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ERISA Preemption of Montana House Bill 740

ERISA preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). A state law "relates to" a plan, and implicates preemption, when it has a "connection with or reference to" an ERISA plan. *Id*. at 147. The Supreme Court has made clear that a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). Notably, the state law at issue in *Gobeille* applied to the third-party administrator ("TPA") acting on behalf of the ERISA-covered plan. In recognition of the statutory "deemer clause," which prevents states from "deeming" a self-insured, ERISA-covered plan to be an insurer for purposes of the insurance savings clause, the Court held that the Vermont law at issue was preempted, notwithstanding the fact that it applied to the insurer acting as a TPA for the plan. ERISA § 514(b)(2). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id*. at 320.

In *Rutledge*, the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law regulating the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that because the state law merely regulated costs rather than dictate ERISA-plan choices, it was not preempted by ERISA . *See id.* at 81. In arriving at that decision, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille* at 320. Moreover, the Court in *Rutledge* also reaffirmed the long-held view of the Court that a state law "which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans," and are thus subject to preemption. *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 97 (1983); *Rutledge*, 592 U.S. at 86-87; *see, also, Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.,* 103 F.4th 597, 605 (9th Cir. 2024) (holding that state law contract claims based on oral representations to out-of-network providers were preempted. "[I]f providers could use state contract law to bind insurers to their representations on verification and authorization calls

regardless of plan rules on billing practices, benefits would be governed not by ERISA and the plan terms, but by innumerable phone calls and their variable treatment under state law. This is the type of discordant regime that 'ERISA's comprehensive pre-emption of state law was meant to minimize.'" (internal citations omitted)).

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023), cert. denied, 145 S. Ct. 2843, 222 L. Ed. 2d 1129 (2025). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1] Notably, the Supreme Court declined to hear the case on appeal leaving intact the decision by the Tenth Circuit.

Following *Mulready*, a number of district courts have reached similar conclusions with respect to similar state laws regulating pharmacy networks. *McKee Foods Corp. v. BFP Inc.*, No. 1:21-CV-279, 2025 WL 968404, at *8 (E.D. Tenn. Mar. 31, 2025); *Iowa Ass'n of Bus. & Indus. v. Ommen*, No. 4:25-CV-00211-SMR-WPK, 2025 WL 2888377, at *4 (S.D. Iowa July 21, 2025).[2] In particular, the Tennessee statute in *McKee Foods* and the Iowa statute in *Ommen*, specifically regulated the pharmacy networks for ERISA-covered group health plans and limited the ability of plans to impose cost-sharing that incentivized the use of certain pharmacies. In those cases, the district courts correctly viewed these as being fundamental components of the plan's pharmacy benefits and held that they were preempted under the "connection with" test as they upset nationally uniform plan administration and bound the plan sponsors to a specific benefit design choice.

MT House Bill 740

Montana House Bill 740 ("HB 740") adds additional requirements to the state's regulation of pharmacy benefit managers ("PBMs"). Current law applies broadly to PBMs acting on behalf of a "health insurance issuer, third-party administrator, or plan sponsor." Mont.

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[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id*. at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id*. at 1195

[2] *McKee Foods* is currently pending appeal at the Sixth Circuit, while an appeal and cross-appeal of the *Ommen* decision are pending before the Eighth Circuit. Should the Sixth and Eighth Circuits affirm the preemption holdings at the district court level, they would join both the Tenth Circuit in *Mulready* and the Ninth Circuit in *Bristol* in finding that *Rutledge* did not upset well-established precedent protecting ERISA-covered plans from state regulation.

Code Ann. § 33-22-170(6). And so, HB 740's amendments to existing law create material concerns regarding the direct and indirect impact they have on self-insured, ERISA-covered plans. As noted above recent challenges to laws that are substantively the same as HB 740 have been successful at the district court level. The state laws in Tennessee and Iowa, which are the subject of appeal in the *McKee Foods* and *Ommen* cases, sought to impose rigid requirements on the pharmacy benefit design of ERISA-covered plans just as HB 740 seeks to do. In particular, all three laws prohibit differential cost-sharing for different pharmacies, limit the flexibility plans have in developing pharmacy networks, and prohibit or limit the use of mail-order only pharmacy benefit designs.

As in these other cases, and because of these impacts on plans, a number of provisions of HB 740 are likely preempted by ERISA based on existing Supreme Court jurisprudence, including *Rutledge*. In the following chart, we identify the specific provision, provide a description of the provision, and include the basis for federal preemption.

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
Mont. Code Ann. § 33-22-172(5)	Requires plan sponsors and PBMs to pay no less than the national average drug acquisition cost (or 100 percent of wholesale acquisition cost in the event no NADAC pricing is available) in addition to a dispensing fee of $15.	This provision imposes direct, and potentially acute, costs on plans. Because the provision applies directly to the plan sponsor and sets the rate paid by the plan, it should be preempted consistent with the holding in *Rutledge*.
Mont. Code Ann. § 33-22-177(2)(b)	Prohibits a PBM from excluding a pharmacy from a network based on time licensed absent a pending investigation for fraud, waste, and abuse.	This provision limits the ability of plans to develop and implement certain network requirements. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
Mont. Code Ann. § 33-22-177(8)(a)	Prohibits a PBM from reimbursing a pharmacy less than the contract price between the PBM and the third-party payer.	This provision could impose acute *and* direct economic burden on plans because it could limit the ability of plans to enter into high-value contracts Moreover, it could directly conflict with ERISA's fiduciary duty to act solely in the interest of the plan. As a result, the provision addresses a central matter of plan administration and fiduciary obligation, and should be preempted per *Gobeille*.

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
Mont. Code Ann. § 33-22-177(8)(b)	Prohibits requiring or coercing a patient to use a pharmacy that is owned by a PBM affiliate.	This provisions limits the ability of plans to adopt plan value-based plan designs, like mail-order only benefits. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
Mont. Code Ann. § 33-22-177(9)	Requires PBMs to impose the same utilization review, cost-shares and other conditions on coverage regardless of whether the patient utilizes a preferred pharmacy, including a mail-order pharmacy.	This provision limits the ability of plans to develop and implement certain value-based network and plan designs. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
Mont. Code Ann. § 33-22-177(10)	Requires retail pharmacy dispensing when the plan utilizes a mail order pharmacy in certain circumstances.	This provision limits the ability of plans to develop and implement certain value-based network and plan designs. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
Mont. Code Ann. § 33-22-177(11)	Prohibits the use of mandatory mail order pharmacies in certain geographies.	This provision limits the ability of plans to develop and implement certain value-based network and plan designs. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.