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

BRIEF IN OPPOSITION

A. J. Kritikos
MCDERMOTT WILL & EMERY LLP
444 West Lake Street
Chicago, IL 60606
(312) 372-2000

M. Miller Baker
Counsel of Record
Sarah P. Hogarth
MCDERMOTT WILL & EMERY LLP
500 North Capitol Street NW
Washington, DC 20001
(202) 756-8000
mbaker@mwe.com

Attorneys for Respondent

QUESTION PRESENTED

Pharmacy benefit managers ("PBMs") are third-party administrators that manage prescription drug benefits on behalf of various entities that provide healthcare benefits, including ERISA-governed health benefit plans. As third-party administrators for ERISA plans, PBMs contract with pharmacies to establish provider networks to dispense prescription-drug benefits to plan beneficiaries according to plan terms. As part of that role, PBMs implement Maximum Allowable Cost ("MAC") lists, which specify the amount a network pharmacy will be reimbursed for dispensing a particular generic drug the plan covers.

In Act 900, the Arkansas legislature amended the state's MAC law to require PBMs to, *inter alia*, (1) allow pharmacies to appeal MAC reimbursements and to reverse and rebill reimbursements less than the wholesaler's invoice price, (2) make certain disclosures to pharmacies, (3) permit network pharmacies to decline to dispense prescription-drug benefits if reimbursement would be less than the wholesaler's invoice price, and (4) update their MAC lists based on certain criteria.

The district court held that the provisions identified above—and others—had an impermissible "connection with" ERISA. The Eighth Circuit below affirmed on "connection with" preemption grounds and the alternative ground of "reference to" preemption.

As framed by the petitioner, the question presented is:

Whether, as the court of appeals below held, ERISA preempts Act 900's provisions requiring PBMs

to allow pharmacies to appeal MAC reimbursements and to reverse and rebill reimbursements less than the wholesaler's invoice price because they have an impermissible "connection with" ERISA.

CORPORATE DISCLOSURE STATEMENT

Respondent Pharmaceutical Care Management Association ("PCMA") states that it has no parent corporation and that no publicly held company owns more than ten percent of its stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES

Page(s)

Statutes

TABLE OF AUTHORITIES

Page(s)

Rules

TABLE OF AUTHORITIES

Other Authorities

STATEMENT

A. ERISA Preemption

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*., is "a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). This case involves employer-provided health benefit coverage.

ERISA "ma[de] benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). "One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a 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)).

To further ERISA's scheme of national uniformity, Congress included an express-preemption provision that preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" subject to ERISA. 29 U.S.C. § 1144(a).[1] This provision "may be the most expansive

[1] ERISA also preempts a state-law claim if an individual could have brought it under ERISA's civil enforcement mechanism and where no other independent legal duty is implicated. *See* 29 U.S.C. § 1132(a); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209–10 (2004). This form of preemption is not implicated here.

express pre-emption provision in any federal statute." *Gobeille*, 136 S. Ct. at 947 (Thomas, J., concurring).

ERISA preemption's purpose was clear: "ERISA's pre-emption clause indicates Congress's intent to establish the regulation of employee welfare benefit plans as exclusively a federal concern." *Id.* at 944 (majority opinion) (internal quotation marks omitted). By including a broad preemption provision, Congress elected to "minimiz[e] the administrative and financial burden[s] on plan administrators—burdens ultimately borne by the beneficiaries" by prohibiting States from "[r]equiring ERISA administrators to master the [50 states'] relevant laws." *Id.* (second alteration in original) (quoting *Egelhoff*, 532 U.S. at 149–50).

Within a decade of ERISA's enactment, this Court established the two familiar tests for preemption that still apply today, 35 years later. *See Shaw*, 463 U.S. at 96–97.

Under the first, ERISA preempts a state law if it has a "reference to" ERISA plans. *Gobeille*, 136 S. Ct. at 943. A state law has a "reference to" ERISA plans "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Id.* (alterations in original) (quoting *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)).

Under the second, ERISA preempts a state law if it has a "connection with" ERISA plans. *Id.* A state law has a "connection with" ERISA plans if it does any one of three things.

First, a state law has a "connection with" ERISA if it " 'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.' " *Id.* (alteration in original) (quoting *Egelhoff*, 532 U.S. at 148). Obligations undertaken with plan administration include "determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records." *Fort Halifax*, 482 U.S. at 9. Plan administration also includes requirements concerning "reporting, disclosure, and recordkeeping." *Gobeille*, 136 S. Ct. at 945.

Second, a state law has a "connection with" ERISA if it "mandate[s] employee benefit structures." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

Third, state law might have a "connection with" ERISA 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.' " *Gobeille*, 136 S. Ct. at 943 (quoting *Travelers*, 514 U.S. at 668).

B. Pharmacy Benefit Managers

PBMs perform a critical function in structuring and delivering of prescription-drug benefits. Specifically, health plans enter into contracts with PBMs to manage and administer prescription-drug benefits. PCMA C.A. App. 121, 169–71.

Among other things, PBMs process and pay prescription drug claims, create networks of pharmacies at which prescriptions will be filled for a specified

price, operate mail order pharmacies, design pharmaceutical benefits, create formularies, and negotiate for discounts or rebates. *Id.* at 132–33.

Insurers and employers that offer a prescription-drug benefit must handle such tasks themselves, contract with a PBM to have them done as a third-party administrator, or do without. *Id.* Because PBMs aggregate the purchasing power of individual insurers/employers, they often obtain better terms than insurers/employers could alone. *Id*.

PBMs enter into contracts with pharmacies to establish pharmacy networks that ensure health-plan clients' members have the access to prescription drugs designed by the plan. *Id.* at 139–40. When a plan member fills a prescription, the PBM reimburses the pharmacy for the portion of the prescription the plan pays. The plan in turn pays the PBM as provided in the contract. *Id.* at 241.

Nearly all health plans use a PBM to manage and administer prescription-drug benefits. *Id*. at 171, 254, 256. Not only do PBMs provide critical services, their services reduce prescription-drug spending by health plans, as several federal agencies have found.[2] Indeed, the undisputed record evidence in this case demonstrates that it would not be cost-effective for

---

[2] *E.g.*, Fed. Trade Comm'n, Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., FTC File No. 111-0210, at 2 (Apr. 2, 2012) ("Our staff's investigation revealed that competition for accounts [for full-service PBM services] is intense, has driven down prices, and has resulted in declining PBM profit margins . . . .").

health plans to perform PBM services in-house. *Id.* at 171, 254.

C. Maximum Allowable Cost Pricing

One way PBMs ensure access while reducing prescription-drug spending is through use of a Maximum Allowable Cost ("MAC") program. A MAC specifies the amount a PBM will reimburse a pharmacy for a particular strength and dosage of a non-branded, generic drug. PCMA C.A. App. 161. Ironically, *state* Medicaid programs pioneered the development of MAC programs vilified by petitioner and her amici states and provided the template private PBMs would later adopt. *Id.* at 139. Indeed, as of January 2012, 45 states—including Arkansas—used MAC programs to control their Medicaid spending for prescription drugs. *Id.* at 135–36.[3]

MAC programs are critical to structuring a prescription-drug benefit. This is because the *pharmacy* negotiates with and purchases drugs or drug ingredients from pharmaceutical wholesalers or manufacturers. *Id.* at 204. Wholesalers do not charge all pharmacies the same price for the same drug. *Id.* at 250, 271. Instead, wholesalers offer different prices and discounts to different pharmacies based on a variety of factors, including purchasing volume, exclusivity, and credit-worthiness. *Id.* at 260, 265.

---

[3] The amici states do not acknowledge that virtually all of them use MAC programs to control prescription drug costs in their state-funded Medicaid programs. PCMA C.A. App. 135–36.

Because pharmacies control the costs of generic-drug acquisition and their *actual* cost in any given transaction is opaque, PBMs create proprietary MAC lists, which include anywhere from dozens to thousands of drugs and set reimbursement amounts on a drug-by-drug basis. *Id.* at 172, 244, 255. The MAC price reflects the average acquisition cost for a particular drug across several purchasers. *Id.* at 172, 208. PBMs maintain multiple MAC lists, adapting them to account for factors specific to the health plans or pharmacy networks to which the particular MAC list applies. *Id.* at 172, 244, 255.

PBMs' use of MAC lists has several consequences.

First, when PBMs pay pharmacies only the amount specified in the MAC, pharmacies have a substantially increased incentive to acquire and dispense less expensive generic drugs. *Id.* at 137. In the absence of a MAC price, a pharmacy's incentive is to dispense more expensive drugs, including more expensive brand drugs. *Id.* Thus, MAC pricing directly affects the drug mix provided by the plan. *Id.*

Second, MAC programs encourage pharmacies to secure the best wholesale price to maximize their margin on each prescription. *Id.* at 140–41, 269. And, as the undisputed evidence below confirmed, the vast majority of generic reimbursements under MAC exceed the pharmacy's acquisition cost. *Id.* at 184, 194, 274. Thus, the undisputed evidence shows that on balance, MAC reimbursements result in pharmacies

profiting overall by filling plan members' prescriptions, *id.* at 173–74, while allowing plans to control costs.[4]

Third, MAC programs avoid the possibility of pharmacies gaming cost-based reimbursement models, which often do not reflect pharmacies' actual acquisition cost after rebates and discounts. *Id.* at 138.

Fourth, MAC programs save plans and beneficiaries money by keeping prescription drug prices lower than they otherwise would have been. *Id.*

Fifth, MAC programs enhance market efficiency by eliminating the need to carry out individualized assessments of a pharmacy's claimed acquisition cost for any given transaction. *Id.*

MAC payment levels sometimes fall below a pharmacy's actual (as opposed to invoice) acquisition costs. *Id.* at 140–41. That is because the whole point of a MAC program is to pay the average cost incurred by well-run pharmacies, not the actual cost in any given transaction. *Id.* Poorly run pharmacies are likely to have higher than average costs. MAC programs create a powerful incentive for less-well-run pharmacies to improve their purchasing practices, which in turn increases competition by wholesalers and manufacturers to sell to such pharmacies. The result is that MAC programs increase overall pharmaceutical market efficiency. *Id.*

---

[4] Thus, petitioner's citation to anecdotal testimony from two Arkansas pharmacists that they lost money filling certain prescriptions below cost (*see* Pet. 10) does not provide the full context.

D. Act 900's Challenged Provisions

Act 900 of the Arkansas General Assembly's 90th Session ("Act 900") took effect on July 22, 2015. Act 900 amended the state's existing law regulating MAC programs. *See* Ark. Code Ann. § 17-92-507 ("Section 507") (reproduced as amended by Act 900 in Pet. App. 45a–50a). And it did so in an unprecedented way. PCMA C.A. App. 251 (explaining that pre-Act 900, Section 507 "was consistent with the other types of laws that were being passed around the country in or around 2013" but that Act 900 made an unanticipated, "unprecedented move" in "prohibiting 'negative reimbursement' ").

Act 900 did not change Section 507's application to PBMs performing services for "plan[s] or program[s] that pay[] for, reimburse[], cover[] the cost of, or otherwise provide[] for pharmacist services to individuals who reside in or are employed in this state." Ark. Code Ann. § 17-92-507(a)(9). Notably, however, Act 900 expanded Section 507's *exemption* of the *in-house* PBM serving the state-funded Medicaid program to also include the in-house PBM serving the state-funded Arkansas public employees health benefit plan. *Id.* § 17-92-507(f)(1).[5]

In relevant part, Act 900 amended Section 507 to:

---

[5] Petitioner's statement that Act 900 thus applies to PBMs "employed by" the state's Medicaid program and public employees' health benefit plan is incomplete because the statute only applies to *third-party administrators* employed by the state. *See* Pet. 16. When the state chooses to perform that function in-house, the function is exempt.

- Add a new term, "pharmacy acquisition cost," defined as "the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice," *id.* § 17-92-507(a)(6) ("Acquisition-Cost Definition");
- Require PBMs to update their MAC lists within seven calendar days from "an increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in" Arkansas, *id.* § 17-92-507(c)(2) ("List Update Provision");[6]
- Require PBMs to provide an administrative appeal procedure to allow pharmacies to challenge MAC lists prospectively and reimbursements retrospectively as being below the "pharmacy acquisition cost," *id.* § 17-92-507(c)(4)(A)(i)(b) ("Appeals Provision");
- Require PBMs, if they do not uphold a pharmacy's appeal pursuant to the Appeals Provision, to adjust the MAC list and permit pharmacies to reverse and rebill each claim affected by the pharmacy's inability to procure a drug at a cost equal to or less than the MAC price if the pharmacy's primary wholesale supplier does not make the price available, *id.*

---

[6] Pre-Act 900, the List Update Provision required PBMs to update their MAC list upon any change in MAC methodology. Act 900 retained that requirement and added the additional requirement outlined above.

§ 17-92-507(c)(4)(C)(iii) ("Primary Wholesaler Provision"); and

- Authorize pharmacies to "decline to provide the pharmacist services to a patient or pharmacy benefits manager" if the MAC would result in the pharmacy being paid less than its acquisition cost, *id.* § 17-92-507(e) ("Decline to Dispense Provision").

The five foregoing provisions of Act 900 are collectively referred to herein as the "Challenged Provisions"[7] as they were the subject of PCMA's complaint and motion for summary judgment in the district court. For the convenience of the Court, Section 507 as amended by Act 900 is reproduced in the attached appendix with the Challenged Provisions in boldface. (The petition only identified two of the five material provisions of Section 507 that PCMA challenged in the district court. *See* Pet. 13.)

In sum, the Challenged Provisions require ERISA plans to (1) update their MAC lists according to state dictates; (2) allow network pharmacies to contest MAC prices through an appeal process and reverse and rebill claims if a drug's invoice cost from a pharmacy's primary wholesale supplier exceeds the MAC price; and (3) allow network pharmacies to decline to dispense covered prescription drugs to plan members

[7] Both the district court and the court of appeals identified the Challenged Provisions in their summaries of the Act 900. *See* Pet. App. 13a–14a (district court's summary of Act 900's provisions); Pet. App. 4a (same by the Eighth Circuit).

if the wholesaler's invoice price exceeds the MAC price.

E. Act 900's Uncertain Provisions

Section 507 as amended by Act 900 contains two other significant categories of provisions whose impact on this Court's consideration of the petition is unclear (the "Uncertain Provisions"):

- In a provision that preexisted Act 900, Section 507(c)(1) requires PBMs to disclose their MAC lists to pharmacies, Ark. Code Ann. § 17-92-507(c)(1) ("MAC Disclosure Requirement");
- In a provision that preexisted Act 900, Section 507(c)(3) requires PBMs to disclose their MAC list updates to pharmacies, *id.* § 17-92-507(c)(3) ("MAC Update Disclosure Requirement"); and
- In a provision that preexisted Act 900, Section 507(c)(4)(C)(ii) requires PBMs, as described by the district court, to "disclose to pharmacies certain sourcing and pricing information when an appeal is denied," Pet. App. 19a; *see* Ark. Code Ann. § 17-92-507(c)(4)(C)(ii) ("MAC Appeal Disclosure Requirement"). Act 900 amended this provision to add additional requirements.

The three foregoing Uncertain Provisions are collectively referred to as the "Pharmacy Disclosure Provisions."

Finally, the Uncertain Provisions also include the following:

- In a provision that preexisted Act 900, Section 507(b) restricts the categories of drugs that PBMs may place on MAC lists. Ark. Code Ann. § 17-92-507(b) ("MAC Category Limitation").

For the convenience of the Court, all of the Uncertain Provisions are identified in italics in the attached statutory appendix.

F. Proceedings Below

1. PCMA, the national trade association for PBMs, filed this suit on behalf of its members. PCMA's narrowly tailored complaint alleged that ERISA expressly preempted the specific Challenged Provisions (rather than the entirety of Section 507 as amended by Act 900) as applied to PBMs administering prescription-drug benefits for ERISA plans.[8]

On cross-motions for summary judgment, PCMA submitted undisputed evidence establishing that the Challenged Provisions had a "connection with" ERISA for various reasons, including:

- Act 900 will force multi-state employers to modify their plans to (1) comply with Act 900

[8] PCMA also alleged that the Medicare statute expressly preempted Act 900 as applied to PBMs administering prescription-drug benefits for Medicare Part D plans. PCMA lost that claim in the district court, *see* Pet. App. 20a–26a, but prevailed in the Eighth Circuit below, Pet. App. 7a–11a. Petitioner has not raised the Medicare preemption issue here. PCMA also unsuccessfully asserted various constitutional claims in the district court, *see* Pet. App. 22a–35a, and did not appeal the dismissal of those claims.

for all employees nationally; (2) adopt Arkansas-specific changes to their plan MAC lists, MAC pricing, and appeals processes; or (3) risk employees being unable to fill prescriptions in Arkansas. PCMA C.A. App. 150–51, 249.

- Act 900 will increase ERISA plans' pharmaceutical spending by undermining the utility of MAC pricing. *Id.* at 152.
- Act 900 will increase plan members' out-of-pocket contributions by increasing premiums and co-payments, which are computed based on the actual cost of the dispensed drug. *Id.* at 126, 153, 165–66. For members with high-deductible plans, the increased cost will be borne by the employee until he can satisfy the deductible (assuming he can). *Id.* at 153.
- Act 900 will cause employers to change their plan design to offset the lost value of MAC pricing, including by modifying covered benefits or changing co-payments and deductibles. *Id.* at 126, 153.
- Act 900 will prevent PBMs from fulfilling ERISA plans' pharmacy access requirements because Arkansas pharmacies can decline to dispense drugs to plan members. *Id.* at 163.
- Act 900 will increase administrative burdens, including those relating to appeals, implementing retroactive changes to MAC pricing, and compiling information about 60% of the wholesalers in Arkansas, information PBMs have no way of obtaining. *Id.* at 152–53.

On the basis of the foregoing record, the district court granted PCMA's motion for summary judgment "on PCMA's ERISA claim because act 900 is invalid as applied to PBMs in their administration and management of ERISA plans." Pet. App. 36a. In other words, Act 900 had an impermissible "connection with" ERISA. The district court reasoned that the Eighth Circuit's decision in *Pharmaceutical Care Management Ass'n v. Gerhart*, 852 F.3d 722 (8th Cir. 2017), "control[led]" PCMA's ERISA claim. Pet. App. 18a.

In *Gerhart*, the Eighth Circuit addressed an Iowa law that (1) required PBMs to report MAC pricing methodologies to the state; (2) limited PBM choices regarding the categories of drugs that could be placed on MAC lists and sources from which PBMs could obtain pricing information; (3) required PBMs to adopt certain pharmacy appeal procedures; and (4) required PBMs to make certain disclosures to pharmacies. 852 F.3d at 727. The Eighth Circuit concluded that the Iowa law had both an impermissible "reference to" and "connection with" ERISA. *See id.* at 728–30 ("reference to" analysis); *id.* at 730–32 ("connection with" analysis).

As relevant here, *Gerhart*'s "connection with" analysis reasoned that the Iowa statute's (1) reporting requirement impermissibly interfered with uniform national plan administration, *id.* at 731 (citing *Gobeille*, 136 S. Ct. at 945); (2) restrictions on the composition and creation of MAC lists impermissibly interfered with the calculation of prescription benefit levels and disbursements for those benefits, *id.* (citing *Fort Halifax*, 482 U.S. at 9); and (3) requirement that

PBMs adopt pharmacy-appeal procedures and permit retroactive pharmacy reimbursements "restrict[ed] an administrator's control in the calculation of drug benefits" and "remove[d] their ability to conclusively determine final drug benefit payments and monitor funds," *id.*

The district court characterized *Gerhart* as holding that ERISA preempted the challenged Iowa statute—which the district court categorized as "similar to Act 900 in many of the ways that it regulates PBMs and MAC pricing"—because it "interfere[d] with nationally uniform plan administration," Pet. App. 18a, i.e, had a "connection with" ERISA. The district court then compared some of the various provisions in Act 900 to what it considered similar provisions in the Iowa statute under a "connection with" analysis. *Id*. at 18a–19a.

The district court directly addressed four of the five Challenged Provisions put at issue by PCMA's motion for summary judgment and found them preempted based on their similarities to the Iowa provisions preempted in *Gerhart*. The district court did not, however, explicitly address the fifth Challenged Provision, the Decline to Dispense Provision, which has no analogue in the Iowa statute.

The district court also compared the Uncertain Provisions to analogous provisions in the Iowa statute. In other words, the district court's opinion ap-

peared to grant more relief—by declaring the Uncertain Provisions preempted—than PCMA sought in its motion for summary judgment.[9]

In sum, the district 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." Pet. App. 19a. The opinion clearly applied the "connection with" prong of ERISA preemption, but did not appear to apply the "reference to" prong.

In theory, a district court's Federal Rule of Civil Procedure 58 separate judgment should clarify for the appellate record the scope of relief the district court actually awarded, but the district court's enigmatic separate judgment here provides no such assistance: "Pursuant to the order entered on this day, this case is dismissed with prejudice."[10] Dist. Ct. R. 108.

---

[9] To summarize, the district court addressed Act 900's Acquisition-Cost Definition, Appeals Provision, the Primary Wholesaler Provision, and the List Update Provision *plus* Section 507's MAC Category Limitation and Disclosure Provisions, neither of which PCMA challenged.

[10] The district court clearly intended to *both* (i) dismiss PCMA's Medicare Part D and constitutional claims with prejudice and (ii) grant PCMA declaratory relief with respect to its ERISA preemption claim against the Challenged Provisions, but the original judgment included no indication which specific provisions of Act 900 were preempted. After the Eighth Circuit's decision affirming as to ERISA preemption but reversing as to Medicare Part D preemption, the district court entered a new and equally enigmatic judgment stating the following: "Pursuant to the

2. On Arkansas's ERISA cross-appeal, petitioner did not raise or challenge the district court's apparent enlargement of PCMA's ERISA preemption relief to include the Uncertain Provisions. Arkansas did, however, raise the issue of "reference to" preemption, even though the district court's preemption analysis below was limited to the "connection with" theory. PCMA, as cross-appellee, endorsed the district court's statements suggesting that ERISA preempted the Disclosure Provisions. PCMA C.A. Response/Reply Brief at 42–43. PCMA also raised "reference to" preemption in response to Arkansas's briefing of the issue. *Id.* at 29–35.

The Eighth Circuit affirmed the district court's ERISA preemption decision and uncertain relief in a short opinion. The Eighth Circuit characterized the Iowa statute in *Gerhart* as "similar in purpose and effect to Act 900" and "preempted by ERISA because it had a prohibited 'reference to' ERISA, and because it interfered with national uniform plan administration." Pet. App. 5a. Without acknowledging that the district court's analysis below was limited to the "connection with" theory, the court of appeals endorsed the district court's conclusion "that *Gerhart* controlled the outcome of the ERISA preemption claim in this case," Pet. App. 5a. The court of appeals then summa-

---

Eighth Circuit's opinion . . . , judgment is entered for plaintiff [PCMA], and this case is dismissed with prejudice." Dist. Ct. R. 122.

rized the Iowa statute's provisions without any comparison to, or analysis of, Act 900's provisions. Pet. App. 5a–6a.[11]

Finally, the court of appeals rejected Arkansas's contentions (1) that *Gerhart*'s discussion of "connection with" and implicit "reference to" preemption was dicta, and (2) that *Gerhart*'s analysis conflicted with this Court's precedents. Pet. App. 6a–7a. It appears then that the court of appeals held that Act 900 failed *both* ERISA preemption tests, including "reference to." But the court provided no substantive discussion as to why Act 900 contained an impermissible "reference to" ERISA.

Thus, the court of appeals endorsed the district court's conclusion that certain provisions of Act 900 are preempted on "connection with" grounds, but like the district court, it did not specify whether its holding is limited to the Challenged Provisions or includes the Uncertain Provisions.

REASONS FOR DENYING THE PETITION

I. This Case Is a Poor Vehicle.

As an initial matter, this case is riddled with several defects that render it a poor vehicle for deciding the putative question presented. Among other defects, the decisions below are opaque in their holdings and reasoning; petitioner's question presented omits an alternative ground supporting the judgment below as well as various statutory provisions held preempted

---

[11] The Eighth Circuit's decision only discussed the provisions of Act 900 in its "Background," identifying the Challenged Provisions and no others. *See* Pet. App. 3a–4a.

below; and petitioner hinges her petition on arguments raised for the first time here.

First, the Court would need to grant review to find out what it is reviewing. With little analysis, the Eighth Circuit's decision below endorsed the district court's decision that ERISA preempts certain portions of Act 900 on grounds of "connection with" preemption. *Which* provisions of Act 900 the lower courts held preempted, however, is in doubt. Petitioner admits that the district court held that "Section 17-92-507 was *partially* preempted," Pet. 14 (emphasis added), yet offers no help to the Court in sorting through this morass of a record and identifying which provisions of Arkansas law would be before this Court if it granted review.[12]

Second, the uncertainty apparent on this record is not limited to the question of *what* the courts below actually decided; it includes the uncertainty of the reasoning of the courts below. The court of appeals simply endorsed the district court's "connection with" analysis on the basis of *Gerhart* and, without substantive explanation, concluded that Act 900 had a "reference to" ERISA—even though the district court's analysis that the Eighth Circuit endorsed was limited to "connection with."

Although the district court's "connection with" analysis did examine all but one of the Challenged Provisions as well as the Uncertain Provisions, the district court failed to analyze the Decline to Dispense

---

[12] The petition only specifically cites the Appeals and Primary Wholesaler Provisions. *See* Pet. 13.

Provision, which is not analogous to any provision of the Iowa statute in *Gerhart*. Petitioner offers no help either; her petition does not even cite, much less discuss, that extraordinary and unprecedented provision.

In these circumstances, much of the reasoning and extent of the relief granted by the courts below must be surmised. Insofar as any of the purported conflicts and circuit splits identified by petitioner exist, this Court should wait for a case in which the relevant issues are identified in the courts below—let alone cleanly presented and supported by thorough analysis.

Third, petitioner's question presented excludes review of the Decline to Dispense Provision, Disclosure Provisions, and List Update Provisions. Petitioner characterizes the "Arkansas statute" as "regulating drug-reimbursement rates," which does not "fairly include" the statute's regulation of the terms of *service* of network pharmacies reflected in the Decline to Dispense Provision. Nor does it "fairly include" Act 900's mandated disclosures and interference with a PBM's MAC list. S. Ct. R. 14.1(a).

"A question which is merely 'complementary' or 'related' to the question presented in the petition for certiorari is not "fairly included therein." *Izumi Seimitsu Kogyo Kabushiki Kaisha v. U.S. Philips Corp.*, 510 U.S. 27, 31–32 (1993) (quoting *Yee v. Escondido*, 503 U.S. 519, 537 (1992)). Questions that are "quite distinct, both analytically and factually," are not "fairly included" for purposes of Rule 14.1(a). *Id.* In the Eighth Circuit below, petitioner accurately

characterized the Decline to Dispense Provision as regulating "service," Arkansas C.A. Principal/Response Br. 56, and treated it separately, *id.* at 52–57. Thus, whether ERISA preempts it is "analytically and factually" distinct from petitioner's putative question regarding the Appeals and Primary Wholesaler Provisions. ERISA preemption of the Disclosure Provisions and List Update Provision is similarly *related*, but analytically and factually distinct.

Fourth, even if preemption of all of the Challenged Provisions is deemed "fairly included" within the question presented, petitioner fails to comply with Rule 14.4's requirement that she "present with accuracy, brevity, and clarity whatever is essential to ready and adequate understanding *of the points requiring consideration*." S. Ct. R. 14.4 (emphasis added). Specifically, although petitioner expressly acknowledges that Section 507 (as amended by Act 900) was only held "partially preempted," Pet. 14, her petition fails to identify or cite, much less discuss, the Decline to Dispense, List Update, or Uncertain Provisions. The petition leaves the Court and PCMA to guess what relevance, if any, those provisions have to the question presented and petitioner's preemption arguments.

Fifth (and as discussed below), petitioner's question presented encompasses only this Court's "connection with" precedent, not "reference to" preemption (an alternative ground to sustain the judgment below). Whether ERISA preempts "rate regulation," Pet. i, is an analysis arising out of this Court's "connection with" precedent, *see Travelers*, 514 U.S. at 667 n.6, which petitioner knows, Pet. 21–25 (addressing "rate

regulation" under "connection with" preemption). Thus, by petitioner's own framing, this case is an inappropriate vehicle to consider "reference to" preemption, *see* S. Ct. R. 14.1(a); *Yee*, 503 U.S. at 536 (where question presented raised a per se Takings issue, regulatory Takings issue not fairly included).

Further, even if petitioner had fairly included "reference to" preemption in her question presented, the court of appeals decided the question with little analysis, making this a poor vehicle for this Court to consider "reference to" preemption. The opaque reasoning below coupled with the petition's imprecision presents an especially acute risk of a bait and switch if the Court grants review. In Rorschach fashion, ten lawyers could review the record and petition and reach ten different reasonable conclusions as to what issue(s) is under review.

Sixth, petitioner's question presented, which characterizes the "Arkansas statute" as "regulating drug-reimbursement rates," presents a new legal theory borrowed from this Court's decision in *Travelers* that petitioner failed to assert below. Petitioner never argued below that the Challenged Provisions regulate drug-reimbursement rates. Instead, petitioner argued the Challenged Provisions have

> no connection with an ERISA-covered plan for four reasons: (1) Act 900's pricing provisions would only inflict indirect economic effects upon health plans, if any, which effects are not a basis for preemption; (2) Act 900's service provisions do not disrupt any contractual

> relationship between health plans and pharmacies as pharmacies will continue to dispense; (3) Act 900 regulates only the PBM-pharmacy relationship and not health plans; and (4) Act 900 would only impact a PBM's discretionary decisions.

Arkansas C.A. Principal/Response Br. 49. Thus, petitioner now asks this Court to consider in the first instance a theory it did not present below, a practice this Court disfavors. *See Granite Rock Co. v. Int'l Bhd. of Teamsters*, 561 U.S. 287, 306 n.14 (2010).

Finally, petitioner has switched arguments regarding an outcome-dispositive issue that is at the heart of petitioner's illusory circuit split—namely, whether ERISA categorically preempts "no PBM regulation at all." Pet. 25 (citing *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294, 305 (1st Cir. 2005)). Below, petitioner cited *Rowe* for the proposition that "PBMs are distinct from plans" for ERISA preemption purposes, *see* Arkansas C.A. Principal/Response Br. 57; *id.* at 58 ("The principal problem with the PCMA's ERISA-preemption challenge is that Act 900 does not regulate health plans. Rather, it regulates the relationship between PBMs and pharmacists . . . ."); Dist. Ct. R. 78 at 9 (materially the same). *Now* petitioner says *Rowe*'s categorical rule that she advanced below was "badly mistaken." Pet. 25. Petitioner's certiorari-stage shift in her principal legal theory is yet another reason to deny her petition out of hand; as that argument was not presented below, neither the district court nor the Eighth Circuit had the opportunity to consider it.

II. Insofar As Petitioner Has Not Waived Her Arguments, the Eighth Circuit's Decision Faithfully Applies This Court's Precedent.

Petitioner claims that the Eighth Circuit's decision warrants review because it allegedly created two new rules of ERISA preemption. Pet. 15. To reach that conclusion, petitioner mischaracterizes the Eighth Circuit's and this Court's decisions.

There is no conflict with this Court's precedents on either prong of the ERISA preemption test—either of which is an independent ground supporting the judgment below.

1. Petitioner asserts that the Eighth Circuit's "reference to" analysis in the decision below conflicts with this Court's precedents. Pet. 16–21. Petitioner, however, waived this argument by limiting her question presented to the "connection with" prong of ERISA preemption. Moreover, the decision below is a poor vehicle for deciding that question. In any event, the decision below's "reference to" holding does not conflict with this Court's precedents.

a. The question petitioner presents for review is whether "the Eighth Circuit erred in holding that Arkansas's statute . . . regulating PBM's drug-reimbursement rates . . . is preempted by ERISA, *in contravention of this Court's precedent that ERISA does not preempt rate regulation*." Pet. i (emphasis added). This question thus focuses on whether ERISA preempts the "Arkansas statute's" so-called "rate regulation" in contravention of this Court's "*connection with*" precedent, *see Travelers*, 514 U.S. at 664–67;

Pet. 21–25 (addressing rate regulation under "connection with" preemption).

As noted above, this Court's ERISA preemption analysis contains two analytically distinct prongs of analysis, "reference to" and "connection with." The former prong speaks to whether the challenged 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 (alterations in original) (quoting *Dillingham*, 519 U.S. at 325).

Under the latter prong, ERISA preempts a state law if it has a "connection with" ERISA plans. *Id.* A state law has a "connection with" ERISA plans if it interferes with plan administration, *Gobeille*, 136 S. Ct. 936, or employee benefit structures, *Travelers,* 514 U.S. at 658.

"A question which is merely 'complementary' or 'related' to the question presented in the petition for certiorari is not 'fairly included therein.' " *Izumi*, 510 U.S. at 31–32 (quoting *Yee*, 503 U.S. at 537). Questions that are "quite distinct, both analytically and factually," are not "fairly included" for purposes of Rule 14.1(a). *Id*.

Petitioner's framing of the question presented is analogous to *Yee*, where the petitioner asked the Court to determine whether the decision below holding that a challenged ordinance did not effect a taking conflicted with two cases. At the merits stage, petitioner attempted to raise a regulatory taking argument. This Court refused to entertain it, reasoning that the cases cited in the question involved physical

takings, not regulatory takings. "Fairly construed, then, petitioners' question presented is the equivalent of the question 'Did the court below err in finding no physical taking?' " *Yee*, 503 U.S. at 537.

The Court explained that the petitioner's regulatory taking theory was "*related* to the one petitioners presented," but it was not "fairly included therein." *Id*. Deciding whether "a regulatory taking occurred would not assist in resolving whether a physical taking occurred as well; neither of the two questions is subsidiary to the other." *Id*.

So too here. By framing her question in terms of whether the decision below is "in contravention of this Court's precedent that ERISA does not preempt rate regulation," petitioner's question is fairly framed as whether the decision below conflicts with this Court's cases addressing the "connection with" prong of ERISA preemption.

The petition's discussion of "reference to" preemption confirms that conclusion. Petitioner assails the decision below as conflicting with those portions of this Court's cases examining "reference to" analysis, but the words "rate regulation" appear nowhere in that discussion. *See* Pet. 16–21. Petitioner did not address "rate regulation" in her "reference to" argument because it is irrelevant to, and never appears in, the portions of this Court's cases examining "reference to" preemption.

Conversely, the petition's discussion of "connection with" preemption begins by distinguishing "the Eighth Circuit's implicit reference to holding" from its

alternative holding "that Arkansas's *drug-reimbursement-rate regulation* 'ha[d] a connection with employee benefit plans.' " Pet. 21 (emphasis added) (alteration in original) (citing Pet. App. 7a). "Like the [former], th[e latter] too directly conflicts with this Court's precedent on ERISA preemption." *Id*. The petition then cites *Travelers* for the proposition that "ERISA was not meant to pre-empt basic rate regulation." *Id*. at 21–22 (citing *Travelers*, 514 U.S. at 667 n.6). The rate-regulation discussion cited in *Travelers* is included in subpart D of that decision's analysis of "connection with" preemption. *See id*. at 656–67 (Part II.A–D).

Had petitioner framed her question presented differently, it could have encompassed both subsidiary questions, "reference to" and "connection with" preemption. *Cf*. *Yee*, 503 U.S. at 537 (observing that regulatory takings and physical takings "might be subsidiary to a question embracing *both*—Was there a taking?—but they exist side by side, neither encompassing the other"). But a "petitioner can generally frame the question as broadly or as narrowly as he sees fit"; thus, the framing of the question presented has significant consequences. *Id*. at 535. Here, petitioner's framing of the question presented does not encompass both grounds of the decision below.

Because the question presented is limited to "connection with" preemption, the decision below stands on the alternative ground of its "reference to" holding, regardless how this Court might resolve petitioner's "connection with" challenge. Therefore, the petition should be denied.

b. In any event, as discussed above, this case is a poor vehicle for deciding whether the decision below violates this Court's "reference to" jurisprudence. The decision below contains no analysis of the "reference to" theory as applied to the statutory provisions at issue. The district court did not even address "reference to" preemption. Insofar as petitioner's "reference to" challenge to the Eighth Circuit's jurisprudence has any merit, the Court should wait for a more appropriate vehicle to reach it.

c. Finally, the decision below's alternative ground of "reference to" preemption does not conflict with this Court's decisions. Petitioner contends that under this Court's cases, state laws that regulate by specific reference to both ERISA and non-ERISA entities cannot have impermissible references because ERISA entities are not essential to the law's operation.

Petitioner is mistaken. Critically, she conflates this Court's disjunctive test for "reference to" preemption by collapsing the exclusivity prong into the "essential" prong. *See Gobeille*, 136 S. Ct. at 943 (a state law has a "reference to" ERISA plans "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . *or* where the existence of ERISA plans is essential to the law's operation." (emphasis added) (alterations in original) (quoting *Dillingham*, 519 U.S. at 325)). Thus, "essential to" need not mean "exclusively." *But see* Pet. 18.

Under the "essential" prong of "reference to" preemption, "[s]tate law imposing requirements by reference to [ERISA]-covered programs must yield to

ERISA," even if the challenged "requirements . . . also 'relate to[]' ERISA-exempt [entities]." *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130–31 (1992). In other words, regulatory exclusivity is not required.

In *Ingersoll-Rand Co. v. McClendon*, this Court held that a state-law wrongful-discharge cause of action made "reference to" ERISA where a former employee alleged he was terminated because the employer did not want to contribute to his pension fund. 498 U.S. 133, 139–40 (1990). The Court explained: "Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension *plan* itself." *Id.* Thus, "[t]he Texas cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan." *Id.* at 140.

Act 900 is similar. Act 900's substantive requirements apply only where there exists a PBM administering a "plan . . . that pays for . . . pharmacist services." Ark. Code Ann. § 17-92-507(a)(9). For the State to enforce Act 900, the State would have to prove the existence of the plan that pays for pharmacist services, which, in the case of ERISA plans, would require proving the existence of that ERISA plan. Thus, Act 900 refers to ERISA plans like the generally applicable state wrongful-discharge law referred to an ERISA plan in *Ingersoll-Rand*—because the law's

specific application was premised on the very existence of the ERISA plan.[13]

2. The only conflict with this Court's "connection with" precedent that petitioner identifies is an alleged conflict with a single sentence buried at the end of a lengthy footnote in *Travelers*, 514 U.S. at 667 n.6, which reads:

> While the history of Medicare waivers and implementing legislation enacted after ERISA itself is, of course, not conclusive proof of the congressional intent behind ERISA, the fact that Congress envisioned state experiments with comprehensive hospital reimbursement regulation supports our conclusion that ERISA was not meant to pre-empt basic rate regulation.

Id. Petitioner thus attributes to the Court the "h[olding] that 'ERISA was not meant to pre-empt

---

[13] Petitioner's reliance on the "reference to" analysis in *Dillingham* and *Travelers* is therefore misplaced. *See* Pet.17–21. In neither case did an ERISA's entity's very existence automatically trigger the relevant regulatory coverage, unlike Act 900. Specifically, in *Dillingham*, the existence of an ERISA apprenticeship program did not trigger the "*substantive standards*" for regulatory approval of paying lower wages. *See* 519 U.S. at 328 (emphasis added). Similarly, in *Travelers*, the challenged law directly regulated hospital *providers* by requiring them to bill surcharges to payers, *see* 514 U.S. at 650; the existence of ERISA entities among the billed payers was irrelevant to the *provider's* obligation. Act 900, in contrast, regulates by reference to *plans*, not pharmacy providers.

basic rate regulation,' " Pet. 21–22, and that the decision below conflicts with that footnote holding.

a. As an initial matter, petitioner failed to raise this theory below—that the Arkansas law qualifies as "basic rate regulation" that this Court wholesale exempts from preemption, Pet. i. *See generally* Arkansas C.A. Response/Reply Br.; Arkansas C.A. Reply Br. The Court should not grant certiorari because of an alleged conflict with this Court's precedent that the lower courts did not address because petitioner failed to present it. *See Granite Rock*, 561 U.S. at 306 n.14.

b. Regardless, Act 900 is anything but the "basic rate regulation" contemplated by *Travelers*. 514 U.S. at 667 n.6; *see also* Pet. 23. In *Travelers*, the state set hospital rates for all in-patient care and then imposed a surcharge on a transaction with a commercial insurer but not on the same transaction with a Blue Cross/Blue Shield insurer. 514 U.S. at 649–50. The Court recognized that even with the surcharge, commercial insurers "may still offer more attractive packages than the Blues" that ERISA plans could select, and thus, the state's setting of a rate did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Id.* at 659–60.

Quite unlike the state setting the rate an insurer must pay which in turn develops a package an ERISA plan can select (or not), Act 900 directly dictates *how* ERISA plans must calculate and disburse benefits and process pharmacy's disputes. "[D]iffering state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely

the burden that ERISA pre-emption was intended to avoid.' " *Egelhoff*, 532 U.S. at 150 (quoting *Fort Halifax*, 482 U.S. at 10).

Act 900 requires PBMs to create pharmacy administrative appeal procedures and to adjudicate them in accord with state law, and to modify interstate benefit plans to conform them to that law. And Act 900 allows a network pharmacy to unilaterally refuse to provide the benefits promised to an ERISA plan member if it will not receive the reimbursement it wants. Ark. Code Ann. § 17-92-507(e). In other words, Act 900 limits the availability of a plan member's promised pharmacy benefits at the pharmacy's election. Thus, Act 900 does not, like the statute at issue in *Travelers*, constitute "basic rate regulation." Rather, it constitutes state interference with the core functions, structure, and administration of an ERISA plan.

III. The Circuit Split Petitioner Asserts Is Illusory.

Petitioner claims that the First, Eighth, and D.C. Circuits disagree regarding whether ERISA categorically preempts PBM regulation. Pet. 25–30.[14] Peti-

[14] Petitioner wrongly attributes to PCMA the position that "state regulations of PBMs . . . are categorically preempted by" ERISA. Pet. i. PCMA has never taken that position. To be clear, PCMA's view is that state regulation of PBMs serving ERISA plans *can*, but does not invariably, implicate "connection with" and "reference to" preemption under ERISA's express preemption provision, 29 U.S.C. § 1144(a).

tioner further argues that the three circuits align differently depending on the theory of preemption, "reference to" or "connection with."

1. Petitioner hyperbolically asserts that the Eighth Circuit holds that *all* PBM regulation invariably makes impermissible ERISA references. Pet. 30. Petitioner also asserts that both the First and D.C. Circuits rejected such a rule in *Rowe* and *District of Columbia*, respectively. *Id*.

a. As an initial matter, the question presented is limited to the question whether the Eighth Circuit's holding regarding so-called "rate reimbursement" violates this Court's "connection with" precedents. *See supra* Part I. As a result, insofar as the claimed split with the First and D.C. Circuits regarding "reference to" preemption exists, it is irrelevant to "connection with" preemption, on which petitioner seeks review.

Moreover, the decision below provides no "reference to" analysis of the Arkansas statute, which renders this case an unsuitable vehicle to resolve the claimed split. *See supra* Part I. This case's suitability is further compromised by petitioner's failure to present in her principal brief below the legal theory she makes now—that "reference to" preemption does not extend to state regulation that refers to *both* ERISA and non-ERISA entities.

Instead, she argued below that for "reference to" purposes, "Act 900 does not refer to ERISA-covered plans in any manner, *whether by inclusion* or exemption." Arkansas C.A. Principal/Response Br. at 70 (emphasis added). It was not until her reply brief that petitioner raised the argument she makes now.

There, petitioner flipped her position and admitted that "Act 900 applies to ERISA and non-ERISA plans alike," s*ee* Arkansas C.A. Reply Br. at 7, but argued (as she does now) that such references to ERISA plans did not trigger preemption because of the statute's references to non-ERISA plans.

Finally, insofar as the claimed split exists, resolving it will not change the outcome of this case, because the alternative ground of the decision below—"connection with" preemption—does not implicate any circuit split or conflict with this Court's cases.

b. In any event, petitioner overstates the tension regarding "reference to" preemption between the Eighth Circuit on the one hand the First and D.C. Circuits on the other. Contrary to petitioner's caricature, *Gerhart* did not hold that *any* state regulation of a PBM necessarily triggers "reference to" preemption. Instead, under *Gerhart*'s reasoning, the regulation must either expressly or implicitly *refer* to ERISA entities, *see* 852 F.3d at 729; absent any such reference, generally applicable regulation of an ERISA entity would not contain any impermissible "reference to" ERISA.

2. Petitioner also argues that the First, Eighth, and D.C. Circuits split over whether ERISA's "connection with" theory categorically preempts or categorically does not preempt PBM regulation. Pet. 26. This claimed split is illusory and in any event does not warrant review.

a. On one side of the ostensible split falls the D.C. and Eighth Circuits, which petitioner hyperbolically contends hold that ERISA categorically

preempts all PBM legislation. Not so. In *Pharmaceutical Care Management Ass'n v. District of Columbia*, the D.C. Circuit concluded that ERISA *did not* preempt several DC law provisions, belying any characterization of its holding as "categorical." *See* 613 F.3d 179, 190 (D.C. Cir. 2010) ("[Sections] 48-832.01(b)(2) and (c) are not pre-empted by ERISA."). And the D.C. Circuit engaged in precisely the analysis this Court has set forth, considering whether the D.C. law "sufficiently constrains an [ERISA plan's] decision-making *in an area of ERISA concern*" such that ERISA preempts it. 613 F.3d at 188 (emphasis added).

Likewise, in *Gerhart*, the Eighth Circuit recited and applied this Court's test for "connection with" preemption, evaluating whether the Iowa law regulating PBMs' relationship with pharmacies "interfere[s] with the structure and administration of ERISA plans in Iowa." 852 F.3d at 730. After outlining the effects of the Iowa law on ERISA plans, the court concluded that the law impermissibly "restrict[ed] an administrator's control in the calculation of drug benefits" and "remove[d] their ability to conclusively determine final drug benefit payments and monitor funds," all areas of ERISA concern. 852 F.3d at 731.

And, in the decision below, the same. The court, applying the reasoning in *Gerhart*, apparently concluded that at least the Challenged Provisions—and possibly the Uncertain Provisions—of Arkansas law

impermissibly constricted ERISA plans in an area of ERISA concern. Pet. App. 5a–7a.[15]

b. On the other side of petitioner's claimed "connection with" circuit split falls the First Circuit, which petitioner hyperbolically claims held that ERISA "connection with" preemption categorically does not apply to state regulation of PBMs *ever*. In *Rowe*, the First Circuit considered a Maine law that regulated a PBM's relationship with its ERISA *plan*, 429 F.3d at 299—not the PBM's relationship with network pharmacies. The First Circuit explained that the law did not have a "connection with" ERISA because plans were not "*bound* to a particular choice of rules," even if the plan wanted to "re-evaluate their working relationships with the PBMs." *Id.* at 303.

Petitioner principally argues for a categorical reading of *Rowe* in the context of "*connection with*" preemption based on the court's statement that because PBMs are not ERISA fiduciaries—as they assuredly are not—PBMs "are outside of the 'intricate web of relationships among the principal players in the ERISA scenario.' " Pet. 25 (citing *Rowe*, 429 F.3d at 305). But this statement from *Rowe* is inapplicable to "connection with" preemption, as it was made in

[15] Had the challenge been to the imposition of a state gross receipts tax, *e.g.*, *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 809 (1997), petitioner could hardly assert that the Eighth and D.C. Circuits would hold the law categorically preempted because it was imposed on a PBM. Such a law would be outside the areas of ERISA concern.

the context of *Rowe*'s discussion of the completely separate sphere of preemption stemming from ERISA's civil enforcement section, 29 U.S.C. § 1132.

Far from a categorical rule precluding ERISA "connection with" preemption from ever applying to regulation of a PBM's relationship with its *network pharmacie*s, the First Circuit considered the specific effect of the state-law provisions before it on plan administration and structure and concluded that the specific obligations imposed on PBMs did not remove "plan administrators['] . . . free hand to structure the plans as they wish in Maine." 429 F.3d at 303. Because *Rowe* did not involve state regulation of the PBM-pharmacy relationship, as *Gerhart* did and this case does, *Rowe* cannot be fairly read as in direct conflict with the Eighth Circuit or otherwise establishing any categorical rule regarding anything other than the PBM's relationship with its *plan*.

c. Insofar as there was any conflict between the Eighth Circuit and the First Circuit over whether ERISA's "connection with" theory categorically does not preempt state regulation of a plan's third-party administrator, this Court's decision in *Gobeille* resolved it. Accordingly, there is no need for this Court to "make plain" what it already made plain in *Gobeille*.

In *Gobeille*, Vermont law required disclosure of payments relating to health care claims by certain entities. 136 S. Ct. at 940–41. Liberty Mutual Insurance Company maintained an ERISA plan for its employees. *Id.* at 941–42. It retained Blue Cross Blue Shield

of Massachusetts, Inc. as its third-party administrator. *Id.* at 942. Though Liberty Mutual's obligation to report was voluntary, Blue Cross was a mandated reporter and thus the Vermont law required *Blue Cross* to report information about Liberty Mutual's plan. *Id.* Though the law imposed the obligation on the third-party administrator, this Court held that the law still had an impermissible connection with ERISA and struck down the statute as applied to ERISA plans. *Id.* at 947. Thus, this Court has already concluded that ERISA preempts state requirements, though imposed on a third-party administrator, that have a "connection with" an ERISA plan in a central area of ERISA concern. Accordingly, insofar as *Rowe* implies that ERISA does not have a "connection with" state regulation of PBMs as third-party administrators, *Gobeille* supersedes it.

d. Finally, any doubts regarding whether this Court should review the purported "connection with" circuit split are dispelled by the switch in petitioner's principal legal theory regarding "connection with" preemption. As described above, petitioner now for the first time argues that the categorical rule she ascribes to *Rowe* is "badly mistaken." Pet. 25. In fact, petitioner took that "badly mistaken" position though the litigation below, arguing repeatedly that PBM regulation categorically has no "connection with" ERISA because it involves regulation of a PBM, not a plan. *E.g.*, Arkansas Principal/Response Br. 58–59.

IV. Petitioner's Claims Of Importance Fail.

Petitioner claims that her question presented is important because PBMs have "strangulated" rural

pharmacies. But she offers no evidence supporting such an assertion, save a single statement of an Iowa representative on the Iowa House floor. Pet. 9–10. But petitioner offered no admissible evidence below to demonstrate that PBMs injure rural pharmacies.

Further, petitioner claims that federalism concerns warrant this Court's review because states need to know whether they "may regulate PBMs at all." Pet. 31. Petitioner overstates this concern. ERISA does not apply to PBMs serving as third-party administrators for non-ERISA plans. Accordingly, states can regulate PBMs in their capacity as third-party administrators for non-ERISA plans (absent some other basis for preemption). Indeed, petitioner herself writes that only 35.7% of Americans that PBMs serve receive benefits under an ERISA plan. *See* Pet. 16 n.7. Petitioner's invocation of federalism does not warrant certiorari in a case with no conflict with this Court's precedent, no circuit split on petitioner's question presented, several new legal theories not presented below, and a record replete with uncertainty concerning both what was actually decided below and the reasoning for those decisions.

CONCLUSION

The Court should deny the petition.

February 28, 2019

Respectfully submitted,

A. J. Kritikos
MCDERMOTT WILL & EMERY LLP
444 West Lake Street
Chicago, IL 60606
(312) 372-2000

M. Miller Baker
Counsel of Record
Sarah P. Hogarth
MCDERMOTT WILL & EMERY LLP
500 North Capitol Street NW
Washington, DC 20001
(202) 756-8000
mbaker@mwe.com

Attorneys for Respondent

APPENDIX

TABLE OF APPENDIX

Ark. Code Ann. § 17-92-507.[1]

Maximum Allowable Cost Lists

(a) As used in this section:

(1) "Maximum Allowable Cost List" means a listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist may be based;

(2) "Pharmaceutical wholesaler" means a person or entity that sells and distributes prescription pharmaceutical products, including without limitation a full line of brand-name, generic, and over-the-counter pharmaceuticals, and that offers regular and private delivery to a pharmacy;

(3) "Pharmacist" means a licensed pharmacist as defined in § 17-92-101;

(4) "Pharmacist services" means products, goods, or services provided as a part of the practice of pharmacy in Arkansas;

---

[1] Boldface type denotes the Challenged Provisions—those provisions added by Act 900 that PCMA challenged. *See* Opp. 8–11.

Italicized type denotes the Uncertain Provisions—those provisions the district court found preempted but that PCMA did not challenge. *See* Opp. 11–12.

Underlined type denotes the Disclosure Provisions—those provisions the district court found preempted, a holding PCMA endorsed on appeal without challenge. *See* Opp. 11–12.

(5) "Pharmacy" means the same as in § 17-92-101;

(6) **"Pharmacy acquisition cost" means the amount that a pharmaceutical wholesaler charges for a pharmaceutical product as listed on the pharmacy's billing invoice**;

(7) "Pharmacy benefits manager" means an entity that administers or manages a pharmacy benefits plan or program;

(8) "Pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager; and

(9) "Pharmacy benefits plan or program" means 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.

(b) *Before a pharmacy benefits manager places or continues a particular drug on a Maximum Allowable Cost List, the drug*:

(1) *Shall be listed as therapeutically equivalent and pharmaceutically equivalent "A" or "B" rated in the United States Food and Drug Administration's most recent version of the "Orange Book" or "Green Book" or has an NR or NA rating by Medi-span, Gold Standard, or a similar rating by a nationally recognized reference*;

(2) *Shall be available for purchase by each pharmacy in the state from national or regional wholesalers operating in Arkansas*; *and*

(3) *Shall not be obsolete*.

(c) A pharmacy benefits manager shall:

(1) *Provide access to its Maximum Allowable Cost List to each pharmacy subject to the Maximum Allowable Cost List*;

(2) **Update its Maximum Allowable Cost List on a timely basis, but in no event longer than seven (7) calendar days from an increase of ten percent (10%) or more in the pharmacy acquisition cost from sixty percent (60%) or more of the pharmaceutical wholesalers doing business in the state** or a change in the methodology on which the Maximum Allowable Cost List is based or in the value of a variable involved in the methodology;

(3) *Provide a process for each pharmacy subject to the Maximum Allowable Cost List to receive prompt notification of an update to the Maximum Allowable Cost List*; and

(4)

(A)

(i) **Provide a reasonable administrative appeal procedure to allow pharmacies to challenge maximum allowable costs and reim-**

bursements made under a maximum allowable cost for a specific drug or drugs as:

(a) Not meeting the requirements of this section; or

(b) **Being below the pharmacy acquisition cost**.

(ii) The reasonable administrative appeal procedure shall include the following:

(a) A dedicated telephone number and email address or website for the purpose of submitting administrative appeals;

(b) The ability to submit an administrative appeal directly to the pharmacy benefits manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization; and

(c) No less than seven (7) business days to file an administrative appeal.

(B) The pharmacy benefits manager shall respond to the challenge under subdivision (c)(4)(A) of this section within seven (7) business days after receipt of the challenge.

(C) If a challenge is under subdivision (c)(4)(A) of this section, the pharmacy ben-

efits manager shall within seven (7) business days after receipt of the challenge either:

(i) If the appeal is upheld:

(a) Make the change in the maximum allowable cost;

(b) Permit the challenging pharmacy or pharmacist to reverse and rebill the claim in question;

(c) Provide the National Drug Code number that the increase or change is based on to the pharmacy or pharmacist; and

(d) Make the change under subdivision (c)(4)(C)(i)(a) of this section effective for each similarly situated pharmacy as defined by the payor subject to the Maximum Allowable Cost List;

(ii) *If the appeal is denied, provide the challenging pharmacy or pharmacist the National Drug Code number and the name of the national or regional pharmaceutical wholesalers operating in Arkansas that have the drug currently in stock at a price below the Maximum Allowable Cost List*; or

(iii) **If the National Drug Code number provided by the pharmacy benefits manager is not available below the pharmacy acquisition cost from the pharmaceutical wholesaler**

from whom the pharmacy or pharmacist purchases the majority of prescription drugs for resale, then the pharmacy benefits manager shall adjust the Maximum Allowable Cost List above the challenging pharmacy's pharmacy acquisition cost and 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 maximum allowable cost.

(d)

(1) A pharmacy benefits manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services.

(2) The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.

(e) **A pharmacy or pharmacist may decline to provide the pharmacist services to a patient or pharmacy benefits manager if, as a result of a Maximum Allowable Cost List, a pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost of the pharmacy providing pharmacist services.**

(f)

(1) This section does not apply to a Maximum Allowable Cost List maintained by the Arkansas Medicaid Program or the Employee Benefits Division of the Department of Finance and Administration.

(2) This section shall apply to the pharmacy benefits manager employed by the Arkansas Medicaid Program or the Employee Benefits Division if, at any time, the Arkansas Medicaid Program or the Employee Benefits Division engages the services of a pharmacy benefits manager to maintain a Maximum Allowable Cost List.

(g)

(1) A violation of this section is a deceptive and unconscionable trade practice under the Deceptive Trade Practices Act, § 4-88-101 et seq., and a prohibited practice under the Arkansas Pharmacy Benefits Manager Licensure Act, § 23-92-501 et seq., and the Trade Practices Act, § 23-66-201 et seq.

(2) This section is not subject to § 4-88-113(f)(1)(B).