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GUIDANCE DOCUMENT—ERISA PREEMPTION AND STATE PBM LAWS

OUTLINE

- I. Introduction
- II. ERISA Preemption
- III. Cases Addressing ERISA Preemption Analysis of State PBM Laws
 - *Rutledge*
 - *Wehbi*
 - *Mulready*
- IV. Lessons for States
 - Principles to apply to the question of whether ERISA may preempt the state law at issue
 - Laws at issue in *Rutledge*, *Wehbi*, and *Mulready*—Chart

I. Introduction

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 laws² 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 Regulation* (ERISA Handbook) provides a more comprehensive overview of ERISA preemption and its impact on state efforts to regulate ERISA plans.

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.

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 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

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.

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).

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

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

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>.

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

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 claims¹⁹ 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

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,”

¹⁶ Act 900 of 2015.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Rutledge*, 592 U.S. 80 at 86.

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.

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 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

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.*

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.

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 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

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>

³⁵ *Wehbi*, 18 F.4th 956 at 969.

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

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

³⁶ *Id.* at 969.

³⁷ 18 F.4th 956 at 968.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* at 968.

⁴¹ *Id.*

⁴² *Id.*

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 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 categories⁴⁹: 1) “network restrictions,” which includes access standards,⁵⁰ discount prohibition,⁵¹ and any willing provider provision⁵² 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

⁴³ *Id.*

⁴⁴ *Id.* at 968-969.

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);

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 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 persuasive authority, they are only binding on states within that circuit

⁵⁴ *Mulready*, 78 F.4th 1183 at 1193.

⁵⁵ *Id.* at 1198.

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.

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 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

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.

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.

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 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

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](#).

⁶³The 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.

⁶⁶ *Id.* at 86-87.

⁶⁷ *Id.* at 88.

⁶⁸ *Id.* at 87

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.

Laws at issue in Rutledge, Wehbi, and Mulready

<u>CATEGORIES OF STATE LAW</u>	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.	<i>Rutledge</i> Act 900 of 2015		
Pharmacies may refuse to sell a drug if the PBM's reimbursement rate is lower than its acquisition cost.	<i>Rutledge</i> Act 900 of 2015		
If a consumer pays a copayment, it is retained by the pharmacy. It cannot be "clawed back" by the PBM.		* <i>Wehbi</i> (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.		* <i>Wehbi</i> (19-02.1-16.1(3))	
A PBM is limited to applying a fee to the professional dispensing fee outlined in the pharmacy contract.		* <i>Wehbi</i> (19-02.1-16.1(3))	
A PBM may not impose a fee related to performance metrics on the pharmacy's cost of goods.		* <i>Wehbi</i> (19-02.1-16.1(3))	
A PBM may not prohibit a pharmacy from disclosing certain health information to the plan sponsor or patient.		<i>Wehbi</i> (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.		<i>Wehbi</i> (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.		<i>Wehbi</i> (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.		<i>Wehbi</i> (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.		<i>Wehbi</i> (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 (<i>for network participation</i>).			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				
PBM's must timely update their minimum acquisition cost (MAC) lists when drug wholesale prices increase.		Rutledge: Ark. Code Ann. §17-92-507(c)(2)		
PBM's 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 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.

⁶⁹ 514 U.S. 645, 659–60 (1995)

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

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

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

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

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

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

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

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

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

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

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

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