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State Action to Lower Prescription Drug Prices: Navigating ERISA Preemption

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In the face of ever-rising health care costs, state policymakers continue to adopt new laws to curb the high cost of prescription drugs—from drug price-gouging protections to prescription drug affordability boards. This momentum, however, has been met with strong opposition from the pharmaceutical industry, which continues to challenge state prescription drug affordability laws in the courts.

Among other legal claims, the pharmaceutical industry often argues that state efforts to curb skyrocketing prescription drug prices conflict with the Employee Retirement Income Security Act (ERISA). ERISA, a federal law that regulates employee benefit plans, including job-based health insurance, preempts some state laws that attempt to regulate these plans. Because employee benefit plans typically cover prescription drug benefits, the pharmaceutical industry has claimed that state laws to curb high drug prices intrude on ERISA's domain and are thus preempted. This publication discusses recent litigation over ERISA preemption and considerations for state policymakers when designing certain prescription drug affordability policies so that they may withstand judicial scrutiny.[1]

This publication is part of a series on legal developments that state policymakers should consider when designing new policies to lower health care costs. This series also addresses considerations for state policymakers related to the Dormant Commerce Clause and patent preemption.

Background

Millions of people rely on prescription drugs to treat disease, improve health, alleviate suffering, and prevent death. Yet the high cost of prescription drugs jeopardizes access for many, forcing patients to make impossible decisions over whether to fill a prescription or ration medication.[2] Medication nonadherence can have devastating effects on health, including worsening health outcomes and increased risks of morbidity and mortality.[3] It can also lead to higher overall health care costs due to complications.[4] And high prescription drug prices are an even greater barrier to access for patients with chronic conditions, low-income patients, and patients of color.[5] The high cost of prescription drugs is thus a public health and health equity issue.

Federal and state policymakers have taken several steps to lower prescription drug costs. At the federal level, Medicare negotiates prices for some of the costliest drugs, and Congress capped monthly cost-sharing for insulin at $35 per month for Medicare beneficiaries. Despite these targeted federal reforms, prescription drugs remain unaffordable for many, especially those with private health insurance who are not covered by programs such as Medicare or Medicaid.

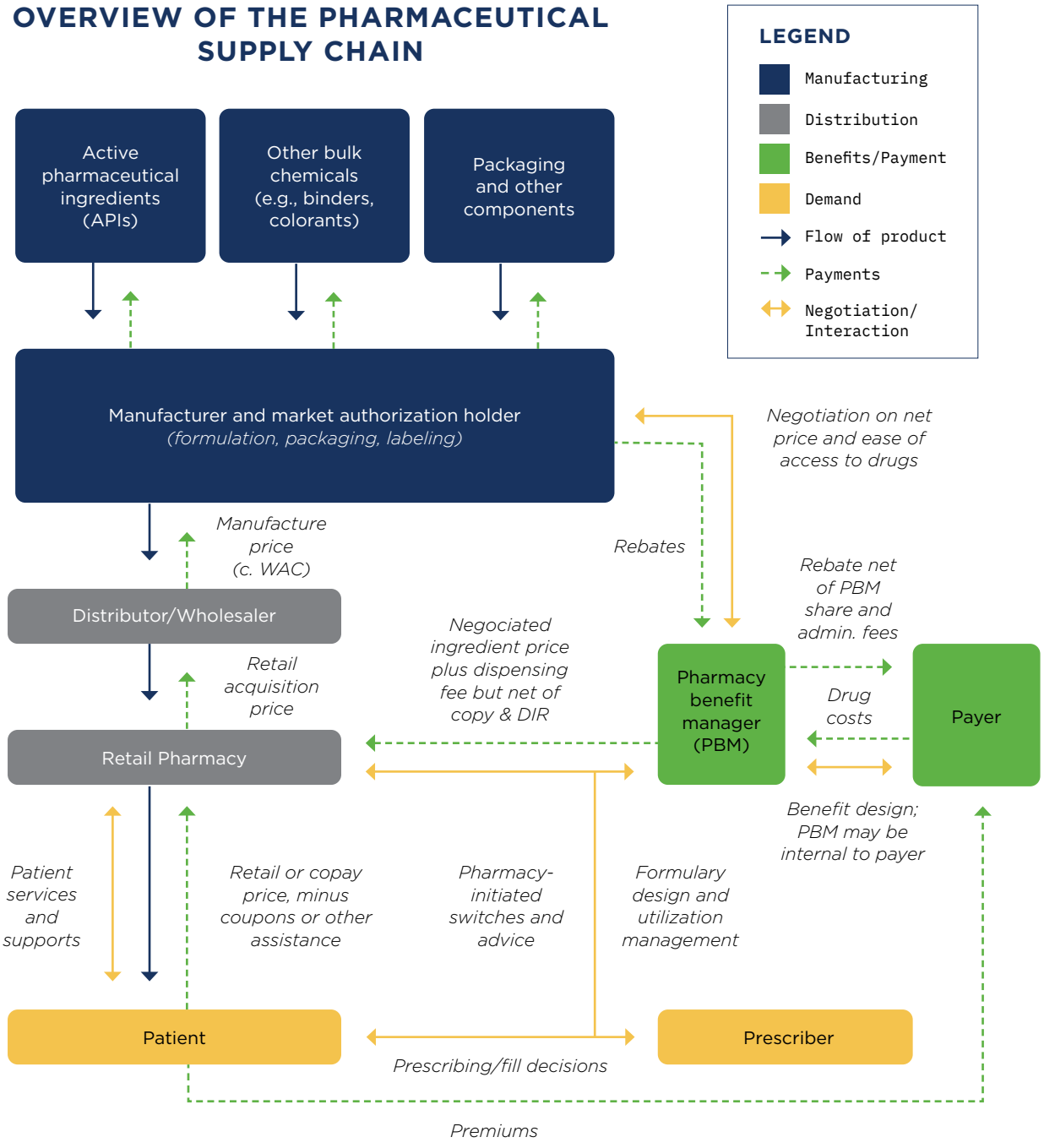
To fill some of these gaps, states have leveraged their traditional powers to protect health, safety, and welfare to address market failures and lower prescription drug costs for consumers. State-level policies have focused on price gouging, price transparency, cost-sharing caps on specific drugs (e.g., insulin), pharmacy benefit manager (PBM) reform, and the creation of prescription drug affordability boards (PDABs), among other approaches.[6]

Understanding The Drug Supply Chain and Market Distortions

Market failures and distortions contribute significantly to high prescription drug prices. The drug market involves many players, each of which helps determine the ultimate price that consumers pay for the prescription drugs they need.[7] At a basic level, drug manufacturers sit at the top of the distribution chain. These manufacturers sell their drugs to wholesalers who, in turn, sell the drugs to pharmacies, hospitals, and other health care providers.[8] Within this seemingly simple chain, however, operates a byzantine web of transactions and stakeholders who leverage their market power to increase the cost of prescription drugs. Indeed, the price that consumers ultimately pay seldom represents a drug's actual price.[9]

Drug manufacturers, for example, engage in various practices that distort the drug market, limit competition, and maintain high drug prices. As the players at the top of the supply chain, manufacturers set the drug prices in the first place. Drug manufacturers also engage in practices, such as reverse payment settlements, improper Orange Book listings, and product hopping, that impede generic competition thus maintaining high prices.[10]

OVERVIEW OF THE PHARMACEUTICAL SUPPLY CHAIN



NOTES: c = circa; DIR = direct and indirect remuneration; WAC = wholesale acquisition cost. Arrows denote relationships involving the flow of product (blue arrows), information or negotiation (yellow arrows), and payments (green dashed arrows).

Source: Office of the Assistant Secretary for Planning and Evaluation, Prescription Drug Supply Chains: An Overview of Stakeholders and Relationships. (Oct. 14, 2021) https://aspe.hhs.gov/reports/prescription-drug-supply-chains.

Additionally, through exclusionary rebates, drug manufacturers work with PBMs to exclude generics or other more-affordable drugs from formularies.[11]

Payers—such as employer health plans, third-party administrators, and health insurers—also drive the price consumers pay. While some directly negotiate drug rebates with manufacturers, many payers rely on PBMs who manage plan drug formularies, cost-sharing terms, and pharmacy networks where prescriptions can be filled. Today, just three PBMs—CVS Caremark (owned by CVS Health), Express Scripts (owned by The Cigna Group), and OptumRx (owned by UnitedHealthcare)—control more than 80 percent of the market, giving them significant leverage over drug manufacturers, payers, and other market participants.[12] What is more, some PBMs are vertically integrated with insurers, pharmacies, manufacturers, and physician practices, which raises concerns about conflicts of interest and limits to competition.[13] Using their substantial market power, PBMs negotiate various rebates, discounts, and other price concessions for their clients.[14] It is estimated that these rebates and discounts exceed $100 billion per year.[15]

All told, there are various players in the pharmaceutical supply chain with varying degrees of negotiating power that contribute to high prescription drug prices. These high prices have created public health crises that states have sought to alleviate using their traditional police powers by enacting consumer protection laws such as PDABs and price-gouging laws.

Preemption Under Erisa

Congress enacted ERISA in 1974 to help safeguard and uniformly regulate employee benefits. ERISA expressly preempts "any and all" state laws that "relate to" employee benefits plans.[16] ERISA preemption has been the subject of a fair amount of litigation—leading even Supreme Court justices to famously refer to this area of law as "an unjust and increasingly tangled ERISA regime."[17]

Citing ERISA's preemption statute, the pharmaceutical industry has argued that state prescription drug pricing laws are preempted because they affect employee health plans that are regulated under ERISA. The specter of ERISA preemption has long chilled state efforts to reform health care.[18] Citing federalism concerns, however, the Supreme Court has cautioned that ERISA preemption should not be lightly deployed to thwart state laws, especially in areas of traditional state regulation.[19]

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Supreme Court precedent shows that states may adopt prescription drug pricing reforms without running afoul of ERISA. As early as 1995, the Court held that ERISA did not preempt state efforts to regulate the rates paid to health care providers. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, the Court considered a challenge to a New York state law imposing surcharges on hospital bills for patients with commercial health coverage.[20] ERISA, the Court concluded, did not preempt this state law—even though insurers and ERISA-governed plans would end up bearing the cost of this surcharge. The "indirect economic influence" that the surcharges had on ERISA plans, the Court explained, was not sufficient to trigger preemption. The Court was concerned that broadly reading ERISA preemption would impermissibly intrude on states' traditional power to regulate health care.[21] Thus, under *Travelers*, states may regulate provider rates without offending ERISA.

The Court reached a similar conclusion as recently as 2020 in *Rutledge v. Pharmaceutical Care Management Association*,[22] which involved an Arkansas law that prohibited PBMs from reimbursing pharmacies for drugs at a price less than the wholesale acquisition cost. Arkansas' law essentially set minimum rates that PBMs must pay to reimburse pharmacies for specific drugs. Pharmaceutical Care Management Association (PCMA)—a trade group representing PBMs—sued, arguing that the law was preempted because pharmacy reimbursement rates affected the administration of plans governed by ERISA. Specifically, PCMA argued that the law was a cost containment measure that impermissibly "mandat[ed] a particular pricing methodology for pharmacy benefits."[23]

The Court unanimously rejected PCMA's argument, reasoning that the Arkansas law did not "directly regulate health benefit plans at all, ERISA or otherwise."[24] As discussed above, ERISA preempts "any and all state laws" that "relate to any employment benefit plan."[25] A state law "relates to an ERISA plan if it has a *connection with* or *reference to*" the plan, the Court explained.[26] The Arkansas law, however, did not have an impermissible connection with ERISA because pharmacy reimbursement rates did not "govern[] a central matter of plan administration or interfere[] with nationally uniform plan administration."[27]

Additionally, the Arkansas law did not "refer to" ERISA plans because it did not "act immediately and exclusively" upon ERISA plans, nor were those plans "essential to the law's operation." The pharmacy reimbursement requirement applied generally to all PBMs regardless of whether they administered ERISA plans. Since the law applied to non-ERISA plans as well, it did not impermissibly refer to ERISA. Nor did the law directly regulate health plans—it affected plans only indirectly through PBMs passing the higher rates to the plans. Because Arkansas' law applied generally, the Court ruled that ERISA plans were not "essential to the law's operation," and the law was allowed to stand.

Just like the New York law in *Travelers*, the Arkansas pricing methodology had only an "indirect" economic effect on ERISA plans and was "merely a form of cost regulation" that set minimum thresholds for pharmacy reimbursement.[28] In *Rutledge*, the Court once again rejected the industry's argument that ERISA preempts any state law that could affect the price or provision of benefits. ERISA, the Court noted, does not preempt state policies that "merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."[29] Although a state's cost regulation *could* be preempted by ERISA if its indirect economic effects are so great that ERISA plans must "adopt a certain scheme of substantive coverage," that was not the case with Arkansas' pharmacy reimbursement rates.[30]

Other ERISA-Related Challenges to State PBM Laws

ERISA preemption has featured prominently in litigation over state regulation of PBMs. This is not surprising, given the outsized role PBMs play in administering health plans. In fact, some courts have treated the regulation of PBMs as a functional regulation of ERISA plans.[31] PBMs and trade associations have argued that ERISA preempts state laws requiring PBMs to disclose their pricing methodologies and to comply with restrictions on pharmacy networks. As just some examples, these entities have challenged multiple PBM laws in states that include Arkansas,[32] Iowa,[33] North Dakota,[34] and Oklahoma.[35] While their claims have not been limited to ERISA preemption, PBMs and trade associations have consistently argued that state efforts to regulate PBMs are preempted and thus impermissible.

Circuit courts that have applied the *Rutledge* decision show that prescription drug pricing reforms are unlikely to be preempted by ERISA.[36] In *PCMA v. Wehbi*, for example, the Eighth Circuit upheld a North Dakota law regulating the relationship between PBMs and pharmacies against an ERISA preemption challenge. The law aimed at curbing PBM abuses by allowing pharmacies to: (i) disclose certain information to plan sponsors; (ii) provide relevant information to patients (e.g., the availability of more affordable drugs); (iii) mail drugs to patients as an ancillary service; and (iv) charge patients shipping fees for mailed drugs. In other words, PBMs could not prevent pharmacies from engaging in these activities. The law further prohibited PBMs from: (i) having ownership interest in patient assistance programs and mail order specialty pharmacies; (ii) imposing onerous accreditation standards for network participation; or (iii) withholding basic information from plan sponsors and pharmacies.

The court ruled that these provisions did not have an impermissible connection with ERISA plans because they only restricted PBMs' ability to prevent pharmacies from engaging in the outlined activities. The law's restrictions, the Eighth Circuit reasoned, did not interfere with plan administration and had only minimal "economic effects and impact on the uniformity of plan administration across states."[37] This reasoning extended to the pharmacy accreditation standard, which essentially restricted PBMs' ability to exclude pharmacies that met state standards from their networks. The accreditation standard, the court found, did not govern a central matter of plan administration and had only nominal economic effects. And the law did not impermissibly refer to ERISA because it applied to all PBMs regardless of whether they administered ERISA plans.[38]

When courts have found state PBM laws to be preempted, it is because such laws require ERISA plans to make substantive coverage and benefit changes, especially when those laws require PBMs to restructure their networks. In *PCMA v. Mulready*, for example, the Tenth Circuit found that ERISA preempted various provisions of an Oklahoma PBM law. Oklahoma's law

TABLE 1: SELECT RECENT APPELLATE DECISIONS ON ERISA PREEMPTION OF STATE PBM LAWS

Case	Court	State Policy	Summary of Decision on ERISA Preemption
Rutledge v. PCMA	Supreme Court (2020)	Arkansas' law prohibits PBMs from reimbursing pharmacies for drugs at a price less than the wholesale acquisition cost.	Arkansas' law was **not preempted** by ERISA because state regulation of pharmacy reimbursement did not directly regulate ERISA plans and was merely a form of cost regulation.
PCMA v. Wehbi	8th Circuit (2021)	North Dakota's law allows pharmacies to (i) disclose certain information to plan sponsors; (ii) provide patients relevant information (e.g., the availability of more affordable drugs); (iii) mail drugs to patients as an ancillary service; and (iv) charge patients shipping fees for mailed drugs. The law also prohibits PBMs from: (i) having ownership interests in patient assistance programs and mail order specialty pharmacies; (ii) imposing onerous accreditation standards for in-network pharmacies; or (iii) withholding certain information from plan sponsors and pharmacies.	North Dakota's law was **not preempted** by ERISA because the state's regulation of the relationship between pharmacies, patients, plan sponsors, and PBMs did not interfere with plan administration. The pharmacy accreditation standard had only minimal economic effects on plan administration.
PCMA v. Mulready	10th Circuit (2023)	Oklahoma's law imposes geographic restrictions on networks, prohibits the promotion of in-network pharmacies through offering discounts, requires PBMs to allow any willing provider into their preferred networks, and prohibits PBMs from terminating pharmacists on probation.	Oklahoma's law was **preempted** by ERISA because the state's regulation of networks dictated the design and structure of ERISA-regulated plans by affecting the drugs covered, where beneficiaries could obtain drugs, and beneficiary cost-sharing obligations.

Source: Author's analysis

imposed geographic restrictions on networks, prohibited the use of discounts to promote in-network pharmacies, required PBMs to allow any willing provider into their preferred networks, and prohibited PBMs from terminating pharmacists on probation.[39]

Although the law did not expressly target ERISA plans, the Tenth Circuit found that it had an impermissible connection with these plans by dictating the design and structure of ERISA plans. Oklahoma's "any willing provider" requirement, for example, would essentially eliminate different tiers of PBM networks used by ERISA plans and thus "hamstring[] a key element of network design."[40] Said another way, these restrictions consequently impacted where ERISA beneficiaries could obtain drugs and how much they would pay—affecting the very heart of ERISA plan administration.[41] In contrast to the Arkansas law in *Rutledge*, the Oklahoma law forced ERISA plans to adopt particular coverage schemes and was thus preempted under ERISA. Oklahoma asked the Supreme Court to review the decision (and thus clarify ERISA preemption), but the Court denied the state's request in June 2025.

While the pharmaceutical industry might argue that *Mulready* constrains state power, other courts have made clear that not every state law that affects PBM networks is *per se* preempted. In *Wehbi*, for example, the Eighth Circuit found that North Dakota's network accreditation standard, which, to a degree, limited PBMs' exclusion of some pharmacies from their networks, was not preempted. And more Eighth Circuit decisions are expected on the scope of ERISA preemption as it relates to state efforts to regulate PBMs and pharmacies. As of December 2025, the Eighth Circuit is considering separate appeals from Arkansas and Iowa over each state's new law to regulate PBMs and pharmacies.[42] Although not discussed in detail in this publication, PBMs and trade associations are likely to continue to argue that state PBM regulations are preempted by ERISA and other federal laws.

Lessons from ERISA Challenges to State PBM Laws for Other Prescription Drug Reforms

While some state drug pricing laws exempt ERISA plans and other state policy makers continue to grapple with ERISA's preemptive scope,[43] *Travelers* and *Rutledge* show that states may adopt prescription drug pricing reforms—such as PDABs and drug price gouging laws—without running afoul of ERISA preemption. Like the Arkansas law upheld in *Rutledge*, state prescription drug pricing reforms are not impermissibly "connected with" nor "refer to" ERISA plans. Such state laws do not dictate how ERISA plans are governed because they do not require ERISA plans to be structured in a specific way or otherwise establish rules for plan beneficiaries—they merely affect the costs of discrete drugs.

PDABs, for example, set upper payment limits (UPLs) for unaffordable drugs. UPLs apply generally to the sales price for specific drugs dispensed to individuals within a state. UPLs affect ERISA health plans only indirectly by setting the maximum ceiling price for prescription drugs dispensed to individuals. What is more, UPLs do not apply across the board to all prescription drugs. Rather, they are tailored to specific drugs that are found to be unaffordable after extensive fact-finding by the PDAB. UPLs, in effect, work much like the Arkansas law that the Court upheld in *Rutledge*, as UPLs affect only the cost of a narrow set of drugs covered by the plans and do not otherwise affect broader plan features, such as pharmacy networks. Just as the Arkansas law in *Rutledge*, which established a pricing methodology that set reimbursement thresholds for pharmacy benefits, prescription drug affordability laws are mere cost regulations that do not go to the heart of benefit plan administration.

While litigation over the scope of permissible state PBM reform continues, other state prescription drug affordability reforms—such as PDABs and price-gouging laws—are unlikely to be preempted by ERISA. This is because these policies do not implicate plan design and benefit structure. PDABs set upper limits on the prices that consumers—including ERISA beneficiaries—pay for a limited number of high-price drugs at the point of sale. Drug price-gouging laws focus upstream on the chain of distribution by prohibiting drug manufacturers and distributors from unconscionably raising prices on certain drugs sold in the state. Upstream price-gouging restrictions are far removed from health plans, making their indirect effect to on ERISA plans even more attenuated. Such restrictions are unlikely to run afoul of ERISA preemption even under the Tenth Circuit's more expansive reading of ERISA preemption in *Mulready*.

Conclusion

In the absence of comprehensive federal action to address high drug costs, states can and will continue to take action — from price-gouging laws to PDABs. States that do so should be mindful of, and prepared to respond to, the pharmaceutical industry's efforts to derail those policies by arguing that these consumer protection laws are preempted by ERISA.

ENDNOTES

1 This publication does not discuss state policies to more broadly regulate pharmacies or PBMs.

2 Grace Sparks et al. Public Opinion on Prescription Drugs and Their Prices. KFF. October 4, 2024. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

3 Marie T. Brown et al. "Medication Adherence: Truth and Consequences." The American Journal of the Medical Sciences vol. 351,4 (2016): 387-99. doi:10.1016/j.amjms.2016.01.010. https://www.amjmedsci.com/article/S0002-9629(15)37996-9/fulltext.

4 *Id*.

5 Sparks, *supra* note 1.

6 National Academy for State Health Policy. State Laws Passed to Lower Prescription Drug Costs: 2017-2025. https://nashp.org/state-tracker/state-drug-pricing-laws-2017-2025/.

7 In re EpiPen (Epinephrine Injection, USP) Mktg., Sales Pracs. & Antitrust Litig., 44 F.4th 959, 965 (10th Cir. 2022) ("Drug pricing is a complex and often confusing issue, shaped by a pharmaceutical distribution and payment system that involves multiple transactions among numerous stakeholders.").

8 *Id*.

9 *See id*.

10 American Economic Liberties Project and Initiative for Medicines, Access, & Knowledge (I-MAK), The Costs of Pharma Cheating (May 16, 2023), https://www.economicliberties.us/our-work/the-costs-of-pharma-cheating/; *see also* Kristi Martin, How Drugmakers Use the Patent Process to Keep Prices High (November 13, 2025), https://www.commonwealthfund.org/publications/explainer/2025/nov/how-drugmakers-use-patent-process-keep-prices-high.

11 The Costs of Pharma Cheating, *supra* note 10.

12 Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183, 1189 (10th Cir. 2023), cert. denied, 145 S. Ct. 2843 (2025).

13 Federal Trade Commission, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies 24, July 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

14 Kristi Martin, *supra* note 10.

15 Vandervelde and Elanor Blalock, The Pharmaceutical Supply Chain: Gross Drug Expenditures Realized by Stakeholders, 12, (2017) https://media.thinkbrg.com/wp-content/uploads/2020/06/15132936/Vandervelde_PhRMA-January-2020.3.3-Addendum-MM.pdf.

16 29 U.S.C. § 1144. ("[T]he provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]").

17 *See Aetna v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).

18 See generally, Erin C. Fuse Brown & Elizabeth Y. McCuskey, Federalism, ERISA, and State Single-Payer Health Care, 168 U. Pa. L. Rev. 389 (2020).

19 New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995).

20 *Id*. at 649-50.

21 *Id*. at 655 ("[I]n cases like this one, where federal law is said to bar state action in fields of traditional state regulation, . . . we have worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'").

22 Rutledge v. Pharm. Care Mgmt. Ass'n, 592 U.S. 80 (2020).

23 *Id*. at 90.

24 *Id*. at 88-89.

25 *Id*. at 86

26 *Id*.

27 *Id*. at 87).

28 *Id*. at 88.

29 *Id*.

30 *Id*. at 87.

31 Pharm. Care Mgmt. Ass'n v. Wehbi, 18 F.4th 956, 966 (8th Cir. 2021) ("Because PBMs manage benefits on behalf of plans, a regulation of PBMs 'function[s] as a regulation of an ERISA plan itself.'"); *see* Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183, 1195–96 (10th Cir. 2023), cert. denied, 145 S. Ct. 2843 (reaching the same conclusion); *see also* Iowa Ass'n of Bus. & Indus. v. Ommen, No. 4:25-CV-00211-SMR-WPK, 2025 WL 2888377, at *43 (S.D. Iowa July 21, 2025) ("The modern structure of employee benefit administration creates functional interdependence between ERISA plans and the intermediaries essential to their operation.").

32 Express Scripts, Inc. v. Richmond, No. 4:25-CV-00520-BSM, 2025 WL 2111057 (E.D. Ark. July 28, 2025).

33 Ommen, No. 4:25-CV-00211- (S.D. Iowa July 21, 2025).

34 *Wehbi*, 18 F.4th 956.

35 *Mulready*, 78 F.4th 1183,

36 This is not an exhaustive discussion of appellate decisions over state regulation of PBMs. This publication discusses two main post-*Rutledge* appellate court decisions to map out the ERISA preemption landscape and how states may regulate prescription drug pricing without offending ERISA.

37 *Wehbi*, 18 F.4th at 968.

38 *Id*. at 969-70.

39 *Mulready*, 78 F.4th at 1190-91.

40 *Id*. at 1199.

41 In this respect, *Mulready* seems to be at odds with *Wehbi*, to the extent that the latter found pharmacy-accreditation requirement for network participation had *de minimis* economic effects.

42 Express Scripts, Inc. v. Richmond, No. 25-2529 (8th Cir., appeal docketed August 5, 2025); Iowa Ass'n of Bus. & Indus. v. Ommen, No. 25-2494 (8th Cir., appeal docketed July 29, 2025).

43 *See e.g.*, Minn. Stat. § 62J.94 (a) ("Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or Medicare Part D plans to comply with decisions of the board."); Colo. Rev. Stat. § 10-16-1407 (8). *See generally*, Oregon Prescription Drug Affordability Board (PDAB) Upper Payment Limit (UPL) Draft Board Report (October 2024), https://dfr.oregon.gov/pdab/Documents/reports/PDAB-upper-payment-limit-report-2024.pdf.