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 Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF OF *AMICUS CURIAE* SOCIETY OF HUMAN RESOURCE MANAGEMENT IN SUPPORT OF RESPONDENT

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INTERESTS OF *AMICUS CURIAE*

As the world's largest association devoted to human resource ("HR") management, the Society for Human Resource Management ("SHRM") represents more than 300,000 individual members, with titles from HR Generalists to Chief Human Resource Officers, working at organizations that are one-person consulting firms to organizations that are Fortune 500 companies. These organizations encompass every major industry and include over 115 million workers.

SHRM's work helps our more than 500 U.S. based affiliated chapters and global members in more than 160 countries address issues of universal concern to work, workers and the workplace. Because human resource professionals sit at the intersection of work, workers, and the workplace, they have a unique perspective about the enhancement of employee benefits to recruit and retain top talent in a twenty-first century workforce. Daily, our members implement and design, manage, and administer benefits. Therefore, as lawmakers work toward health care reform, SHRM continues to advocate for public policy solutions that lower costs, strengthen the employer-based system,

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[1] Pursuant to Rule 37.6, amicus confirms that no counsel for any party authored this brief in whole or in part, and no person or entity, other than *amicus curiae*, their members, or their counsel contributed money to fund the brief's preparation or submission. Pursuant to Rule 37.3, the parties have consented to the filing of this brief.

improve quality of care, and offer access to affordable coverage to all Americans.

With employee benefits making up approximately one-third (thirty-one percent) of total compensation costs, organizations must engage in strategic benefits planning to maximize their return on investment.[2] For purposes of employee recruitment and retention, most SHRM members have voluntarily offered robust prescription drug coverage under plans regulated by the Employee Retirement Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. For SHRM members, many of whom are large, multi-state employer organizations, one of the essential features of ERISA is its preemptive authority over state regulations of self-funded employer health plans. ERISA preemption is critical to the success of the employer-based system, providing certainty and affording employers of all sizes the ability to confidently design uniform, equal, and more robust benefit plans and prescription drug offerings for employees and their families nationwide. According to SHRM's 2019 annual member survey of benefit offerings, 99.1% of SHRM's U.S. members reported that their organization offers healthcare coverage, with an estimated 89,000 employer members implementing self-funded ERISA pharmacy benefit plans.[3]

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[2] *2018 Employee Benefits: The Evolution of Benefits*, Society for Human Resource Management (June 2018), https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2018%20Employee%20Benefits%20Report.pdf.

[3] Society for Human Resource Management, *2019 Employee Benefits Toplines* (2019) (unpublished report) (on file with author) (reflecting 98% offering by businesses of 100-499 employees, 99.7% for businesses of more than 500, and 99.1% across businesses of all sizes).

ERISA simplifies and streamlines administration and reduces costs for covered members by allowing employers to engage a single nationwide pharmacy benefit manager ("PBM") that can negotiate better rates with drug manufacturers. Most employers rely heavily on PBMs, essentially outsourcing to them the design of the plan's formulary (*i.e.*, covered drugs), the value-based insurance designs (reimbursement rates for retail and mail-order drugs), and claims administration. In fact, most employers delegate full fiduciary discretionary authority to PBMs, meaning the PBM controls the final decision on prescription drug benefit claims. SHRM views the orderly development and preservation of ERISA's preemptive authority as crucial to preserving self-funded employer pharmacy benefit plans for tens of millions of Americans.

Prescription drug costs are one of the fastest growing expenses for businesses and American workers today.[4] Recent FDA approval of a host of new specialty drugs, many of which are life-saving, but which can also cost hundreds of thousands of dollars annually for a single employee, have amplified this financial burden.[5]

To be clear, SHRM supports the uniform and orderly development of laws governing employer-sponsored prescription drug benefit plans. We generally support prescription drug price transparency and other efforts to reduce associated healthcare costs to SHRM members

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[4] Joanne Sammer, *How HR Can Help Control Prescription Drug Costs*, Society for Human Resource Management (May 25, 2017), https://www.shrm.org/hr-today/news/hr-magazine/0617/pages/take-control-of-prescription-drug-costs.aspx.

[5] Ed Silverman, *New Tactic Emerges To Control Rx Spending*, HR Magazine (Sep. 4, 2019), https://www.shrm.org/hr-today/news/hr-magazine/fall2019/pages/new-tactic-emerges-to-control-rx-spending.aspx.

and the employees they serve. But the administrative burden on SHRM members, and the financial impact to American workers by state regulation of PBM administration of self-funded plans, must be avoided because of ERISA preemption.

SUMMARY OF THE ARGUMENT

Act 900, Arkansas Code § 17-92-507 ("the Act") regulates PBMs, and thus the administration of self-funded employer pharmacy plans governed by ERISA. The Act's provisions are preempted by ERISA, including those that (a) mandate new disclosures regarding prices PBMs will pay, (b) establish new administrative appeal procedures for denied or allegedly unpaid claims, (c) allow pharmacies to reverse and re-bill individual pharmacy claims,[6] and (d) allow pharmacies to "decline-to-dispense" if they deem the PBM's reimbursement level to be too low.

ERISA already regulates such matters. Plan disclosure requirements, including disclosure of reimbursement levels, are already governed by 29 C.F.R. §§ 2520.102-2 *et seq*. The required contents of and explanation of benefits — *i.e.*, notification of claim determinations — are already governed by 29 C.F.R. § 2560.503-1. The administrative processes for appealing claims determinations are already governed by 29 C.F.R. 2590.715-2719 *et seq*. In attempting to create parallel processes, the Act thus purports to regulate "central matter[s] of plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 945 (2016) (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). This Court's decision in *Gobeille* squarely resolves the question at issue here

[6] A "re-bill" occurs when a provider (such as a pharmacy) resubmits a claim for benefits after the payor denies a claim or pays less than the provider believes is owed.

and commands the same outcome: a holding that ERISA preempts the Act.

SHRM's membership is keenly attuned to the fact that ensuring uniform and predictable regulation of PBMs across state lines is essential to controlling administrative cost and to leveraging employer plans' purchasing power to lower drug prices for participants. This Court has noted that one of the key purposes of ERISA, and its preemptive authority over state law, is to encourage employers to offer benefits plans that they are not otherwise legally obligated to provide. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). State regulation of PBMs jeopardizes ERISA's statutory scheme for uniform plan administration. Therefore, SHRM believes that regulation of ERISA-governed, self-funded employee pharmacy benefit plans should take place at the federal level.[7]

ARGUMENT

I. The Eighth Circuit Correctly Applied *Gobeille*

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plans." 29 U.S.C. § 1144(a). This section "may be the most expansive express pre-emption provision in any federal statute." *Gobeille*, 136 S. Ct. at 947 (Thomas, J., concurring). In mapping the parameters of state laws that impermissibly "relate to" an ERISA-

[7] While ERISA preemption could also extend to state regulation of fully-insured employer pharmacy plans, SHRM limits its comments to self-funded plans and does not address the application of the insurance exception to ERISA preemption under 29 U.S.C. § 1144.

governed plan, this Court has identified two categories of state law that run afoul of § 1144(a).

First, "ERISA pre-empts a state law if it has a '***reference to***' ERISA plans," meaning that the state law "acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Gobeille*, 136 S. Ct. at 943 (citing *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)) (internal quotations omitted) (emphasis added).

Second, ERISA preempts state laws that have an "impermissible '***connection with***' ERISA plans, meaning a state law that governs . . . a central matter of plan administration or interferes with ***nationally uniform plan administration***." *Gobeille*, 136 S. Ct. at 943 (citing *Egelhoff*, 532 U.S. at 148) (internal quotations omitted) (emphasis added).

As the Eighth Circuit held below, the Arkansas Act impermissibly does both. *Pharmaceutical Care Mgmt. Ass'n v. Rutledge*, 891 F.3d 1109, 1112 (8th Cir. 2018). The Act "refers to" ERISA plans; indeed, it does so in its very definitions. The Act defines a "[p]harmacy benefits plan or program" as "***a 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 this state." Ark. Code Ann. § 17-92-507(a)(9) (emphasis added). Because the Act includes "plan[s]" that are governed by ERISA within its ambit, it necessarily "refers to" such plans.

As Respondent noted in its brief opposing certiorari, it is of no moment that the Act also covers plans that are not governed by ERISA. Opp. at 28 (Feb. 28, 2019). Under *Gobeille* and *Dillingham*, so long as "the exist-

ence of ERISA plans is essential to the law's operation," the state law will have "reference to" ERISA. *Gobeille*, 136 S. Ct. at 943 (citing *Dillingham*, 519 U.S. at 325). While a PBM is not, in and of itself, governed by ERISA, many PBMs serve as ERISA plan fiduciaries in their claims administration capacity, and all PBMs are core to the administration of ERISA plans. "[T]he existence of ERISA plans is essential to the law's operation," *Dillingham*, 519 U.S. at 325, so the Act "refers to" ERISA-governed plans and is preempted.

The Act also has an impermissible "connection with" ERISA plans, as it purports to govern plan administration. *Egelhoff*, 532 U.S. at 148. In determining the allowable scope of state-law interference with plan administration, *Gobeille* is again instructive. In *Gobeille*, the State of Vermont enacted new legislation requiring several types of health care entities, including payors, to "report any information relating to health care costs, prices, quality, utilization, or resources required." 136 S. Ct. at 941 (quotations omitted). The Act imposes similar disclosure obligations, requiring PBMs to disclose their Maximum Allowable Cost ("MAC") Lists to pharmacies. Ark. Code Ann. § 17-92-507(c)(1). MAC lists established by PBMs are adopted by, and therefore become a component of, an ERISA self-funded plan.[8] Such a "reporting regime" implicates "central matter[s] of plan administration" and "interferes with nationally uniform plan administration," *Gobeille*,

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[8] *See* 29 CFR § 2520.102-3(j)(3) (describing required content in a plan's Summary Plan Description, including "[f]or employee welfare benefit plans that are group health plans, as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of any cost–sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible").

136 S. Ct. at 945 (citing *Egelhoff*, 532 U.S. at 148), and therefore ERISA preempts the Act. Provisions like the one at issue limit employers' ability to quickly and unilaterally modify plan design, because PBMs will require advanced notice so that they may comply with these various state disclosure obligations.

The ERISA claims regulations — authorized, *inter alia*, by 29 U.S.C. §§ 1133, 1135 — provide detailed requirements for plan administrators in the areas of disclosures, notification of claims status, and appeals procedures. *See*, *e.g.*, 29 C.F.R. §§ 2520.102, 2560.503-1, 2590.715-2719. The Act purports to create its own parallel processes for PBMs; this dual-regulation is forbidden by ERISA. ERISA provides plans with certainty that if they comply with the ERISA-required procedures, they will be afforded deference on judicial review. The Act's separate layer of review creates uncertainty for both plans and participants as to which review controls. The coverage and administrative issues the Act purports to regulate plainly interfere with nationally uniform plan administration.

The practical implications of such state-level regulation are easily illustrated by examining how SHRM members provide employee benefit plans. When SHRM members — especially large employers operating with employees in multiple states — negotiate an agreement with a PBM administrator, they focus on crafting a single prescription drug benefit that can operate across state lines. SHRM members will want to offer the same benefit plan to employees in Arkansas that they offer to employees in Alabama. But the Act interferes with employers' ability to do so: a benefit plan that complies with Alabama law might not comply with the Act, and as a result, SHRM members are forced to have multiple pharmacy plans.

Specifically, SHRM recommends that when employers negotiate with PBM administrators for pharmacy plans, they insist upon a "contract that has enough transparency so that they can have access to the PBM's data," and receive "comprehensive audit rights over claims and fees."[9] SHRM further recommends that "coverage program[s] . . . include a fair appeal process too." *Id.* (quotations omitted). If the Act is not preempted, then such contracts could comply with some state laws but not others.

II. ERISA Preemption Is Intended To Encourage Employers To Provide Employee Benefit Plans But Permitting The Act To Stand Will Lead to Increased Administrative Costs and Loss of Prescription Drug Coverage

SHRM has a unique perspective as a leader in the field of human resources that allows it to offer its perspective on the risks associated with permitting state-by-state regulation of ERISA plans offering prescription drug coverage. This Court has explained that one of the most important features of ERISA is that it encourages employers to offer benefits plans that they are not otherwise required to provide. In exchange, in large part through preemption, ERISA offers employers predictable and nationally uniform benefits administration.

ERISA "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in ***encouraging the formation of***

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[9] Greg Goth, *Negotiating Price Transparency with PBMs Pays Off*, Society for Human Resource Management (Jan. 5, 2017), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/negotiating-drug-prices-pbms.aspx.

employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)) (emphasis added).[10] In other words, in enacting ERISA, Congress recognized that employers would be better able to provide employee benefits plans if they were guaranteed that such plans would be governed by federal law. Employers would thus avoid the administrative burden of having to comply with 50 different regulatory regimes. The Act endangers this bargain.

A. The Act Interferes with Risk Pooling and Pricing Mechanisms In Ways That May Lead to Decreased Pharmacy Coverage

The Act prohibits PBMs from reimbursing independent pharmacies for filling prescriptions at a rate below what that PBM would pay an affiliated pharmacy. Ark. Code Ann. § 17-92-507(d)(1). This materially impacts an ERISA self-funded plan sponsor's ability to implement a value-based insurance design. A fundamental tenet of group health coverage is that aggregating many covered lives into a single risk pool will reduce costs (and risks) for individual members. While any given member may experience prescription drug expenses in any given year, those costs will be spread out and shared among the entire population, thereby creating uniformity and predictability in annual costs. To mitigate the risk to the greater employee population, ERISA plan sponsors regularly implement value-based insurance designs to incentivize employees to seek out

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[10] Although *Davila* was discussing a different preemption provision of ERISA, 29 U.S.C. § 1132, the same logic applies when the legislative goal is to encourage employers to offer benefits plans by promising them a nationally consistent regulatory structure.

lower-cost, more effective drugs. For example, most plans impose a surcharge if a participant fills a brand name drug where a generic equivalent is available. This benefits the entire risk pool (covered employees), because the plan's overall spend is reduced, and other participants have lower premiums, contributions, or otherwise applicable cost-sharing.

Network pricing serves the same purpose. Plans establish a list of preferred pharmacies who have agreed to accept a negotiated rate to gain access to a larger population of potential customers. To encourage participants to use a network pharmacy (thereby reducing the cost to the broader risk pool), plans will often charge a higher copay or coinsurance if a participant seeks to fill a prescription at a non-network pharmacy. The Act affords independent pharmacies the right to decline to fill prescriptions if the reimbursement rate the pharmacy will receive from the PBM (and ultimately from the ERISA plan) is determined by the pharmacy to be too low. Ark. Code Ann. § 17-92-507(e). This can force an ERISA plan to either pay an increased rate (thereby defeating the purpose of the value-based insurance design) or to exclude coverage for prescriptions filled at the pharmacy.

Almost uniformly, PBM administrative service agreements include a clause that permits the PBM to increase the administrative fees to ERISA plans or even cease administration entirely in a state that passes a new law regulating the PBM's operations. State regulations like the Act lead to increased costs for administration in that state, which lead to increased costs for the plan and its participants as a whole. Or worse, if the regulation causes the PBM to conclude it is no longer in the PBM's business interests to operate in that state, ERISA self-funded plan sponsors could

be forced to find a new PBM just for that state, switch PBM administration nationwide (impacting network and drug formulary for all plan participants), or perhaps even cease offering prescription drug coverage to participants in that state.

B. Any Regulation of PBMs Should Be Enacted at the Federal Level To Ensure Consistency, Predictability and Lower Cost

SHRM believes that a nationally uniform approach at the federal level, or under existing federal law, rather than state-by-state regulation, is far superior for its member employers and their employees. Any solution to the challenge of prescription drug costs must be a national effort for the reasons outlined herein, including, but not limited to, uniform administration, increased purchasing power, and lower fees for plans and their participants.

C. Congress and the President Are Aware of Policy Issues Related to PBMs and Are Considering Whether and How To Regulate PBMs

Both Congress and the Executive Branch are currently examining potential policy changes related to PBMs and are actively considering whether and how to regulate PBM activity. For example, in February 2019, SHRM reported that the Administration "published a proposed rule to lower prescription drug prices . . . by encouraging drug manufacturers to pass their rebates directly to consumers instead of to [PBMs]."[11]

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[11] Stephen Miller, *HHS Proposes Targeting PBM Rebates for Prescription Drugs*, Society for Human Resource Management

The same article also noted that President Trump had recently signed into law the Patient Right to Know Drug Prices Act, Pub. L. 115-263 (2018), which forbids payors or PBMs from trying to keep pharmacists from discussing cheaper price options with consumers. *Id.*

There are at least two bills pending before Congress that pertain to prescription drug prices and regulation of PBMs.[12] There is little doubt that federal policy-makers are paying close attention to these issues and considering new legislation or regulations that would apply on a nationwide basis. This federal legislative deliberation should not be upended by one (or more) states.

(Feb. 7, 2019), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/hhs-proposes-targeting-pbm-rebates.aspx.

[12] *See* Lower Health Care Costs Act, S. 1895, 116th Cong. (2019) (requiring pass-through of drug manufacturer rebates and imposing fee transparency requirements on PBMs); and Ban Surprise Billing Act, H.R. 5800, 116th Cong. (2020) (imposing fee transparency requirements on PBMs).

CONCLUSION

A*micus curiae* Society for Human Resource Management urges the Court to affirm the judgment of the court of appeals and find, consistent with *Gobeille*, that ERISA preempts the Act.

Respectfully submitted,

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