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by Practical Law Employee Benefits & Executive Compensation

Pharmacy Reimbursement Rule

An Illinois district court has dismissed litigation brought by a self-funded health plan challenging an Arkansas rule that imposes reporting and dispensing requirements regarding pharmacy reimbursements (*Cent. States, Se. & Sw. Areas Health & Welfare Fund v. McClain*, (N.D. Ill. Sept. 2, 2025)). The court rejected the plan's arguments regarding why ERISA preempted the rule.

Arkansas Rule Imposes Requirements Regarding Pharmacy Reimbursements

The plaintiffs in this case were a self-funded multiemployer health plan and the plan's fiduciary/trustee (collectively, plan). The plan challenged an Arkansas rule issued under a state pharmacy benefit manager (PBM) licensure act and intended to ensure "fair and reasonable" pharmacy reimbursements and adequate pharmacy networks (known as Arkansas Rule 128). To achieve these goals, the rule permits the Arkansas insurance commissioner to review the adequacy of pharmacy reimbursement payments made by health plan PBMs. In addition, the Arkansas rule:

- Requires health plans to provide certain information about pharmacy payments to the state (referred to as the reporting requirement).
- Permits the commissioner to require plans to make additional payments to dispensing pharmacies if the commissioner concludes that the payments were not "fair and reasonable" (known as the dispensing fee requirement).

The Arkansas rule applies to:

- All "health benefit plans," defined to include individual, blanket, or group plans, policies, or contracts for health services issued or delivered by a "healthcare payor" to Arkansas residents.
- "Healthcare payors," defined to include health insurers, health maintenance organizations (HMOs), and entities that either provide or administer self-funded health plans.

The plan sued the Arkansas Insurance Department and its insurance commissioner (collectively, commissioner) under ERISA, seeking a declaration that the rule's reporting and dispensing fee requirements were preempted by ERISA (see ERISA Litigation Toolkit and Practice Note, ERISA Litigation: Preemption of State Laws (P to R): Pharmacy Benefit Manager Laws). The commissioner asked the court to dismiss the litigation.

District Court's ERISA Preemption Analysis

In analyzing whether to dismiss the plan's claims, the court observed that ERISA expressly preempts any state law that may "relate to" an employee benefit plan (29 U.S.C. § 1144(a)). In turn, a law relates to an employee benefit plan if it has a connection with or reference to the plan. The plan challenged the Arkansas rule as preempted on both grounds. However, the court concluded that the plan failed to sufficiently allege that the rule referred to, or had an impermissible connection with, ERISA plans, and therefore dismissed the action.

For more information on ERISA's preemption provision, see Practice Note, ERISA Litigation: Preemption of State Laws: Overview and State Laws (A to C).

Reference to ERISA Plans. The plan asserted that the rule's reporting and dispensing fee requirements had a reference to ERISA plans because the rule imposes obligations directly on ERISA plans (as opposed to merely regulating PBMs). Rejecting this argument, the court concluded that the rule did not act "immediately and exclusively" on ERISA plans. Citing the related statutory definitions of health benefit plan and healthcare payor, the court reasoned that benefit plans subject to the rule did not necessarily need to be ERISA plans. Rather, in the court's view, the rule:

- Applied to all health plans and healthcare payors, not just ERISA plans.
- Functioned regardless of whether plans were covered by ERISA.

The court concluded that the plan failed to allege that the rule acted exclusively on ERISA plans or that the existence of an ERISA plan was essential to the rule's operation.

Impermissible Connection with ERISA Plans

In determining whether the rule had an impermissible connection with ERISA plans, the court analyzed the reporting requirement and dispensing fee requirement separately.

Reporting Requirement. For the reporting requirement, the court addressed whether the rule was fundamentally a reporting rule or a dispensing rule (with incidental reporting requirements). In arguing that the rule was a reporting requirement, the plan relied on the Supreme Court's decision in *Gobeille*, which involved a Vermont law that required extensive data reporting to support a state health care database (*Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312 (2016); see Legal Update, Supreme Court Holds That ERISA Preempts State Health Care Reporting Law). In *Gobeille,* the Supreme Court held that the Vermont law was preempted by ERISA because "reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA" (577 U.S. at 323). The district court noted that the Supreme Court (in *Gobeille*) acknowledged that the preemption analysis might be different for state laws requiring only incidental reporting by ERISA plans (for example, a tax on hospitals).

The commissioner relied on a post-*Gobeille* ruling by the Sixth Circuit holding that a Michigan law that imposed a tax on health claim payments was not ERISA-preempted (*Self-Ins. Inst. of Am., Inc. v. Snyder,* 827 F.3d 549, 558 (6th Cir. 2016); see Legal Update, State Health Claims Tax Law Survives ERISA Preemption Challenge, Once Again). In *Snyder*, the Sixth Circuit had noted that other Supreme Court precedents supported the conclusion that ERISA does not preempt state laws that impose incidental reporting obligations on ERISA plans (see *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997)).

Applying these principles, the district court in this case determined that:

- The Arkansas rule's main purpose was to ensure "fair and reasonable" pharmacy reimbursements and adequate PBM networks.
- The rule was implemented to address issues concerning cost-related procedures, rather than plan design.
- The plan acknowledged that the purpose of the rule's reporting requirement was to further its cost and reimbursement purposes (meaning, in the court's view, that the reporting requirement was incidental to the rule's other purposes).

Accordingly, the court distinguished the Arkansas rule from the reporting law at issue in *Gobeille* and concluded that the plan failed to sufficiently allege the reporting requirement was preempted by ERISA.

Dispensing Fee Requirement. In arguing that the dispensing fee requirement was not ERISA-preempted, the commissioner relied on the Supreme Court's *Rutledge* decision (*Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80 (2020); see Legal Update, Supreme Court: Arkansas PBM Law Is Not ERISA-Preempted). In *Rutledge*, the Supreme Court held that an Arkansas law that regulated reimbursement rates paid to PBMs was not ERISA-preempted because it was essentially a cost regulation that did not impose substantive requirements for ERISA plans.

The district court in this case agreed, characterizing the Arkansas rule as a cost regulation. The court reasoned that:

- The dispensing fee requirement stated that a plan **may** have to pay additional dispensing fees.
- The potential fee did not force plans to adopt a particular coverage scheme.
- Any "indirect economic influence" the rule had was not enough to establish an impermissible connection with an ERISA plan.

The court also rejected the plan's assertion that the Arkansas rule impermissibly dictated plan design (for preemption purposes) by prohibiting plans from requiring participants to pay for dispensing costs outside the plan's cost-sharing requirements (that is, copayments, coinsurance, and deductibles). Agreeing with the commissioner, the court concluded that this requirement did not prevent plans from increasing participant cost-sharing to account for any required dispensing fees.

As a result, the court concluded that the plan also failed to sufficiently allege that ERISA preempted the dispensing fee requirement.

Practical Impact

The district court's ruling decision reflects the ongoing tension between increasingly far-reaching state laws to regulate PBMs and plan sponsors' concerns over preserving nationwide uniformity in plan administration. It remains to be seen whether other courts will agree with the district court's ERISA preemption analysis in this case (for example, the court's reasoning regarding the plan's *Gobeille*-based argument).

For more information on recent PBM-related litigation, see Article, Pharmacy Benefit Managers (PBMs): Pharmacy Drug Pricing and Potential Fiduciary Issues.