Issue brief: ERISA Preemption and challenges to health care plans

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I. Why this issue brief?

During its 2023 Interim Meeting, the American Medical Association House of Delegates adopted Resolution 224 – ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers. The resolution required the AMA to study, and create resources for states, on the implication of *Rutledge, Attorney General of Arkansas v. Pharmaceutical Care Management Association*,[1] and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of ERISA.

This issue brief provides the study and resources for states concerning the implications of *Rutledge* as required by Resolution 224. This issue brief also examines subsequent federal circuit ERISA preemption decisions[2] interpreting *Rutledge*.

II. How to understand the limitations of this resource

This issue brief discusses ERISA preemption under 29 USC section 1144.[3] Part of this provision states that ERISA preempts "any and all state laws insofar as they may now or hereafter **relate to** any ERISA plan." The "relate to" language is very broad, giving courts little guidance. Courts have continually struggled to determine when a state law relates to an ERISA plan and when it does not. A few U.S. Supreme Court decisions give us some clarity with respect to individual fact situations. Outside of these cases, the scope of the "relates to" language can quickly become murky. Cases can turn on subtle fact and textual distinctions and federal courts can vary widely on how they interpret the "relates to" language, reaching conflicting decisions.

III. How to use this resource

While in many cases it can be difficult to accurately predict with confidence whether a court will apply ERISA preemption to a particular state law, this issue brief presents some general principles extracted from Supreme Court cases that might in some instances help a person develop an informed opinion. These principles are listed in IX.B. below. IX.B. discusses how these principles might be applied with respect to some state law managed care reforms that are a priority for physicians, e.g., recoupment. While obviously the specific reforms

[1] *Rutledge v. Pharmaceutical Care Management Assoc,* 141 S. Ct. 474, 479 (2020)
[2] *PCMA v. Wehbi,* 18 F.4th 956 (8th Cir. 2021); *Pharmaceutical Care Management Association v. Mulready,* 78 F.4th 1183 (10th Cir. 2023)
[3] ERISA's "relates to" preemption is one of two kinds of ERISA preemption. The Supreme Court has also determined that ERISA completely preempts any state law that provides a remedy for a wrongful benefit denial other than ones set out in ERISA. This is why ERISA preempts states laws attempting to impose damages on ERISA plans that fail to exercise ordinary care when making medical necessity decisions. *See e.g., Aetna Health Inc. v. Davila,* 542 U.S. 200 (2004)

discussed in IX.B. are not exhaustive *the point is that one can use those discussions as a guide to analyzing the prospects of preemption to any state law in which a physician advocate might have an interest.*

IV. The structure of ERISA preemption

(A) The General Preemption, Savings, and Deemer Clauses

Before one can understand the impact that *Rutledge* and other recent cases may have on ERISA preemption of state health care plan regulations, it helps to understand how ERISA preemption is structured. ERISA preemption is made up of three provisions:

1. General Preemption Clause

ERISA's General Preemption clause preempts any state law that *relates to* an ERISA plan.[4]

2. Savings Clause

ERISA then has a second so-called "Savings Clause" that protects some state insurance laws from preemption, even if those laws relate to an ERISA plan.[5] The Savings Clause could be thought of as an exception to the General Preemption clause, "relates to" clause, because even if a state law relates to an ERISA plan, ERISA will not preempt that law if it regulates the business of insurance. The Supreme Court has developed a two-part test to determine if a state law regulates the "business of insurance."[6]

This issue brief does not discuss the Savings Clause because Rutledge was not a Savings Clause case,[7] and, because of the Deemer Clause, the Savings Clause does not "save" from preemption state laws insofar as they regulate self-insured ERISA plans.

3. Deemer Clause

Finally, ERISA has a "Deemer Clause" that prohibits state insurance laws from regulating self-insured ERISA plans, even if those laws are otherwise saved from preemption under the Savings Clause.[8] This is the reason a state law that can regulate a fully-insured ERISA plan, e.g., by requiring the plan to cover certain mandated benefits, but not impose the same requirement on self-insured ERISA plans. So, if a court finds that a state law relates to a self-insured ERISA plan, ERISA preempts that law, period. Obviously, if a court finds that a state law does not relate to an ERISA plan, then the Savings Clause and Deemer Clause are irrelevant and the law can regulate both fully-insured and self-insured ERISA plans.

Again, *Rutledge* did not involve the Savings Clause; the only question was whether an Arkansas PBM law related to an ERISA plan.

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[4] 29 U.S.C. § 1144(a)
[5] 29 U.S.C. § 1144(b)(2)(A)
[6] *Kentucky Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329 (2003)
[7] The Supreme Court case *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2002) is, in addition to *Kentucky Ass'n of Health Plans, Inc. v. Miller*, an example of a state health care law saved from preemption under the Savings Clause because the law regulated the business of insurance. In *Miller*, a Kentucky any willing provider state was saved from preemption; in Moran the saved law was an Illinois external review statute.
[8] 29 U.S.C. § 1144(b)(2)(B). *See e.g., FMC Corp. v. Holliday,* 498 U.S. 52 (1990)

V. General preemption: When does a state "relate to" an ERISA plan?

Because the phrase "relate to" is so broad, the Supreme Court has tried to narrow it down. According to the Court, a state law *relates to* an ERISA plan if it:

- *refers to* an ERISA plan; or
- has an *impermissible connection with* an ERISA plan.

(A) When does a state law *refer to* an ERISA plan?

The Supreme Court has stated that a state law *refers to* an ERISA plan if:

- acts *immediately and exclusively* upon ERISA plans;[9] or
- if the *existence of ERISA plans is essential* to the law's operation.[10]

(B) When does a state law have an *impermissible connection with* an ERISA plan?

According to the Supreme Court, a state law has an impermissible connection with an ERISA plan if, for example, the law:

- binds plan administrators to specific rules for determining beneficiary status;[11]
- requires benefit plans to be structured in particular ways, such as requiring payment of specific benefits;[12]
- forces an ERISA plan to adopt a certain scheme of substantive coverage or effectively restricts its choice of insurers;[13]
- has acute, albeit indirect, economic effects on an ERISA plan that it forces a plan to adopt a particular form of coverage;[14]
- interferes with national uniform administration;[15] or
- governs a central matter of plan of administration.

VI. The Rutledge decision

(A) The Arkansas PBM statute did not relate to an ERISA plan because it did not *refer to* an ERISA plan.

The *Rutledge* Court found that the Arkansas PBM law did not relate to an ERISA plan because it neither: (1) acted immediately and exclusively upon ERISA plans; nor was (2) the existence of ERISA plans was essential to the law's operation.

- Regarding (1), the law did not "act immediately and exclusively on ERISA plans" because the law applied to PBMs whether they administered ERISA plans or not.[16]

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[9] *See e.g., California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.,* 519 U. S. 316, 325 (1997)
[10] *Rutledge* at 87
[11] *Id*
[12] *Id* at 86
[13] *Id* note 1 at 95
[14] *Id* at 87
[15] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U. S. 645 (1995); *Egelhoff v. Egelhoff,* 532 U. S. 141 (2001)
[16] *Rutledge* at 88-89

- Concerning (2), ERISA plans were not essential to the PBM law's operation because the Arkansas law regulated PBMs whether the plans they serviced fell within ERISA's coverage.[17]

1. **Not difficult to meet.** A state law that is sufficiently broad to cover more than ERISA plans is likely to pass the "reference to" test. Preemption arguments most often focus on whether the state law has an impermissible connection with an ERISA plan.

(B) The Arkansas law did not have an impermissible connection with an ERISA plan.

The Rutledge court held that the Arkansas law did not have an impermissible connection with an ERISA plan. The Court based this decision on the 1995 Court case *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*[18] (*Travelers*) ("The logic of *Travelers* decides this case").[19]

1. **The Travelers case-hospital surcharges regarding non-Blues insurers not preempted.**

In *Travelers*, the Court had to decide whether a New York law imposing surcharges of up to 13% on hospital billing rates for patients covered by insurers *other than* Blue Cross/Blue Shield (Blues) had an impermissible connection with an ERISA plan. Because of the surcharge, ERISA plans that bought insurance from the Blues *paid less* for hospital services than ERISA plans that purchased coverage from other insurers. Several insurers filed a lawsuit arguing that ERISA preempted the surcharge law.

The Court found that the New York law did not have an impermissible connection with an ERISA plan. True, the law made it less expensive for ERISA plans to buy insurance from the Blues, and thus the surcharge law incentivized ERISA plans to choose the Blues over other health insurers. But this difference in cost was not so high that it *forced* ERISA plans to buy coverage from the Blues. More generally, the Supreme Court stated that ERISA does not relate to *state payment or cost regulations* that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.

(C) The Rutledge decision—specifics

Like *Travelers*, the *Rutledge* Court ruled that the following sections of the Arkansas PBM law did **not** have an impermissible connection with an ERISA plan.

- PBMs had to reimburse pharmacies at a price at least equal to the pharmacies' acquisition costs;
- PBMs had to increase a pharmacy's reimbursement rates to compensate the pharmacy in cases where the pharmacy could not buy the drug at a lower price;
- PBMs had to timely update their maximum allowable cost lists when the price of wholesale drugs increased;
- PBMs had to have an appeal process that pharmacies could use to challenge reimbursement rates;
- PBMs had to allow pharmacies to decline dispensing a drug if the PBM reimbursement rate was below the acquisition cost; and
- PBMs had to allow pharmacies to "reverse and rebill" each reimbursement claim affected by the wholesaler at a price equal to or less than the maximum allowable cost.

[17] *Id* at 89
[18] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,* 514 U. S. 645 (1995)
[19] *Rutledge* at 88

Following *Travelers*, the *Rutledge* Court decided that ERISA did not preempt these provisions because they were merely cost regulations.[20] Although the law would require PBMs to pay more for drugs, and so too would ERISA plans (assuming that PBMs would pass those costs on to ERISA plans), the increased drug costs were not so high as to dictate what kind of coverage or benefits that ERISA plans had to buy.[21] In fact, the *Rutledge* Court stated that the Arkansas PBM law was *less intrusive* than the New York surcharge law in *Travelers*, which created a *compelling incentive* for plans to buy insurance from the Blues instead of other insurers.[22]

VII. Subsequent federal circuit cases: *Pharmaceutical Care Management Association* v. *Wehbi*, and *Pharmaceutical Care Management Association v. Mulready*

Since *Rutledge*, two federal circuit courts have applied *Rutledge* in deciding whether ERISA preempted state PBM laws. In November 2021, the U.S. Circuit Court of Appeals for the Eighth Circuit decided *Pharmaceutical Care Management Association v. Wehbi*,[23] which found that ERISA did not preempt a North Dakota PBM statute, as summarized below. On the other hand, in August 2023, the U.S. Circuit Court of Appeals for the Tenth Circuit decided *Pharmaceutical Care Management Association v. Mulready*.[24] In this case the court ruled that ERISA did preempt certain provisions of an Oklahoma PBM law.

(A) The Wehbi case—state PBM law did not have an impermissible connection with an ERISA plan.

In *Wehbi,* the court ruled that provisions of a North Dakota PBM statute, including but not limited to those below, did not have an impermissible connection with an ERISA plan.

- A pharmacist had to be allowed to tell a plan sponsor, e.g., an ERISA plan, or a patient, how much was paid to the pharmacy;
- A pharmacist had to be free to tell a patient about the efficacy of a drug and if there were more affordable alternative drugs;
- PBMs could not impose pharmacy accreditation standards that were more restrictive than state licensure requirements;
- Upon request, a pharmacy benefits manager or third-party payer had to provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefits manager to enable the pharmacy to make an informed contracting decision.

(B) Challenged provisions and holding of *Pharmaceutical Care Management Association v. Mulready*

In August 2023, the 10th Federal Circuit Court in *Mulready* concluded that ERISA preempted the following sections of an Oklahoma PBM law because they had an impermissible connection with an ERISA plan:

- PBMs had to have enough retail pharmacies in their networks so that a specific percentage of plan beneficiaries living in a geographic area had to live within a set number of miles from a retail pharmacy.[25]

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[20] *Id*
[21] *Id*
[22] *Id*
[23] *Pharmaceutical Care Management Association v. Wehbi,* 18 F.4th 956 (8th Cir. 2021)
[24] *Pharmaceutical Care Management Association v. Mulready,* 78 F.4th 1183 (10th Cir. 2023)
[25] So, e.g., at least ninety percent (90%) of plan beneficiaries living in an urban area lived within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy network, at least ninety percent (90%) of plan beneficiaries living in a suburban area live had to live within five (5) miles of a retail pharmacy participating in the PBM's retail pharmacy network, etc.

- PBMs could not use mail-order pharmacies to meet these access standards.
- a provision stating that an individual's choice of in-network provider may include a retail pharmacy or a mail-order pharmacy, that such choice could not be restricted, and that neither a health insurer nor PBM could not require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy.
- a PBM could not deny a provider the opportunity to participate in any pharmacy network at preferred participation status if the provider was willing to meet network requirements.
- a PBM could not limit or end a provider's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the state board of pharmacy.

Subsequent courts have found that ERISA preempted other network design-related provisions in state PBM laws. In *McKee Foods Corporation v. BFP Inc.,* No. 1:2021cv00279 (E.D. Tenn. 2025), the federal district court ruled that ERISA preempted an AWP provision in a Tennessee PBM law as well as a another prohibiting a PBM from providing a patient with any financial incentive for using any pharmacy within a given pharmacy network.

(C) Note regarding Medicare Part D Preemption in *Wehbi* and *Mulready*.

While Resolution 224 requested resources concerning ERISA preemption, preemption under Medicare Part D[26] also played in role *Wehbi* and *Mulready*.[27] Those wanting more information about Part D preemption are encouraged to contact the AMA's Advocacy Resource Center (see below).

VIII. *Gobeille v. Liberty Mut. Ins*:[28] Vermont's all-payer-claims-database preempted by ERISA

Before we go further in the preemption analysis, we need to have a brief discussion of the Supreme Court's 2016 decision in *Gobeille*. This case involved a Vermont all-payer-claims-database law requiring health insurers, health care providers, and others to report information about health care costs, prices, quality, utilization, claims, and enrollment to the state. Blue Cross Blue Shield of Massachusetts, Inc., which administered Liberty Mutual Insurance Company's ERISA plan, filed a lawsuit arguing that ERISA preempted the Vermont law. The Supreme Court ruled that ERISA preempted the Vermont law because it intruded upon a central matter of plan administration.[29] This was because ERISA itself imposed detailed reporting and record keeping requirements on ERISA plans, which the court found were "fundamental components of ERISA's regulation of plan administration."[30] Further, "The fact that reporting is a principal and essential feature of ERISA demonstrates that Congress intended to pre-empt state reporting laws like Vermont's, including those that operate with the purpose of furthering public health."[31]

However, the Supreme Court seemed to qualify its holding by stating that "The analysis may be different when applied to a state law, such as a tax on hospitals, *see De Buono v. NYSA–ILA Medical and Clinical Services Fund*, 520 U. S. 806 (1997), the enforcement of which necessitates incidental reporting by ERISA plans…."

Gobeille is important because it gives us some practical information concerning the likelihood of a state law being preempted in certain circumstances: the closer a state law comes to an area specifically regulated by

[26] Part D helps cover the cost of prescription drugs (including many recommended shots or vaccines). A Medicare beneficiary may join a Medicare drug plan in addition to Original Medicare, or you get it by joining a Medicare Advantage Plan with drug coverage. Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.
[27] *See* 42 U.S.C. § 1395w-112(g) (incorporating § 1395w26(b)(3))
[28] *Gobeille v. Liberty Mut. Ins. Co.,* 577 U. S. 312 (2016)
[29] *Id* at 323
[30] *Id*
[31] *Id* at 325

ERISA, the more likely the law may be at risk for preemption, and vice versa.

However, just how close may one come to a "fundamental component" like reporting without suffering ERISA preemption? Two cases subsequent to *Gobeille* may provide some insight. One case is the *Snyder*[32] decision by the Sixth Circuit Court of Appeals in 2016, which relied on the *Gobeille* court's allusion to a different preemption analysis when state law reporting requirements are "incidental." The other case is *McClain*, discussed below, which relied heavily on *Snyder*.

Snyder involved a Michigan law, the Health Insurance Claims Assessment Act (HICAA), which as enacted to help fund Michigan's Medicaid program. HICAA imposed a one-percent tax on all paid claims by carriers, which included ERISA plans and ASOs. To help collect the tax, every carrier had to submit quarterly returns to the state and keep accurate and complete records. The *Snyder* court ruled that ERISA did not preempt the Michigan law because, unlike the Vermont APCD law in *Gobeille*, the Michigan law did not directly regulate any integral aspects of ERISA. Instead, the HICAA was, at its core, a law to generate the revenue necessary to fund Medicaid. So, while the law did "touch upon reporting and record-keeping, the thrust of the Act was to collect taxes—not to amass data." In reaching this conclusion, the court found an analytical difference in preemption analysis between a state law that directly regulated integral aspects of ERISA plan administration and a state law that touched on these aspects only peripherally.[33]

In September of 2025, an Illinois federal district court in *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. McClain*, 2025 U.S. Dist. LEXIS 170229, followed *Snyder* rather than *Gobeille* with respect to a rule (Rule 128) authorizing the Arkansas Department of Insurance (Department) to require health benefit plans, including ERISA self-insured plans, and PBMs to pay pharmacies a "fair and reasonable" rate. Rule 128 required health plans to submit reports to the Department so that the Department could confirm whether pharmacy payments were fair and reasonable. If not, the Department could require the ERISA plan or PBM to pay the pharmacy an additional dispensing fee so that payments were fair and reasonable, thereby ensuring that the health benefit plan offered an adequate network of pharmacy providers.

A self-funded ERISA plan argued ERISA preempted Rule 128 because the rule, like the APCD law in *Gobeille*, was primarily a reporting rule, while the Department argued against preemption because Rule 128 was primarily a cost regulation with incidental reporting requirements. The court ruled in Department's favor. The court found that Rule 128 was primarily a cost regulation since the rule's stated purpose was to "ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefit plan." This finding brought Rule 128 under *Snyder's* preemption analysis, not *Gobeille's*. Note that the reporting requirement here was attached to set payment requirements, i.e., full and fair payment rates, as opposed to some other cases, where reporting was attached to taxes or surcharges. The ruling in *McClain* has been appealed.

[32] *Self-Insurance Inst. of Am., Inc. v. Snyder,* 827 F.3d 549 (6th Cir. 2016)

[33] The *Snyder* court based its decision in part on Supreme Court cases like In *Travelers*, *De Buono*, and *Gobeille* itself. The court noted that the New York law in *Travelers* imposing the surcharge on hospital billing also required hospitals to 'furnish to the [state tax] department such reports and information as may be required by the commissioner to assess the cost, quality and health system needs for medical education provided.'" *Snyder* at 557. The *Snyder* court found the *Gobeille* Court's reference to *De Buono* "significant" because in *De Buono*, the Supreme Court upheld a New York law that both imposed a gross receipts tax on the income of medical centers operated by ERISA funds and required "[e]very hospital [to] submit reports on a cash basis of actual gross receipts received from all patient care services." *Id.* Based on its analysis of these cases, the *Snyder* court concluded that "*Gobeille*'s citation to *De Buono* reinforces the difference between a state law that directly regulates integral aspects of ERISA plan administration and a state law that touches on these aspects only peripherally." *Id.*

IX. What guidance might be drawn from these cases?

(A) Framework to analyze state laws

As discussed above, there are several very general criteria that one may use in an effort to determine if a state law "relates to" an ERISA plan. If any of the following questions are answered in the affirmative, then the state law relates to an ERISA plan.

1. "Reference to" an ERISA plan

(a) Does the state law act immediately and exclusively upon ERISA plans?
(b) Is the existence of ERISA plans essential to the state law's operation?

As noted above, both (a) and (b) are not difficult to satisfy. The key thing here is whether the law is sufficiently broad to apply to entities regardless of whether those entities are ERISA plans.

2. "Impermissible connection with" an ERISA plan

(a) Does the state law bind plan administrators to specific rules for determining beneficiary status?
(b) Does the state law require benefit plans to be structured in particular ways, such as by requiring payment of specific benefits?
(c) Does the state law force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restricts its choice of insurers?
(d) Does the state law govern a central matter of plan of administration?
(e) Does the state law interfere with national uniform administration (see (IX)(H) below)?
(f) Does the state law have an acute, albeit indirect, economic effect on an ERISA plan that forces the plan to adopt a particular form of coverage.

(B) State law application to ASOs

Rutledge extended *Travelers* to PBMs administering ERISA plans. It is reasonable to infer that *Rutledge* could also extend to price regulations applicable to other plan administrators like ASOs or third-party administrators. If so, this is a significant advance.

(C) Price setting

Based on *Rutledge,* a good argument could be made that a state law mandating how much an ASO is required to pay physicians would likely survive ERISA preemption. As already noted, the *McClain* court followed *Rutledge* by refusing to preempt Arkansas Rule 128 requiring PBMs to pay pharmacies "fair and reasonable rates," and, upon failure to do so, the Arkansas Department of Insurance could impose certain dispensing fees on noncompliant PBMs. Perhaps a similar rationale to that underlying a floor on pharmacy reimbursement rates might also apply to independent physician practices, viz., if price setting is needed to protect community pharmacies, price setting with regard to small independent practices might also be justified to support them and foster competition in the market for the purchase of physician services.

(D) ASOs and administrative fees

In Mulready, PCMA withdrew its preemption challenge to the following provision of the Oklahoma PBM law:

2. A PBM or third-party payer may not directly or indirectly charge or hold a pharmacy responsible for a fee related to a claim:

a. that is not apparent at the time of claim processing;

b. that is not reported on the remittance advice of an adjudicated claim; or

c. after the initial claim is adjudicated at the point of sale.

Based on our criteria above in IX.A.2., and that the ERISA challenge to this provision was abandoned, it appears that a good argument could be made that ERISA would not preempt a similar provision applicable to physicians and ASOs serving ERISA plans. It may also be reasonable to infer that ERISA would not preempt state laws prohibiting ASOs from imposing administrative fees on physician practices and laws such as those that would bar ASOs from preventing physicians from asking patients to pay surcharges when paying by credit card. These kinds of laws are arguably mere cost regulations.

(E) State recoupment or "claw back" statutes

Because the Supreme Court in *Rutledge* ruled that ERISA did not preempt the part of the Arkansas PBM law requiring PBMs to have an appeal process that pharmacies could use to challenge reimbursement rates, an argument could be made that ERISA would not preempt a state law giving physicians rights to challenge attempts by ASOs and other ERISA plan administrators to recoup part of the money paid to a physician through refund demands, offsets, etc.

However, it may make a difference if:

(1) the ASO is seeking to recover only a portion of the money paid to the physician, i.e., the dispute concerns the amount of payment owed; or

(2) the ASO is seeking to recover all of the money paid because the service provided was not medically necessary, not covered by the ERISA plan, the patient was no longer covered, etc.

It is possible that preemption under (1) may be less likely than (2). Under (1), the law only concerns payment amounts and as such constitutes a cost regulation just as the appeal process provision that the *Rutledge* Court did not preempt. *Gobeille* might help here, insofar as ERISA does not appear to say anything about physician and health care provider payment rates.

(2) might present a different challenge because the request for repayment would be based on coverage determinations, i.e., plan administration, which may venture closer to plan administration than pure price regulations. The U.S. Department of Labor (DOL) has adopted regulations concerning governing coverage determinations, including those having to do with medical necessity decisions, which may or may not require one to take the reasoning of *Gobeille* into account.

(F) Transparency of edits, fee schedules, payment rules, contract amendments, etc.

An argument could be made that a state law requiring ASOs to disclose at least some types of information to physicians would not be preempted. Disclosure might concern fee schedules, rental networks, edits and payment rules, value-based payment requirements, contract amendments, etc. *Wehbi* may provide support. As noted above, *Wehbi* held that ERISA did not preempt a provision in a North Dakota law requiring a PBM to give a pharmacy or pharmacist the processor control number, bank identification number, and group number for each pharmacy network established or administered by a PBM to enable

the pharmacy to make an informed contracting decision. This line of reasoning might support arguments that ERISA does not preempt other, perhaps more extensive transparency requirements, e.g., laws having to do with rental networks.

One concern here may be the extent to which disclosure obligations might create dis-uniformity sufficient to trigger ERISA preemption. The ERISA DOL claims processing regulation[34] has extensive disclosure requirements, particularly with respect to coverage determinations. But it does not appear to contain ERISA plan disclosure obligations with respect to physicians. So, one might be able to make an argument that at least modest state transparency requirements would not implicate *Gobeille*.

(G) Accreditation requirements

Recall that *Wehbi* concluded that ERISA did not preempt a provision in a North Dakota PBM law that prohibited a PBM or third-party payer from requiring pharmacy accreditation standards or recertification requirements to participate in a network which were inconsistent with, more stringent than, or in addition to the federal and state requirements for licensure as a pharmacy in North Dakota. The court reasoned that this provision, at most, regulated a noncentral "matter of plan administration" with de minimis economic effects. Although the *Wehbi* court acknowledged that the provision might "cause some disuniformity in plan administration" by requiring PBMs to maintain different accreditation requirements in different states, the provision did not require payment of specific benefits" or "bind[] plan administrators to specific rules for determining beneficiary status." Based on this ruling and its rationale, a good argument might be made that similar accreditation protections could be extended to physicians if desired.

(H) Credentialing requirements

Analogous to accreditation, it appears that a plausible argument could be made that ERISA would not preempt a state law placing modest credentialing requirements on ASOs, including a requirement to process complete physician credentialing applications within a specific deadline, e.g., 45 days. ERISA does not appear to address physician or health care provider credentialing and, similarly to the accreditation requirements at issue in *Wehbi*, modest state law credentialing requirements would not appear to govern a central matter of administration, require payment of specific benefits, or bind plan administrators to specific rules for determining beneficiary status. Credentialing requirements would address only how expeditiously an ASO would have to complete the accreditation process; those requirements would say nothing regarding the physicians who should be included in a physician network let alone how a PBM or ERISA plan should structure or design its physician network.

(I) Network design

Some states have enacted laws that regulate how PBMs can set up provider networks, e.g., any willing provider laws, tiered networks.[35] As noted above, the *Mulready* court ruled that ERISA preempted the Oklahoma PBM law's network requirements. Recently, a federal district court ruled that ERISA preempted similar PBM network provisions in a Tennessee PBM law.[36]

Given the uncertainties regarding the scope of ERISA preemption, simply because some courts have ruled that ERISA preempts individual statutes of a certain kind, e.g., those having to do with some aspect of network design, that does not necessarily mean that other courts must or will reach a similar conclusion. Nor does it mean that those cases were correctly decided. Indeed, 33 states (including Oklahoma) asked the Supreme Court to hear and reverse the 10th Circuit's Mulready decision in part on the grounds that the

[34] 29 CFR § 2560.503-1
[35] Note that courts have saved any willing provider laws from preemption under ERISA's Savings Clause. *See e.g., KAHP v. Miller, 538 U.S. 329 (2003).* These cases do not help with respect to self-funded ERISA plans because of the application of the Deemer Clause.
[36] *McKee Foods Corp. v. Tennessee,* 2025 U.S. Dist. LEXIS 60638 (E.D. Tenn., March 31, 2025)

decision conflicted with *Rutledge* and other Supreme Court cases.[37] The text of state laws can vary significantly, and subtle differences in text and structure can change the preemption analysis. Preemption decisions can also vary from one federal circuit jurisdiction to another.

(J) Reporting requirements

Based on prior Supreme Court cases such as *Travelers*, *De Buono*, and the text of *Gobeille* itself, as well as cases like *Snyder* and *McClain*, an argument could be made that ERISA does not preempt at least some reporting requirements that are incidental to a state law whose primary purpose is directed to the protection of patients and/or physicians. See the discussion above. How such a law should be structured would require further thought, obviously.

(K) A note on the dis-uniformity criterion

As noted above, one of the reasons for preemption is to ensure that ERISA plans are not subject to a multitude of differing state requirements. So, it is likely that any effort to enact state managed care reform proposals will have to deal with opposition claiming that ERISA preempts those proposals because they would interfere with national uniform plan administration if enacted.

Perhaps the most significant Supreme Court case on this issue is *Egelhoff v. Egelhoff*, 532 U. S. 141 (2001). In *Egelhoff*, Mr. Egelhoff had designated his wife as the beneficiary of his ERISA life insurance policy. The Egelhoffs divorced and shortly afterwards Mr. Egelhoff died without changing his wife as beneficiary. The life insurance company paid the life insurance policy proceeds to the ex-wife. Mr. Egelhoff's children from a former marriage sued the ex-wife for those proceeds under a Washington law that, due to the divorce, revoked her beneficiary status in favor of the children. The Supreme Court ruled that ERISA preempted the Washington law because it bound ERISA plan administrators to a particular choice of rules for determining beneficiary status.[38]

But ERISA also preempted the Washington law because it interfered with nationally uniform plan administration. While recognizing that all state laws create some potential for a lack of uniformity, the Supreme Court stated that differing state regulations affecting an ERISA plan's "system for processing claims and paying benefits" impose "precisely the burden that ERISA pre-emption was intended to avoid."[39]

It is an open question as to how much lack of uniformity ERISA will tolerate. On one hand we have *Egelhoff*, which tells us that state law dis-uniformity will trigger preemption when those laws tell ERISA plans how to process claims and to whom payments must be made. On the other hand, *Rutledge*, *Travelers*, and other Supreme Court cases[40] tell us that not all state law dis-uniformity is subject to ERISA preemption, and that this is true particularly for state cost regulations. The Supreme Court has seemingly left open the possibility that ERISA will also not preempt at dis-uniformity created by state laws that are not cost regulations. But it is unclear where a line can be drawn. *Egelhoff* does show us that ERISA preempts a state non-cost regulation that governs the core functions of an ERISA plan. So perhaps one can use *Egelhoff* as a guide in the sense that the more one can distance a state managed care reform law from the type of state law in *Egelhoff*, the better argument one may have against preemption, particularly if the state laws are relatively modest in what they require.

[37] The Supreme Court decided not to review the *Mulready* decision.
[38] *Egelhoff,* at 147
[39] *Id* at 150 *citing Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1, 10 (1987)*
[40] *See e.g., California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997)

ERISA preemption is complicated and whether ERISA preempts a particular state law or laws is determined by courts on a case-by-case basis. There is much more that can be said regarding ERISA preemption. If you have any questions or desire more information, please contact Wes Cleveland, JD, Senior Attorney, AMA Advocacy Resource Center, at wes.cleveland@ama-assn.org.