No. 18-540

In the Supreme Court of the United States

LESLIE RUTLEDGE, ATTORNEY GENERAL OF ARKANSAS,
PETITIONER

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts a State's regulation of the rates at which pharmacy benefits managers reimburse pharmacies.

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INTEREST OF THE UNITED STATES

This case concerns whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, preempts a state law that regulates the rates at which pharmacy benefits managers reimburse pharmacies. The Secretary of Labor has primary authority for administering ERISA. 29 U.S.C. 1002(13), 1132-1135. In response to an invitation from the Court, the United States filed an amicus brief in this case at the petition stage.

STATEMENT

1. "ERISA was passed by Congress in 1974 to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Massachusetts* v. *Morash*,

490 U.S. 107, 112 (1989). The statute "sets forth reporting and disclosure obligations" for employee benefit plans, and "imposes a fiduciary standard of care for plan administrators." *Id.* at 113. The purpose of those provisions is "to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* at 115.

Section 1003 of Title 29 specifies ERISA's coverage. Section 1003(a) provides that the statute shall apply to "employee benefit plan[s]" that are "established or maintained" by an "employer" or "employee organization" "engaged in commerce or in any industry or activity affecting commerce." 29 U.S.C. 1003(a). Such plans include "employee welfare benefit plan[s]," 29 U.S.C. 1002(3), which are established or maintained for the purpose of providing, "through the purchase of insurance or otherwise," "medical" or other benefits, 29 U.S.C. 1002(1). Section 1003(b) exempts certain plans from ERISA's coverage, including "governmental" and "church" plans. 29 U.S.C. 1003(b).

Subject to certain exceptions, ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of [Title 29] and not exempt under section 1003(b) of [Title 29]." 29 U.S.C. 1144(a). This Court has "observed repeatedly that this broadly worded provision is 'clearly expansive.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001) (citation omitted). "But at the same time," the Court has "recognized that the term 'relate to' cannot be taken 'to extend to the furthest stretch of its indeterminacy,' or else 'for all practical purposes pre-emption would never run its course.'" *Ibid.* (citation omitted).

The Court has held that "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). And it has "addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 654 (1995). Thus, where ERISA "is said to bar state action in fields of traditional state regulation," the Court has "worked on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997) (citation omitted).

2. Pharmacy benefits managers (PBMs) serve as intermediaries between pharmacies and health benefit plans, including plans covered by ERISA. Pet. App. 3a, 15a; J.A. 69; Br. in Opp. i. PBMs contract with pharmacies to establish pharmacy networks, J.A. 347-348, and contract with health benefit plans to provide access to those pharmacies, J.A. 145. When a participant in a plan goes to a network pharmacy to fill a prescription, the pharmacy checks with the PBM to determine the participant's coverage and copayment information. J.A. 69-70. "After the prescription is filled, the PBM reimburses the pharmacy" a certain amount (minus any copayment by the participant). J.A. 70; see J.A. 145. And the health benefit plan, in turn, reimburses the PBM. See J.A. 316-319; Advisory Council on Employee

Welfare and Pension Benefit Plans, U.S. Dep't of Labor, *PBM Compensation and Fee Disclosure* 6 (Nov. 2014) (ERISA Advisory Council Report).[1]

a. The amount the PBM reimburses the pharmacy is governed by the PBM's contract with the pharmacy. Such contracts typically require that the amount be set by reference to a "MAC" list. J.A. 324-325. A MAC list is a list of generic prescription drugs; for each drug, the list specifies a maximum allowable cost (MAC). J.A. 343-344. The MAC is the amount the PBM reimburses the pharmacy for that particular drug, regardless of the pharmacy's actual cost of acquiring the drug from a pharmaceutical wholesaler or manufacturer. See J.A. 324-325; ERISA Advisory Council Report 6, 10.

"PBMs each develop and administer their own unique and confidential MAC list(s)." J.A. 69. The methodology they use to develop those lists, as well as the lists themselves, are considered "proprietary trade secrets." J.A. 73; see J.A. 320 ("MAC pricing methodologies are highly protected, confidential, and not subject to disclosure by PBMs."); see also J.A. 97, 126, 135-136. At any given time, a PBM may have hundreds to thousands of MAC lists, tailored to different pharmacies and plans. D. Ct. Doc. 75-3, at 343 (Aug. 15, 2016); see J.A. 152, 321-322 & n.55. The MAC for a particular drug may vary from list to list. J.A. 321.

Although the MAC price is sometimes less than the pharmacy's cost of acquiring a drug, pharmacies agree

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[1] https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014-pbm-compensation-and-fee-disclosure.pdf. The ERISA Advisory Council consists of 15 members appointed by the Secretary of Labor "to advise the Secretary with respect to the carrying out of his functions" under ERISA. 29 U.S.C. 1142(b); see 29 U.S.C. 1142(a).

to be reimbursed at the MAC price in exchange for being part of the PBM's pharmacy network—which can be a key source of a pharmacy's business. See Pet. App. 16a; J.A. 136, 218, 228-229, 262, 326. Pharmacies' contracts with PBMs generally require pharmacies to dispense all prescriptions regardless of the MAC price, while allowing pharmacies to appeal the determination of that price through procedures within the PBM. J.A. 324-325; see J.A. 127-129, 137, 175, 349.

b. The amount the health benefit plan reimburses the PBM is governed by a separate contract between the PBM and the plan. See J.A. 316-318; ERISA Advisory Council Report 6. Such contracts typically follow one of two pricing arrangements: (1) "lock-in" (or "spread") pricing, or (2) "pass-through" (or "transparent") pricing. J.A. 316. Under a lock-in arrangement, the PBM charges its customer—*i.e.*, the plan—a set price. J.A. 187. The PBM then keeps the difference between what it receives from the plan and what it pays the pharmacy. J.A. 316-317. That spread can represent a significant part of a PBM's net revenue. ERISA Advisory Council Report 10. Under a pass-through arrangement, by contrast, the PBM charges the plan the same MAC price the PBM pays to the pharmacy, but also charges an administrative fee on each transaction; the PBM "makes its money off of [the] administrative fees." J.A. 318; see J.A. 187; J.A. 318-139 (stating that it is "[u]ndisputed" that "PBMs and health plans in pass-through contracts arrive at the same result as a lock-in/spread contract").

In exchange for payment, the PBM provides various services to the plan. J.A. 145. Those services include access to a network of pharmacies where plan participants may fill their prescriptions, and the processing of

claims submitted by pharmacies for reimbursement. See J.A. 145, 302-303. Contracts between plans and PBMs typically last from one to three years. J.A. 316. Plans typically award such contracts through a bidding process, in which PBMs compete to provide services at the lowest price. J.A. 124, 183-186.

3. In 2015, the Arkansas Legislature enacted Act 900. 2015 Ark. Laws Act 900 (S.B. 688). Act 900 was motivated by concerns that MAC prices were often too low to cover a pharmacy's cost of acquiring a drug and that, as a result, many pharmacies within the State—particularly independent pharmacies in rural areas—were losing money and at risk of closing. See Pet. App. 3a, 12a; D. Ct. Doc. 75-1, at 23 & n.9 (Aug. 15, 2016). To "create accountability in the establishment of prescription drug pricing," and thus ensure access to prescription drugs throughout the State, the Legislature enacted Act 900. 2015 Ark. Laws Act 900 (S.B. 688) (capitalization omitted).

Act 900 amended Section 17-92-507 of the Arkansas Code, a statute regulating the use of MAC lists. See Ark. Code Ann. § 17-92-507.[2] As amended by Act 900, Section 17-92-507 effectively requires PBMs that use MAC lists to reimburse pharmacies at a price equal to or higher than the "[p]harmacy acquisition cost"—"the amount that a pharmaceutical wholesaler charges for a

[2] All references in this brief to Section 17-92-507 of the Arkansas Code are to Ark. Code Ann. § 17-92-507 (Supp. 2018), the version of the law, as amended by Act 900, that was in effect when the court of appeals in this case rendered its decision. Since then, Arkansas has further amended Section 17-92-507. See 2019 Ark. Laws Act 994 (S.B. 520). Those amendments do not materially affect the operation of the law and are not relevant to the question presented here.

pharmaceutical product as listed on the pharmacy's billing invoice." *Id.* § 17-92-507(a)(6); see J.A. 159, 175. Section 17-92-507, as amended, effectuates that requirement through various provisions.

First, Section 17-92-507(c)(2) requires a PBM to timely update its MAC lists to reflect increases in pharmacy acquisition costs. Specifically, the statute requires a PBM to "[u]pdate its [MAC] List" no longer than seven days following an increase in the pharmacy acquisition cost charged by 60% or more of the pharmaceutical wholesalers doing business in the State. Ark. Code Ann. § 17-92-507(c)(2).

Second, Section 17-92-507(c)(4) requires PBMs to provide a "reasonable administrative appeal procedure" to allow a pharmacy to challenge the MAC price for a particular drug as being below the cost at which the pharmacy acquired it. Ark. Code Ann. § 17-92-507(c)(4)(A)(i)(b). If, as part of that challenge, it is shown that the drug was not available at a lower cost from "the pharmaceutical wholesaler from whom the pharmacy" acquires "the majority" of its prescription drugs, Section 17-92-507(c)(4) requires the PBM to "adjust" its MAC list "above the challenging pharmacy's pharmacy acquisition cost" and to "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 challenged MAC price. *Id.* § 17-92-507(c)(4)(C)(iii).

Third, Section 17-92-507(e) allows a pharmacy to decline to dispense a drug "to a patient or pharmacy benefits manager if, as a result of a [MAC] List, [the pharmacy] is to be paid less than the pharmacy acquisition cost" by the PBM. Ark. Code Ann. § 17-92-507(e).

4. Respondent is a national trade association of PBMs. J.A. 66-67. Its 11 member companies—among them,

CVS Health, Express Scripts, Optum Rx, and Prime Therapeutics—administer prescription drug benefits for both ERISA and non-ERISA plans. J.A. 66-67. "The ERISA-covered health plans include both insured and self-funded plans sponsored by employers and labor unions." J.A. 66. "The non-ERISA covered health plans include plans sponsored by state and local governments that contract directly for PBM services," "plans sold in the individual health insurance market," and Medicare Part D plans. *Ibid.*

In 2015, respondent sued petitioner in the Eastern District of Arkansas, alleging, among other things, that ERISA preempts Act 900 because Act 900 "relate[s] to" ERISA plans. J.A. 81 (brackets in original); see J.A. 80-81. Respondent sought a declaratory judgment and an injunction prohibiting the enforcement of Act 900. J.A. 88-89.

The district court granted respondent's motion for summary judgment on its ERISA claim. Pet. App. 12a-36a. The court concluded that "Act 900 is invalid as applied to PBMs in their administration and management of ERISA plans." *Id.* at 17a. The district court noted that in *Pharmaceutical Care Management Ass'n* v. *Gerhart*, 852 F.3d 722 (2017), the Eighth Circuit had found a "similar" Iowa statute "preempted by ERISA because it interferes with nationally uniform plan administration." Pet. App. 18a. The district court further noted that *Gerhart* had "held that the Iowa statute interferes with uniform plan administration by requiring PBMs * * * to provide a procedure by which pharmacies can contest and appeal MAC reimbursements." *Ibid.* The court observed that Act 900 likewise "requires PBMs to provide a 'reasonable administrative appeal procedure' that allows pharmacies to challenge

MAC costs and to reverse and rebill the claim in question." *Ibid.* The 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." *Id.* at 19a.[3]

5. The court of appeals affirmed in relevant part. Pet. App. 1a-11a. The court explained that, in *Gerhart*, it had "held that an Iowa statute, similar in purpose and effect to Act 900, was preempted by ERISA because it had a prohibited 'reference to' ERISA, and because it interfered with national uniform plan administration." *Id.* at 5a (citation omitted). The court agreed with the district court that "*Gerhart* controlled the outcome of the ERISA preemption claim." *Ibid.* In particular, the court of appeals observed that *Gerhart* had found that the Iowa statute "makes implicit reference to ERISA through regulation of PBMs who administer benefits for 'covered entities,' which, by definition, include * * * entities [that] are necessarily subject to ERISA regulation." *Id.* at 6a (quoting *Gerhart*, 852 F.3d at 729). The court concluded that it was bound by that reasoning to hold that Act 900 is likewise preempted. *Id.* at 6a-7a. Although the court acknowledged that "there is generally a presumption against preemption," it reasoned that, "where, as here, the state law both relates to and

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[3] Respondent also brought a Medicare preemption claim and various constitutional claims, and the district court granted summary judgment in petitioner's favor on those claims. Pet. App. 20a-36a. Respondent appealed only the rejection of its Medicare preemption claim, Br. in Opp. 12 n.8, and the court of appeals reversed, holding that the Medicare statute preempts the Arkansas statute as applied to PBMs that administer pharmacy benefits for Medicare Part D plans, Pet. App. 7a-11a. Petitioner does not seek review of that Medicare preemption holding.

has a connection with employee benefit plans, the presumption is gone and the law is preempted." *Id.* at 7a.

SUMMARY OF ARGUMENT

ERISA does not preempt Arkansas's regulation of the rates at which PBMs reimburse pharmacies for prescription drugs. In concluding otherwise, the court of appeals reasoned that the Arkansas statute makes "reference to" ERISA plans, Pet. App. 5a (citation omitted), and has an impermissible "connection with" them, *id.* at 7a. See *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). That reasoning is incorrect.

A. The Arkansas statute does not make "reference to" ERISA plans. The statute applies to PBMs—entities that administer or manage a pharmacy benefits plan. Under the statute, the pharmacy benefits plan the PBM administers need not be an ERISA plan. Rather, the pharmacy benefits plan can be a non-ERISA plan, such as a governmental plan or a plan sold on the individual health-insurance market. Because the Arkansas statute imposes obligations on PBMs, regardless of whether the PBM provides services to an ERISA plan, the Arkansas statute does not "act[] immediately and exclusively upon ERISA plans"; nor is "the existence" of an ERISA plan "essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). Under this Court's precedents, the Arkansas statute therefore does not make "reference to" ERISA plans.

B. The Arkansas statute likewise does not have an impermissible "connection with" ERISA plans. This Court has declined to find such a connection where a state law has only an "indirect economic influence" on the choices of an ERISA plan. *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers*

Ins. Co., 514 U.S. 645, 659 (1995). That is the case here. The Arkansas statute may affect a PBM's cost of providing pharmacy benefits, which may, in turn, affect an ERISA plan's decision to contract with a particular PBM (or with any PBM at all). But that "indirect economic influence" "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Ibid.* The Arkansas statute therefore does "not bear the requisite 'connection with' ERISA plans to trigger pre-emption." *Id.* at 662.

The objectives of the ERISA statute reinforce that conclusion. "[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661. And holding that ERISA preempts Arkansas's regulation of pharmacy reimbursement rates would call into question a broad range of traditional state regulation that could be said to affect a plan's costs but that "Congress could not possibly have intended to eliminate." *Id.* at 668.

Respondent's concerns about the consequences of the Arkansas statute for nationally uniform plan administration are misplaced. The Arkansas statute regulates the price of prescription drugs, which may indirectly affect a plan's cost of providing benefits. This Court's decisions make clear, however, that costs of benefits are not a central matter of plan administration. Moreover, the Arkansas statute imposes obligations on PBMs, not plans. Its provisions thus regulate PBM administration, not ERISA plan administration. The Arkansas statute therefore does not threaten the uniformity of the latter.

ARGUMENT

ERISA DOES NOT PREEMPT ARKANSAS'S REGULATION OF THE RATES AT WHICH PHARMACY BENEFITS MANAGERS REIMBURSE PHARMACIES

Subject to certain exceptions, ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. 1144(a). Under this Court's precedents construing that provision, "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

The state law at issue here is an Arkansas statute that regulates the rates at which PBMs that use MAC lists reimburse pharmacies for prescription drugs. Ark. Code Ann. § 17-92-507. The statute effectively requires that those rates be equal to or higher than the pharmacy's cost of acquiring those drugs. See pp. 6-7, *supra*. The court of appeals held that ERISA preempts the Arkansas statute as applied to PBMs that provide services to plans covered by ERISA (known as ERISA plans). Pet. App. 5a-7a; see *id.* at 17a. It did so on the grounds that the Arkansas statute makes reference to such plans and that it has an impermissible connection with them. *Id.* at 5a-7a. Each of those grounds is incorrect.

A. The Arkansas Statute Does Not Make "Reference To" ERISA Plans

1. Under this Court's precedents, a state law makes "reference to" ERISA plans if (1) it "acts immediately and exclusively upon ERISA plans" or (2) "the existence of ERISA plans is essential to the law's operation."

California Div. of Labor Standards Enforcement v. *Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). Neither test is satisfied here.

First, the Arkansas statute does not "act[] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325. The Arkansas statute imposes obligations on PBMs, not plans. See, *e.g.*, Ark. Code Ann. § 17-92-507(c) (setting forth what "[a] pharmacy benefits manager shall" do). And though it defines a PBM as "an entity that administers or manages a pharmacy benefits plan or program," *id.* § 17-92-507(a)(7), it does not require that the "pharmacy benefits plan or program" be covered by ERISA. Rather, the statute defines "[p]harmacy benefits plan or program" to include any "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 th[e] state." *Id.* § 17-92-507(a)(9).

That definition is indifferent to whether the plan falls within ERISA's coverage. It encompasses not just ERISA plans, but also non-ERISA plans, such as "plans sold in the individual health insurance market," "plans sponsored by state and local governments," and Medicare Part D plans. J.A. 66; see 29 U.S.C. 1003(a)(1) and (2) (providing that ERISA applies only to employee benefit plans established or maintained by an "employer" or "employee organization"); 29 U.S.C. 1003(b) (exempting "governmental" plans from ERISA's coverage). Because the Arkansas statute imposes obligations on PBMs, regardless of whether the PBM provides services to an ERISA plan, the Arkansas statute does not "act[] immediately and exclusively upon ERISA plans." *Dillingham*, 519 U.S. at 325.

Second, the "existence of ERISA plans" is not "essential" to the Arkansas statute's "operation." *Dillingham*, 519 U.S. at 325. Because its definition of "[p]harmacy benefits plan or program" encompasses non-ERISA plans as well as ERISA plans, Ark. Code Ann. § 17-92-507(a)(9), the Arkansas statute "functions irrespective of . . . the existence of an ERISA plan," *Dillingham*, 519 U.S. at 328 (citation omitted). And because a PBM's obligations under the Arkansas statute do not vary depending on the nature of the plan the PBM administers or manages, application of the Arkansas statute does not require any "inquiry" "directed to the plan." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 140 (1990). The Arkansas statute thus does not resemble the Texas common-law cause of action found preempted in *Ingersoll-Rand*, which was "premised on" the existence of an ERISA plan. *Ibid.*; see *id.* at 139-140 (explaining that "the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law"). Nor does the Arkansas statute resemble the D.C. workers' compensation law found preempted in *District of Columbia* v. *Greater Washington Board of Trade*, 506 U.S. 125 (1992), which set employee benefits "by reference to" the coverage provided under an ERISA plan. *Id.* at 130.

This Court's precedents support the conclusion that there is no "reference to" preemption here. In *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995), for example, this Court held that a New York statute that required hospitals to collect surcharges from certain commercially insured patients and health maintenance organizations (HMOs) could not "be said to make 'reference to' ERISA plans" because "[t]he surcharges

[we]re imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, [wa]s ultimately secured by an ERISA plan, private purchase, or otherwise." *Id.* at 656. Similarly, in *Dillingham*, this Court held that a California statute that permitted contractors to pay an "apprentice wage" to workers participating in an "approved apprenticeship program," 519 U.S. at 319, did not make "reference to" ERISA plans because the "approved apprenticeship programs need not necessarily be ERISA plans," *id.* at 325. Because the Arkansas statute here is likewise indifferent to whether a plan falls within ERISA's coverage, it does not make "reference to" ERISA plans.

2. In reaching a contrary conclusion, the court of appeals reasoned that the plans to which PBMs provide services may "*include*" ERISA plans. Pet. App. 6a (emphasis added; citation omitted). This Court's decisions, however, require that the state law "act[] immediately and *exclusively* upon ERISA plans." *Dillingham*, 519 U.S. at 325 (emphasis added); see *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830 (1988) (holding that ERISA preempted a Georgia statute that "single[d] out," by "express reference," "ERISA employee welfare benefit plans for different treatment under state garnishment procedures"). Thus, in *Travelers* and *Dillingham*, ERISA plans were included along with other plans among those covered by the state law. See *Dillingham*, 519 U.S. at 325-326; *Travelers*, 514 U.S. at 656. Because ERISA plans were not the only plans that were included, however, the Court found no "reference to" preemption. The court of appeals' approach cannot be squared with those decisions. And if the mere inclusion of ERISA plans among those affected by a statutory scheme were enough to

qualify as a "reference to" such plans, the scope of ERISA preemption would extend far beyond what any "'sensible person could have intended.'" *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (citation omitted).

B. The Arkansas Statute Does Not Have An Impermissible "Connection With" ERISA Plans

Even if a state law does not make "reference to" ERISA plans, it is preempted if it has "an impermissible 'connection with' ERISA plans." *Gobeille*, 136 S. Ct. at 943 (citation omitted). That standard, however, is likewise not satisfied here.

1. The Arkansas statute has only an indirect economic effect on the choices of ERISA plans

a. "Acknowledging that 'connection with' is scarcely more restrictive than 'relate to,'" this Court has "cautioned against an 'uncritical literalism' that would make pre-emption turn on 'infinite connections.'" *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 147 (2001) (citation omitted). "Instead, to determine whether a state law has the forbidden connection," this Court "look[s] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Ibid.* (citations and internal quotation marks omitted).

Applying that framework, this Court has held that a state law has an "impermissible 'connection with' ERISA plans" if it "'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Gobeille*, 136 S. Ct. at 943 (citation omitted). The Court has identified an ERISA plan's

"payment of benefits" as "a central matter of plan administration." *Egelhoff*, 532 U.S. at 148. The Court has thus held that state laws "relate to" ERISA plans when they "require[] employers to pay employees specific benefits," *Shaw*, 463 U.S. at 97; "bind[] ERISA plan administrators to a particular choice of rules for determining beneficiary status," *Egelhoff*, 532 U.S. at 147; "eliminate[] [a] method for calculating pension benefits" permitted by federal law, *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981); "prohibit[] employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy," *Shaw*, 463 U.S. at 97; or "prohibit[] plans from being structured in a manner requiring reimbursement in the event of recovery from a third party," *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990). All of those state laws "mandate[] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658.

Conversely, this Court has sustained state laws that "alter[] the incentives, but do[] not dictate the choices, facing ERISA plans." *Dillingham*, 519 U.S. at 334. To be sure, the Court has declined to rule out the possibility that "a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Travelers*, 514 U.S. at 668. But the Court has recognized that "[a]n indirect economic influence" generally "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." *Id.* at 659. Indeed, the Court has cautioned that, if state laws that merely influenced the choices of ERISA plans were preempted, courts would "scarcely see the end of ERISA's pre-emptive reach,

and the words 'relate to' would limit nothing." *Dillingham*, 519 U.S. at 329. The Court accordingly has held that generally applicable state laws that "have an indirect economic effect on choices made by" ERISA plans are not preempted. *Travelers*, 514 U.S. at 659.

In *Travelers*, for example, this Court held that ERISA did not preempt a New York statute that regulated hospital rates for in-patient care. 514 U.S. at 649. The New York statute "require[d] hospitals to collect surcharges from patients covered by a commercial insurer but not from patients insured by a Blue Cross/Blue Shield plan." *Ibid.* It also imposed surcharges on certain HMOs. *Ibid.* The New York statute's regulation of hospital rates made "the Blues more attractive (or less unattractive) as insurance alternatives" than competing commercial insurers and HMOs. *Id.* at 659. The statute thus had "an indirect economic effect on choices made by insurance buyers, including ERISA plans." *Ibid.*

Notwithstanding that "indirect economic influence," *Travelers*, 514 U.S. at 659, the Court held that the New York statute did "not bear the requisite 'connection with' ERISA plans to trigger pre-emption," *id.* at 662. The Court explained that the New York statute did "not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself," *id.* at 659; nor did the statute produce such "acute" economic effects "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," *id.* at 668.

The Court in *Travelers* acknowledged that the New York statute "bears on the costs of benefits and the relative costs of competing insurance to provide them." 514 U.S. at 660. The Court further acknowledged that such costs, in turn, "can affect a plan's shopping

decisions"—*i.e.*, its decisions whether to contract with the Blues rather than a competing commercial insurer or HMO. *Ibid.* The Court emphasized, however, that many other forms of "state action"—from "[q]uality standards" to "basic regulation of employment conditions"—can likewise "affect the cost and price of services." *Ibid.* And the Court explained that "to read the preemption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in [the preemption provision] out of the statute." *Id.* at 661. Finding "nothing in the language of [ERISA] or the context of its passage [that] indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern," *ibid.*, the Court held that ERISA did not preempt New York's "hospital reimbursement methodology," *id.* at 649 (capitalization omitted).

b. This Court's decision in *Travelers* resolves this case. Just as the New York statute affected a commercial insurer's or HMO's cost of providing hospital coverage, so too the Arkansas statute affects a PBM's cost of providing pharmacy benefits. It does so by effectively requiring PBMs to reimburse pharmacies for prescription drugs at a price equal to or higher than the pharmacy's cost of acquiring the drug from a pharmaceutical wholesaler or manufacturer. See pp. 6-7, *supra*. When the pharmacy's cost of acquiring the drug is higher than the MAC price for that drug, the Arkansas law has the effect of requiring the PBM to pay more for the drug than it otherwise would under its contract with the pharmacy.

Thus, "[t]he increased drug costs caused by Act 900 will be born[e] directly by PBMs," which could then pass those costs along to others, including ERISA plans. J.A. 77; see J.A. 146 (explaining that when the PBM's contract with the plan "is priced on a pass-through basis," "the costs are simply passed on to the employee benefit plan"). And just as the effect on costs in *Travelers* could influence an ERISA plan's decisions to contract with a commercial insurer or HMO, so too the effect on costs here could influence an ERISA plan's decision to contract with a particular PBM—or with any PBM at all.

For example, the effect on costs may cause a plan to prefer a PBM offering a lock-in arrangement over a PBM offering a pass-through arrangement, on the view that "when the contract is priced on a lock-in basis, the PBM assumes the costs associated with over-runs." J.A. 146; see J.A. 336 (stating that "it is undisputed that health plans with pass-through contracts * * * will bear the added costs of Act 900's reimbursement provisions"); p. 5, *supra*. Or the effect on costs may cause a plan to prefer a PBM that does not use MAC lists over a PBM that does, on the view that the former would not be subject to the Arkansas statute at all. See J.A. 78, 169 (explaining that the Arkansas statute will "create pressure to develop new pricing models for handling generic drugs that may not be subject to a MAC"); J.A. 184 (explaining that "[m]ost PBMs will develop whatever pricing model it would take to bring new business in the door," provided that the PBM can still earn a profit); J.A. 320 (stating that it is "[u]ndisputed" that MAC pricing methodologies are subject to "whatever the market will bear (*i.e.*, whether a health plan customer will buy the PBM[']s services or go elsewhere)").

Or the effect on costs may cause a plan to forgo contracting with a PBM altogether, on the view that the plan can manage pharmacy benefits itself. See D. Ct. Doc. 75-3, at 9 (explaining that plans themselves could handle pharmacy benefits management "in theory"); J.A. 145 (explaining that "[i]nsurers and employers that offer a prescription drug benefit" may "handle such tasks themselves"); Resp. Cert. Supp. Br. 1 ("ERISA-covered benefit plans can undertake the massive effort of administering prescription-drug benefits themselves.").

Like the New York law in *Travelers*, however, the Arkansas statute "does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself." 514 U.S. at 659. Rather, the Arkansas statute "leave[s] plan administrators right where they would be in any case," *id.* at 662, with the responsibility to decide whether it would be worthwhile to contract with a particular PBM for services. Thus, although the Arkansas statute "can affect a plan's shopping decisions"—making particular arrangements seem "more attractive (or less unattractive)" in light of the obligations the statute imposes on PBMs—the statute "does not affect the fact that any plan will shop for the best deal it can get." *Id.* at 659-660. Through an "extremely competitive" bidding process, J.A. 124, in which PBMs compete to provide services at the lowest price "[e]ach time a contract is up for re-negotiation or re-bidding," J.A. 184; see J.A. 183-186, 349-350, plans will continue to "evaluat[e] which is the best PBM to partner with," J.A. 96.

The effects of the Arkansas statute on ERISA plans distinguish it from the state laws this Court has found preempted. The Arkansas statute regulates only the relationship between PBMs and pharmacies. It does

not regulate the relationships between plans and their participants, between plans and their insurers, or even between plans and their PBMs. Thus, unlike the state laws this Court has found to "relate to" ERISA plans, see p. 17, *supra*, the Arkansas statute does not "force an ERISA plan to adopt a certain scheme of substantive coverage," *Travelers*, 514 U.S. at 668, or "mandate[] employee benefit structures or their administration," *id.* at 658. Rather, "[i]t simply bears on the costs of benefits and the relative costs of competing [PBMs] to provide them." *Id.* at 660; cf. *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 214 (1979) (describing "Pharmacy Agreements"—agreements between insurers and pharmacies on the "maximum prices" the insurer "will pay for drugs"—as mere "cost-savings arrangements" that enable the insurer "to minimize costs and maximize profits").

The Arkansas statute therefore does "not bear the requisite 'connection with' ERISA plans to trigger preemption." *Travelers*, 514 U.S. at 662; see *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 816 (1997) ("Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."); *Dillingham*, 519 U.S. at 334 (holding that ERISA did not preempt a California "prevailing wage statute" that "alter[ed] the incentives, but d[id] not dictate the choices, facing ERISA plans").

c. The "objectives of the ERISA statute," *Egelhoff*, 532 U.S. at 147 (citation omitted), reinforce that conclusion. As this Court explained in *Travelers*, "nothing in the language of [ERISA] or the context of its passage

indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 514 U.S. at 661. The state law in this case represents an exercise of Arkansas's "historic police powers" on "matters of health and safety." *De Buono*, 520 U.S. at 814. It embodies Arkansas's considered judgment that ensuring access to prescription drugs, particularly in rural areas of the State, justifies regulating the use of MAC lists in determining drug prices. See p. 6, *supra*. There is no indication that this is "the type of state law that Congress intended ERISA to supersede." *De Buono*, 520 U.S. at 814.

Indeed, the context of ERISA's passage suggests that ERISA was not meant to preempt state regulation of health care costs. See *Travelers*, 514 U.S. at 664-667, 668 n.6. The Court in *Travelers* noted, for example, that the same Congress that enacted ERISA also enacted the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §§ 1-3, 88 Stat. 2225-2257 (later repealed by the Health Maintenance Organization Amendments of 1986, Pub. L. No. 99-660, Tit. VII, § 701(a), 100 Stat. 3799), which "sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health services." 514 U.S. at 665. A permanent select committee of that same Congress also held hearings on pharmacy agreements similar to those subject to the Arkansas statute—so-called "[t]hird party prepaid prescription programs," whereby insurers "reimburse[d] the pharmacists on the basis of a preestablished formula for the cost of filling a subscriber-patient's prescription." H.R. Rep. No. 730, 93d Cong., 1st Sess. 5 (1973); see H.R. Rep. No. 1651, 93d Cong., 2d Sess. 154

(1974) (Final Report). The hearings studied the relevant legal landscape, and there is no indication in the committee's final report that it thought ERISA would affect that landscape. Final Report 153-158; see, *e.g.*, *Problems on Third Party Prepaid Prescription Programs: Hearings Before the House Subcomm. on Environmental Problems Affecting Small Business of the Permanent Select Comm. on Small Business*, 93d Cong., 1st. Sess. 14, 51-98 (1973) (discussing federal antitrust laws); see also, *e.g.*, *Third Party Prepaid Prescription Programs: Hearings Before the House Subcomm. on Environmental Problems Affecting Small Business of the Select Comm. on Small Business*, 92d Cong., 1st Sess. 46-48, 55-57 (1971) (discussing Missouri sales tax); *id.* at 122, 124-125 (discussing Illinois insurance and tax laws); *id.* at 204 (discussing state laws encouraging "generic prescriptions").

Holding that ERISA preempts Arkansas's regulation of pharmacy reimbursement rates would thus stretch ERISA's preemption provision beyond what history suggests Congress contemplated. And it would call into question a broad range of traditional state regulation that could be said to affect a plan's costs—not just state regulation of rates charged by pharmacies, but also state regulation of rates charged by drug manufacturers, pharmaceutical wholesalers, and pharmacy services administrative organizations (which negotiate network contracts on behalf of pharmacies), J.A. 144, 182-183; and not just state regulation of the cost of providing pharmacy benefits (and medical services and equipment more generally), but also state regulation of the cost of providing other benefits covered by ERISA, such as death benefits, day care services, and prepaid legal services, 29 U.S.C. 1002(1). Because

giving ERISA's preemption provision such scope "would effectively read the limiting language in [the provision] out of the statute," *Travelers*, 514 U.S. at 661, the Court should reject the court of appeals' conclusion that the Arkansas statute has an impermissible "connection with" ERISA plans.

2. Respondent's counterarguments lack merit

a. Relying on this Court's decision in *Gobeille*, respondent contends that the Arkansas statute intrudes upon a central matter of plan administration and interferes with nationally uniform plan administration. Resp. Cert. Supp. Br. 4-5. That contention is mistaken.

Gobeille involved a Vermont statute "requiring disclosure of payments relating to health care claims and other information relating to health care services." 136 S. Ct. at 940. Although the respondent in *Gobeille*, an ERISA health plan, had too few members for the plan itself to be subject to the Vermont statute's mandatory reporting requirements, the state statute still required "data about the Plan or its members" to be disclosed by the plan's third-party claims administrator, which "manage[d] the 'processing, review, and payment' of claims for [the plan]." *Id.* at 942 (citation omitted).

The Court in *Gobeille* held that the Vermont statute, as applied to ERISA plans, was preempted. 136 S. Ct. at 943. The Court observed that ERISA imposes "extensive" "reporting, disclosure, and recordkeeping requirements" on "welfare benefit plans." *Id.* at 944. Those requirements "make[] plain," the Court explained, that "reporting, disclosure, and recordkeeping" are "central" matters of "plan administration contemplated by ERISA." *Id.* at 945; see *ibid.* ("These matters are fundamental components of ERISA's regulation of plan ad-

ministration."). The Court found that the Vermont statute regulated those same matters: "plan reporting, disclosure, and—by necessary implication—recordkeeping." *Ibid.*; see *id.* at 946 ("Vermont orders health insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner."). The Court thus viewed the Vermont statute as "a direct regulation of a fundamental ERISA function." *Id.* at 946. And it concluded that, by "compel[ling] plans to report detailed information about claims and plan members," the Vermont statute "intrude[d] upon 'a central matter of plan administration' and 'interfere[d] with nationally uniform plan administration.'" *Id.* at 945 (citation omitted). The Court therefore held that preemption was "necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Ibid.*

Unlike the Vermont law in *Gobeille*, the Arkansas statute in this case does not regulate "a central matter of plan administration." 136 S. Ct. at 945 (citation omitted). Rather, it regulates the prices charged for prescription drugs sold by pharmacies, which may have an indirect effect on the cost of pharmacy benefits. This Court's decisions make clear that, unlike a plan's payment of benefits to plan participants, "the cost[] of benefits" is not a central matter of plan administration. *Travelers*, 514 U.S. at 660. As the Court in *De Buono* explained, "[a]ny state * * * law[] that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." 520 U.S. at 816. After all, "[s]uch state laws leave plan administrators right where they would be in any case,

with the responsibility to choose the best overall coverage for the money." *Travelers*, 514 U.S. at 662. Because the Arkansas statute affects only "a plan's shopping decisions," *id.* at 660, it neither intrudes upon a central matter of plan administration nor interferes with nationally uniform plan administration, see *id.* at 662 (explaining that "cost uniformity was almost certainly not an object of pre-emption").

b. Respondent contends that the Arkansas statute does govern plan administration by "set[ting] detailed standards for how *plans* may structure and administer the *plan*." Resp. Cert. Supp. Br. 1 (emphases added). But the Arkansas statute imposes obligations on PBMs, not plans. See, *e.g.*, Ark. Code Ann. § 17-92-507(c) ("A pharmacy benefits manager shall * * * ."); D. Ct. Doc. 3, at 36 (Aug. 13, 2015) ("Act 900 is clearly directed at a single entity: PBMs."); D. Ct. Doc. 91, at 1 (Sept. 16, 2016) (acknowledging that the Arkansas statute's "requirements are directed at PBMs, rather than their clients, the plan sponsors"). Its provisions thus regulate PBM administration, not ERISA plan administration. And they do so only for the limited purpose of giving effect to Arkansas's requirement that PBMs that use MAC lists reimburse pharmacies at a price equal to or higher than the pharmacy acquisition cost.

Section 17-92-507(c)(2), for example, provides that "[a] *pharmacy benefits manager* shall * * * [u]pdate its [MAC] List on a timely basis." Ark. Code Ann. § 17-92-507(c)(2) (emphasis added). Respondent reads that provision to require that "the *plan's* MAC list * * * be updated." Resp. Cert. Supp. Br. 2 (emphasis added). But Section 17-92-507(c)(2) makes no mention of the plan. And MAC lists do not even belong to plans; rather, they belong to PBMs. See J.A. 229 ("[T]he MAC

price list is owned and controlled by the PBM."). Indeed, "PBMs consider both their MAC lists and MAC pricing methodologies to be proprietary trade secrets, and protect them as such." J.A. 72-73; see J.A. 126 ("Prime treats its MAC information as highly confidential."); *ibid.* (explaining that "no external person"—"not the pharmacy, and not the client for which the MAC list is created"—"can access" the "methodology that Prime uses to create the MAC pricing"); J.A. 136 ("Express Scripts treats its MAC lists as highly confidential and proprietary.").

Section 17-92-507(c)(4) likewise provides that "[a] *pharmacy benefits manager* shall * * * [p]rovide a reasonable administrative appeal procedure to allow pharmacies to challenge [MACs]," Ark. Code Ann. § 17-92-507(c)(4)(A)(i)(b) (emphasis added), and that "the *pharmacy benefits manager s*hall adjust the [MAC] List" and "permit the pharmacy to reverse and rebill" each of the pharmacy's claims for reimbursement affected by the pharmacy's inability to acquire the drug at or below the MAC, *id.* § 17-92-507(c)(4)(C)(iii) (emphasis added). Respondent reads those provisions to "dictate[] detailed appeal procedures that *plans* must establish." Resp. Cert. Supp. Br. 2 (emphasis added). But the required procedures pertain to an appeal before the PBM, not before the plan. Indeed, even prior to the enactment of the Arkansas statute, "contracts between PBMs and their network pharmacies generally" allowed pharmacies "to appeal certain reimbursements." J.A. 324-325; see J.A. 137. Section 17-92-507(c)(4) simply expands those procedures to allow pharmacies to challenge reimbursements as below the pharmacy acquisition cost.

The final provision at issue in this case—Section 17-92-507(e)—allows a pharmacy to decline to dispense a drug "to *a patient or pharmacy benefits manager* if, as a result of a [MAC] List, [the pharmacy] is to be paid less than the pharmacy acquisition cost" by the PBM. Ark. Code Ann. § 17-92-507(e) (emphasis added). Although the "patient" may be a participant in an ERISA plan, that does not make the provision a regulation of plan administration. The provision does not impose any obligations on the plan itself. And its effect is to supersede a requirement generally found in contracts between pharmacies and PBMs—namely, the requirement that the pharmacy "dispense all prescriptions regardless of the amount of the reimbursement." J.A. 325; see J.A. 137. Moreover, States impose all sorts of requirements that may affect whether a pharmacy may dispense a drug at any given time. See, *e.g.*, Ark. Code Ann. § 17-92-404 (Supp. 2010) (imposing pharmacy permit requirements); see also Pet. Br. 47 (identifying other state-law provisions that "authorize[] pharmacies to decline to dispense drugs for a variety of health-and-safety reasons"). Section 17-92-507(e) is no more a regulation of plan administration than those other state laws. Thus, although a plan whose participants are too often unable to have their prescriptions filled might think twice about contracting with the same PBM again, Section 17-92-507(e) does not "function as a regulation of an ERISA plan itself." *Travelers*, 514 U.S. at 659.[4]

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[4] In its certiorari-stage supplemental brief, respondent contended that the Arkansas statute also "requires disclosure of detailed *plan information* to pharmacies in the plan's network." Resp. Cert. Supp. Br. 1 (emphasis added). In its brief in opposition, however, respondent acknowledged that it did not challenge those "Disclosure Provisions" in its motion for summary judgment. Br. in Opp.

c. Finally, respondent contends that even if the Arkansas statute imposes obligations only on PBMs, sometimes "a plan manages prescription drug benefits itself," rather than "engage[] a third-party PBM to manage those benefits." Resp. Cert. Supp. Br. 5. Respondent argues that when a plan manages such benefits itself, it meets the definition of a PBM under the Arkansas statute, and that because the statute would then be directly regulating the plan, the statute would be preempted. *Id.* at 4.

i. There is no occasion for the Court to address the question whether ERISA would preempt the application of the Arkansas statute to a plan that manages prescription drug benefits itself. Respondent's members are not plans themselves; they are third-party PBMs, which contract with ERISA and non-ERISA plans to administer prescription drug benefits. See J.A. 66; D. Ct. Doc. 75-3, at 2-3; D. Ct. Doc. 98, at 39-40 (Nov. 14, 2016) (respondent's counsel stating that there is "no real evidence" that "any plan" has gone without a third-party PBM); Br. in Opp. 4-5 (arguing that "it would not be cost-effective for health plans to perform PBM services in-house"). Thus, the only question the Court needs to decide in this case is whether ERISA preempts the application of the Arkansas statute to third-party PBMs that administer prescription drug benefits for ERISA plans. The Court can reserve judgment on whether ERISA preempts the application of

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16 n.9; see *id.* at 11; U.S. Amicus Cert. Br. 20. Those provisions therefore are not properly before this Court. In any event, the information referenced in those provisions is not plan information, but rather MAC information, Ark. Code Ann. § 17-92-507(c)(1) and (3), and information about pharmaceutical wholesalers, *id.* § 17-92-507(c)(4)(C)(ii).

the Arkansas statute to ERISA plans that manage prescription drug benefits themselves.

Indeed, the Court followed a similar course in *Travelers*. The Court in that case reversed the court of appeals' judgment that ERISA preempted the application of the New York statute to any commercial insurers or HMOs in connection with their coverage of an ERISA plan. See 514 U.S. at 652-654. But the Court left open the question whether ERISA preempted the application of the New York statute to self-insured ERISA plans, which were required to pay the mandated surcharges directly. *Id.* at 653 n.4; see U.S. Amicus Br. at 12 n.3, *Travelers*, *supra* (No. 93-1408).

Likewise here, the Court could address only the application of the Arkansas statute to third-party PBMs, leaving for a future case its application to plans that manage their own pharmacy benefits. Leaving that question open would be particularly appropriate given that it is far from clear that a plan that manages prescription drug benefits itself would be subject to the Arkansas statute in the first place. The statute defines a "[p]harmacy benefits manager" as "an entity that administers or manages a pharmacy benefits plan or program." Ark. Code Ann. § 17-92-507(a)(7). That definition could be read to contemplate only third-party PBMs—"entit[ies]" distinct from the "plan or program" itself. *Ibid.* In any event, respondent did not argue below that a plan itself could qualify as a PBM under the Arkansas statute. See D. Ct. Doc. 91, at 7 (arguing instead that "plans do not fall directly under the [Arkansas statute's] requirements"). Thus, neither the district court nor the court of appeals addressed that issue of state law.

ii. In any event, at least in the case of a plan that owns or operates a PBM, there would still be no ERISA preemption. This Court confronted a similar issue in *De Buono*. The New York statute in that case imposed "a tax on gross receipts for patient services at hospitals." 520 U.S. at 809. The respondents were trustees of a self-funded ERISA plan that owned and operated its own hospitals. *Id.* at 810. The court of appeals held that ERISA preempted the state tax as applied to plan-owned hospitals, reasoning that unlike the surcharges at issue in *Travelers*—which "had only an indirect economic influence on the decisions of ERISA plan administrators"—the tax "'depletes the [plan's] assets directly, and thus has an immediate impact on the operations of an ERISA plan.'" *Id.* at 812 (citation omitted).

This Court reversed. *De Buono*, 520 U.S. at 816. The Court observed that the tax was a "tax on hospitals" and that "[m]ost hospitals are not owned or operated by ERISA funds." *Ibid.* It then explained that if the plan had chosen instead to "purchase[] health care services from a hospital, that facility would have passed the expense of the [tax] onto the [plan] and its plan beneficiaries through the rates it set for the services provided." *Ibid.* The Court reasoned that "[a]lthough the tax in such a circumstance would be 'indirect,' its impact on the [plan's] decisions would be in all relevant respects identical to the 'direct' impact felt here." *Ibid.* The Court thus rejected "the supposed difference between direct and indirect impact." *Ibid.* And it concluded that the state tax "is one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *Id.* at 815 (citation omitted).

The reasoning of *De Buono* would apply here to a PBM owned or operated by an ERISA plan. The Arkansas statute imposes obligations on PBMs. See, *e.g.*, Ark. Code Ann. § 17-92-507(c). Most PBMs are not owned or operated by plans, because "[m]ost" plans "elect to use a [third-party] PBM." Resp. Cert. Supp. Br. 1. If a particular plan chose to own or operate a PBM itself, rather than purchase the same services from a third-party PBM—and if such a plan's PBM met the definition of a PBM under the Arkansas statute and used a MAC list to calculate reimbursements to pharmacies—then the Arkansas statute would apply to the plan through its ownership or operation of the PBM. But just as in *De Buono*, "the supposed difference between direct and indirect impact" would not justify preemption. 520 U.S. at 816. Nothing in ERISA suggests that by choosing to engage in activity subject to traditional state regulation, such as the purchase of prescription drugs or the ownership or operation of a PBM, a plan can immunize itself from the generally applicable requirements of such regulation. Cf. *Mackey*, 486 U.S. at 830-841 (holding that ERISA did not preempt a generally applicable state garnishment statute, even though that statute imposed administrative costs and burdens on ERISA plans).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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MARCH 2020