HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 14, 2026, Minutes

- Consumer Information (B) Working Group July 23, 2026, Minutes (Attachment One)
- Consumer Information (B) Working Group April 10, 2026, Minutes (Attachment Two)
- Health Care Affordability and Mitigation (B) Working Group Aug. 13, 2026, Minutes (Attachment Three)
  - Health Care Affordability and Mitigation (B) Working Group, June 2, 2026, Minutes (Attachment Three-A)
  - Health Care Affordability and Mitigation (B) Working Group, May 5, 2026, Minutes (Attachment Three-B)
  - Health Care Affordability and Mitigation (B) Working Group, April 21, 2026, Minutes (Attachment Three-C)
  - Health Care Affordability and Mitigation (B) Working Group, April 7, 2026, Minutes (Attachment Three-D)
- *Guidance Document—ERISA Preemption and State PBM Laws* Adopted by the Committee (Attachment Four)

Draft Pending Adoption

Draft: 8/20/26

Health Insurance and Managed Care (B) Committee
Columbus, Ohio
August 14, 2026

The Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 14, 2026. The following Committee members participated: John F. King, Vice Chair (GA); Charles Bassett (AZ); Dean L. Cameron (ID); Ann Gillespie (IL); Marie Grant (MD); Mike Chaney represented by Bob Williams (MS); Alice T. Kane represented by Viara Ianakieva (NM); Ned Gaines (NV); Glen Mulready (OK); Michael Humphreys (PA); Jon Pike (UT); and Erin K. Hunter and Joylynn Fix (WV). Also participating were: Heather Carpenter (AK); Doug Ommen (IA); Kevin Dyke (MI); Julia Dreier (MN); Angela L. Nelson (MO); TK Keen (OR); Michael Wise (SC); and Scott A. White (VA).

1. Adopted its Spring National Meeting Minutes

Commissioner Grant made a motion, seconded by Director Cameron, to adopt the Committee's March 25 minutes (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee*). The motion passed unanimously.

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

Prior to asking for a motion to adopt the Committee's task force and working group reports, Commissioner King said that in adopting the report of the Regulatory Framework (B) Task Force, the Committee is not adopting the *Guidance Document—ERISA Preemption and State PBM Laws* (Guidance Document). The Committee will consider its adoption as the next meeting agenda item.

Commissioner Gaines made a motion, seconded by Commissioner Pike, to adopt the following task force and working group reports: 1) Consumer Information (B) Working Group, including its July 23 (Attachment One) and April 10 (Attachment Two) minutes; 2) Health Care Affordability and Mitigation (B) Working Group (Attachment Three); 3) Health Actuarial (B) Task Force; 4) Regulatory Framework (B) Task Force; and 5) Senior Issues (B) Task Force. The motion passed unanimously.

3. Adopted the Guidance Document

Commissioner Grant said the Regulatory Framework (B) Task Force adopted the Guidance Document during its Aug. 13 meeting. The Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group adopted it July 22. Commissioner Grant said the purpose of the Guidance Document is to provide information to state department of insurance (DOI) regulators and other state government officials regarding ERISA preemption of state pharmacy benefit manager (PBM) laws. The Guidance Document considers the different types of state PBM laws and how appellate courts have applied the reasoning of the U.S. Supreme Court case *Rutledge v. Pharmaceutical Care Management Association (PCMA)* to those laws. Commissioner Grant said the Guidance Document does not analyze cases that were still being litigated as of July 22, which is the date the ERISA and Alternative Health Coverage (B) Working Group adopted it. She noted, however, that recognizing the ongoing legal activity in this area, the Guidance Document includes an addendum summarizing ongoing cases involving ERISA preemption of state PBM laws.

Commissioner Grant made a motion, seconded by Director Cameron, to adopt the *Guidance Document—ERISA Preemption and State PBM Laws* (Attachment Four). The motion passed unanimously.

4. Heard Remarks from the Mark Cuban Cost Plus Drug Company on Prescription Drug Affordability and Access

Mark Cuban (Mark Cuban Cost Plus Drug Company) discussed potential state insurance regulatory approaches to improve prescription drug affordability and access for consumers. The approaches he suggested included: 1) allowing cash purchases of prescription drugs that cost less than a patient's insurance cost-sharing amount to count toward the patient's deductible and out-of-pocket obligations. This would enable consumers to shop for lower-cost medications without losing credit toward their health plan requirements; 2) creating standardized PBM contracts to eliminate confusing or misleading terminology and make contract terms easier for employers, state insurance regulators, and purchasers to understand and make PBM and health plan contract pricing publicly available rather than treating it as proprietary information; 3) requiring greater PBM transparency regarding prescription drug pricing, rebates, fees, and PBM compensation arrangements; 4) requiring PBM licensing and condition licensure on compliance with state requirements and consumer protection standards and impose stronger consequences for repeat violations, including restricting PBMs from bidding on state contracts after repeated regulatory fines; 5) banning or limiting spread pricing and ensuring pricing is tied more closely to actual acquisition costs; 6) making specialty drug reforms by removing PBM discretion to determine which drugs are classified as "specialty drugs;" 7) eliminating gag clauses that prevent employers and purchasers from discussing PBM contracts or comparing terms; 8) requiring PBMs, third-party administrators (TPAs), and other entities providing claims processing services to give employers and plan sponsors access to their full claims data so they can analyze spending and identify cost-saving opportunities; 9) reducing PBM control over formularies and consider greater involvement by state medical directors, pharmacists, and other clinical experts in formulary development; and 10) expanding health care service and prescription drug price transparency so consumers can compare prices and choose lower-cost options.

Commissioner King thanked Cuban for the suggestions. He said that, like other state insurance commissioners, he is frustrated with the status quo with the high cost of health care and prescription drugs. Commissioner King acknowledged Cuban's efforts to lower the cost of prescription drugs for consumers with the founding of the Mark Cuban Cost Plus Drug Company. He outlined several obstacles hindering efforts by state insurance regulators to understand and address health care cost drivers. He asked Cuban, moving forward, what strategies and/or approaches he would suggest for state insurance regulators to address the rising cost of health care and prescription drugs. Cuban said he believes his suggestion to create standardized PBM contracts, coupled with requiring greater PBM transparency, particularly regarding contract pricing, and prohibiting gag clauses, could be a big step forward to address health care costs, particularly prescription drug costs.

Commissioner Mulready asked Cuban what has surprised him most in the health care arena since he launched his company. Cuban said he is surprised how uninformed company chief executive officers (CEOs) are regarding the cost of providing health care benefits to their employees. He acknowledged that CEOs are not expected to understand how their company's health care benefits work but given that health care benefit expenses are typically a company's second largest expense after payroll, perhaps they should have such awareness. Cuban outlined the complexities companies and their human resource (HR) departments faced when trying to negotiate contracts with insurers, TPAs, administrative services only (ASO) organizations, and PBMs to provide health care and prescription drug coverage to their employees.

Director Cameron said that in his remarks, Cuban mentioned that his company does not offer all prescription drugs. He asked Cuban to explain why. Cuban said the Mark Cuban Cost Plus Drug Company only offers about 78 brand-name drugs from the thousands of brand-name and specialty drugs available. He said that when he talks to the drug manufacturer company CEOs about selling their brand-name drugs through his company, the answer he receives about why they will not is that the big three PBMs, which control about 80% of the market, will diminish the positioning of the company's brand-name drug on the PBM's formularies, costing their company millions and millions of dollars. Cuban said that to address this, state insurance regulators should consider ways to reduce the control PBMs have on formulary development, such as creating standardized formularies.

Commissioner Humphreys said Pennsylvania has been working on legislation consistent with one of Cuban's suggestions for reducing prescription drug costs, which is to require insurers to count the cost of a prescription drug the consumer has found at the cheapest available to them toward a consumer's deductible and maximum out-of-pocket (MOOP) limit. He said that among the issues Pennsylvania has encountered is that insurers want the drug to be on the consumer's health plan formulary, require the consumer to go through step therapy, and impose prior authorization (PA) requirements. Commissioner Humphreys remarked that he knows of a Pennsylvania company that has been contracting with Mark Cuban Cost Plus Drug Company to make it the company's in-network pharmacy. He asked Cuban if he is seeing more interest from insurers in directing their PBMs to work with his company to obtain the lowest-cost available prescription drugs. Cuban said there has been some uptick in interest. He said Sidecar Health and Network Health are examples of insurers that have shown such recent interest.

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

Peter Nelson (Center for Consumer Information and Insurance Oversight—CCIIO) discussed the Trump Administration's vision for a more competitive individual health insurance market that delivers higher quality, more affordable health care to consumers. He said the CCIIO believes the keys to making this happen are: 1) emphasizing fraud prevention; 2) increasing price transparency; 3) providing more consumer choice; 4) encouraging innovative plan designs; and 5) expanding the use of individual coverage health reimbursement arrangements (ICHRAs).

Nelson said the CCIIO is still looking to provide more flexibility through the Affordable Care Act (ACA) Section 1332 waivers provision to potentially address some core problems with the ACA, such as its age rating curves. He said the rating curves have caused young people to leave the individual market because their premiums were too expensive, resulting in a smaller risk pool.

Fix asked Nelson about the CMS' proposed rule "Medicaid Program: Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes" (CMS-2452-P). The proposed rule would replace the current 6% indirect hold harmless threshold with state-specific thresholds based on tax structures enacted and imposed as of July 4, 2025. The proposed rule would formally implement Section 71115 of the One Big Beautiful Bill Act (OBBBA) H.R. 1, which was intended to crack down on state Medicaid financing. She asked for clarification on its application, particularly if it would impact ACA exchange user fees and Section 1332 assessments used to support state reinsurance programs. Nelson acknowledged that there have been some questions about this. He suggested that she submit comments on it during the public comment period. Commissioner Mulready said he had a similar question to Fix's question. He noted that if the CMS interprets the proposed rule as affecting Section 1332 assessments, it would discourage states from pursuing Section 1332 waivers, when the CMS would most likely want to incentivize the pursuit of such applications.

Director Carpenter said she was encouraged to hear Nelson discuss the Trump administration's vision for the individual market to address health care costs. She discussed Alaska's individual and small group market challenges, the increasing lack of affordable health care options, and the lack of tools in its toolbox to address it. Nelson acknowledged Alaska's unique issues with its markets. He reiterated that the Trump administration is working to implement policies that have the potential to address some of these issues in the long-term. Nelson encouraged Director Carpenter to reach out to the CCIIO to discuss some potential short-term solutions, such as using the Section 1332 waiver process.

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

Draft: 7/29/26

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

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

1. Discussed a Consumer Guide on the No Surprises Act

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

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

2. Discussed a Consumer Guide on Mental Health Parity

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

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

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

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

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

3. Discussed Other Matters

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

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

Draft: 4/17/26

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

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

1. Discussed its 2026 Projects and Priorities

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

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

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

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

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

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

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

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

Draft: 8/20/26

Health Care Affordability and Mitigation (B) Working Group
Columbus, Ohio
August 13, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Columbus, OH, Aug. 13, 2026. The following Working Group members participated: Kate Harris, Chair, and Debra Judy (CO); Kevin P. Beagan, Vice Chair, and Cara Libman (MA); Sarah Bailey (AK); Kelli Littlejohn Newman (AL); Andria Seip (IA); Weston Trexler (ID); Alex Peck (IN); Josh Carlson and Craig Van Aalst (KS); Patricia Dorn and Megan Mason (MD); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys and Valerie Romig (PA); Jill Kruger (SD); Daniel McAdams (TX); Shelley Wiseman (UT); Debbie Hughes (WV); and Coral Manning (WI). Also participating were: Julia Dreier (MN); Michael Muldoon and Maggie Reinert (NE); Michelle Heaton (NH); and Alice McKenney (NY).

1. Adopted its June 2, May 5, April 21, April 7, and Spring National Meeting Minutes

The Working Group met June 2, May 5, April 21, and April 7. During these meetings, the Working Group took the following action: 1) discussed its work plan for the year with a focus on developing a series of short issue briefs covering state options for improving the affordability of health care. The Working Group received updates on the work of its drafting groups and compiled a list of potential topics to cover in the issue briefs; 2) discussed the *State Options for Reducing Health Insurance Costs* document; 3) discussed a list of policy topics to focus on when developing briefs describing state options for addressing health care affordability. The Working Group conducted a poll among its members to identify the top priority affordability options; and 4) heard presentations from the Georgetown University Center on Health Insurance Reforms (CHIR) and the Health Care Affordability Lab at Yale on drivers of health care costs and strategies for controlling them.

Manning made a motion, seconded by Mason, to adopt the Working Group's June 2 (Attachment Three-A), May 5 (Attachment Three-B), April 21 (Attachment Three-C), April 7 (Attachment Three-D), and March 24 (*see NAIC Proceedings – Spring 2026, Health Insurance and Managed Care (B) Committee, Attachment* Four) minutes. The motion passed unanimously.

2. Heard a Presentation on the Impacts of the No Surprises Act Independent Dispute Resolution

Jennifer Jones (Blue Cross Blue Shield Association—BCBSA) presented on the cost impacts of the federal No Surprises Act, particularly those associated with the Act's process for independent dispute resolution (IDR).

Jones presented BCBSA's estimates of avoidable costs resulting from the federal IDR process from 2025–2030. To estimate the total cost, BCBSA added estimates of administration fees, fees to IDR entities, and award amounts in excess of qualifying payment amounts (QPAs). It then used observed IDR case growth in recent years to project continued growth through 2030. Using this formula, BCBSA projects $291 billion in avoidable costs from 2025–2030. Jones noted this projection does not include any increase in award amounts over the QPA, costs to plans, providers, and the federal Centers for Medicare & Medicaid Services (CMS) or impacts on network participation.

Jones said that the IDR process is subject to gaming due to flawed incentives. She noted that IDR entities are paid per case, so they have an incentive to encourage providers to file more disputes. She said providers are increasingly filing disputes for high-cost services that should be excluded from the IDR process, including services

scheduled in advance. She said nearly 40% of IDR cases have been identified as ineligible for the process and that more than 40% of disputes come from just three private equity-backed provider groups.

Jones offered suggestions for how state insurance regulators can reduce the impact of the federal IDR process. She said states can adopt or improve their own state processes to resolve payment disputes, shifting more cases from federal IDR to state processes. State improvements could include allowing self-insured health plans to opt in to state surprise billing processes and establishing penalties for ineligible submissions. She said states could also include additional services in their surprise billing processes and discourage defaulting to the federal process. She further recommended that state insurance regulators urge federal regulators to improve the federal process by reducing incentives for providers to submit ineligible cases and enhancing the quality of IDR entity decision-making through increased oversight and accountability.

Harris asked how many states use the federal IDR process rather than their own state process. Jones responded that there is a continuum of state-federal responsibilities, rather than a binary division. She said the federal process serves as a stopgap, resolving disputes when a state process is not applicable. She said state laws may cover certain services or medical specialties, while the federal process handles those not covered. She said all disputes arising under self-funded plans go through the federal process unless the state has created an opt-in for such plans.

Trexler asked what criteria IDR entities should use in deciding cases that they are not currently using. Jones said federal statutes lay out several required factors and allow the Secretary of Health and Human Services (HHS) to define others. She said the law seems to intend the QPA to be a primary factor, but the courts have changed the weight it can be given. She said firms representing providers use strategies to game the process—for instance by sending more than 1,000 cases on the day before a holiday, when a default decision will be entered after four business days. She cited another example of providers submitting voluminous documentation to encourage entities to make an award based on the quantity rather than the quality of the information submitted. She said IDR entities make errors, such as issuing awards for Medicare claims, Medicaid claims, or in-network claims, when none of these are eligible for IDR. Trexler asked about any audit processes to hold IDR entities accountable. Jones said CMS is currently the responsible party, and BCBSA is looking into whether states could play a larger role. She said CMS could decertify IDR entities or set up audits.

Manning asked whether BCBSA plans have made it easier for providers to join networks to avoid out-of-network payment disputes. Jones said plans have taken action to improve credentialing and streamline contracting. Jones said providers who engage in surprise billing are generally those that do not have an incentive to join networks because they are not driven by volume. They are providers with inelastic demand and are not subject to choice by consumers.

Trexler asked whether any of the recommendations for improvement can be implemented without legislation and whether any states have successfully addressed the issue. Jones said California has had the least impact from the federal IDR process. She said California uses a benchmark process before pursuing independent dispute resolution. She said other states that use benchmarks have also had success. She said the ability to act without legislation depends on a state's existing laws and rules.

3. Heard a Presentation from Equality Arlington on Limited Benefit Plans

Amy Killelea (Equality Arlington and the Georgetown University CHIR) presented on the potential for misleading marketing and consumer harm from limited benefit plans. Killelea referenced plan types including short-term,

limited-duration (STLD) insurance, fixed indemnity, Farm Bureau coverage, association health plans (AHPs), and health care sharing ministries (HCSMs). The cash pay market—including direct primary care arrangements, on-demand telehealth applications, and direct-to-consumer drug —may raise concerns similar to those with limited benefit plans.

Killelea said that consumers may misunderstand the limited nature of some plan types because of the complexity of health insurance in general and because of deliberately misleading marketing that casts limited benefit plans as comparable to Marketplace plans. Consumers may not recognize that their health status may change, making a limited benefit plan inappropriate for them.

Killelea described the potential impact of limited benefit plans on the individual market risk pool in a state. Individuals most likely to choose limited benefit plans are those who do not expect to use a significant amount of health care services. If these lower-risk consumers replace individual market coverage with limited benefit plans, the remaining risk pool will consist of higher-risk consumers and those who are more costly to cover.

Killelea shared research from the Georgetown University CHIR on the marketing of limited benefit plans. Researchers used two consumer profiles to conduct a secret shopper study in May 2026. Both profiles were for consumers in West Virginia, one eligible for premium tax credits with no pre-existing conditions and another not eligible for premium tax credits with type 2 diabetes.

Killelea reported that researchers found online searches led to lead generators who passed consumers to other screeners, agents, and brokers. Marketers often described marketplace coverage as best suited for consumers in poor health, while healthier consumers were directed to limited benefit plans. Killelea said marketers provided misleading and inaccurate information about both limited benefit plans and marketplace coverage. Marketers use aggressive tactics and work to capitalize on marketplace affordability challenges.

Killelea recommended state approaches to regulating limited benefit plans. Marketing regulation can be done under state unfair trade practice statutes. State insurance regulators can establish guardrails for limited benefit plans or prohibit the sale of certain types of plans entirely. Killelea also suggested that marketplace interventions, like a state premium subsidy wrap, could be useful to increase affordability for plans with more consumer protections.

Harris asked what types of plans were most frequently encountered in the secret shopper survey. Killelea said the report includes a chart showing how frequently different plan types came up, and the most frequent by far were fixed indemnity plans.

Commissioner Humphreys asked whether direct primary care embedded in a health care plan presents the same issues as limited benefit plans. He said the insurer can pay the monthly service fee to allow a consumer to access primary care and ultimately save money over the long term. Killelea said the research has not explored this arrangement, but the affordability benefits to both consumers and payers are clear. Killelea said stand-alone direct primary care is more concerning. Humphreys said direct primary care should include a disclosure that the care plan should be paired with a major medical plan.

4. Received an Update on its Drafting Groups and Collected Feedback on Draft Affordability Briefs

Harris reviewed the work of its six drafting groups. She said the drafting groups' draft affordability briefs were exposed in July for a 45-day public comment period ending Aug. 31. She said each group met in open session to

gather feedback from interested parties. Harris said the drafting groups heard feedback from consumer representatives that affordability should be better defined and more clearly state how state action can improve affordability.

Harris said the drafting groups also received comments from the health insurance industry, including comments on one brief's reference to specific insurers. She said the brief on integration in health care cited specific companies as examples of integration among insurers, providers, and pharmacy benefit managers (PBMs). In some cases, only a single company was cited in a particular example. She said the Working Group received a request to remove specific company names. Harris said she supports the goal of not singling out insurers for positive or negative comments in NAIC publications. She said company names presented neutrally, factually, and with publicly available information could be included. She asked Working Group members to weigh in on whether the names of individual companies should remain in the briefs. Trexler supported including company names if the references are neutral and use publicly available information.

Stephanie Hengst (The AIDS Institute) provided comments from consumer representatives. She said consumer representatives fully support the Working Group's efforts as a whole and would provide written comments by the Aug. 31 deadline. She offered a summary of their comments, including a request to add a uniform definition of affordability that centers on consumers and takes into account both premiums and out-of-pocket costs. She said a clear and concise problem statement may help consolidate similar ideas into a single one. She encouraged the Working Group to focus on policy changes that would result in consumer savings rather than shifting costs from one party to another. She suggested adding a section on the pros and cons of each affordability option.

Kris Hathaway (AHIP) commended the Working Group for taking on the issue of affordability. She said affordability is also a priority of AHIP. She said two key cost drivers, hospital consolidation and facility fees, are not clearly included in the briefs. She said the brief on direct-to-consumer drug platforms achieved a good balance in discussing drug coupons and related issues, and she encouraged other briefs to adopt a similar balanced approach. She suggested including only enacted state legislation, not proposed legislation. In the utilization management brief, she suggested including cost savings to providers in adopting electronic prior authorization. In the integration brief, Hathway recommended paying as much attention to hospital consolidation as insurer and PBM integration and explaining the potential benefits of integration in care coordination, quality, and efficiency. She said the inclusion of references to specific companies in the brief is not necessary to explain the concepts.

Lucy Culp (Blood Cancer United) expressed support for the briefs and hoped that content and concepts from the briefs could be integrated into future work. She asked that facility fees and hospital consolidation be added to the briefs. She said that references to specific companies are not problematic if they are neutral and based on widely available information.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

Draft: 6/11/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
June 2, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met June 2, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Andria Seip (IA); Weston Trexler (ID); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Coral Manning (WI); and Joylynn Fix (WV). Also participating was: Gio Espinosa (AZ).

1. Received Updates on Drafting Group Work

Harris reminded the Working Group that it plans to complete six briefs that describe state options for addressing health care affordability. She said six drafting groups have begun work on the briefs, and each drafting group would release an outline or other written draft and hold an open meeting to gather feedback. Drafts should be completed by August and final briefs by November. Harris asked for an update from each drafting group.

A. Drafting Group 1: Utilization Review Standardization

Beagan said the group discussed efforts to standardize and limit utilization review processes to reduce administrative costs in health insurance. The group highlighted examples, such as standardized prior-authorization forms and gold card programs, that exempt certain providers from prior authorization. The group is seeking to collect data on administrative cost savings.

Beagan noted that many states use standardized prior-authorization forms to reduce provider burden. He said Massachusetts regulations exempt certain primary and behavioral health care from prior authorization. He emphasized the goal of reducing unnecessary utilization review to lower health insurance costs.

B. Drafting Group 2: Horizontal and Vertical Integration

Cly said the group is examining horizontal and vertical integration in health care, focusing on the use of medical loss ratio (MLR) data and regulatory tools to understand and address impacts on affordability. The group is exploring how state insurance regulators can leverage existing authorities, such as rate review, to gain insights into the effects of integration, including potential areas such as facility fees and pharmacy benefit manager (PBM) integration.

Lindsey Murtagh (Brown University) urged broad consideration of integration effects, including facility fees and PBM-pharmacy relationships. Harris emphasized the challenge for state insurance regulators in identifying mergers and the role of regulators in using tools like rate review. Mason highlighted the need to use existing regulatory levers to gather useful information on integration.

C. Drafting Group 3: State Defined Plans with Premium Reduction Targets

Beagan said the group is exploring state-defined health plans that aim to reduce premiums through options such as limited-network products, site-of-service plans, and mandate-light products. The group is collecting information

on existing laws and considering the policy objectives and target populations for these plans, while maintaining quality and improving affordability.

Beagan described Massachusetts' limited-network plans that require 14% lower premiums. He noted that some states have site-of-service plans that restrict certain services in hospital settings.

Jalisa Clark (Georgetown University) emphasized the need to clarify policy objectives and target populations for these plans.

D. Drafting Group 4: Reference Based Pricing

Bailey said the group is drafting a brief on adopting reference-based pricing (RBP) to control health insurance costs, focusing primarily on commercial markets and provider/hospital reimbursement. They are reviewing state laws, researching RBP models, conducting cost-savings analyses, planning to confirm details with states implementing RBP, and aiming for a draft in late June.

Elizabeth Hagan (United States of Care) requested clarity on the drafting group's focus areas, asking whether they include prescription drugs, providers, state employee health benefit plans, and commercial payers. Harris confirmed the focus is on commercial markets and provider/hospital pricing. Hagan offered to share resources on cost savings and state experiences with RBP.

E. Drafting Group 5: Enhanced Price Transparency

Trexler said the group is working on a brief covering both consumer-facing and market-level price transparency initiatives. The group has identified successes and barriers, including legal and technical challenges, and views transparency as a tool to enable other affordability actions. It is seeking additional examples and data to support its analysis. He noted the group is looking at federal and state transparency efforts. He invited written input on transparency issues related to third-party administrators.

Clark suggested including transparency around ownership and systemic price transparency.

F. Drafting Group 6: Direct to Consumer Drug Platforms

Mason said the group is analyzing direct-to-consumer drug platforms, categorizing them by structural type and reviewing state policy options such as limits on insurer out-of-pocket cost calculations and bulk purchasing programs. The group is considering impacts on insured and uninsured consumers and seeking additional input to refine the brief.

Carl Schmid (HIV+Hepatitis Policy Institute) raised questions about the group's approach to affordability and insurance coverage implications. Mason confirmed the inclusion of the accumulator and maximizer program considerations.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

Draft: 5/19/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
May 5, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met May 5, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Gio Espinosa (AZ); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Weston Trexler (ID); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Tanji J. Northrup (UT); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation from the Center on Health Insurance Reforms on Site Neutral Payments

Christine Monahan (Georgetown University Center on Health Insurance Reforms) presented on the problem of excessive hospital outpatient charges and potential solutions. She said hospitals have provided a greater share of services in outpatient settings in recent years, and at the same time have acquired physician practices and turned them into outpatient departments.

Monahan shared data to indicate that hospital outpatient departments and hospital-affiliated physicians are more expensive than independent physicians for the same services. Hospital outpatient departments often use split billing, under which the hospital charges a facility fee in addition to a provider fee, which raises total costs. Split billing occurs in both Medicare and the commercial market, but price differences between hospital outpatient departments and physician offices are much larger and, overall, much higher in the commercial market due to market forces. These dynamics lead to more vertical integration, greater total spending, higher out-of-pocket costs, and potential problems with access to care.

Monahan said that Medicare has eliminated cost differentials by site of service for a small portion of its payments. States have enacted a variety of reforms, including bans on facility fees, patient billing protections, billing transparency, and reporting and notification requirements. She said the National Academy for State Health Policy (NASHP) has released model legislation on site-neutral payments.

She said that site-neutral payment policies align with several of the state options for reducing insurance costs, which are expected to be included in the Working Group's series of affordability briefs. Site-neutral policies could be considered by drafting groups focused on vertical integration, reference-based pricing, and price transparency.

2. Discussed the *State Options for Reducing Health Insurance Costs* Document

Harris explained the Working Group's plans for completing the *State Options for Reducing Health Insurance Costs* document. She said Working Group members had been assigned to six drafting groups. She said members may choose different drafting groups than those to which they were assigned or may join any group if they were not assigned. Bailey said that Alaska had been assigned to three drafting groups but could only participate in two. Harris said the Working Group would receive brief verbal updates from the drafting groups at its next meeting, as well as feedback from interested parties. She said the drafting groups would expose outlines for comment during July and draft briefs in August. She said the Working Group expects to finalize the document containing all the briefs by November.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

Draft: 4/28/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
April 21, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 21, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Stesha R. Hodges and Gabrielle Lessard (CA); Howard Liebers (DC); Weston Trexler (ID); Paula Wallin (IA); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Jeana Thomas (MO); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Tanji J. Northrup (UT); Todd Lovshin (WA); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation from the Health Care Affordability Lab at Yale on Hospital Costs

Zack Cooper (Health Care Affordability Lab at Yale) presented research on the drivers of U.S. health spending growth, particularly hospital and insurance market competition. He estimated that 90% to 95% of health insurance premium growth over the past 25 years was driven by health care spending growth. Hospitals account for about 40% of private health spending, and their prices have increased faster than inflation and other health care components—driving overall spending growth.

Cooper discussed the extensive consolidation in the hospital industry, with more than 1,200 mergers since 2000, many raising market concentration and prices. He explained that mergers significantly increase concentration, and this leads to price hikes, which in turn affect premiums and the broader economy. Since 2000, 238 hospital mergers raised market concentration by 200 points or more measured by the Herfindahl-Hirschman Index (HHI), often leading to price increases. Mergers that do not increase concentration generally do not affect hospital prices.

Cooper said rising hospital prices due to consolidation have negative labor market effects outside health care, including job losses and increased income inequality. Higher premiums lead employers to reduce hiring or cut jobs, especially affecting lower-income male workers, and also reduce tax revenues while increasing mortality. He said rising hospital prices cause dollar-for-dollar increases in premiums and health care spending.

Cooper described a new online tool developed by the Health Care Affordability Lab to analyze hospital market concentration and mergers nationwide. The tool uses hospital data and travel time to define markets, calculates concentration indices, and flags potentially problematic mergers to assist policymakers in evaluating hospital market dynamics and merger impacts.

Cooper demonstrated how hospital consolidation has increased market concentration and premiums, using Connecticut, New Jersey, and West Virginia as examples. He contrasted mergers with minor concentration changes versus those flagged as problematic, illustrating the tool's practical application for assessing merger impacts. Connecticut experienced significant hospital consolidation, with many hospitals moving into highly concentrated markets. New Jersey shows a minor increase in concentration, deemed less problematic. He cited the West Virginia University Health System merger with Independence Health System as one that will lead to large concentration increases and likely raise prices.

Cooper discussed potential policy responses to hospital consolidation, including antitrust enforcement, price regulation in concentrated markets, and promoting competition by encouraging patient travel to alternative providers. He emphasized the need for tools to screen mergers and regulate prices to control health care costs.

Cooper addressed questions about efficiency gains from mergers, potential hospital closures as a rationale for mergers, certificate of need laws, and Maryland's unique hospital pricing controls. He said there is limited evidence of efficiency or quality improvements from mergers, and he discussed regulatory approaches to address consolidation and pricing. Claims that a hospital will close without a merger are common but should be carefully scrutinized to avoid anti-competitive outcomes.

2. Discussed State Options for Reducing Health Insurance Costs

The Working Group discussed prioritizing topics for state affordability briefs, focusing on utilization review, health care integration, premium reduction plans, reference-based pricing, and price transparency. Hodges requested the addition of direct-to-consumer prescription drug platforms, and Harris agreed to add this topic to the priority list. Harris said the Working Group plans to form drafting groups, develop templates, and allow input from interested parties to produce concise, actionable briefs for policymakers.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

Draft: 4/16/26

Health Care Affordability and Mitigation (B) Working Group
Virtual Meeting
April 7, 2026

The Health Care Affordability and Mitigation (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 7, 2026. The following Working Group members participated: Kate Harris, Chair (CO); Kevin P. Beagan, Vice Chair (MA); Sarah Bailey (AK); Gio Espinosa (AZ); Gabrielle Lessard (CA); Howard Liebers (DC); Paula Wallin (IA); Alex Peck (IN); Julie Holmes (KS); Megan Mason (MD); Chrystal Bartuska (ND); Viara Ianakieva (NM); Kristin Cly (OH); Michael Humphreys (PA); Jill Kruger (SD); Rachel Bowden (TX); Jane Beyer and Todd Lovshin (WA); Coral Manning (WI); and Joylynn Fix (WV).

1. Heard a Presentation on Affordability Priorities

Sabrina Corlette (Georgetown University Center on Health Insurance Reforms) presented on the root causes of high health care costs and on state options to improve the affordability of health insurance. She said high prices paid to providers drive spending rather than utilization. She said complex financial relationships and consolidation in health care also contribute to high costs.

Corlette outlined policy options, including price transparency, antitrust enforcement, and price regulation. She said price transparency is an option that requires minimal government intervention and has a low impact on costs. She said price regulation requires high government intervention and can produce greater reductions in costs. Antitrust enforcement falls in the middle of this spectrum.

Corlette highlighted several transparency and disclosure strategies, including strengthening existing transparency requirements, developing all-payer claims databases, reforming medical loss ratio (MLR) standards, and improving consumer shopping tools. Corlette discussed state roles in antitrust activities and monitoring provider-payer contracts.

Corlette identified competition and ownership reforms. Reforms within the authority of state insurance regulators include monitoring transactions, prohibiting anti-competitive clauses in payer-provider contracts, and increasing accountability for state-regulated third-party administrators.

Corlette said that price regulations can include cost-growth benchmarks, enhanced rate review and affordability standards, prohibitions on facility fees, site-neutral payment caps, No Surprises Act (NSA) reforms, and reference pricing or price caps.

Beagan asked Corlette to elaborate on MLR reform ideas regarding transparency. Corlette explained that the idea is to enhance MLR reporting to reveal financial relationships and incentives in integrated systems. Beyer added that state insurance regulators could use MLR data to compare payments to affiliated versus non-affiliated providers and investigate non-claims payments and their destinations.

Beyer discussed Washington's pre-existing arbitration process for balance billing disputes, noting it results in fewer arbitrations and different outcomes compared to the federal NSA system. Harris asked about data on the impact of NSA arbitration on premiums. Corlette shared information from New York, attributing a 10% premium increase to independent dispute resolution processes.

2. Discussed Topics List for Affordability Options

Harris reviewed a narrowed list of 12 policy topics to focus on when developing briefs describing state options for addressing health care affordability. Manning suggested that 12 topics may be too many for in-depth coverage. Harris and Beagan suggested conducting a poll of Working Group members to identify top priorities. Working Group members discussed the feasibility of including briefs on price transparency, administrative costs, and horizontal and vertical integration in health care. Members said that horizontal and vertical integration are complex topics and suggested narrowing the scope.

Kris Hathaway (AHIP) requested that facility fees be included on the topics list. Noah Isserman (American Hospital Association) supported addressing utilization management within administrative costs and separating horizontal and vertical integration. Beyer said cost growth targets and prescription drug affordability boards have been in place in some states for years, so they may not need to be addressed by the Working Group.

Having no further business, the Health Care Affordability and Mitigation (B) Working Group adjourned.

Adopted by the Employee Retirement Income Security Act (ERISA) and Alternative Health Coverage (B) Working Group, July 22, 2026
Adopted by the Regulatory Framework (B) Task Force, Aug. 13, 2026
Adopted by the Health Insurance and Managed Care (B) Committee, Aug. 14, 2026

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

GUIDANCE DOCUMENT—ERISA PREEMPTION AND STATE PBM LAWS

OUTLINE

I. Introduction

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

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[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 claims[19] affected by the pharmacy's inability to get the drug at a lower price from its usual wholesaler. Act 900 also includes a fifth provision allowing the pharmacy to refuse to fill a prescription if the PBM reimbursement to the pharmacy is less than the pharmacy paid for the drug.

The court reviewed each of these provisions in the Arkansas law and concluded that they did not "relate to" ERISA plans and were not preempted. The court explained that in order to impermissibly "relate to" an ERISA plan, the state law must have a "connection with" or make a "reference to" ERISA plans.[20]

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,"

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[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]

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[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]

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[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 categories[49]: 1) "network restrictions," which includes access standards,[50] discount prohibition,[51] and any willing provider provision[52] and 2) "integrity and quality restriction," which is the probation provision that prohibits "PBMs from denying, limiting or terminating a pharmacy's contract because one of its pharmacists is on probation" with the state pharmacy board.[53] The 10th Circuit analyzed whether the provisions "govern[] a central matter of plan administration" or "interfere[] with nationally uniform plan administration" so as to be preempted. Emphasizing the importance of uniformity under ERISA, the 10th Circuit stated that "ERISA's promise of

[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

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[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]

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[62] Washington state law authorizes self-funded group health plans to opt into their PBM law beginning Jan. 1, 2026. Refer to RCW 48.200.330. This approach has been incorporated into state balance billing protections in several states. In Washington state, over 300 self-funded group health plans have opted into the Balance Billing Protection Act. To give an opportunity for local and governmental self-funded group health plans to opt in, whether or not governed by or exempt from ERISA, refer to RCW 48.49.130.

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

[64] *Gobeille*, 577 U.S. at 319–320

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

[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

CATEGORIES OF STATE LAW	UPHELD (SCOTUS)	UPHELD (8th Cir. Court of Appeals)	**NOT** UPHELD (10th Cir. Court of Appeals)
PBM PAYMENT TO PHARMACIES			
Requires PBMs to reimburse pharmacies at a price equal to or higher than the pharmacy's wholesale cost.	*Rutledge* Act 900 of 2015		
Pharmacies may refuse to sell a drug if the PBM's reimbursement rate is lower than its acquisition cost.	*Rutledge* Act 900 of 2015		
If a consumer pays a copayment, it is retained by the pharmacy. It cannot be "clawed back" by the PBM.		**Wehbi* (19-02.1-16.1(4))	
PBM OVERSIGHT OF PHARMACY OPERATIONS			
A PBM may not collect a fee from a pharmacy if the pharmacy's performance scores or metrics meet the criteria identified by the electronic quality improvement platform for plans and pharmacies or by another unbiased nationally recognized entity that aids in improving pharmacy performance measures.		**Wehbi* (19-02.1-16.1(3))	
A PBM is limited to applying a fee to the professional dispensing fee outlined in the pharmacy contract.		**Wehbi* (19-02.1-16.1(3))	
A PBM may not impose a fee related to performance metrics on the pharmacy's cost of goods.		**Wehbi* (19-02.1-16.1(3))	
A PBM may not prohibit a pharmacy from disclosing certain health information to the plan sponsor or patient.		*Wehbi* (19-02.1-16.1(5))	
Gag orders are prohibited. A PBM may not prevent a pharmacy from providing relevant drug pricing and efficacy information to a patient.		*Wehbi* (19-02.1-16.1(7))	
A PBM may not prevent the mailing or delivery of drugs to a patient as a pharmacy's ancillary service.		*Wehbi* (19-02.1-16.1(8))	
A PBM may not prevent a pharmacy from charging shipping and handling fees to patients who request that prescriptions be mailed or delivered.		*Wehbi* (19-02.1-16.1(9))	
A PBM may be required to provide pharmacists with information about each pharmacy network established or administered by a PBM.		*Wehbi* (19-02.1-16.1(10))	

A PBM may not require accreditation or recertification requirements that are more stringent than federal and state licensure requirements (*for network participation*).		*Wehbi* (19-02.1-16.1(11) & *16.2(4))*	
A PBM may not prohibit a pharmacy from dispensing any drug allowed under its license.		**Wehbi* (19-02.1-16.2(5))	
Any Willing Pharmacy (AWP) Provision: Any willing pharmacy already in the PBM/plan's network must be permitted to join a preferred network if it agrees to accept the contractual terms.			*Mulready*: Okla. Stat. tit. 36, § 6962(B)(4) (2019).
Probation Prohibition: A PBM may not deny or terminate a pharmacy license based on the license status of a pharmacy employee (being on probation with the state pharmacy board).			*Mulready*: Okla. Stat. tit. 36, § 6962(B)(5) (2019).
TRANSPARENCY IN PBM OPERATIONS			
PBMs must timely update their minimum acquisition cost (MAC) lists when drug wholesale prices increase.	*Rutledge*: Ark. Code Ann. §17–92–507(c)(2)		
PBMs must have an appeal procedure for pharmacies to challenge MAC reimbursement rates.	*Rutledge* Act 900 of 2015		
A PBM may not charge or hold a pharmacy responsible for fees that they do not disclose to the pharmacy.		**Wehbi* (19-02.1-16.1(2))	
Disclosing Spread Pricing: If requested, a PBM (or third-party payer) that has an ownership interest in a pharmacy, must disclose the difference between a PBM's pharmacy payments and what is charged to the plan.		*Wehbi* (19-02.1-16.2(2))	
If a patient pays a copayment, a PBM may not redact the adjudicated cost paid.		**Wehbi* (19-02.1-16.1(4))	
A PBM may not have ownership interest in a patient assistance program or mail order specialty pharmacy unless it agrees to NOT participate in a transaction that would benefit the PBM.		*Wehbi* (19-02.1-16.2(3))	
Access Standards: A PBM must meet certain network adequacy requirements for retail pharmacies (that do not include mail order pharmacies).			*Mulready*: Okla. Stat. tit. 36, § 6961((A)-(B) (2019).
Discount Prohibition: A PBM shall not use any discounts in cost-sharing or a reduction in copay for individuals to receive prescription drugs from an individual's choice of in-network pharmacy.			*Mulready*: Okla. Stat. tit. 36, § 6963(E) (2019).

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

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

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

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

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

Addendum

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

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

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

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

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

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

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

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

On April 16, 2025, Arkansas enacted Act 624, prohibiting PBMs from acquiring, owning, or operating retail or mail-order pharmacies in the state. The act was challenged by several PBMs and the Pharmaceutical Care Management Association (PCMA) in the U.S. District Court for the Eastern District of Arkansas. The plaintiffs alleged that Act 624 was unconstitutional and preempted under the Medicare Part D, TRICARE, and ERISA. The plaintiffs filed motions for a preliminary injunction to enjoin the act from taking effect pending the resolution of the litigation.

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

Clause, the Takings Clause, the Equal Protection Clause, Medicare Part D preemption, and ERISA preemption claims.

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

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

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

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

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

