No. 23-1213

In the
# Supreme Court of the United States

GLEN MULREADY, in his official capacity as Insurance Commissioner of Oklahoma; OKLAHOMA INSURANCE DEPARTMENT,

*Petitioners*,

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,

*Respondent*.

**On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit**

## SUPPLEMENTAL BRIEF FOR PETITIONERS


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## SUPPLEMENTAL BRIEF FOR PETITIONERS

Oklahoma has no beef with ERISA plans, but it has grave concerns about pharmacy benefit managers (PBMs), intermediaries that have distorted competition, driven up prices, and devastated rural pharmacies and rural communities. PBMs, unlike ERISA plans, are not meaningfully regulated by ERISA or other federal statutes, making the need for state oversight particularly clear. Even respondent's own witness conceded below that PBMs need oversight and accountability. CA10.App.68. To that end, Oklahoma's Legislature enacted the Patient's Right to Pharmacy Choice Act in 2019 by a unanimous vote. The Act regulates only PBMs—by, *inter alia*, restricting their ability to use their market power to drive patients to PBM-preferred (or PBM-owned) pharmacies—not ERISA plans. The notion that sovereign States could lose their traditional authority to regulate the practice of pharmacy just because PBMs voluntarily contract with ERISA plans—without themselves serving as fiduciaries—never made any sense. And any lingering doubt on that score should have been erased by this Court's unanimous decision in *Rutledge v. PCMA*, 592 U.S. 80 (2020), which vindicated the States' sovereign authority to respond to the distinct problems posed by PBMs without running afoul of ERISA. Yet in the decision below, the Tenth Circuit read ERISA so broadly and *Rutledge* so narrowly as to effectively transform PBMs into a law unto themselves, not meaningfully regulated at the federal level but immune from regulation by the States.

The United States agrees that the decision below is unsound. "In the United States' view," the Tenth Circuit "was mistaken in concluding that the probation-status provision in the [Act] … has an impermissible 'connection with' ERISA plans." U.S.Br.15, 18. The government *also* agrees that ERISA does not preempt the other provisions at issue, though it thinks ERISA's savings clause does the work. U.S.Br.19. The government even acknowledges that the Tenth Circuit's "mistaken" holding that Oklahoma's "probation-status provision" is connected to and thus preempted by ERISA is in tension with the Eighth Circuit's conclusion that a similar North Dakota law did *not* "'meet the connection-with standard' for ERISA preemption." U.S.Br.18 (quoting *PCMA v. Wehbi*, 18 F.4th 956, 968 (8th Cir. 2021)). In short, the United States confirms that the traditional criteria for plenary review are amply satisfied.

Despite all that, the Solicitor General argues that this case is not important enough to justify plenary review. He is right on the merits but wrong on importance. Indeed, the Solicitor General's inability to grasp the gravity of the problem is revealing. PBMs may not pose the kind of uniform, nationwide problems that capture federal attention, but they are devastating certain States. In particular, PBMs pose a pressing problem for rural communities—a healthy percentage of which lie in the Eighth and Tenth Circuits. That is why 34 States of varying shapes, sizes, and political persuasions have come together on an amicus brief urging plenary review.

Simply put, the problem Oklahoma and other States want to tackle is PBMs, not ERISA (or

Medicare) plans. Nothing in law or logic supports preventing a sovereign State from doing something about the former because of some hard-to-articulate relationship with the latter. While the Eighth Circuit has correctly recognized this, the Tenth Circuit elided it. The Court should grant certiorari.

## I. The Decision Below Conflicts With This Court's ERISA Precedent And Decisions Of Other Circuits Faithfully Applying It.

### A. The Decision Below Stretches ERISA Past its Breaking Point.

As this Court has long held, ERISA does not preempt laws in "traditionally state-regulated" areas about which "ERISA has nothing to say." *Cal. Div. of Lab. Standards Enf't v. Dillingham*, 519 U.S. 316, 330 (1997). And as the Solicitor General acknowledges, ERISA says nothing about PBMs—or even the practice of pharmacy more broadly, which has long been understood to be an area traditionally left to state regulation. *See* Pet.23. Those realities confirm that Oklahoma's PBM law is not preempted and the Tenth Circuit was wrong to hold otherwise. The Discount Prohibition prohibits PBMs from steering patients to pharmacies the PBMs own or dominate, the Access Standards regulate the quality of the networks to which PBMs sell access, the Any Willing Provider Provision prevents PBMs from discriminating against pharmacies already in their networks, and the Probation Provision ensures that PBMs cannot transform probationary status into a permanent disability. ERISA does not address any of these topics, and nothing in ERISA even remotely suggests that PBMs are immune from state efforts to

restrain them from driving independent pharmacies out of business. *See* Pet.21-23. In finding preemption nonetheless, the decision below turned bedrock federalism principles on their heads.

To be sure, on three of the four provisions, the United States disagrees with petitioners on the proper route to non-preemption, but it agrees on the bottom line that "application[] of those provisions to PBMs" should *not* be preempted. U.S.Br.19. And with respect to the "probation-status provision in Oklahoma's 2019 law," the government goes even further, agreeing with petitioners that that provision "is not preempted by ERISA" and "the Tenth Circuit was mistaken to conclude otherwise." U.S.Br.18. The United States and Oklahoma thus concur that the Tenth Circuit has intruded upon Oklahoma's sovereignty and wrongly enjoined its laws.

To the extent the United States believes that only the savings clause rescues the first three provisions from preemption (and thus the law is preempted as to PBMs "acting as or for an insurer for an ERISA plan," U.S.Br.19), it fails to account for this Court's precedents. Remarkably, the government does not even mention *Dillingham* or the distinction between traditional areas of state concern and "areas with which ERISA is expressly concerned," 519 U.S. at 330, instead viewing ERISA preemption as turning entirely on the "degree of effect on plan administration" generated by a given state-law provision, U.S.Br.18. But this Court has never endorsed the government's theory that ERISA can preempt *any* state law—even one that regulates in the heartland of traditional state prerogatives (like

pharmacy regulation) on matters ERISA does not address—just because it has some amorphous degree of (indirect) "effect on plan administration."

The Solicitor General's embrace of the contrary view is not just mistaken; it enhances the need for this Court's review. After all, as the multiple amicus briefs supporting certiorari underscore, PBMs have insinuated themselves into nearly every corner of American healthcare. Thus, if the government were right about how ERISA preemption works, then nearly *any* state-level regulation of PBMs (at least that is not strictly limited to cost/rate regulations, *see* U.S.Br.12) will be preempted. The government's logic takes ERISA preemption to places this Court has long deemed off-limits.

That cannot be what this Court meant in *Rutledge*. *Contra* U.S.Br.12. *Rutledge* was not just about rate regulation. After all, States' traditional authority to regulate the practice of pharmacy is not narrowly limited to rate regulation, and ERISA does not distinctly foreswear rate regulation while itself addressing other aspects of PBM operation. Instead, consistent with *Dillingham*, the clear lesson of *Rutledge* is that States retain ample tools to respond to the problems posed by PBMs and to hold them responsible for those problems without triggering ERISA preemption. *See, e.g.*, *Rutledge*, 592 U.S. at 91 ("When a pharmacy declines to dispense a prescription, the responsibility lies first with the PBM for offering the pharmacy a below-acquisition reimbursement."). The decision below clouded what

this Court made clear in *Rutledge*, which is a sufficient reason to grant review.[1]

Finally, while the Solicitor General views the court of appeals' bizarre refusal to address ERISA's savings clause, *see* App.39—the government's preferred route to non-preemption—as a vehicle problem, *see* U.S.Br.19, it is, if anything, an additional reason to intervene. The government itself viewed the savings clause issue as sufficiently teed up that it addressed it in its Tenth Circuit brief, and even respondent admits that the savings clause issue was fully presented below, BIO.26, which suffices to preserve it for this Court's review. *See also* Pet.28. Regardless, as long as "a federal claim is properly presented, a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido*, 503 U.S. 519, 534 (1992). And this Court has previously treated an ERISA savings clause argument as simply one argument in support of the basic preemption defense. Indeed, in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), this Court reached the merits of whether ERISA's savings clause saved a state law from preemption even though the respondents there did not argue in the court below that "the [statute] is a law that regulates insurance" and raised the savings clause argument "for the first

[1] The Solicitor General's retreat from the narrower view of ERISA preemption the United States set forth in *Rutledge*, *see* Br. for the U.S. as Amicus Curiae, *Rutledge*, 2019 WL 6609430 (U.S. Dec. 4, 2019); Br. for the U.S. as Amicus Curiae, *Rutledge*, 2020 WL 1190622 (U.S. Mar. 2, 2020), further adds to the confusion and justifies plenary review.

time in their brief to this Court." *Id.* at 216; *see id.* at 216-18. That too eliminates any possible forfeiture. To state the obvious, no one doubts that petitioners have properly presented the claim (or, rather, defense) that ERISA, properly understood, does not preempt the State's PBM law. So, *contra* U.S.Br.19-20, the savings clause remains in this case as a matter of both fact and law. In all events, the government agrees the Tenth Circuit erred on the probation issue, which does not implicate the savings clause.

### B. The Decision Below Creates a Clear Circuit Split That Warrants Review.

As the Solicitor General notes, the Eighth Circuit upheld in *Wehbi* a North Dakota law prohibiting "PBMs from imposing, as a condition of network participation, pharmacy accreditation requirements 'inconsistent with' or 'more stringent than'" state standards. U.S.Br.18 (quoting *Wehbi*, 18 F.4th at 965-66); *see* Pet.23-25. And, consistent with the position it took below, "[i]n the United States' view, the probation-status provision in Oklahoma's 2019 law is not preempted by ERISA for similar reasons." U.S.Br.18. In other words, the decision below creates a clear circuit split and lands on the wrong side of it.

The government nonetheless hedges, arguing that the split "between *Wehbi* and the decision below does not warrant further review." U.S.Br.18. But the distinction the government tries to draw between the North Dakota and Oklahoma laws is illusory, as the Solicitor General's own description of the laws betrays. The North Dakota law in *Wehbi* "effectively forb[ade] PBMs from imposing greater accreditation standards than [North Dakota] law." U.S.Br.18. The

Oklahoma law here is no different. It prohibits PBMs from imposing greater punishments for transgressions than the State's own regulations for the practice of pharmacy. *See* Pet.22-23. To be sure, the laws may not have *identical* "effect[s] on plan administration." U.S.18. But not even the United States thinks that preemption turns on such an ephemeral inquiry; it agrees that neither law is preempted.

Furthermore, the split here is not just between *Wehbi* and the decision below. As respondent noted, the decision below invoked and sided with pre-*Rutledge* "cases from the Fifth and Sixth Circuits." BIO.22. The Solicitor General ignores those pre-*Rutledge* cases, but they belie his efforts to claim that there is nothing to see here. Nor do they stand alone. In "overlooking" a "PBM-plan distinction," the "decision below … also conflicts with the First Circuit's decision in *PCMA v. Rowe*, 429 F.3d 294 (2005)." Am.Dental.Ass'n.Br.20. In all events, whether the split is 1-1, 3-1, or 3-2, certiorari is amply justified. The holding below prevents Oklahoma from preserving its decision that certain transgressions merit probationary status, not permanent punishment. The Eighth Circuit allowed North Dakota (and its sister States) to preserve comparable control over pharmacy regulation. That is not a state of affairs this Court should tolerate, especially when the United States itself agrees that the Tenth Circuit got it wrong.[2]

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[2] Given the square conflict with *Wehbi* on materially identical probation regulations, the absolute least this Court should do is grant certiorari limited to the probation issue. If probation-

## II. The Decision Below Opens Up A Circuit Split On The Scope Of Medicare Preemption That Warrants This Court's Review.

The Tenth Circuit's overreading of federal preemption extended beyond ERISA to Medicare—and drove it to create yet another circuit split. Under the decision below, "a specific federal-state overlap is unnecessary" for Part D preemption under 42 U.S.C. §1395w-26(b)(3). App.48; *see* Pet.32-33. In stark contrast, the Eighth Circuit holds that a state law is preempted under 42 U.S.C. §1395w-26(b)(3) as applied to Part D plans "only if" it "regulate[s] the same subject matter as a federal Medicare Part D standard." *Wehbi*, 18 F.4th at 972; *see* Pet.15-16.

The United States recognizes, as it must, that the Tenth Circuit "express[ed] disagreement with" the Eighth Circuit's approach "to defining the relevant field occupied by particular federal standards." U.S.Br.21-22. The government also acknowledges that the decision below derided the Eighth Circuit's "approach" as "overly 'fastidious.'" U.S.Br.21-22 (quoting App.47). The government nonetheless claims that the conflict is less severe than it appears, because each court "construed the express preemption provision for the Part D program as codifying a form of 'field preemption.'" U.S.Br.21 (quoting App.43) (citing *Wehbi*, 18 F.4th at 971). That does not wash. When it comes to applying field preemption, "defining the field" is the whole ballgame. *See, e.g.*, *English v.*

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centric regulation really is the only avenue ERISA leaves available to States when it comes to reining in PBM abuses, then Oklahoma should be allowed to do at least that much, as the Solicitor General agrees.

*Gen. Elec. Co.*, 496 U.S. 72, 84-85 (1990); *see also Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 213 (1983) (recognizing that the federal government can occupy "an identifiable portion" within a given field).

Nor can the government seriously deny that the Eighth and Tenth Circuits have now read the exact same Medicare regulation, 42 C.F.R. §423.505(b)(18), to mean two different things. *Compare* App.48-50 (holding that it preempts state-law efforts to cabin the conditions that PBMs may impose on pharmacies); *with Wehbi*, 18 F.4th at 972-73 (holding that it "leave[s] to the states the specifics of what plans and PBMs may or may not demand of pharmacies"). *See* Pet.32-33. Indeed, rather than grapple with that clear conflict, the government turns to "[t]he rulemaking record"—i.e., the regulatory equivalent of legislative history—and leans on the Tenth Circuit's dictum that it "would have reached the same result 'even under Oklahoma's narrower approach.'" U.S.Br.21-22 (quoting App.49). But the resort to the former just shows how far the decision below strayed from statutory and regulatory text. As for the latter, the United States does not even try to explain how the Tenth Circuit's nothing-to-see-here dictum could possibly be true. *See* Reply.Br.10.

Perhaps that is why the government quickly pivots to trying to downplay the split as "recent and shallow." U.S.Br.22. But the government elides the full scope of the issue. The First Circuit has adopted a "sweep[ing]" view of Medicare preemption under 42 U.S.C. §1395w-26(b)(3) that tracks the decision below but is irreconcilable with *Wehbi*. *See Medicaid &*

*Medicare Advantage Prods. Ass'n of P.R., Inc. v. Emanuelli Hernández*, 58 F.4th 5, 12 (1st Cir. 2023); Pet.33-34. And while *Hernández* was a Part C case rather than a Part D case, that is a distinction without a difference in this context, as Part D's preemption provision *is* Part C's preemption provision. The split on Medicare preemption is thus real and square, and it too warrants this Court's intervention.

## III. The Questions Presented Are Important, And States Desperately Need Clarification.

Perhaps the most telling aspect of the Solicitor General's invitation brief is what it leaves unsaid. Nowhere does the United States deny the serious problems PBMs have wrought, driving already-high prescription-drug prices through the roof and driving PBM-disfavored (typically rural) community pharmacies to the brink of extinction. The Solicitor General's failure to rank those problems as serious enough to merit this Court's attention is symptomatic of the federal government's failure to act. But even if the problems are not uniform enough to prompt a national response, they are devastating rural regions of the country, as the multiple amicus briefs underscore, and they are only getting worse. *See, e.g.*, Am.Phar.Br.7-17; PRO.Br.8-17; Spec.Phar.Br.10-17.

The one thing the Solicitor General's brief does not do is suggest that the federal government is on the scene, taking control and political ownership of the widely recognized problems posed by PBMs. Federal law does next to nothing to address PBMs. PBMs barely even existed when ERISA was enacted; and to the extent Part D regulations address PBMs at all, they merely recognize the problem without providing

a solution even for Part D plans, let alone the rest of the market. Thus, "the States stand alone as the single bulwark against PBM abuse." Am.Pharms.Br.17. That dynamic explains both the extraordinary and extraordinarily diverse coalition of States that support review here. *See* States.Br.1.

By finding that nothing preempts something, the decision below creates a perilous vacuum in which PBMs devastate rural communities and undermine state priorities without any meaningful regulation or oversight. Leaving a decision standing that says that the only sovereigns taking steps to address this problem are powerless is a recipe for disaster. Indeed, the fact that 34 States and the federal government seemingly disagree on the importance of the PBM crisis—and yet federal laws that say next to nothing about the issue are deemed to displace state efforts—powerfully underscores the need for this Court's review. The decision below "leaves a cloud hanging over all provisions of PBM reform." Am.Pharms.Br.4. It is imperative for this Court to clear things up.

## CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted,

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