No. 18-540

In the Supreme Court of the United States

LESLIE RUTLEDGE, in her official capacity as Arkansas Attorney General,

Petitioner,

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,

Respondent.

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

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF

Act 900 does not regulate any central matter of plan administration and is not preempted. Nothing Respondent Pharmaceutical Care Management Association says changes that fact.

Act 900 regulates what pharmacy benefit managers (PBMs) pay pharmacies for prescription drugs. "To implement that requirement," Br. 15, it requires PBMs to regularly update their maximum allowable cost (MAC) lists and allow pharmacies to appeal unlawful reimbursements. It imposes no obligations on plans. To the contrary, any impact on plans would—as PCMA effectively concedes—be strictly financial and the result of PBMs' decision to pass on any cost increases associated with Act 900.

Travelers plainly holds that state laws, like Act 900, that regulate the costs of goods or services are not preempted because the Employee Retirement Income Security Act does not "pre-empt basic rate regulation." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 667 n.6 (1995). Indeed, to hold otherwise would call into question the validity of any number of other state laws that similarly affect the cost of providing goods or services and potentially influence—but do not dictate—plan decisions. *Id.* at 660-61. Act 900 is not preempted.

To avoid that straightforward conclusion, PCMA tries a combination of mental gymnastics and sleights of hand. *First*, PCMA suggests that Act 900 isn't really rate regulation because it dictates what PBMs *pay* pharmacies, not what pharmacies *charge* PBMs. That's a distinction without a difference. Either way, the PBM is required to pay the statutory rate. And the

validity of the laws of 40 States does not turn on such inconsequential semantics.

Second, PCMA conflates the payment of benefits (and benefits administration) with the cost of providing benefits. The two concepts are fundamentally different, and Act 900 only regulates the latter. Under this Court's precedents, state laws impermissibly regulate the payment of benefits where they dictate *what* benefits ERISA plans provide or *who* plans' beneficiaries are. Act 900 does neither. It does not, for instance, require plans (or plans employing PBMs) to cover certain drugs or beneficiaries.

By contrast, *Travelers* holds that the cost of providing benefits is not a central matter of plan administration and that state laws regulating (or imposing) costs are not preempted. That's because, unlike laws that regulate the payment of benefits, costs do not dictate a plan's choice of benefits or beneficiaries. They merely "affect a plan's shopping decisions" by potentially increasing costs, while still leaving the plan free to "shop for the best deal it can get." *Travelers*, 514 U.S. at 660. And PCMA's relentless focus on Act 900's potential cost impact on PBMs (and eventually, it claims, the plans that hire them) underscores that Act 900 only regulates the cost of benefits and is not preempted.

Third, PCMA wrongly equates PBMs with plans. In particular, PCMA contends that Act 900 improperly dictates the contents of a *plan's* MAC list and how a plan interacts with pharmacies. Neither is true. Contrary to PCMA's suggestions, PBMs—not plans—control the MAC list, and "PBMs consider both *their* MAC lists and MAC pricing methodologies to be proprietary trade secrets, and protect them as such," *even from plans*. JA72-73 (emphasis added). Indeed,

PBMs so closely guard those contracts that they had to be filed under seal in this Court. It therefore strains credulity to suggest, as PCMA does, that Act 900 has regulated a central matter of plan administration by regulating things that are not even shared with plans.

The Court should reverse the judgment of the court of appeals.

I. ERISA does not preempt Act 900's regulation of drug reimbursement rates.

A. Act 900 is basic rate regulation.

Travelers resolves this case. There, New York regulated the rates at which widely employed types of third-party administrators—there, insurers and HMOs—reimbursed hospitals for healthcare. 514 U.S. at 650. Abolishing traditional reimbursement methodologies based on actual treatment costs, New York instead required insurers to reimburse the average costs of treating their insureds' diagnoses. *Id.* at 649. Then, to support a particular market player, Blue Cross, whose open-enrollment practice made it less profitable, New York required Blue Cross's competitors to pay hospitals a hefty surcharge above the state's base rate, thereby making Blue Cross's insurance cheaper and more attractive to plan customers. *Id.* at 650, 658-59.

Those competitors challenged the surcharge as an indirect regulation of ERISA plans' choice of administrators. This Court held that ERISA preempted neither the surcharges nor the underlying reimbursement rates that those surcharges rested upon.

ERISA's preemption clause, the Court explained, was intended to ensure nationally uniform regulation of plan administration and design, not "cost uniformity."

Id. at 662. Accordingly, the Court concluded that "ERISA was not meant to pre-empt basic rate regulation." *Id.* at 667 n.6.

Consistent with that principle, Arkansas's regulation of drug reimbursement rates is patently not preempted. Indeed, the only distinguishing features of Arkansas's rate regulation make it *less* arguably preempted than New York's. Much like New York, Arkansas has regulated the rates at which a widely employed type of third-party administrator (PBMs) reimburses service providers (pharmacies) to stem the ill effects of below-cost reimbursements on pharmacies that serve rural and underserved communities.[1] But unlike New York, which required some administrators to reimburse hospitals well above actual costs to influence plans to choose other administrators, Arkansas has simply required all PBMs to reimburse at a pharmacy's drug acquisition costs.[2] And beyond that

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[1] Attempting to downplay the effects of below-cost reimbursements, PCMA cites its own newly published advocacy piece claiming that the number of independent Arkansas pharmacies declined by only five between 2010 and 2019—half of which period postdates Act 900's enactment. Br. 13. Yet PCMA stipulated below that in the nine years preceding Act 900's enactment, 2006 to 2014, the number of independent pharmacies in Arkansas fell by 57, or more than 12%. JA310.

[2] Those costs do not account for pharmacies' total costs in selling and dispensing a drug, because they do not include the cost of dispensing itself. The record establishes that PBMs typically undercompensate pharmacies for the cost of dispensing by more than 80%. JA231 (average cost of dispensing is $10, while PBMs' average dispensing fee is under $2). Thus, PCMA's concern that Act 900 overcompensates pharmacies, Br. 5-6, 15, because it does not account for "negligible" (JA282) post-purchase discounts is both factually inaccurate and legally irrelevant. *See Travelers*, 514 U.S. at 659 n.5 ("[I]t is not our responsibility to review the . . . substantive rationale for the surcharges.").

rate floor, Arkansas leaves reimbursement rates to PBMs' discretion.

PCMA concedes that *Travelers* "rejected the suggestion that Congress had intended to require cost uniformity" in enacting ERISA. Br. 37. PCMA also acknowledges that *Travelers* held "'basic rate regulation'" is "not preempted under ERISA." Br. 36. And PCMA agrees that Act 900 "requires [PBMs] to reimburse pharmacies according to their invoice prices"—in other words, that Act 900 regulates pharmacies' reimbursement rates. Br. 15. Yet PCMA insists that requirement is preempted on the startling theory that "Act 900 is not rate regulation." Br. 36.

While PCMA's basis for the claim is less than clear, it appears to rest largely on a strained distinction between "regulat[ing] the price a [provider] charges" and regulating the rates a third-party administrator pays. Br. 37. It contends that while the law in *Travelers* regulated the former, Act 900 only regulates the latter, leaving pharmacies "free" to charge what they wish. *Id.*

PCMA's supposed distinction defies common sense. Whether a regulation dictates the rate an administrator must pay or the rate a provider charges, it regulates the going rate for a good or service. Whichever phraseology the law employs, the impact on administrators is the same: they must pay the statutory rate. To suggest, as PCMA does, that preemption turns on an utterly inconsequential drafting exercise ignores the principle that, as this Court has said in reviewing the constitutionality of rate regulation, "'It is not theory, but the impact of the rate order that counts.'" *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 314 (1989) (quoting *Fed. Power Comm'n v. Hope Nat. Gas Co.*, 320 U.S. 591, 602 (1944)).

PCMA's distinction also ignores the all-too-obvious reason why Act 900 "does not regulate the price a pharmacy charges" PBMs for drugs. Br. 37. The reason is that pharmacies do *not get to decide* what prices they "charge" PBMs for drugs. Rather, as PCMA ably explains, when a pharmacy sells a drug, the PBM unilaterally "*informs* the pharmacy of . . . the amount of reimbursement the PBM will make." Br. 8 (emphasis added). Indeed, PBMs' unilateral power to simply dictate reimbursements is the defining hallmark of PBM-pharmacy agreements. And while Arkansas theoretically could—as PCMA seems to suggest it should have done to avoid preemption—have simply deprived PBMs of *any* discretion to set reimbursement rates and instructed pharmacies to charge the rates the State set, nothing in any of this Court's ERISA-preemption cases suggests Arkansas had to adopt that vastly *more* intrusive approach to avoid preemption. *Cf.* Br. 37 (faulting Act 900 for leaving pharmacies "free . . . to agree (or not) to contractual rates").

Moreover, PCMA's reliance on *Travelers* for a supposed distinction between billing and paying is misplaced. PCMA contends that the law in *Travelers* regulated "the price of goods or services in the marketplace," Br. 37, and amounted to rate regulation because it "requir[ed] hospitals to add a surcharge" to non-Blues' "bill." Br. 36. But in reality, New York's law operated precisely like Act 900's regulation of PBMs' reimbursements. It was not directed at hospital bills, but at insurers' "*[p]ayments to* general hospitals *for reimbursement* of impatient hospital services." N.Y. Pub. Health Law 2807-c(1)(a) (McKinney 1993) (emphasis added) (Blues' rates); 2807-c(1)(b) (non-Blues' rates). And while New York hospitals undoubtedly billed the statutory surcharges (just as pharmacies will seek their acquisition costs), New York's law (just like Act

900) imposed obligations that were "the responsibilities of the payors," not the provider. *Id.*, 2807-c(3)(d)(v).

PCMA also complains that Act 900 only regulates what PBMs pay and not the "usual and customary prices" pharmacies charge uninsured customers. Br. 37. That too does not distinguish the commercial-insurer surcharges upheld in *Travelers*, or even the diagnosis-based rate regulation underlying them, which did not apply to uninsured patients. See N.Y. Pub. Health Law 2807-c(1)(c) (providing that those patients would pay "the hospital's charges" as set by "[e]ach general hospital" at its discretion, subject only to a cap well above DRG rates). In any event, Arkansas hardly needed to command pharmacies to set those prices at or above their acquisition cost.

Finally, PCMA erroneously suggests Act 900 is not rate regulation because it contains several enforcement procedures. Br. 37. But that was equally true of the New York regulatory scheme in *Travelers*, which required insurers to submit to a "payment dispute resolution system" presided over by "utilization review organizations." N.Y. Pub. Health Law 2807-c(3)(d)(i)-(ii). Indeed, if anything, Act 900 is less intrusive than New York's enforcement scheme because it leaves it to PBMs to resolve reimbursement disputes. And more fundamentally, the fact that Act 900—like all rate regulations—contains procedures for its enforcement does not make it any less rate regulation. At most, it raises a separate question about the permissibility of those procedures.

Act 900's requirement that PBMs reimburse a minimum of pharmacies' acquisition costs is basic rate regulation and accordingly is not preempted.

B. Act 900 does not regulate the "payment of benefits."

Ultimately, PCMA's quest to immunize its industry from regulation rests on an assertion that Act 900 impermissibly regulates the "payment of benefits." Br. 22 (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). But while it is true that the payment of benefits is a matter of central plan administration, it is equally true that Act 900 does not regulate the payment of benefits as that term is used in this Court's case law. Rather, Act 900 regulates the cost of providing benefits and, at most, might marginally "influence . . . a plan's shopping decisions" about the PBM it hires or the drug benefits it provides. *Travelers*, 514 U.S. at 660.

PCMA relies heavily on *Egelhoff*'s observation that the "'payment of benefits' is 'a central matter of plan administration'" that States cannot regulate. Br. 22 (quoting *Egelhoff*, 532 U.S. at 148). It argues that Act 900 regulates the payment of benefits because a PBM's "MAC [reimbursement] methodology" informs plans' "[c]ost assumptions" and those assumptions influence decisions about what to cover, copayments, and beneficiaries. Br. 25. Indeed, PCMA ultimately concludes that Act 900 is preempted because it may "increase[] what plans must spend for prescription drugs." Br. 34.

That argument does not withstand scrutiny because it erroneously conflates payment of benefits with the cost of providing benefits. The former, which states may not generally regulate, includes decisions about *who* a plan's beneficiaries are and *what* benefits to provide. For instance, *Egelhoff* held that the provision at issue there was preempted because it required administrators to "pay benefits to the *beneficiaries chosen by state law*, rather than to those identified in

the plan documents." 532 U.S. at 147 (emphasis added). And *Alessi v. Raybestos-Manhattan, Inc.*, held States could not prohibit plans from offsetting workers' compensation benefits against pension payments because doing so "eliminate[d] one method for calculating pension benefits" that plans might choose. 451 U.S. 504, 525 (1981).

Nothing of the sort is at issue here. Plans remain free to provide prescription-drug benefits of whatever kind, to whatever degree of coverage, and to whomever they choose.

Instead, Act 900 regulates the cost of providing benefits, and laws that merely regulate what administrators (or even plans) pay non-beneficiaries for goods and services do not regulate a central matter of plan administration. *Travelers* aptly illustrates that principle with its holding that the surcharges at issue there did not regulate plan administration because they did "not bind plan administrators to any particular choice" but "simply [bore] on the costs of benefits." 514 U.S. at 659-60. Indeed, as the Court explained, the rates insurers were required to pay hospitals under New York's regime were merely "an influence that can affect a plan's shopping decisions" among insurers; they did "not affect the fact that any plan will shop for the best deal it can get." *Id.* at 660.

The same is true here. As a result of Act 900, PBMs will be required to reimburse pharmacies at somewhat higher rates, and PBMs may respond by demanding greater compensation from plans. And that may—as PCMA argues—affect a plan's coverage decisions. But "if ERISA were concerned with any state action . . . that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's

preemptive reach." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 329 (1997). What matters for ERISA's purposes is that nothing in Arkansas's law "bind[s] plan administrators to any particular choice" of coverage, PBM, or PBM compensation. *Travelers*, 514 U.S. at 659. It merely acts as an "indirect economic influence" on those choices. *Id.*

No more persuasive is PCMA's related contention that Act 900 is preempted because it "effectively prohibits the use of MAC methodology in prescription-drug benefit plans" and thereby disturbs plan cost assumptions. Br. 25. To start, what PCMA labels a prohibition is really just a requirement that PBMs set MAC rates at or above acquisition cost. And given PCMA's representation that its members *already* do that 90% of the time, Br. 12, it is difficult to understand how that requirement abolishes MAC.[3]

Yet even if Act 900 had abolished MAC, it would not be preempted. Indeed, the law in *Travelers* did what PCMA claims Act 900 does: It mandated administrators reimburse service providers (there insurers and hospitals) based on a particular methodology. 514 U.S. at 649. By definition, that regulation voided contrary methodologies and contractual reimbursement

[3] PCMA fears that absent the threat of below-cost reimbursement, pharmacies would lack incentive to negotiate on price with wholesalers. Br. 10. This is illogical. Even if Act 900 guaranteed pharmacies a *marginal* profit—which it does not given pharmacies' uncompensated dispensing costs, *see* n.2 *supra*—pharmacies would still have an incentive to maximize their profits by buying drugs for the lowest price. *See* JA239 ("Pharmacies will still search for wholesalers who offer competitive pricing because of the importance of having a gross margin large enough to cover expenses."); JA272 ("[Pharmacies] need to buy [drugs] at the lowest possible cost regardless of what the MAC is. Because the lower they can get their price, the more money they can make.").

rates and undoubtedly—as PCMA alleges here—unmoored any number of "[c]ost assumptions" and led to changes in plan design. Br. 25. But just as was true in *Travelers*, while those changes might influence a plan's shopping decisions, they do not dictate what or who a plan covers or its choice of administrators.

Finally, PCMA's claim that MAC methodologies are a central matter of plan administration conflicts with the fact that PBMs do not share their MAC methodologies with plans. To the contrary, as PCMA stressed below, "PBMs consider both their MAC lists and MAC pricing methodologies to be proprietary trade secrets" and they "protect them as such." JA72-73; *see also* JA126 (explaining PBMs so closely guard their MAC reimbursement methodologies that "[n]o external person can access it–not the pharmacy, and *not the client for which the MAC list is created*" (emphasis added)). Thus, it is simply implausible to suggest, as PCMA does, that by regulating something plans cannot even access, Arkansas has regulated plan administration.[4]

[4] PCMA implies that by modifying PBMs' reimbursement rates, Act 900 requires administrators to flout plan documents. Br. 22-23. That argument ignores the fact that PBMs' undisclosed MAC rates do not appear in plan documents. Moreover, their absence from plan documents further underscores that pharmacy reimbursement rates are not a "payment of benefits" since, if they were, they would have to be included in plan documents. *See Egelhoff*, 532 U.S. at 147 ("ERISA[] commands that a plan shall 'specify the basis on which payments are made to and from the plan'") (quoting 29 U.S.C. 1102(b)(4)).

II. ERISA does not preempt Act 900's enforcement mechanisms.

A. Act 900's enforcement mechanisms are necessary incidents to its rate regulation.

As Arkansas previously explained, Pet'r Br. 27-30, Act 900's enforcement mechanisms are necessary incidents to its rate regulation. That means they are not preempted. Indeed, it would make little sense to say that ERISA does not preempt state rate regulation, but that States may not impose procedures that are reasonably necessary to enforce that regulation. Otherwise, rate regulation would be permissible in theory but not in fact. *Cf. Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 834 (1988) (reasoning that since ERISA did not bar suits by creditors against ERISA plans, "state-law methods for collecting money judgments must . . . remain undisturbed by ERISA; otherwise, there would be no way to enforce such a judgment").

PCMA apparently does not dispute that Act 900's "procedures" are reasonably necessary "[t]o implement [its] requirement" that PBMs reimburse pharmacies' acquisition costs. Br. 15. It argues instead that even procedures that are necessary to enforce a permissible rate regulation are preempted if they incidentally touch on central matters of plan administration. Br. 40-41. That is incorrect.

PCMA argues that Arkansas's rule would "open a significant hole in ERISA's preemptive scope" and allow States to enact whatever regulations they wished "merely by tying them to a regulation of rates." Br. 41. That claim, however, ignores the requirement that State procedures be *reasonably necessary* to

enforce valid rate regulations. That is, to put it differently, they must be procedures for resolving (or avoiding) rate disputes between third-party administrators and service providers.

PCMA also disputes (Br. 40-41) that *Gobeille* endorsed that rule when it distinguished preempted State laws requiring reporting in the abstract from unproblematic "state law[s] . . . the enforcement of which necessitates incidental reporting by ERISA plans." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016). But even the plan challenging the reporting requirement in *Gobeille* conceded reporting requirements were permissible when "incident to a substantive obligation that the State could impose." Transcript of Oral Argument at 30, *Gobeille* (No. 14-181).

And PCMA ultimately does not dispute that the Court has twice upheld incidental plan-reporting requirements that enforced otherwise permissible laws, most notably in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). *See* Pet'r Br. 26. PCMA's only attempt to distinguish those cases consists of little more than the circular assertion that those reporting requirements had merely "incidental effect[s] on ERISA plans" and did not regulate "a central matter of plan administration." Br. 41. Plan reporting, however, *is* "a central matter of plan administration." *Gobeille*, 136 S. Ct. at 945. Taken together, then, *Gobeille* and *De Buono* demonstrate that States may incidentally regulate even central matters of plan administration in order to enforce an otherwise permissible law.

B. Act 900's enforcement mechanisms do not regulate central matters of plan administration.

In any event, Act 900's enforcement procedures do not regulate any central matters of plan administration. PCMA claims those procedures—requiring PBMs to periodically update their reimbursement rates and allowing pharmacies to appeal illegal reimbursements—regulate plans' procedures for "paying for benefits" and "processing claims." Br. 23.

As explained above, the first claim rests on PCMA's conflation of laws that regulate the "payment of benefits" with laws that merely influence (or even regulate) the cost of benefits. Act 900's enforcement mechanisms concern the latter, and as such, they are not preempted.

Likewise, PCMA's attack on Act 900's appeals and MAC update provisions fails because those mechanisms do not regulate any *plan* procedure. They regulate *PBM procedures* that are not shared with plans. Again, not even "the client for which the MAC list is created" has access to a PBM's MAC list or is told how it is created and updated. JA126; *see* JA 72-73. Nor are PBM-pharmacy contracts—which govern reimbursement appeals—shared with plans. *See* JA96 (PBM-pharmacy contracts are confidential). Thus, it strains credulity to suggest that Act 900 regulates central matters of plan administration when the things it regulates are not even shared with plans. Instead, at most, Arkansas has regulated PBM administration and no case holds such regulation preempted.

Act 900 also does not regulate claims-processing. As Arkansas previously explained, Pet'r Br. 39-40, ERISA's claims-processing provisions and implementing

regulations only govern the procedures by which plans process claims by *beneficiaries* and appeals from the denial of those claims. *See* 29 U.S.C. 1133; 29 C.F.R. 2560.503-1. Those provisions and regulations say nothing whatsoever about how plans or administrators "process" reimbursement disputes with service providers. And while PCMA protests that there is "no artificial line" between reimbursement and claims processing, Br. 41 (heading), it does not dispute that ERISA is silent as to third-party reimbursement disputes. And where "ERISA has nothing to say," *Egelhoff*, 532 U.S. at 148 (quoting *Dillingham*, 519 U.S. at 330), this Court has been extremely reluctant to find preemption.

PCMA, moreover, effectively concedes that provider-reimbursement procedures are governed by state, not federal, law. For example, PCMA notes that absent regulation, PBM-pharmacy "dispute-resolution procedures" are governed by PBMs' "contracts with pharmacies." Br. 23. Those contracts are enforced—or, if illegal, voided—under state contract law. And if contractual dispute-resolution procedures fail, PCMA all but concedes the provider's next step is a state-court contract suit.[5] Br. 44.

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[5] PCMA doesn't dare argue those suits are preempted, but it claims the panoply of cases holding they are not concern only complete preemption. Br. 44 n.15. That is incorrect. Some address ERISA's preemption clause. *See, e.g.*, *Access Mediquip v. United Healthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012) (en banc), *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp.*, 187 F.3d 1045, 1052-54 (9th Cir. 1999). And even the complete-preemption cases freely rely on preemption-clause doctrine. *See, e.g.*, *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347 n.7 (11th Cir. 2009).

Recognizing that, PCMA resorts to claiming that state-court suits are different from internal reimbursement appeals because contract suits enforce contract rates, not rate regulation. *Id.* That misses the point; whatever substantive rule of decision applies (and Arkansas's is valid), in either case it is state law that provides the *procedures* for resolving the reimbursement dispute. And if States can impose their rules of civil procedure on reimbursement disputes, there is no reason why they may not take the lesser step of requiring PBMs to design their own procedure for resolving reimbursement disputes—which is all Act 900 does. *See* Ark. Code Ann. 17-92-507(c)(4)(A)(i) (requiring PBMs to "[p]rovide a reasonable administrative appeal procedure").

At the end of the day, PCMA's only substantive argument for conflating reimbursement procedures and claims processing is its claim that a successful reimbursement appeal might collaterally affect how much a beneficiary in a co-insurance or high-deductible plan owes. Br. 42-43. That argument has no application to the 80% of plans that charge flat co-pays. Pet'r Br. 4. Moreover, even in the other 20%, PCMA does not seriously suggest that pharmacies would ever attempt to collect the "additional $1" that PCMA hypothesizes would be their due weeks after a patient paid for his prescription. Br. 43.

Yet even supposing reimbursement appeals had real-world effects on co-insurance payments, PCMA's argument proves far too much. On the same logic, state-court contract suits by providers, which lower courts universally permit, would be preempted because they also collaterally recalibrate coinsurance amounts. Were that true, reimbursement disputes would be a

procedural no-man's land, governed neither by state nor federal law. That cannot be true.[6]

Instead, beneficiaries' disputes over the plan's co-insurance terms are claims-processing disputes governed by ERISA and providers' disputes over reimbursement rates—to which co-insurance is merely applied—are governed by state law.

C. PCMA's arguments about uniformity and burden are overstated and irrelevant.

No one disputes that Congress intended ERISA to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983). But that purpose does not extend to each and every thing that plans—or their third-party administrators—do. Rather, like preemption itself, that interest is limited to "core ERISA concern[s]." *Egelhoff*, 532 U.S. at 147. Because, as explained, Act 900 does not regulate a central matter of plan administration, PCMA's complaints about burdens and disuniformity ring hollow.

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[6] PCMA vaguely implies that the Department of Labor has regulatory authority over "PBM reimbursements," citing a proposed rule on the entirely different subject of *plan* disclosures of cost-sharing information to beneficiaries. Br. 14 (citing 84 Fed. Reg. 65,464 (Nov. 27, 2019)). The Department has authority to "carry out the provisions" of ERISA, 29 U.S.C. 1135, including its provisions on disclosure, *see Gobeille*, 136 S. Ct. at 944 ("The Secretary of Labor has authority to establish . . . reporting and disclosure requirements for ERISA plans"), but ERISA is silent on reimbursement rates and procedures and the Department accordingly has no authority (and has never asserted any) to regulate them.

Travelers illustrates the point. There, New York imposed 24% surcharges on non-Blue insurers, and the Court presumed those surcharges were passed along in large part to the plans that hired those insurers. *Travelers*, 514 U.S. at 650, 659. Those financially burdensome surcharges were also unique to New York.

Yet the Court found those surcharges unproblematic because ERISA was not intended to make costs uniform and such "rate differentials" were common even absent state action. *Id.* at 660, 662. Moreover, as for the surcharge's financial burdens, the Court explained that burden would only be relevant if it were so "acute" that it "force[d] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers"—that is, if the burden effectively regulated central matters of plan administration. *Id.* at 668.

Likewise, in *Dillingham*, when California imposed a substantially higher minimum wage on ERISA apprenticeships that did not meet California's voluntary standards for apprenticeship-program design, the Court was not troubled by the disuniformity of California's wage law or the burdens it imposed. What mattered, the Court said, was that the wage differential was not so large that it was "tantamount to a compulsion upon apprenticeship programs" to meet California's standards. 519 U.S. at 333.

By the same token, where a law directly regulates core ERISA concerns, this Court's analysis has not turned on whether that regulation is materially disuniform or burdensome. PCMA reads *Gobeille*, for example, as a case about disuniformity and administrative cost. Br. 26-27. In reality, the plan in *Gobeille* failed to prove the law it challenged had

"caused it to suffer economic costs." 136 S. Ct. at 945. Yet the Court found that failure of proof irrelevant because the law "regulate[d] a central aspect of plan administration" and exposed plans to "the possibility of a body of disuniform" laws on the subject. *Id.*

Thus, whether Act 900 is preempted turns not on uniformity or whether compliance is burdensome, but whether the provisions at issue regulate, directly or indirectly, a central matter of plan administration.

As already explained, reimbursement rates and procedures are not central areas of plan administration. And PCMA concedes Arkansas's regulation of PBM reimbursements is not so burdensome that it compels plans to dismiss their PBMs, Br. 37-38, or to adopt any particular "scheme of substantive coverage." *Travelers*, 514 U.S. at 668. It only claims that Act 900 imposes certain costs on PBMs, which PBMs may pass along in part to plans, which might (as they see fit) make any number of compensating adjustments. Br. 34 ("For example, a plan might . . . Or plans might . . . or . . . ."). Such "indirect economic influence[s]" that may or may not lead a plan to do any number of things do not suffice for preemption. *Travelers*, 514 U.S. at 659.

Further, as a factual matter, there is no burden on plans (which have no role in reimbursement appeals) and any burden on PBMs is slight. Prior to Act 900, PBM-pharmacy contracts already provided for reimbursement appeals, and despite PCMA's obscure claim that Act 900's procedure is "far more burdensome" than preexisting procedures, Br. 33 n.13, the fact is Act 900 largely leaves PBMs free to design the appeals process. Indeed, the only real difference PCMA points to is that when States provide a rule of decision for reimbursement appeals, appeals go up. *Id.* But that

is simply a policy argument against Arkansas's unquestionably permissible rate regulation, not an argument about the burdensomeness of Arkansas's procedures. And in any event, whatever the burden on tweaking existing appeals procedures, PBMs will be required to do so anyway since Act 900—even on PCMA's theory—is only preempted as applied to some PBM customers.[7]

III. ERISA does not preempt Act 900's decline-to-dispense provision.

Act 900's decline-to-dispense provision merely makes explicit what is always implicit with rate regulation: a business offered less than the statutory rate for its wares does not have to sell them. As previously explained, Pet'r Br. 29, rate regulation supplants contrary contractual rates with the price terms it sets. So when a party refuses to pay a statutory rate, the effect is just as if it refused to pay a contractual one; its counterparty is not obliged to sell.

Indeed, if the non-Blue insurers in *Travelers* had simply refused to pay New York's surcharges, New York hospitals would have been entitled to decline their insurance. PCMA responds with the non sequitur that on that theory, New York could simply have authorized hospitals to refuse to serve non-Blues altogether. Br. 43-44. But that would not have been incident to, or an enforcement of, New York's rate

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[7] One additional uniformity point merits mention. PCMA claims Act 900 applies whenever someone travels to Arkansas to fill a prescription and argues that, as a result, plans nationwide will be required to conform to Arkansas's requirements. Br. 32, 34. But Act 900 only applies to Arkansas employees or residents, not to anyone visiting an Arkansas pharmacy. Ark. Code Ann. 17-92-507(a)(9).

regulation (though it might have served that rate regulation's purposes). By contrast, Arkansas's decline-to-dispense provision merely ensures compliance with—and indeed is a necessary outgrowth of—Arkansas's valid rate regulation.

The decline-to-dispense provision also does not alter beneficiaries' benefits. As previously explained (Pet'r Br. 46-48), that provision does not alter a plan's promise to cover the cost of drugs that are for sale. Rather, like any number of other contract doctrines and pharmacy regulations, it merely provides that a pharmacy is not required to sell drugs under certain circumstances. Nor does it contravene any plan documents since plans are not privy to—and in fact are barred from seeing—PBM-pharmacy agreements. JA96 (PBMs keep pharmacy contracts confidential).

PCMA does not really claim that laws that authorize pharmacies not to sell drugs regulate benefits or are generally preempted. Instead, it argues that Act 900 is unique because it authorizes pharmacies to decline to dispense on the basis of the plan's (actually, the PBM's) conduct. Br. 24-25 n.5. But that argument fails to distinguish any number of unquestionably permissible contract-law doctrines that would permit a pharmacy to decline to dispense because a PBM failed to pay contract rates or made misrepresentations.

In any event, PCMA's attack on Act 900's decline-to-dispense provision ultimately fails for the same reason its entire connection-with argument fails: States *can* regulate a PBM's reimbursement rates, and that regulation voids contractual promises to sell at lesser rates.

IV. Act 900 does not refer to ERISA plans.

Since this Court's decision in *Dillingham* over two decades ago, this Court has held that a state law only impermissibly refers 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." *Gobeille*, 136 S. Ct. at 943 (quoting *Dillingham*, 519 U.S. at 325). PCMA does not contend Act 900 meets *Dillingham*'s test, Br. 49, nor could it. Indeed, just as the law in *Travelers* did not refer to ERISA plans because it regulated insurers' reimbursement rates regardless of whether ERISA plans "secured" their "coverage," 514 U.S. at 656, Act 900 regulates PBMs' reimbursement rates regardless of who hires them.

PCMA contends that under two pre-*Dillingham* cases, a different rule applies when a law "depend[s] on the existence of a plan . . . *including* ERISA plans." Br. 49 (emphasis added).

That is not how this Court has understood those cases. In *District of Columbia v. Greater Washington Board of Trade*, the District required employers to provide workers' compensation benefits that were "measured by reference to" the specific benefits provided by employee-benefit plans, which were overwhelmingly ERISA plans. 506 U.S. 125, 130 (1992). Given that metric, *Dillingham* understood *Greater Washington* as a case where "the existence of ERISA plans"—not just any plans—"[wa]s essential to the law's operation." *Dillingham*, 519 U.S. at 325.

Likewise, in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), a State forbade benefit plans, including ERISA plans, from reducing their benefits on account of a tort recovery. *Id.* at 55. That rule too was measured by

reference to a plan's existing "benefit levels," *id.* at 60, and thus was deemed (in just a paragraph of what was arguably dictum) reference-to preempted.

Here, while Act 900 could not operate absent prescription-drug plans of some sort, just as the *Travelers* law could not have operated absent healthcare plans of some sort, the existence of *ERISA* prescription-drug plans is not essential to its operation. Act 900 would still regulate PBMs whether ERISA plans existed or not, and unlike the laws in *Greater Washington* and *FMC*, it does not regulate by reference to the benefits that ERISA plans offer. Act 900 is not preempted.

CONCLUSION

This Court should reverse the court of appeals' judgment.

Respectfully submitted,

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