No. 18-540

In the Supreme Court of the United States

LESLIE RUTLEDGE, ATTORNEY GENERAL OF ARKANSAS,
PETITIONER

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts a State's regulation of the rates at which pharmacy benefit managers reimburse pharmacies.

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INTEREST OF THE UNITED STATES

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be granted.

STATEMENT

1. With specified exceptions, the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of [Title 29] and not exempt under section 1003(b) of [Title 29]." 29 U.S.C. 1144(a). The "employee benefit plan[s]" described in Section 1003(a) include "any employee benefit plan" that is "established or maintained" by an "em-

ployer" or "employee organization" "engaged in commerce or in any industry or activity affecting commerce." 29 U.S.C. 1003(a). Such plans include "employee welfare benefit plan[s]," 29 U.S.C. 1002(3), which are established or maintained for the purpose of providing, "through the purchase of insurance or otherwise," "medical" or other benefits, 29 U.S.C. 1002(1).

Under this Court's precedents construing ERISA's express preemption provision, "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). A state law has a "reference" to ERISA plans if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). A state law has an "impermissible 'connection with' ERISA plans" if it "'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (citation omitted). "A state law also might have an impermissible connection with ERISA plans if 'acute, albeit indirect, economic effects' of the state law 'force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" *Ibid.* (citation omitted). The Court has stated that those "formulations ensure that ERISA's express pre-emption clause receives the broad scope Congress intended while avoiding the clause's susceptibility to limitless application." *Ibid.*

2. Pharmacy benefit managers (PBMs) serve as intermediaries between pharmacies and health benefit plans, including plans covered by ERISA. Pet. App. 3a.

PBMs contract with pharmacies to establish pharmacy networks, *id.* at 15a, and contract with health benefit plans to provide access to those pharmacy networks. D. Ct. Doc. 89, at 6-7 (Sept. 9, 2016). When a participant in a health benefit plan fills a drug prescription at a network pharmacy, the PBM pays the pharmacy at the rate negotiated in the contract between the PBM and the pharmacy (less any copayment by the participant), and the health benefit plan then reimburses the PBM at the rate negotiated in the contract between the PBM and the health benefit plan. Advisory Council on Employee Welfare and Pension Benefit Plans, U.S. Dep't of Labor, *PBM Compensation and Fee Disclosure* 6 (Nov. 2014) (ERISA Advisory Council Report);[1] see D. Ct. Doc. 89, at 5.

The difference between the price the PBM pays to the pharmacy and the price it receives from the health benefit plan is known as the "retail spread"—"a significant source of PBMs' net revenue." ERISA Advisory Council Report 10; see D. Ct. Doc. 85-1, at 14 (Sept. 9, 2016). In the case of generic drugs, the price the PBM pays the pharmacy is typically based on a predetermined maximum allowable cost (MAC), which is the same for any generic version of a particular drug, regardless of the pharmacy's actual cost of acquiring the drug from a pharmaceutical wholesaler or manufacturer. See Pet. App. 15a-16a; D. Ct. Doc. 85-1, at 20-21; ERISA Advisory Council Report 6, 10. Although the

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[1] https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014-pbm-compensation-and-fee-disclosure.pdf. The ERISA Advisory Council consists of 15 members appointed by the Secretary of Labor "to advise the Secretary with respect to the carrying out of his functions" under ERISA. 29 U.S.C. 1142(b); see 29 U.S.C. 1142(a).

MAC-based price often reflects a favorable discount to the PBM, pharmacies agree to be reimbursed at that reduced price in exchange for being part of the PBM's pharmacy network—which can be a key source of a pharmacy's business. See Pet. App. 16a; D. Ct. Doc. 85-1, at 22; ERISA Advisory Council Report 6.

As noted above, the amount the health benefit plan pays the PBM for a prescription is governed by a separate contract between the PBM and the plan. See D. Ct. Doc. 85-1, at 13; ERISA Advisory Council Report 6. In exchange for that payment, as well as for an administrative fee, the PBM provides various services to the plan. See ERISA Advisory Council Report 9. Those services include access to a network of pharmacies, the creation of a list of drugs covered by the plan, and the processing of claims submitted by pharmacies for reimbursement. See *ibid.*; Pet. App. 15a.

3. In 2015, the State of Arkansas enacted Act 900. 2015 Ark. Laws Act 900 (S.B. 688). Act 900 amended Section 17-92-507 of the Arkansas Code, a statute primarily regulating MAC lists—the "listing of drugs used by a [PBM] setting the [MAC] on which reimbursement to a pharmacy or pharmacist may be based." Ark. Code Ann. § 17-92-507(a)(1) (Supp. 2017).[2] As amended, Section 17-92-507 requires PBMs that use MAC lists to reimburse pharmacies at a price equal to or higher than the "[p]harmacy acquisition cost"—"the amount that a

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[2] All references in this brief to Section 17-92-507 of the Arkansas Code are to Ark. Code Ann. § 17-92-507 (Supp. 2017), the version of the law, as amended by Act 900, that was in effect when the court of appeals in this case rendered its decision. Since then, Arkansas has further amended Section 17-92-507. See 2019 Ark. Laws Act 994 (S.B. 520). Those amendments do not materially affect the operation of the law and are not relevant to the question presented here.

pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice." *Id.* § 17-92-507(a)(6).

Section 17-92-507 effectuates that requirement through various provisions. First, Section 17-92-507 requires a PBM to "[u]pdate its [MAC] List on a timely basis, but in no event longer than seven (7) calendar days" following a 10% or more increase in the "pharmacy acquisition cost" charged by 60% or more of the pharmaceutical wholesalers doing business in the State. Ark. Code Ann. § 17-92-507(c)(2). Second, Section 17-92-507 requires a PBM to provide a "reasonable administrative appeal procedure to allow pharmacies to challenge [MACs] and reimbursements made under a [MAC] for a specific drug or drugs as * * * [b]eing below the pharmacy acquisition cost." *Id.* § 17-92-507(c)(4)(A)(i)(b). If, as part of that challenge, it is shown that the pharmacy is unable to purchase the drug "below the pharmacy acquisition cost from the pharmaceutical wholesaler from whom the pharmacy" purchases "the majority" of its prescription drugs, Section 17-92-507 requires the PBM to "adjust" its MAC list and to "permit the pharmacy to reverse and rebill each claim affected by the inability to procure the drug at a cost that is equal to or less than the previously challenged [MAC]." *Id.* § 17-92-507(c)(4)(C)(iii). Third, Section 17-92-507 allows a pharmacy to decline to dispense a drug to a patient "if, as a result of a [MAC] List, [the pharmacy] is to be paid less than the pharmacy acquisition cost" by the PBM. *Id.* § 17-92-507(e).

4. Respondent is a national trade association of PBMs. Compl. ¶¶ 8, 10. In 2015, respondent sued petitioner in the Eastern District of Arkansas, alleging,

among other things, that ERISA preempts Act 900 because Act 900 "relate[s] to" ERISA plans. Compl. ¶ 57 (brackets in original); see Compl. ¶¶ 54-59. Respondent sought a declaratory judgment and an injunction prohibiting the enforcement of Act 900. Compl. 22-23.

The district court granted respondent's motion for summary judgment on its ERISA claim. Pet. App. 12a-36a. The court concluded that "Act 900 is invalid as applied to PBMs in their administration and management of ERISA plans." *Id.* at 17a. The district court noted that in *Pharmaceutical Care Management Ass'n* v. *Gerhart*, 852 F.3d 722 (2017), the Eighth Circuit had found a "similar" Iowa statute "preempted by ERISA because it interferes with nationally uniform plan administration." Pet. App. 18a. The district court further noted that *Gerhart* had "held that the Iowa statute interferes with uniform plan administration by requiring PBMs * * * to provide a procedure by which pharmacies can contest and appeal MAC reimbursements." *Ibid.* The court observed that Act 900 likewise "requires PBMs to provide a 'reasonable administrative appeal procedure' that allows pharmacies to challenge MAC costs and to reverse and rebill the claim in question." *Ibid.* The court concluded that "[b]ecause Act 900 regulates PBMs in ways fundamentally similar to the Iowa statute in *Gerhart*, Act 900 is preempted by ERISA." *Id.* at 19a.[3]

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[3] Respondent also brought a Medicare preemption claim and various constitutional claims, and the district court granted summary judgment in petitioner's favor on those claims. Pet. App. 20a-36a. Respondent appealed only the rejection of its Medicare preemption claim, Br. in Opp. 12 n.8, and the court of appeals reversed, holding that the Medicare statute preempts the Arkansas statute as applied to PBMs that administer pharmacy benefits for Medicare Part D

5. The court of appeals affirmed in relevant part. Pet. App. 1a-11a. The court explained that, in *Gerhart*, it had "held that an Iowa statute, similar in purpose and effect to Act 900, was preempted by ERISA because it had a prohibited 'reference to' ERISA, and because it interfered with national uniform plan administration." *Id.* at 5a (citation omitted). The court agreed with the district court that "*Gerhart* controlled the outcome of the ERISA preemption claim." *Ibid.* In particular, the court of appeals observed that *Gerhart* had found that the Iowa statute "makes implicit reference to ERISA through regulation of PBMs who administer benefits for 'covered entities,' which, by definition, include * * * entities [that] are necessarily subject to ERISA regulation." *Id.* at 6a (quoting *Gerhart*, 852 F.3d at 729). The court concluded that it was bound by that reasoning here. *Id.* at 6a-7a. It therefore held that Act 900 is likewise "preempted by ERISA" because "the state law both relates to and has a connection with employee benefit plans." *Id.* at 7a.

DISCUSSION

The court of appeals held that ERISA preempts Arkansas's regulation of the rates at which PBMs reimburse pharmacies. That decision is incorrect. It is contrary to this Court's precedent and the decisions of other courts of appeals on an important question of federal law. And this case is a suitable vehicle for this Court's review. The petition for a writ of certiorari should be granted.

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plans, Pet. App. 7a-11a. Petitioner does not seek review of that Medicare preemption holding.

A. The Court Of Appeals Erred In Holding That ERISA Preempts Arkansas's Regulation Of The Rates At Which Pharmacy Benefit Managers Reimburse Pharmacies

The court of appeals held that the Arkansas statute is preempted as applied to PBMs that provide services to ERISA plans because the Arkansas statute both refers to and has an impermissible connection with such plans. Pet. App. 5a-7a. That decision is incorrect.

1. The Arkansas statute does not make "reference to" ERISA plans

A state law has a "reference to" ERISA plans if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). That standard is not satisfied here.

As amended by Act 900, Ark. Code Ann. § 17-92-507 does not "act[] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325. Section 17-92-507 imposes obligations on PBMs, not ERISA plans. See, *e.g.*, Ark. Code Ann. § 17-92-507(c) (setting forth what "[a] pharmacy benefits manager shall" do). Under Section 17-92-507, a PBM "means an entity that administers or manages a pharmacy benefits plan or program." *Id.* § 17-92-507(a)(7). But the "pharmacy benefits plan or program" that the PBM administers or manages need not be an *ERISA* plan or program. Rather, the statute defines "[p]harmacy benefits plan or program" to include any "plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in th[e] state." *Id.* § 17-92-507(a)(9).

That definition is indifferent to whether the plan falls within ERISA's coverage. It encompasses not just

ERISA plans, but also non-ERISA plans, such as "plans sold in the individual health insurance market." Compl. ¶ 8; see 29 U.S.C. 1003(a)(1) and (2) (providing that ERISA applies only to employee benefit plans established or maintained by an "employer" or "employee organization"). Because the plans that PBMs administer or manage "need not necessarily be ERISA plans" in order for a PBM to be subject to Section 17-92-507, the state law does not "act[] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325; see *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (holding that a state statute that imposed surcharges on patients and health maintenance organizations could "not be said to make 'reference to' ERISA plans" because the surcharges were imposed "regardless of whether" the benefits were "ultimately secured by an ERISA plan, private purchase, or otherwise").

Nor is the "existence of ERISA plans * * * essential" to Section 17-92-507's "operation." *Dillingham*, 519 U.S. at 325. Because its definition of "[p]harmacy benefits plan or program" encompasses non-ERISA plans as well as ERISA plans, Ark. Code Ann. § 17-92-507(a)(9), Section 17-92-507 "functions irrespective of[] the existence of an ERISA plan," *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 139 (1990). And because a PBM's obligations under Section 17-92-507 do not vary depending on the nature of the plan the PBM administers or manages, application of Section 17-92-507 does not require any "inquiry" "directed to the plan." *Id.* at 140. Section 17-92-507 thus does not resemble state laws that this Court has previously found preempted under a "reference to" theory. See *District of Columbia* v. *Greater Wash. Bd. of Trade*, 506 U.S. 125, 128 (1992) (finding

preempted a D.C. workers' compensation law that set employee benefits "by reference to" the coverage provided by ERISA plans) (citation omitted); *Ingersoll-Rand*, 498 U.S. at 140 (finding preempted a Texas common-law cause of action that made "specific reference to," and was "premised on," the existence of an ERISA-covered pension plan and that required a court to conduct an "inquiry * * * directed to the plan").

The court of appeals found Section 17-92-507 to contain an "implicit" reference to ERISA plans because the plans to which PBMs provide services may "*include*" ERISA plans. Pet. App. 6a (emphasis added; citation omitted). But if such an "implicit" reference were enough to trigger ERISA preemption, there would never be any point in asking whether the state law "acts immediately and *exclusively* upon ERISA plans," *Dillingham*, 519 U.S. at 325 (emphasis added). The approach of the court of appeals thus would give ERISA's preemption provision nearly "limitless application," far beyond what any "'sensible person could have intended.'" *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (citation omitted).

2. The Arkansas statute does not have an impermissible "connection with" ERISA plans

Even if a state law does not make "reference to" ERISA plans, it is preempted if it has "an impermissible 'connection with' ERISA plans." *Gobeille*, 136 S. Ct. at 943 (citation omitted). That standard, however, is likewise not satisfied here.

a. In *Travelers*, this Court considered whether ERISA preempted a New York statute that regulated hospital rates for in-patient care. 514 U.S. at 649. The New York statute "require[d] hospitals to collect surcharges from patients insured by a commercial insurer

but not from patients insured by a Blue Cross/Blue Shield plan." *Ibid.* It also imposed surcharges on certain health maintenance organizations (HMOs). *Ibid.* The state statute's regulation of hospital rates made "the Blues more attractive (or less unattractive) as insurance alternatives" than competing commercial insurers and HMOs. *Id.* at 659. The statute thus had "an indirect economic effect on choices made by insurance buyers, including ERISA plans." *Ibid.*

Notwithstanding that "indirect economic influence," *Travelers*, 514 U.S. at 659, the Court held that the New York law did "not bear the requisite 'connection with' ERISA plans to trigger pre-emption," *id.* at 662. The Court explained that the law did "not bind plan administrators to any particular choice" and thus did not "function as a regulation of an ERISA plan itself." *Id.* at 659; see *id.* at 668 (concluding that "New York's surcharges" did not produce such effects "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers").

The Court in *Travelers* acknowledged that the New York statute "bears on the costs of benefits and the relative costs of competing insurance to provide them." 514 U.S. at 660. The Court further acknowledged that such costs, in turn, "can affect a plan's shopping decisions"—*i.e.*, its decisions whether to contract with the Blues rather than a competing commercial insurer or HMO. *Ibid.* The Court emphasized, however, that many other forms of "state action"—from "[q]uality standards" to "basic regulation of employment conditions"—can likewise "affect the cost and price of services." *Ibid.* And the Court explained that "to read the pre-emption provision as displacing all state laws affecting

costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in [Section 1144(a)] out of the statute." *Id.* at 661. Finding "nothing in the language of the Act or the context of its passage [that] indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern," *ibid.*, the Court held that ERISA did not preempt New York's "hospital reimbursement methodology," *id.* at 649 (capitalization omitted).

Although this case involves a State's methodology governing payments to pharmacies, not hospitals, the principle is the same. Just as the New York statute affected a commercial insurer's or HMO's costs of providing hospital coverage, so too the Arkansas statute affects a PBM's costs of providing pharmacy benefits, requiring a PBM to reimburse pharmacies at a price equal to or higher than the "[p]harmacy acquisition cost." Ark. Code Ann. § 17-92-507(a)(6); see pp. 4-5, *supra*. And just as the effect on costs in *Travelers* may have influenced an ERISA plan's decisions to contract with a commercial insurer or HMO, so too the effect on costs here may influence an ERISA plan's decision to contract with a PBM.

But like the New York law in *Travelers*, the Arkansas law here does not "bind plan administrators to any particular choice," 514 U.S. at 659; "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," *id.* at 668; or otherwise "function as a regulation of an ERISA plan itself," *id.* at 659. The Arkansas law regulates only the relationship between PBMs and pharmacies. It does

not regulate plans themselves or their relationships with PBMs, pharmacies, or plan participants. Like the New York law in *Travelers*, the Arkansas law "leave[s] plan administrators right where they would be in any case," *id.* at 662, with the responsibility to decide whether it would be worthwhile to contract with a PBM for services.

The Arkansas law therefore does "not bear the requisite 'connection with' ERISA plans to trigger preemption." *Travelers*, 514 U.S. at 662; see *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 (1997) ("Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."); *Dillingham*, 519 U.S. at 334 (holding that ERISA did not preempt a California "prevailing wage statute" that "alter[ed] the incentives, but d[id] not dictate the choices, facing ERISA plans").

b. This Court's decision in *Gobeille* is not to the contrary. *Gobeille* involved a Vermont statute "requiring disclosure of payments relating to health care claims and other information relating to health care services." 136 S. Ct. at 940. The statute imposed such requirements on "[h]ealth insurers," Vt. Stat. Ann. tit. 18, § 9410(c) (Supp. 2014)—a term defined to include "any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities," Vt. Stat. Ann. tit. 18, § 9402(8) (2012); see *Gobeille*, 136 S. Ct. at 941. "The state law, by its terms," thus "applie[d] to health plans established by employers and regulated by [ERISA]." *Gobeille*, 136 S. Ct. at 940; see *id.* at 946 ("Vermont orders health

insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner."). And the information the state law required to be disclosed included information about those plans and their members. See *id.* at 941 (describing the information subject to disclosure); *id.* at 942 (explaining that, although the respondent in *Gobeille*, an ERISA health plan, had too few members for the plan itself to be subject to the law's mandatory reporting requirements, "data about the Plan or its members" was still required to be disclosed by the plan's third-party claims administrator, which was subject to those requirements).

The Court in *Gobeille* held that the state law, as applied to ERISA plans, was preempted. 136 S. Ct. at 943. The Court explained that, by "compel[ling] plans to report detailed information about claims and plan members," the Vermont law "both intrude[d] upon 'a central matter of plan administration' and 'interfere[d] with nationally uniform plan administration.'" *Id.* at 945 (citation omitted). The Court observed that ERISA already imposed "extensive" "reporting, disclosure, and recordkeeping requirements" on "welfare benefit plans." *Id.* at 944. Yet the Vermont law sought to regulate those same matters: "plan reporting, disclosure, and—by necessary implication—recordkeeping." *Id.* at 945. The Court therefore concluded that preemption was "necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Ibid.*

Unlike the Vermont law in *Gobeille*, the Arkansas law here does not require plans to do anything—let alone disclose information about themselves and their members. The Arkansas law imposes obligations on

PBMs, not plans. See Ark. Code Ann. § 17-92-507(c) ("A pharmacy benefits manager shall * * * ."). To ensure that PBMs reimburse pharmacies at a price equal to or higher than the "[p]harmacy acquisition cost," *id.* § 17-92-507(a)(6), the Arkansas law requires PBMs to update or adjust their own, "proprietary" MAC lists. D. Ct. Doc. 85-1, at 20-21; see, *e.g.*, Ark. Code Ann. § 17-92-507(c)(2) and (4)(C)(iii). The Arkansas law thus regulates PBM administration, not ERISA plan administration. And because the Arkansas law does not "govern, or interfere with the uniformity of, plan administration," it does not "have an impermissible '"connection with"' ERISA plans." *Gobeille*, 136 S. Ct. at 943 (citation omitted). The court of appeals therefore erred in deeming the Arkansas law preempted.

B. The Court Of Appeals' Decision Conflicts With The Decisions Of Other Courts Of Appeals On An Important Question Of Federal Law

Each of the Eighth Circuit's holdings in this case—that the Arkansas statute makes "reference to" ERISA plans, Pet. App. 6a (citation omitted), and that it has an impermissible "connection with" such plans, *id.* at 7a—implicates a circuit conflict on an important question of federal law. As intermediaries between pharmacies and health benefit plans, PBMs "play a central role in the healthcare market," and "many States have enacted laws regulating [PBMs]" in the interest of "protecting the health and well-being of their residents." States Amicus Br. 1. Whether, or to what extent, ERISA preempts such state laws raises important issues on which the courts of appeals are divided, and this Court's review is warranted to resolve those conflicts.

1. The Eighth Circuit's holding that the Arkansas statute makes "reference to" ERISA plans conflicts

with the First Circuit's decision in *Pharmaceutical Care Management Ass'n* v. *Rowe*, 429 F.3d 294 (2005), cert. denied, 547 U.S. 1179 (2006), and the D.C. Circuit's decision in *Pharmaceutical Care Management Ass'n* v. *District of Columbia*, 613 F.3d 179 (2010). Both *Rowe* and *District of Columbia* involved laws imposing obligations on PBMs that contract with "covered entities." *Rowe*, 429 F.3d at 299; see *District of Columbia*, 613 F.3d at 189. The Maine law in *Rowe* required PBMs "to act as fiduciaries for" those entities; for example, it required that they "disclose conflicts of interest, disgorge profits from self-dealing, and disclose to the covered entities certain of their financial arrangements with third parties." 429 F.3d at 299. The D.C. law in *District of Columbia* likewise required PBMs to act as a "fiduciary" for covered entities by, for instance, disclosing certain conflicts and disgorging certain payments. 613 F.3d at 183.

In *Rowe*, the First Circuit held that the Maine law did not make "reference to" ERISA plans. 429 F.3d at 303-304. The court observed that "[c]overed entities" under the Maine law encompassed "a broad spectrum of health care institutions and health benefit providers, including but not limited to ERISA plans." *Id.* at 304. The court then explained that "'[a] state law that applies to a wide variety of situations, including an appreciable number that have no specific linkage to ERISA plans, constitutes a law of general application'" that does not satisfy the standard for "reference to" preemption. *Ibid.* (brackets in original; citation omitted).

In *District of Columbia*, the D.C. Circuit likewise held that the D.C. law did not make "reference to" ERISA plans. 613 F.3d at 189-190. The court observed that the D.C. law applied "to any PBM that contracts

with a 'covered entity,' defined as '[a]ny hospital or medical service organization, insurer, health coverage plan, or [HMO] . . . that contracts with another entity to provide prescription drug benefits for its customers or clients.'" *Ibid.* (brackets in original; citation omitted). The court therefore concluded that the provisions of the D.C. law did "not act exclusively upon [employee benefit plans]" and that "'the existence of ERISA plans . . . is [not] essential to [their] operation.'" *Id.* at 190 (second and third sets of brackets in original; citation omitted).

Like the Maine law in *Rowe* and the D.C. law in *District of Columbia*, the Arkansas law here applies to PBMs that contract with entities that include, but are not limited to, ERISA plans. See Ark. Code Ann. § 17-92-507(a)(9); pp. 8-9, *supra*. The Eighth Circuit, however, concluded that because the covered entities "include" ERISA plans, the Arkansas law makes "implicit reference" to ERISA plans and therefore is preempted. Pet. App. 6a (citation omitted). That holding cannot be reconciled with the decisions in *Rowe* and *District of Columbia*.

2. The Eighth Circuit's decision also implicates a conflict among the circuits concerning the "connection with" prong of ERISA preemption. In concluding that the Arkansas law has an impermissible "connection with" ERISA plans, the Eighth Circuit in this case relied on its prior decision in *Pharmaceutical Care Management Ass'n* v. *Gerhart*, 852 F.3d 722 (2017). Pet. App. 7a; see *id.* at 5a-7a. In *Gerhart*, the Eighth Circuit held that an Iowa law imposing obligations on PBMs had an impermissible "connection with" ERISA plans. 852 F.3d at 730. Drawing no distinction between obligations imposed on PBMs and obligations imposed on

plans, the court reasoned that the obligations imposed by the Iowa law "implicat[ed]" an "area central to plan administration—that is, the calculation of prescription benefit levels and making disbursements for these benefits." *Id.* at 731.

In *District of Columbia*, the D.C. Circuit adopted similar reasoning in deeming the D.C. law preempted under a "connection with" theory. 613 F.3d at 184-189. Like the Eighth Circuit in *Gerhart*, the D.C. Circuit equated the "requirements" imposed on PBMs with "'regulation of an ERISA plan itself.'" *Id.* at 188 (citation omitted). And like the Eighth Circuit in *Gerhart*, the D.C. Circuit concluded that because those requirements "also regulate an area of ERISA concern," *ibid.*—namely, the "administration of employee benefits," *id.* at 184—"they are pre-empted," *id.* at 188.

By contrast, the First Circuit in *Rowe* concluded that the Maine law at issue there did not have an impermissible "connection with" ERISA plans. 429 F.3d at 302-303; see *District of Columbia*, 613 F.3d at 190 n.* (acknowledging the conflict with *Rowe*). Unlike the Eighth and D.C. Circuits, the First Circuit in *Rowe* distinguished the "duties" the law imposed on PBMs from the "ability of plan administrators to administer their plans." 429 F.3d at 302. The First Circuit acknowledged that the Maine law "require[d] PBMs to engage in certain 'required practices.'" *Id.* at 303 (citation omitted). And it acknowledged that those requirements could have led ERISA plans to "re-evaluate their working relationships with the PBMs." *Ibid.* But the First Circuit found "nothing" in the Maine law that "compel[led]" ERISA plans to do so, and it concluded that the law left "plan administrators" "free * * * to structure the plans as they wish." *Ibid.*

The First Circuit's reasoning in *Rowe* applies equally here. Like the Maine law in *Rowe*, the Arkansas law in this case imposes duties on PBMs, but does not "circumscribe the ability of plan administrators to structure or administer their ERISA plans." 429 F.3d at 303. And though the Arkansas law may prompt some ERISA plans to "re-evaluate" their contracts with PBMs, nothing in the law "compels" ERISA plans to do so or binds them to "a particular choice of rules." *Ibid.* Thus, if this case had arisen in the First Circuit, the Arkansas law would have been upheld. Indeed, given that *Rowe* upheld a law that directly regulated the relationship between PBMs and plans—requiring PBMs to "act as fiduciaries for their clients," *id.* at 299—it follows that a law further removed from plans—governing only a PBM's relationship with downstream pharmacies—would be upheld as well.

Respondent contends (Br. in Opp. 38) that, "insofar as *Rowe* implies that ERISA does not have a 'connection with' state regulation of PBMs as third-party administrators, *Gobeille* supersedes it." But *Gobeille* did not cast doubt on *Rowe*'s distinction between regulation of third-party service providers, on the one hand, and regulation of plans themselves, on the other. The Vermont law at issue in *Gobeille* imposed obligations on plans themselves. See 136 S. Ct. at 940 ("The state law, by its terms, applies to health plans established by employers and regulated by [ERISA]."). Although the respondent health plan in that case was not itself subject to any mandatory reporting requirements, the law still required disclosure of information about the plan and its members, through the plan's third-party claims administrator. See *id.* at 942. The Court in *Gobeille* therefore found the law preempted because it viewed the state-

mandated disclosure of plan information as inconsistent with "nationally uniform plan administration," *id.* at 945 (citation omitted), not because it viewed regulation of a third-party service provider as necessarily equivalent to regulation of the ERISA plan itself. *Gobeille* therefore did not "resolve[]," Br. in Opp. 37, any conflict involving the First Circuit. This Court's review in this case is warranted to resolve that conflict.

C. This Case Is A Suitable Vehicle For This Court's Review

Contrary to respondent's contention (Br. in Opp. 18-23), this case is a suitable vehicle for this Court's review. Respondent expresses uncertainty (*id.* at 19) about the state-law provisions at issue. But in its motion for summary judgment, respondent identified the provisions of Ark. Code Ann. § 17-92-507, as amended by Act 900, that it was challenging. D. Ct. Doc. 75-1, at 35 (Aug. 15, 2016). The district court granted respondent's motion, identifying those same provisions. Pet. App. 13a-14a; see Br. in Opp. 10 n.7. And the court of appeals affirmed, likewise identifying those same provisions. Pet. App. 3a-4a; see Br. in Opp. 10 n.7, 18 n.11. The provisions at issue therefore are the ones that respondent challenged.

Respondent also expresses concern (Br. in Opp. 19-20, 22-23) about the scope of the arguments raised below and the depth of the court of appeals' consideration of them. But respondent pursued theories of both "reference to" and "connection with" preemption in the lower courts. See Resp. C.A. Response/Reply Br. 15-42; D. Ct. Doc. 75-1, at 8-12. Petitioner argued below that neither theory had merit. See Pet. C.A. Br. 46-80; Pet. C.A. Reply Br. 2-23; D. Ct. Doc. 88, at 4-13 (Sept. 9, 2016). And relying on circuit precedent, the court of appeals found the Arkansas law preempted under both theories. See Pet. App. 5a-7a (citing *Gerhart*, *supra*). The issues

of "reference to" and "connection with" preemption therefore were pressed and passed upon below.

Finally, respondent expresses concern (Br. in Opp. 20-22) about the scope of the question presented in the petition for a writ of certiorari. That question asks "[w]hether the Eighth Circuit erred in holding that Arkansas's statute regulating PBMs' drug-reimbursement rates * * * is preempted by ERISA, in contravention of this Court's precedent that ERISA does not preempt rate regulation." Pet. i. Contrary to respondent's contention (Br. in Opp. 20-21), that question fairly encompasses all of the state-law provisions at issue, which together effectuate Arkansas's regulation of "PBMs' drug-reimbursement rates." Pet. i; see pp. 4-5, *supra*. By asking whether "Arkansas's statute * * * is preempted by ERISA," Pet. i, the question presented also fairly encompasses both theories of preemption pressed and passed upon below. This case therefore is a suitable vehicle for this Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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