuous service with the employer; under FMLA, that threshold is 12 months.

Minnesota

Here is a summary of the ESST regulations, now in effect:

- **Eligibility.** An employer must determine in good faith whether employees meet the law's eligibility standard: "anticipated … to perform work for at least 80 hours in a year." Employers must evaluate the work schedule and location "in a manner that is not knowingly false or in reckless disregard of the truth."
- **Accruals and front-loading.** ESST must be credited for each pay period no later than the payday after the end of the corresponding pay period and must accrue in one-hour units rather than fractionally. For example, if 80 hours are worked in a pay period, the employee is credited with two hours of ESST (one for every 30 hours worked) on payday, and another ESST hour in the next pay period after working 10 more hours. Front-loading avoids the need to accrue. An employer may switch between accrual and front-loading but must provide notice of the change, which cannot take effect until the first day of the next accrual year.
- **Indeterminate shifts and ESST use.** Employers have three options for determining the amount of ESST used by employees whose start and end times vary: 1) Use the hours worked by a replacement worker; 2) Use the hours the employee worked in the most recent similar shift; or 3) Use the highest number of hours worked by a similarly situated employee who worked the shift for which ESST was used.
- **ESST use.** Employers cannot require employees to use ESST for a leave of absence. If an employee chooses not to use ESST for an absence, the law's job protections do not apply.
- **Documentation.** Employers can request reasonable documentation for absences of three or more consecutive work days as long as the requirement is clearly communicated and employees have a reasonable amount of time to respond. This request can occur for shorter absences if there is a pattern or clear instance of ESST misuse; the rules provide examples. An employer cannot deny ESST use based on a previous misuse, or suspicion of misuse, but misused ESST is not entitled to law's protections, and such employees may be disciplined.
- **Incentive programs.** The law prohibits an employer from taking adverse action for ESST use based on an absence control or similar policy. However, the rules allow an employer's bonus, reward, or incentive program based on hours worked to exclude ESST leave periods in determining whether a goal has been met, unless other leave periods count toward the goal.
- **Accrual year.** The law allows employers to define the accrual year. If an employer fails to designate and communicate it to employees, the rules default to a calendar year. Any change

to the definition requires advance notice and cannot negatively impact an employee's ability to accrue PSSL.

Employers subject to the ESST law (in effect since January 1, 2024) should review the rules and FAQs to address any compliance gaps.

New York — New York City

New York City. The October 2025 ESSTA amendments took effect February 22, 2026; see Roundup of selected state health developments, fourth-quarter 2025 (February 19, 2026). While the February FAQs remain unchanged, the final rules, now in effect, were adopted in June. The rules contain necessary revisions based on the amendments and also impose new requirements. Here is a summary:

- **Pay statements.** Employers must notify employees of the amount of paid leave time accrued and used each pay period. The final rules clarify that the statement must differentiate between paid and unpaid protected time off (PTO).
- **Post-employment obligation.** After employment terminates, employers must provide employee access to their PTO tracking system for six months or provide a written statement containing the amount of paid PTO accrued and used during the last pay period, and the employee's total balance of paid PTO. Employers must also provide, as applicable, the amount of paid prenatal leave used during the last pay period and the employee's total balance of paid prenatal leave no later than one week following the last payday.
- **Unpaid leave issues.** The law requires employers to make 32 hours of unpaid PTO immediately available at the start of each year. The final rules clarify that some or all of this time may be satisfied with an equivalent amount of paid PTO. Employers should make this immediately available PTO paid (rather than unpaid) when necessary to comply with state and federal law (e.g., salary basis test overtime exemption under the Fair Labor Standards Act).
- **Rehires.** For rehires in the same calendar year, an employer must reinstate the unused portion of the immediately available unpaid PTO. Unused accrued paid PTO must be reinstated for employees rehired within six months of separation.

Virginia

Under 2026 Chs. 1128/1129 (HB 5/SB 199), employees will accrue one hour of PSSL for every 30 hours worked with a carryover and annual usage maximum of 40 hours. Front-loading instead of accrual is permissible. Accrued PSSL can be used for:

- An employee's or family member's need for medical care (including preventive)

- Issues involving domestic violence, sexual assault, or stalking experienced by an employee or family member

Certain healthcare workers are excluded. "Family member" is broadly defined to include domestic partners, any individual related by blood or with a close association, and individuals for whom the employee is responsible for providing or arranging health or safety-related care.

The law has a rolling effective date based on employer size:

- **July 1, 2027:** Employers with at least 50 employees
- **January 1, 2028:** Employers with at least 25 employees
- **January 1, 2029**: Employers with at least one employee

It is unclear whether these thresholds are based on national or Virginia headcount. Currently, a separate PSSL mandate applies to home health workers only. That requirement remains unchanged. See Virginia passes paid sick leave mandate (with slide deck) (July 14, 2026).

Prescription drugs (Rx)

A Colorado insurance law aims to create coverage parity for nonopioid pain management drugs, and the state received federal Food and Drug Administration (FDA) approval to import prescription drugs from Canada. A Kansas law imposes new restrictions on PBMs and annual reporting requirements that may extend to self-funded ERISA plans. Louisiana enacted an insurance law prohibiting prior authorization requirements for generic drugs. A Rhode Island law protected participant Rx choice and increased PBM transparency, the other requiring a PBM certificate of authority. Another Rhode Island law focused on plans' vaccine coverage. Parts of a Tennessee PBM law remain preempted on ERISA grounds. A separate Tennessee law prohibiting PBM ownership was quickly contested in federal court. Virginia passed laws addressing rebates, Rx prior authorization, insulin copayments, and cost sharing.

Colorado

New law. SB26-006 imposes three new coverage requirements related to nonopioid pain management drugs. First, it prohibits cost sharing, copayments, and deductibles for these drugs from exceeding rates applicable to opioid drugs for similar purposes. The prohibition does not apply to the extent that it would affect the HSA-qualifying status of a high-deductible health plan (HDHP).

Second, utilization review standards — including prior authorization and step therapy — for FDA-approved nonopioid pain management drugs can be no more restrictive than the least restrictive utilization review standards for opioid drugs prescribed for similar purposes.

Third, as of January 1, 2027 (individual and small group markets) and January 1, 2028 (large group market), fully insured plans must offer at least one nonopioid drug as a clinically appropriate alternative to an opioid. The coverage requirement for individual and small group markets becomes inoperative if the state is required to defray coverage costs under the ACA.

The law, effective August 12, does not apply to the state employee group health plan(s). Colorado 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.

Imported drug approval. The FDA approved Colorado's plan to import certain prescription drugs from Canada under applicable federal law. Colorado joins Florida (January 2024) as the only states to receive the FDA go-ahead. Additional steps are necessary for each drug to be imported, as well as cooperation from Canada. Florida's program is not yet operational despite four FDA extensions (the latest until November 6), per an FDA letter.

Kansas

SB 20, now in effect, imposes restrictions and reporting obligations, primarily on PBMs.

Restrictions. These rules apply to PBMs (with an express exemption for self-funded ERISA plans):

- **Reimbursements.** PBMs cannot reimburse a pharmacy less than the National Average Drug Acquisition Cost (NADAC) — or Wholesale Acquisition Cost (WAC), if NADAC is unavailable — for a drug, plus a dispensing fee equal to greater of $10.50 or state Medicaid (KanCare) rate. PBMs cannot reimburse a pharmacy less than the amount it reimburses an affiliated pharmacy.
- **Spread pricing.** The practice is banned.
- **Rebates.** PBMs must pass through 100% of rebates to the fully insured plan or to participants at point of sale. Rebates are broadly defined to include all payments received by the PBM or the health plan, directly or indirectly from a manufacturer, including discounts, administration fees, credits, incentives, or penalties. There is an express exemption for the 340B program.
- **Cost sharing.** PBMs cannot collect participant cost sharing that exceeds a pharmacy's submitted charges.

Reporting. PBMs, health plans, and covered entities will be subject to regular reporting requirements. The definition of a covered entity was changed to include "any entity that provides, administers, or manages a self-funded health benefit plan, including a governmental plan or any other entity that provides prescription drug coverages." This duty does not apply to insurers of property and casualty coverage or workers' compensation. PBMs must include fully insured and self-funded plan data on rebates, pricing, and other items in quarterly and annual reports to the state department of insurance. They must further disclose spread information to health plans and covered entities on an annual basis. In turn, health plans and covered entities must annually

report to the state department of insurance on credits, rebates, and discounts received from PBMs and drug manufacturers.

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

Louisiana

Under 2026 Act 706 (HB 1154), fully insured commercial plans cannot require prior authorization for nonopioid, generic drugs when prescribed by a board-certified physician or provider with an appropriate specialty certification and the WAC is $250 or less per prescription. The law does not apply to state and local governmental plans, including Medicaid. The law will take effect for plan years starting in 2027.

Louisiana 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).

The law does not affect self-funded ERISA plans.

Rhode Island

Here is a summary of the two PBM laws:

HB 8582/SB 3059. Effective January, 1, 2027, the following PBM activities are banned:

- Substituting or changing prescriptions without prescriber approval, except as explicitly required or permitted by law
- Prohibiting or penalizing pharmacy-patient discussions on drug costs or therapeutic equivalents
- Collecting copays greater than the pharmacy's submitted charge, or recouping patient copays paid to the pharmacy

Also effective January 1, 2027:

- All pharmacy contracts must include a reasonable appeal process to investigate and resolve disputes regarding multisource generic drug pricing.
- PBMs must operate with care, skill, prudence, diligence, and professionalism, owing a duty of good faith and fair dealing to all parties, including participants and pharmacies.
- PBMs must hold in trust all funds related to their services (including administrative fees and spread pricing).

Effective August 1, 2027, PBMs must:

- Pass through all discounts, rebates, credits, and other fees to the insurer
- Give insurers access to all financial and utilization information related to the PBM services provided, as well as pharmacy dispensing fee terms and conditions and any conflicts of interest (until reports required by the Consolidated Appropriations Act of 2026 are provided on or after August 1, 2028)

HB 8579/SB 3060 (Pharmacy Benefit Managers Act). In addition to obtaining a certificate of authority, PBMs must submit annual reports (by July 1) to the state insurance commission, detailing rebates, discounts, fees, chargebacks, clawbacks, and other payments, as well as contract terms for any other party related to the services they offer. Violations are subject to a significant penalty scheme.

The application of these laws to PBMs administering self-funded ERISA plans is unclear. While there is no specific carve-out for these plans, both laws use the existing statutory definition of PBMs, which is limited to entities working "on behalf of any carrier that provides prescription drug benefits to residents of this state."

Rhode Island generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Tennessee

Two PBM laws are subject to litigation:

Pharmacy benefit design. The 6th Circuit Court of Appeals upheld a lower court ruling in *McKee Foods v. BFP*, preempting several provisions of the state's PBM law under ERISA. Of particular concern was the statute's any willing pharmacy requirement. The 6th Circuit distinguished the Tennessee law from an Arkansas law upheld in the US Supreme Court's 2020 *Rutledge* decision: "Notably, these provisions did not target pharmacy reimbursement rates (like the law in Rutledge); they targeted more fundamental elements of how PBMs design benefit structures for health plans."

The time frame for appealing to the US Supreme Court has not yet expired.

PBM ownership. Starting January 1, 2027, the Freedom, Access, and Integrity in Registered Pharmacy (FAIR Rx) Act (SB 2040) prohibits any PBM ownership of a pharmacy operating in the state. A limited-use license exists for certain rare, orphan, or FDA-designated limited-distribution drugs, through September 1, 2028; the state board of pharmacy has discretion in issuing such a license. The board of pharmacy was tasked with reviewing all active pharmacy licenses by July 1 and sending notices to affected license holders by October 1.

Since enactment, three lawsuits have been filed (by CVS Pharmacy, Inc., Express Scripts, Inc. (ESI), and the Pharmaceutical Care Management Association (PCMA)) alleging that SB 2040 violates the US Constitution and is preempted by ERISA, Medicare, and TRICARE. CVS argues the new law would cause it to close 136 retail and specialty pharmacies and stop Tennessee residents from using its mail-order program, affecting almost 1.5 million people. Cigna, ESI's parent company, estimates that over 180,000 residents will be affected if ESI-affiliated pharmacies are forced to close.

The FAIR Rx Act largely mirrors a 2025 Arkansas law, currently on hold due to a preliminary injunction. For background, see State legislatures target PBM ownership (March 26, 2026).

Virginia

Here is a summary of the four laws:

- **Rebates.** Per 2026 Ch. 678 (HB 830), PBMs must pass through 100% of rebates to the insurer, plan, or participant (at the point of sale), as well as offer a contract limiting income to management fees upon plan sponsor request. The law explicitly excludes ERISA self-funded plans, Medicaid, Medicare Part D, and CHIP from its scope but applies to the state employee health plan. Most provisions will take effect July 1, 2027.
- **Prior authorization.** Under 2026 Ch. 925 (HB 481), insurers (other than HMOs) may not make an adverse determination of an Rx prior authorization unless reviewed and approved by a licensed physician or, if unavailable, a licensed pharmacist. The same holds true for healthcare services unless approved by a licensed physician or, if unavailable, a licensed mental health provider (for mental health services) or licensed dentist (for dental services). The healthcare services restriction does not apply to Medicare, Medicaid, CHIP, TRICARE, and HMOs. These requirements will take effect January 1, 2027.
- **Insulin copays.** As a result of 2026 Ch. 752 (HB 1214), fully insured plans cannot charge more than $35 in aggregate (currently $50) for a 30-day supply of insulin, and separately, more than $35 in aggregate (currently no cap) for a 30-day supply of standard diabetes equipment. The caps apply even if more than one insulin drug is prescribed and regardless of the amount or type of equipment or supplies needed. The diabetes equipment copay rule excludes Medicare, Medicaid, and the state governmental plan. The law will take effect for plan years starting in 2027.
- **Other Rx cost-share limits.** 2026 Chs. 641/642 (HB 625/SB 161) requires insurers in the individual and small group markets to offer at least one coverage option that meets these Rx cost-sharing limits:

Coverage level	Maximum cost sharing for a 30-day supply
Platinum	$150

Coverage level	Maximum cost sharing for a 30-day supply
Gold	$200
Silver	$250
Bronze	$300

The above cost sharing is pre-deductible, with an exception for HDHPs. The law will take effect for plan years starting in 2028.

Virginia generally does not apply their insurance laws on an extraterritorial basis to fully insured plans issued outside the state. These laws do not affect self-funded ERISA plans.

Vaccine coverage

Connecticut, Oregon, and Rhode Island passed laws addressing fully insured plan coverage of vaccines.

Connecticut

Under prior law, individual and group health plans covering Rx were required to cover vaccines recommended by the American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecology, American Academy of Family Physicians, and the federal Advisory Committee on Immunization Practices (known as ACIP). Pub. Act 26-3 (HB 5044), now in effect, requires these plans to cover vaccine schedules from the state commissioner of public health and ACIP, and vaccine recommendations from one other aforementioned organization.

Connecticut generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, unless 51% of covered employees are employed in the state.

Oregon

Previously, nongrandfathered 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) at no cost to plan members. Under SB 1598, now in effect, HHS recommendations in effect on June 30, 2025, apply, as well as those recommended by the state public health officer. These recommendations will be published on the Oregon Health Authority's website, and plans must cover a recommended vaccine within 15 business days of publication.

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.

Rhode Island

The vaccine law (HB 7625) requires fully insured individual and group medical plans, HMOs, the state employee and retiree plans, state Medicaid, and other medical assistance programs to cover vaccines recommended by the Rhode Island department of health (RIDOH) without cost sharing. The law adds RIDOH recommendations to the existing statutory requirement to include recommendations by the federal ACIP and the AAP. The coverage requirement applies to all policies, plans, and programs delivered, issued, or renewed in the state on or after January 1, 2027.

Insurance

Alabama, Georgia, and Texas addressed AI use in health insurance. California and Virginia required menopausal coverage. Kentucky restricted use of prior authorization by fully insured plans. Maryland changed how it determines mandated preventive services for fully insured plans. A New Mexico emergency rule requires fully insured plans to cover specified sex trait modification procedures, consistent with existing state nondiscrimination laws. None of the laws in this section affect self-funded ERISA plans.

Alabama

Act 2026-589 (SB 63) empowers the department of insurance to adopt rules limiting the use of AI in insurance processes and imposes these general restrictions:

- **Prior authorization.** Insurers must base medical necessity determinations on the participant's medical history, clinical circumstances unique to the participant, and additional relevant clinical information about the participant. Annually, insurers must certify that any AI use does not rely on a group data set, is fairly and equitably applied, and does not discriminate in violation of state or federal law. Only a licensed physician or healthcare professional can make an adverse decision.
- **Utilization review.** Insurers must disclose any AI use in utilization review in policies and procedures and attest that outcomes are subject to periodic review and that AI use of patient data complies with HIPAA.

Violations can subject the insurer to administrative fines up to $5,000 and license suspension or revocation. The law will take effect October 1.

California

As a result of 2026 Ch. 27 (SB 164), fully insured plans and healthcare service plans (including HMOs) must cover FDA-approved treatments for menopause, perimenopause, and postmenopause symptoms, subject to these requirements:

- Plans must include a program to ensure participants have access to current clinical care recommendations for menopause, including hormone therapy, and information about covered items and services to evaluate and treat menopause.
- Coverage must be available without discrimination on the basis of gender expression or identity.
- Specific standards for medical necessity determination and utilization review criteria apply.

These provisions will take effect January 1, 2027, except for the information program requirement, which is effective July 1, 2027. The law does not affect self-funded ERISA plans.

Georgia

Per 2026 Act 411 (SB 444), certain entities using AI and related tools in utilization review must also involve clinical peer review by a qualifying natural person for adverse determinations. The law will take effect January 1, 2027.

Iowa

As a result of 2026 Ch. 1105 (HF 2185), now in effect, if any fully insured plan's cost sharing for state-mandated covered benefits other than preventive care would result in HSA ineligibility, the cost sharing will apply only after the participant has met the minimum annual deductible.

Kentucky

HB 176 requires fully insured plans to create an exemption program for prior authorizations. While plans have some discretion on the terms and conditions, a plan cannot require prior authorization for a particular healthcare service if the provider has a prior authorization exemption for that service. A prior authorization exemption is received when a provider's prior authorization approval rate exceeds 93% during the evaluation period (a 12-month period determined by the insurer). The law will take effect January 1, 2028.

Maryland

As a result of 2026 Chs. 7/8 (HB 637/SB 385), mandated no-cost preventive services will be based on recommendations by the state secretary of health, in addition to the federal agencies authorized by the Affordable Care Act. Previously, insurers had to implement changes within three months of the recommendations; the time period will now be one year. The law also allows pharmacists to administer vaccines recommended by the secretary of health in addition to those recommended by ACIP. The new coverage requirements apply to plan years starting in 2027.

New Mexico

The New Mexico Office of Superintendent of Insurance (OSI) adopted the emergency rule, based on laws prohibiting health plan discrimination because of gender, sexual orientation, or health status (among other factors). Plans must cover medically necessary sex trait modification procedures (as defined by federal law) and include a coverage description in the evidence of coverage document. The rule does not contain a minimum age requirement. OSI adopted the rule because "[r]ecent updates to federal regulations created ambiguity about whether health insurers needed to cover aspects of gender-affirming healthcare." The emergency rule technically expires 180 days after May 5, but OSI indicated it intends to adopt a final rule. The rule applies to plan years starting in 2027.

Texas

The Texas Department of Insurance (TDI) published Bulletin B-0003-26, describing 10 separate laws applicable to regulated entities' development, acquisition, and use of AI, primarily in the areas of unfair trade practices and discrimination. Overall, TDI provided six expectations:

- **Standards.** All decisions made using AI must comply with applicable legal and regulatory standards, and cannot be inaccurate, arbitrary, capricious, or unfairly discriminatory.
- **Controls.** Entities must implement controls to mitigate the risk of adverse consumer outcomes.
- **Decisions.** A person must review and agree with "consequential" AI decisions (an undefined term) before action is taken.
- **Governance.** Robust governance, risk management controls, and internal audits mitigate risk that AI use will violate legal standards, and the development and use of verification and testing methods identifies errors and bias in AI use.
- **Monitoring.** TDI will monitor AI use through examinations, product filings, and investigations driven by consumer complaints.
- **Inquiries.** Entities should expect TDI to inquire about specific AI use and application, governance frameworks, risk management, data and privacy protections, and internal controls.

Virginia

Under 2026 Ch. 955 (SB 790), fully insured plans must cover medically necessary perimenopause and menopause care and treatment. The law applies to plan years starting in 2027.

Extraterritorial application of laws in this section

Alabama, Georgia, Iowa, New Mexico, Maryland, and Virginia generally do not apply insurance laws on an extraterritorial basis to fully insured plans issued outside the state. With a few exceptions (like domestic partner coverage), California generally does not apply its insurance laws on an extraterritorial basis to fully insured plans issued in another state, as long as both an employer's principal place of business and a majority of employees are located outside of California. Texas generally applies its insurance laws on an extraterritorial basis to state residents covered by fully insured plans issued in another state.

Telehealth

Iowa and Louisiana became the latest states to join an interjurisdictional mental health compact. For background, see PSYPACT gets an A (for access, among other things) (May 29, 2025). Louisiana also enacted a telehealth law addressing weight-loss providers. Maryland's telehealth law affects professional counselors and therapists. New Jersey's telehealth parity mandate — requiring reimbursement parity between in-person and telehealth providers — was extended by 18 months.

Iowa

The Iowa Make America Healthy Again Act (2026 Ch. 1129, HF 2676) is a far-reaching law affecting health-related professions, nutrition, medication, and education. Of particular note is a provision adopting the Psychology Interjurisdictional Compact (PSYPACT), facilitating the practice of mental health services across state boundaries.

Louisiana

Here is a summary of the two laws:

- **PYSPACT.** With 2026 Act 302 (HB 486), Louisiana joined the compact, although practice within the state by out-of-state providers and practice out of state by in-state providers isn't permitted until January 1, 2028.
- **Weight-loss providers.** Under 2026 Act 345 (SB 30), now in effect, licensed providers may use telehealth to evaluate, diagnose, or treat obesity or deliver weight-management services if care involves a synchronous interaction and a provider remains within his or her license scope and standard of care.

Maryland

A Maryland telehealth law repeals the existing temporary telehealth license scheme for out-of-state clinical professional counselors and social workers managed by the Board of Professional

Counselors and Therapists, replacing it with a licensing exemption. Under 2026 Ch. 242 (HB 1483), certain out-of-state counselors and therapists may provide care to individuals in the state if they:

- Are licensed and in good standing in another state
- Have established the client-counselor relationship outside of Maryland
- Are unable to provide in-person counseling because the client is located in Maryland
- Are willing to provide counseling through telehealth for continuity of care to the client for no more than six months after the client relocates or returns to Maryland

The law will take effect October 1.

New Jersey

The existing telehealth parity mandate was set to expire on July 1, 2026. 2026 Ch. 105 (SB 3947) extends the reimbursement parity between in-person and telehealth providers required of insured plans to December 31, 2027.

New Jersey 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.

Other benefit-related issues

The fiscal years of California and New Jersey started on July 1, and their respective budgets included tax provisions likely to impact plan sponsors' health plan costs. Georgia and Louisiana established PBAs for gig workers; for background, see Independent contractors "got a brand new (benefits) bag" (April 24, 2025). The second quarter saw an annual update to the Massachusetts MCC program. A Mississippi law provides employers with fewer than 50 employees an income tax credit for offering an individual coverage health reimbursement arrangement (ICHRA) instead of employer-sponsored health insurance. Los Angeles and San Francisco announced new health benefit rates applicable to certain employers.

California

The new law — 2026 Ch. 26 (SB 125) — increases provider taxes on commercial managed care organizations (MCOs), which include HMOs subject to state law, while simultaneously significantly reducing the tax on Medi-Cal MCOs. For calendar years 2027, 2028, and 2029, a tax of $8.85 per enrollee per month applies to MCOs both inside and outside of Medi-Cal.

Changes from the One Big Beautiful Bill Act (OBBBA) were the impetus for SB 125, specifically related to provider taxes used to fund Medicaid (Medi-Cal in California) and eligible for matching federal funds. The current MCO tax levied on health plans to help fund Medi-Cal has a higher rate

for Medi-Cal managed care plans ($274 per enrollee per month) than commercial managed care plans ($2.25 per enrollee per month), which is not permitted under the OBBBA. CMS required states to bring their MCO tax scheme into compliance by the end of the fiscal year ending in 2026. See the legislative bill analyses for additional background information.

The new tax rate is subject to CMS approval, unless the state director of healthcare services certifies that the tax is federally permissible. In July, the California Assembly Republican Caucus sent a letter urging CMS to deny California's application because "its practical effect is a new tax on health plans that will ultimately be passed on to employers, workers, retirees, and families through higher health insurance premiums." For details, see States eye Medicaid taxes that could affect employers (July 30, 2026).

California — Los Angeles

In May, the city of Los Angeles amended its Citywide Hotel Worker Minimum Wage Ordinance (CHMWO) and the airport worker provisions of its Living Wage Ordinance. In addition to adjusting downward the minimum wage annually every July through the year 2030, the amendment changed the minimum value of health benefits that each employer must offer covered employees:

Effective date	Hotel workers	Airport workers
July 1, 2026	$4.25 per hour	$7.65 per hour (in effect since July 1, 2025)
July 1, 2027	$6.00 per hour	$8.15 per hour
July 1, 2028	Equal to airport workers' rate	$8.35 per hour (further adjusted by the Department of Managed Healthcare Large Group Aggregate Rates (LGAR) report)

Beginning on July 1, 2029, and annually thereafter each July 1, the payment amount for health benefits that are provided to covered employees shall be adjusted and announced on April 1, or within two weeks of the release of the prior year's LGAR report, whichever is later, to take effect on July 1 of each year.

The amendment further clarifies that health benefits include coverage for health, dental, vision, mental health, and disability income. Health benefits do not include retirement benefits, accidental death and dismemberment insurance, life insurance, and other benefits that do not provide medical or health related coverage.

California — San Francisco

HCAO. This ordinance requires most city contractors to provide health benefits meeting minimum standards. Alternatively, employers can make a payment to the San Francisco General Hospital

based on an hourly rate for each covered employee. Effective July 1, the new rate is $8.00 per hour (capped at $320 per week), up from $7.50 per hour (capped at $300 per week).

HAO. This ordinance requires most employers at the San Francisco International (SFO) Airport to provide health benefits meeting minimum standards, make a payment based on hours worked to the City Option Program, or adopt a tiered "Irrevocable Health Care Expenditure" approach that meets minimum spending requirements. For the period of July 1, 2025–December 31, 2026, the City Option contribution rate increases from $12.15 per hour to $12.95 per hour, subject to a $518 weekly maximum.

Starting in 2027, the tiered approach is the only compliant option. Recently announced rates for 2027 are:

Coverage tier	As of January 1, 2027	As of February 28, 2026
Employee-only	$6.55/hour (capped at $262.00/week)	$6.17/hour (capped at $246.80/week)
Employee + one dependent	$13.10/hour (capped at $524.00/week)	$12.33/hour (capped at $493.20/week)
Employee + two or more dependents	$18.55/hour (capped at $874.00/week)	$17.44/hour (capped at $697.60/week)

MCO. This ordinance requires most city service contractors and SFO airport tenants to provide covered employees all of the following:

- Minimum hourly wage
- 12 days off with pay per year (or cash equivalent)
- 10 days off without pay per year

The minimum hourly wage increases at specified times. Here is the latest information:

Employer type	As of July 1, 2026	Through June 30, 2026
For-profit employers	$22.01	$21.54
Nonprofit employers	$23.50	$23.00
Public-entity employers	$23.00 $25.00 (as of September 1, 2026) $25.50 (as of January 1, 2027)	$23.00

For other details on the HCAO and HAO, see San Francisco contractor-lessee health plan standards, pay rates updated (September 5, 2025).

Georgia

The Voluntary Portable Benefit Plan Act (2026 Act 466, HB 987), now in effect, enables voluntary contributions to PBAs, allowing independent contractors to fund the accounts via withdrawals from compensation. PBAs can be used to fund health insurance, unemployment insurance, disability insurance, life insurance, or retirement benefits. PBA contributions will not affect the individual's employment classification. The law does not provide favorable state tax treatment for these contributions, which will be subject to state personal income tax.

Louisiana

The Independent Contractor Voluntary Portable Benefits Act (2026 Act 299, HB 301), now in effect, establishes PBAs, administered by banks, investment managers, or technology/program managers offering services through a bank or investment management firm. The accounts can fund benefits, including health, income-replacement, disability, life, and retirement. A hiring party may contribute or withhold contributions from pay with proper notice to, and consent of, the individual. Contributions cannot be used to determine employment classification, employer liability, or as evidence of an employment relationship under Louisiana workers' compensation or employment laws. The law does not provide favorable state tax treatment for these contributions, which will be subject to state personal income tax.

Massachusetts

The Massachusetts Health Connector announced MCC cost-sharing limits for 2027:

Cost-sharing limits	2027	2026
Individual-tier deductible	$3,200	$3,200
Individual-tier separate Rx deductible	400	400
Family-tier deductible	6,400	6,400
Family-tier separate Rx deductible	800	800
Individual-tier out-of-pocket maximum (OOPM)	12,000	10,150
Family-tier OOPM	24,000	20,300

As background, the deductibles were supposed to increase significantly, but a February Health Connector board meeting froze them for 2027.

In addition, the Department of Revenue recently announced the 2026 monthly penalties for uninsured Massachusetts residents (based on individual income as a percentage of the federal poverty level (FPL)):

% of FPL	Monthly penalty
150.1%-200%	$26
200.1%-250%	$51
250.1%-300%	$76
300.1%-400%	$117
Above 400%	$211

The state's individual mandate requires state residents to maintain MCC or face a potential state tax penalty. Plan sponsors (or their vendors) must determine whether coverage meets MCC standards. For more information on MCC reporting, see Massachusetts sets 2027 individual-mandate coverage dollar limits (May 28, 2026).

Mississippi

HB 343 authorizes a small employer (fewer than 50 employees) tax credit of up to $400 per ICHRA-covered employee in the first tax year. This amount drops to $200 per covered employee in the second tax year. Minimum ICHRA funding levels apply. The law provides up to $1 million per year in program funding. The employer's tax credit cannot exceed its state tax liability, although excess credits may be carried over for up to 10 years. The law is effective for the 2026 tax year.

As background, ICHRAs are solely employer-funded and are used to buy individual health insurance or pay Medicare premiums. For background, see IRS Outlines How Individual-Coverage HRAs Can Meet ACA Employer Mandate (October 29, 2019) and Final Rules Ease Restrictions on Health Reimbursement Arrangements (June 14, 2019).

New Jersey

As a result of AB 5324, employers with 50 or more workers on Medicaid in the previous calendar year will be subject to an annual fee expected to raise $145 million in annual revenues. The fee imposed — and due each April 15 — is determined based on the number of employees and dependents of employees on Medicaid on December 31 of the preceding year. The tax applies starting with the July 1, 2026–June 30, 2027, budget year.

Here is how the tax is calculated:

Employees + dependents receiving Medicaid	Annual fee (per Medicaid recipient)
50-249	$325
250-499	$525
500 and above	$725

Employees excluded from the calculation include:

- Those employed for less than 90 days at the time the fee is determined, or
- Part-time, per-diem, temporary, and seasonal (these terms are not defined) employees

The law requires an employer appeal process with the labor and workforce development department. Proponents argue the law was needed to offset projected increases in Medicaid costs. Opponents argue that the law will disincentivize hiring and retention of lower-income employees.

Washington

The Washington Partnership Access Line (WAPAL) Fund Advisory Committee increased covered-lives assessment (CLA) rates for fiscal year 2027, which started July 1. As background, the state has a CLA and reporting obligation for health insurers and plan sponsors with covered state residents. The monthly rate (July 1, 2026–June 30, 2027) is now $0.09 (up from $0.07) per covered life.

For details on the WAPAL fee and other state reporting requirements, see Some states require group health plan sponsor reporting (December 3, 2025).

Related resources

Mercer Law & Policy resources

- States eye Medicaid taxes that could affect employers (July 30, 2026)
- Virginia passes paid sick and safe leave mandate (with slide deck) (July 14, 2026)
- Paid family and medical leave — snapshots across the US (slide deck) (June 26, 2026)
- Virginia hits 'back of the net' on PFML; who's next? (June 24, 2026)
- Virginia enacts paid family and medical leave mandate (with slide deck) (June 17, 2026)
- Massachusetts sets 2027 individual-mandate coverage dollar limits (May 28, 2026)
- Roundup of selected state health developments, first-quarter 2026 (May 1, 2026)

- State legislatures target PBM ownership (March 26, 2026)
- Roundup of selected state health developments, fourth-quarter 2025 (February 19, 2026)
- 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)
- Some states require group health plan sponsor reporting (December 3, 2025)
- San Francisco contractor-lessee health plan standards, pay rates updated (September 5, 2025)
- Roundup: State accrued paid leave mandates (July 23, 2025)
- PSYPACT gets an A (for access, among other things) (May 29, 2025)
- Independent contractors "got a brand new (benefits) bag" (April 24, 2025)
- Beyond state lines: A primer on insurance law extraterritoriality (March 26, 2025)
- Supreme Court upholds Arkansas law regulating PBMs (December 10, 2020)
- Final Rules Ease Restrictions on Health Reimbursement Arrangements (June 14, 2019)
- IRS Outlines How Individual-Coverage HRAs Can Meet ACA Employer Mandate (October 29, 2019)

Other Mercer resources

- Benefits strategy & innovation
- Life, absence, and disability benefits
- MercerRx
- MercerWell
- Voluntary benefits

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