No. 18-540

In the Supreme Court of the United States

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas,
Petitioner,

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,
Respondent.

On Petition for a Writ of Certiorari to The United States Court of Appeals for the Eighth Circuit

SUPPLEMENTAL BRIEF FOR RESPONDENT

ANDREW C. LIAZOS
McDermott Will & Emery LLP
28 State Street
Boston, MA 02109

MICHAEL B. KIMBERLY
Counsel of Record
PAUL W. HUGHES
MATTHEW A. WARING
SARAH P. HOGARTH
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Respondent

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SUPPLEMENTAL BRIEF

The United States asserts that further review is warranted because the Eighth Circuit erred on the merits and its decision conflicts with decisions of the First and D.C. Circuits. Both contentions are wrong.

A. Act 900 is preempted

1. "The basic thrust of [ERISA's] pre-emption clause" is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 657 (1995). Act 900 is squarely at odds with that basic purpose.

a. ERISA-covered benefit plans can undertake the massive effort of administering prescription-drug benefits themselves, or they can engage third-party "pharmacy benefits managers" (PBMs) to fill that role on their behalves. Most elect to use a PBM, which can take advantage of better economies of scale. The PBM helps the plan design its prescription drug coverage, and it manages and delivers the benefits on the plan's behalf.

Regardless whether a plan manages pharmacy benefits itself or turns to a third-party PBM to assist with that function, Act 900 sets detailed standards for how plans may structure and administer the plan. In particular, it:

- requires disclosure of detailed plan information to pharmacies in the plan's network (Ark. Code Ann. § 17-92-507(c)(1), (c)(3), (c)(4)(C));
- sets strict criteria and timelines by which plans must update their Maximum Allowable Cost (MAC) lists in response to pharmacies' asserted acquisition costs (*id.* § 17-92-507(c)(2));

- dictates detailed appeal procedures that plans must establish for pharmacies to challenge MAC list rates and particular claim reimbursements, including a minimum amount of time for pharmacies to file appeals and a maximum amount of time for plans to resolve appeals (*id.* § 17-92-507(c)(4));
- requires plans to permit the reversal or rebilling of claims when the MAC list rate is less than the pharmacy's acquisition cost (*id.* § 17-92-507-(c)(4)(C)(i)(b)); and
- permits a pharmacy to refuse to serve a plan participant altogether if the pharmacy concludes that the MAC list rate is below the pharmacy's acquisition cost (*id.* § 17-92-507(e)).

In practice, these detailed requirements apply to plans and their members, not just to PBMs—it is the plan's MAC list that must be updated, the plan's data that must be disclosed, and the plan's participants who may be denied service by pharmacies.

These requirements apply only with respect to prescription drug benefits furnished to participants living or working in Arkansas. See Ark. Code Ann. § 17-92-507(a)(9). At the same time, other "States have enacted laws regulating the conduct of PBMs *in a variety of ways*" all across the country. States Amicus Br. 2 (emphasis added). This panoply of competing state laws set different requirements for amending MAC list prices, different procedures for processing appeals, and different disclosure rules, among various other inconsistent obligations. See generally Emma J. Chapman, *Pharmacy Maximum Allowable Cost (MAC) Laws: A 50 State Survey*, Am. Health Lawyers Ass'n (2017), perma.cc/XFN5-TAMH.

Absent preemption of statutes like Act 900, ERISA plans would have to comply with a crazy-quilt of conflicting rules governing the administration of prescription drug benefits. The resulting patchwork of inconsistent standards is anathema to ERISA's goal "[of] establish[ing] a uniform administrative scheme, which provides a [single] set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987)).

Where (as here) a state law requires ERISA plans "to make certain benefits available in some States but not in others" and "to process claims in a certain way in some States but not in others," it is preempted. *Fort Halifax Packing Co.*, 482 U.S. at 9.

b. All of this suggests straightforwardly that Act 900 is preempted because it has a "connection with" ERISA plans. On this score, the United States offers two responses. It says that (1) PBMs are merely third-party intermediaries as to which "connection with" preemption does not apply, and (2) the "connection with" analysis is controlled by *Travelers* in any event. Neither position has merit.

i. The United States implies (Br. 15) that ERISA is not triggered here at all. As the U.S. sees it (Br. 2, 15), PBMs are merely "intermediaries between pharmacies and health benefit plans." Act 900 must therefore be understood to "regulate[] only the relationship between PBMs and pharmacies," not "plans themselves" or plans' "relationships with PBMs, pharmacies, or plan participants" (Br. 12-13). In short, according to the United States (Br. 15), Act 900 "regulates PBM administration, not ERISA plan administration."

Even Arkansas recognizes that this "categorical rule[]" is "badly mistaken." Pet. 25. That is because it elevates form over substance. Prescription drug benefits may be administered by the plan itself or (more commonly) by a PBM that the plan employs to fill that administrative role in its place. Act 900 applies either way; it regulates *any* "entity that administers or manages a pharmacy benefits plan or program" (Ark. Code Ann. § 17-92-507(a)(7)), regardless whether it is the plan itself or a PBM acting on the plan's behalf.

ERISA preemption does not depend on the option that a plan chooses. That follows from *Gobeille* v. *Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), which involved an ERISA preemption challenge to a Vermont healthcare data reporting law. The plaintiff there, Liberty Mutual, sponsored a national "self-insured and self-funded" health benefit plan. *Id*. at 941. But it did not process claims or report data itself (although it could have). Rather, it engaged Blue Cross, "a third-party administrator," to "manage[] the 'processing, review, and payment' of claims" on the plan's behalf. *Id*. at 942. It was Blue Cross that, in turn, had to "report the information it possess[ed] about the Plan's members in Vermont." *Ibid*.

In the same way that PBMs operate with respect to prescription drug benefits, Blue Cross operated as an "intermediar[y]" (U.S. Br. 15) between Liberty Mutual and its network of healthcare providers and state regulators. Yet the Court did not hesitate in holding that the state reporting law at issue in *Gobeille* was preempted. No matter that plan administration was undertaken by Blue Cross in Liberty Mutual's stead, the regulation "intrude[d] upon 'a central matter of plan administration' and 'interfere[d] with nationally uniform plan administration.'" *Gobeille*, 136 S. Ct. at 945 (quoting *Egelhoff*, 532 U.S. at 148).

That same principle applies here. The United States does not even attempt to explain why ERISA preemption should apply when a plan manages prescription drug benefits itself, but not when it engages a third-party PBM to manage those benefits in the same way on its behalf.

Against this background, the question is simply whether Act 900 requires ERISA benefit plans to administer their prescription drug benefits in particular ways. The answer is plainly *yes*, regardless whether the plan administers prescription benefits itself or hires a PBM to help design and administer those benefits for it. To allow Act 900 to stand would therefore mean that ERISA plans must "comply[] with conflicting directives among States" concerning the management of prescription drug benefits, requiring them (or their third-party administrators) to "tailor[]" their "conduct to the peculiarities of the law of each jurisdiction." *Travelers*, 514 U.S. at 657 (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990)). That is exactly what Congress set out to prevent with ERISA.

ii. The Court's decision in *Travelers* does not alter that conclusion. The New York law at issue in *Travelers* required healthcare providers to assess surcharges against patients using certain commercial insurance; patients using Blue Cross, Medicaid, and certain HMO plans were exempt. 514 U.S. at 649-650. The Court held that the selective surcharge was not preempted because it "[did] not bind plan administrators to any particular choice" concerning plan design or administration; it merely had an "indirect economic influence" that "ma[de] the Blues more attractive (or less unattractive) as insurance alternatives." *Id*. at 659. Nothing about that "indirect influence * * * preclude[d] uniform administrative practice or the provision of a

uniform interstate benefit package." *Id*. at 660. As we have explained, not so here.

The United States incorrectly asserts (Br. 12) that the "principle" of *Travelers* applies here. According to the United States (*ibid*.), Act 900 establishes nothing more than a "methodology governing payments to pharmacies" by "requiring a PBM to reimburse pharmacies at a price equal to or higher than the '[p]harmacy acquisition cost.'" The United States thus takes the mistaken position (*ibid.*) that Act 900 only indirectly "influence[s] an ERISA plan's decision to contract with a PBM" and does not directly "force an ERISA plan to adopt a certain scheme of substantive coverage."

As we have noted, Act 900 does far more than merely govern reimbursement rates. See Ark. Code Ann. § 17-92-507(a)(7). Rather, it directly governs the structure and management of prescription drug benefits provided by ERISA plans. See *supra*, at pp. 1-2. And as the D.C. Circuit correctly held, state laws that "regulate a PBM's administration of benefits on behalf of" covered ERISA plans are preempted. *PCMA* v. *District of Columbia*, 613 F.3d 179, 185 (D.C. Cir. 2010). Indeed, a clearer example of direct regulation of plan administration would be difficult to conceive.

c. The foregoing analysis shows why Act 900 is preempted under the "connection with" strand of ERISA preemption. The law is preempted under the "reference to" line of analysis, as well. See BIO 28-32; Pet. App. 6a. That is because, among other things, Act 900 "specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is preempted." *Travelers*, 514 U.S. at 656 (quoting *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125, 130 (1992)). In particular, the law applies to any "plan or program that pays for * * * pharmacist services to individuals who * * * are *employed* in this

state." Ark. Code Ann. § 17-92-507(a)(9) (emphasis added). This is an express reference to ERISA-covered benefit plans offered by employers in the State.

The Eighth Circuit was therefore correct to hold that Act 900 is preempted.

B. There is no circuit split implicated here

Although the presence of a circuit conflict is typically essential to a grant of certiorari, Arkansas does not address the supposed conflict in this case until page 25 of its petition. That is little surprise, because the asserted conflict does not hold up with respect to the statute at issue here.

The United States offers two points concerning the alleged circuit conflict. First, it says (Br. 15-17) that the decision below conflicts with *PCMA* v. *Rowe*, 429 F.3d 294 (1st Cir. 2005), and *PCMA* v. *District of Columbia*, 613 F.3d 179 (D.C. Cir. 2010), on the "reference to" strand of ERISA preemption. Second, it says (Br. 17-19) that the decision below aligns with *District of Columbia* but conflicts with *Rowe* on the "connection with" strand. The first contention is immaterial, because the second contention is wrong.

The United States acknowledges (Br. 18) that the D.C. Circuit is in accord with the Eighth Circuit on "connection with" preemption. But it contends (Br. 18-19) that the First Circuit would reject "connection with" preemption here because it held in *Rowe* that laws "impos[ing] duties on PBMs" do not impose duties on plans themselves and therefore fall outside ERISA's preemptive scope.

The First Circuit's decision in *Rowe* predates—and is inconsistent with—*Gobeille*. See BIO 38. It is therefore unlikely that the First Circuit would hold that the cited portions of *Rowe* remain good law, assuming the

government's reading of those portions is correct (see BIO 36-37).

The United States rejoins (Br. 19) that "[a]lthough the respondent health plan in [*Gobeille*] 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." That is a distinction, the United States asserts (Br. 12-13), because Act 900 "regulates only the relationship between PBMs and pharmacies" and not "plans themselves or their relationships with PBMs, pharmacies, or plan participants."

Once more, that is wrong. Just like the regulation at issue in *Gobeille*, Act 900 works on plans and their members themselves, not just PBMs. A plan that engages a PBM must disclose detailed information about *the plan* through the PBM. See Ark. Code Ann. § 17-92-507(c)(1), (c)(3), (c)(4)(C). It is the *plan's* MAC list that must be updated according to strict criteria, albeit by its PBM. See Ark. Code Ann. § 17-92-507-(c)(2). And it is the *plan's members* whose covered drug purchases may be rejected by pharmacists pursuant to Section 17-92-507(e). More to the point, PBMs merely administer the plan in a non-discretionary manner at the plan's behest; regulation of the PBM's administration of the plan is thus regulation of plan administration, plain and simple. Even Arkansas admits this much. See Pet. 25-26 (because "PBMs administer plans' drug benefits," they are at least sometimes "protected from regulation by ERISA preemption.").

Because the First Circuit's decision in *Rowe* has been superseded in relevant part by *Gobeille*, the United States is wrong to insist (Br. 19) that "if this case had arisen in the First Circuit, the Arkansas law would have been upheld." And because there is no conflict on "connection with" preemption, any disagree-

ment among the lower courts on "reference to" preemption is immaterial.

CONCLUSION

The Court should deny the petition.

Respectfully submitted.

ANDREW C. LIAZOS
McDermott Will & Emery LLP
28 State Street
Boston, MA 02109

MICHAEL B. KIMBERLY
Counsel of Record
PAUL W. HUGHES
MATTHEW A. WARING
SARAH P. HOGARTH
McDermott Will & Emery LLP
500 North Capitol St. NW
Washington, DC 20001
(202) 756-8000
mkimberly@mwe.com

Counsel for Respondent