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Supreme Court Holds that ERISA Does Not Preempt Arkansas PBM Law: The Impact on Employer Sponsored Group Health Plans

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In a recently decided case, *Rutledge v. Pharmaceutical Care Management Association*, the U.S. Supreme Court held that the Employee Retirement Income Security Act of 1974 (ERISA)[1] does not preempt an Arkansas statute that regulates reimbursement levels paid by Pharmacy Benefit Managers (PBMs) to local pharmacies.[2] The Court determined that the Arkansas law affected only the cost of prescription drugs, thus lacking the requisite connection to ERISA-covered plans to trigger preemption.[3] The decision gives the green light for state-by-state regulations of PBM networks and payment practices. The impact of *Rutledge* on employer-sponsored group health plans, particularly multi-state arrangements, is difficult to underestimate. Employers will need to grapple with the inevitable proliferation of state PBM laws that, while purporting to regulate the relationship between a PBM and a pharmacy, will in all likelihood have unintended and unwelcome consequences for their group health plans.

This article explains the Supreme Court's holding in *Rutledge* and its likely impact in employer sponsored group health plans.

BACKGROUND

PBMs occupy a central role in the administration of pharmacy benefit programs. Medicare Part D plans, the Federal Employees Health Benefits Program and state government employee plans, and private sector group health plans routinely use PBMs to administer their prescription drug benefits. When a beneficiary of a prescription-drug plan goes to a pharmacy to fill a prescription, the pharmacy checks with a PBM to determine that person's coverage and co-payment information. After the beneficiary leaves with his or her prescription, the PBM reimburses the pharmacy for the prescription, less the amount of the beneficiary's copayment. The prescription drug plan, in turn, reimburses the PBM.

The amount a PBM reimburses a pharmacy for a drug is not necessarily tied to how much the pharmacy paid to purchase that drug from a wholesaler. In the case of brand name drugs, PBMs and pharmacies generally negotiate a price tied to a drug's list price (usually, the average wholesale price). In the case of generic drugs, PBMs generally set reimbursement rates according to a list specifying a PBM-specified maximum allowable cost (MAC). PBMs negotiate price discounts from retail pharmacies and mail service pharmacies, and rebates from pharmaceutical manufacturers. The extent to which pharmacy discounts and manufacturer rebates are shared with a PBM's client is governed by contract.

According to the Kaiser Family Foundation, about 156,199,800 Americans, or around 49% of the country's total population, are covered under employer-sponsored health insurance. The Society for Human Resource Professionals reports that prescription drug

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[1] Pub. L. No. 93-406.

[2] 141 S. Ct. 474, 482-483 (2020).

[3] *Rutledge*, 141 S. Ct. at 483.

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spending by these plans averages more than 30% of claims, the vast majority of which are administered by PBMs. The Affordable Care Act[4] established pharmacy benefits as an essential health benefit. As a consequence, any pronouncement by the nation's highest court will inevitably have far reaching consequences for employer-sponsored group health plans.

Arkansas Act 900 was enacted in response to concerns that the reimbursement rates set by PBMs were often too low to cover pharmacies' costs, and that many pharmacies, particularly rural and independent ones, were at risk of losing money and closing. (In Arkansas, nearly 13% of the independent pharmacies closed between 2006 and 2014 alone). Act 900 requires PBMs operating in Arkansas to:

- Reimburse pharmacies for generic drugs at a price equal to or higher than the pharmacies' cost for the drug;
- Update their MAC lists at least seven days after a certain increase in acquisition costs;
- Follow certain administrative appeals procedures;
- Allow pharmacies to reverse and re-bill each claim when a pharmacist cannot procure a drug at a cost that is equal to or less than the MAC price; and
- Allow pharmacies to decline to dispense a drug if the reimbursement rate is lower than the pharmacy's acquisition cost.

The Pharmaceutical Care Management Association (PCMA), a trade association that represents 11 of the country's largest PBMs, sued claiming that Act 900 is preempted by ERISA. Relying on precedent both the trial and appellate courts ruled in PCMA's favor. The State of Arkansas appealed to the Supreme Court.

ERISA PREEMPTION

ERISA made the regulation of employee benefit plans principally a matter of federal concern. The law broadly and generally preempts — or renders inoperative — state laws that ''relate to'' employee benefit plans. Since 1974, the Supreme Court has developed a robust ERISA preemption jurisprudence. At issue in *Rutledge* is ERISA §5141(b), which reads in relevant part:

> [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.

This provision makes ERISA the sole source of rules governing the maintenance and operation of employee benefit plans by preempting, or rendering inoperative, all state laws relating to such plans. (ERISA does, however, include an exception under which state laws regulating insurance, banking, and securities are saved from preemption).

The early Supreme Court cases construed the term ''relates to'' expansively. In *Shaw v. Delta Air Lines*, the Supreme Court held that the term ''relates to'' was to be given its broad common sense meaning, such that a state ''law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.''[5] But a state law would survive a preemption-based challenge where the relationship between the state law and ERISA is ''tenuous, remote or peripheral.''[6] *Shaw* identified, and later cases fleshed out, two categories of state laws that ERISA preempts:

- **State laws that have a "reference to" ERISA plans**. Thus 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, such reference will result in preemption.
- **State laws that have "an impermissible connection with" ERISA plans**. Thus, a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration would fail this test.

Shaw's expansive reading of the ERISA preemption was subsequently moderated in *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., wherein the Supreme Court held that ERISA did not preempt a state hospital surcharge statute because the statute's indirect economic influence did not bind plan administrators to any particular choice and thus did not function as a regulation of an ERISA plan itself.[7] The Court also expressed concern for the role of the states, noting that there is nothing in the language of the ERISA statute ''or the context of its passage'' that ''indicates that Congress chose to displace general health care regulations, which historically has been a matter of local concern.''[8]

Travelers was followed by two other cases, *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*,[9] and *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund.* [10] These three cases, which are sometimes referred to as the ''Travelers Trilogy,''

[4] Pub. L. No. 111-148.

[5] 463 U.S. 85, 100 (1983).

[6] *Shaw,* 463 U.S. at 100, n.21.

[7] 514 U.S. 645 (1995).

[8] *Travelers,* 514 U.S. at 668.

[9] 519 U.S. 316 (1997).

[10] 520 U.S. 806 (1997).

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established a new test under which a state law has the requisite connection with an employee benefit plan only if it affects the plan's structure or administration, binds plans to particular choices, or establishes alternative remedies.

PBMs, which act as intermediaries between pharmacies and prescription-drug plans, are not themselves ERISA-covered plans. Rather, they provide administrative services to ERISA covered plans as well as plans that are not subject to ERISA, e.g., group health plans maintained by churches and units of government. In the parlance of group health plans, they are generically referred to as ''third party administrators'' or ''TPAs.'' But, as a practical matter, a PBM contract can supply plan terms. In *Pegram v. Herdrich*, the Supreme Court clarified what is meant by an ERISA-covered plan, saying:

> One is thus left to the common understanding of the word ''plan'' as referring to a scheme decided upon in advance . . . Here the scheme comprises a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan.[11]

The Court went on to observe that the terms of the underlying insurance contract can be relied on to furnish some of the terms of the plan. This reasoning applies with equal force to a PBM agreement: the terms of the agreement can supply and flesh out plan terms.

PCMA's challenge to Arkansas Act 900 was premised on the role of PBMs as plan service providers. Their claim is that, by regulating PBMs, Act 900 affects the plan structure or administration, binds plans to particular choices, or establishes alternative remedies. The law should, as a result, be preempted. Despite failing to carry the day in *Rutledge*, this argument deserves to be taken seriously. One can imagine any number of PBM-related state laws that might rise to this level. For example, a state law prohibiting step therapies of fail first protocols would ''bind plans to particular choices.''[12]

THE MAJORITY OPINION

Speaking for a unanimous Court, Justice Sotomayor said that, ''Arkansas' Act 900 regulates the price at which pharmacy benefit managers reimburse pharmacies for the cost of drugs covered by prescription-drug plans.''

The Court's analysis of Act 900 hews closely to its prior ERISA jurisprudence. The starting point is unsurprisingly the statute itself, i.e., ERISA §514(a) (set out above). The Court next cites a 2001 case, *Egelhoff v. Egelhoff*, for the proposition that ''a state law relates to an ERISA plan if it has a connection with or reference to such a plan.''[13] (*Egelhoff* merely restates the post *Travelers* law described above). In the Court's view, Act 900 has neither of these impermissible relationships with an ERISA plan. The law is therefore not pre-empted.

IMPERMISSIBLE CONNECTION

Under the impermissible connection prong, the Court looks to Congressional intent, noting that when considering whether a state law has an impermissible connection with an ERISA plan, the Court considers ERISA's objectives ''as a guide to the scope of the state law that Congress understood would survive.''[14] A core theme of the impermissible connection prong is grounded in Congress' desire:

> [To] ensure that plans and plan sponsors would be subject to a uniform body of benefits law,'' thereby ''minimiz[ing] the administrative and financial burden of complying with conflicting directives'' and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions.[15]

ERISA is thus primarily concerned with preempting laws that require plan administrators and service providers to structure benefit plans in particular ways, e.g., requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status.

This, in the Court's view, Act 900 does not do. Importantly, the Court recognizes that a state law that merely affects cost may be pre-empted if ''acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage.''[16] This recognition could prove pivotal in future disputes over the proper reach of state laws regulating PBMs. The Court also opined that ''not every state law that affects an ERISA plan or causes some dis-uniformity in plan administration has an impermissible connection with an ERISA plan. *That is especially so if a law merely affects costs*.'' (Emphasis added)[17]

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[11] 530 U.S. 211, 213 (2000).

[12] *Pegram*, 530 U.S. at 213.

[13] 52 U.S. 141, 147 (2001).

[14] *Rutledge,* 141 S. Ct. at 480.

[15] *Rutledge*, 141 S. Ct. at 480.

[16] *Rutledge*, 141 S. Ct. at 480 (quoting *Gobeille v. Liberty Mut. Ins. Co*, 577 U.S. 312, 320 (2016)).

[17] *Rutledge*, 141 S. Ct. at 480.

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REFERENCE TO ERISA

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.''[18] The Court was quick to conclude that Act 900 does not act immediately and exclusively upon ERISA-covered plans because it applies to PBMs whether or not they manage an ERISA plan. The Court underscored this point, saying that the law ''does not directly regulate health benefit plans at all, ERISA or otherwise.''[19] Rather, the law affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.

THE CONCURRING OPINION

In *Gobeille v. Liberty Mut. Ins. Co*., Justice Thomas delivered a concurring opinion in which he asked whether Congress overstepped its Constitutional authority in enacting a law (i.e., ERISA) that abrogates the right of states to regulate in an area (health care) that is traditionally a matter of state concern.[20] The approach seemed radical, heretical perhaps, and it got little attention. In *Rutledge*, Justice Thomas revisited the issue, again in a concurring opinion, in which he moderated his earlier view, saying instead that the Court's ERISA preemption tests have strayed from the text of the relevant statutory language.[21]

Justice Thomas is considered the Court's most conservative justice, and his jurisprudence is often described as textualist. This means that he looks for guidance to the original meaning of the Constitution and the various statutes promulgated thereunder. His textualist views are on full display here. He claims that the plain text of ERISA suggests a two-part preemption test:

- Do any ERISA provisions govern the same matter as the state law at issue, and
- Does that state law have a meaningful relationship to ERISA plans?

In his view, ''[o]nly if the answers to both are in the affirmative does ERISA displace state law.''[22] His particular beef is with the word ''supersede'' in ERISA §514(b), as in certain of ERISA's provisions ''shall *supersede* any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.''[23] Why not ''preempts''? Justice Thomas thinks this is significant. In his view, the term ''supersede'' precludes reading the statute as categorically preempting any state law related to employee benefit plans.[24] If Congress meant for ERISA to preempt state laws without replacing them, it would have chosen different words.

Justice Thomas bemoans the Court's existing preemption jurisprudence for its ''accordion-like' (text) that seems to expand or contract depending on the year'' (this is a reference to changing scope of the doctrine over time). In his view, only if ERISA governs the same subject matter as the disputed state law should the court ask whether the state law ''relates to'' employee benefit plans.[25] Since no provision of Act 900 governs the same subject matter as ERISA, the law is not preempted. In support of this view, Justice Thomas revisited an oft-cited statement by Justice Souter in an opinion in *Travelers* concerning the potential reach of the ERISA preemption clause:[26]

> If ''relate to'' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course. . . . That is a result ''no sensible person could have intended.''

In support of his textualist view of how ERISA preemption should operate, Justice Thomas deploys and expands on this logic saying:

> But many times it is the ordinary, not literalist, meaning that is the better one. See, e.g., *McBoyle v. United States*, 283 U. S. 25, 26 (1931) (''vehicle'' in the 1930s did not include aircraft because ''in everyday speech 'vehicle' calls up the picture of a thing moving on land''). ''[A] reasonable person conversant with applicable social conventions'' would not understand ''relate to'' as covering any state law with a connection to employee benefit plans, no matter how remote the connection.[27]

It is not clear to us, however, whether a reasonable person conversant with terms like ''supersede'' or ''relates to'' would reach a different result irrespective of interpretive approach. The problem, in our view, is not which words Congress used; it is rather that resort to their meaning in everyday speech does not help here. What is required is a resort to Congressional intent, which, admittedly, a textualist loathes to do.

At bottom, Justice Thomas would overturn decades the Court's ERISA jurisprudence in favor of a text-

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[18] *Rutledge*, 141 S. Ct. at 481.
[19] *Rutledge*, 141 S. Ct. at 481.
[20] *Gobeille v. Liberty Mut. Ins. Co*, 577 U.S. 312, 320 (2016).
[21] *Rutledge*, 141 S. Ct. at 483-485 (Thomas, J., concurring).
[22] *Rutledge*, 141 S. Ct. at 483.
[23] *Rutledge*, 141 S. Ct. at 483.
[24] *Rutledge*, 141 S. Ct. at 483-484.
[25] *Rutledge*, 141 S. Ct. at 483-484.
[26] *Travelers,* 514 U.S. at 655.
[27] *Rutledge*, 141 S. Ct. at 484.

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based approach. The result would be a far less robust preemption doctrine. The remaining seven Justices (Justice Barrett did not participate) would have none of this. They instead looked to and faithfully applied the court's existing precedents.

CONCLUSION

The majority opinion in *Rutledge* is short (a mere 21 pages), and its holding is straightforward: Act 900 is merely a form of cost regulation, which has neither an impermissible connection with, nor an improper relation to, ERISA-covered plans. The starkness of this holding makes the ERISA preemption analysis appear easy and straightforward. It is not. Future cases will undoubtedly consider a range of state and other regulations that, while purporting to merely address costs, will nevertheless to some degree require plans to adopt a particular substantive coverage scheme.

It is too soon to tell whether *Rutledge* will significantly modify the arc of ERISA jurisprudence. On its face the case simply applies existing law to facts that are familiar and uncomplicated. What gives us pause, however, is that *Rutledge* gives states the leeway to impose regulations on PBMs even when PBMs are acting on behalf of ERISA-covered plans. This will likely invite a new and aggressive round of state efforts to expand the case's holding well beyond pharmacy benefits. At a minimum, *Rutledge* will impact price negotiations between PBMs and employee group health plans. Historically, PBMs have been able to offer prices to these plans based on the understanding that certain state laws did not apply. *Rutledge* has changed that. PBMs will at a minimum need to reconsider and adapt to state laws and will likely adjust prices accordingly.

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