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Supreme Court upholds Arkansas law regulating PBMs

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ERISA doesn't preempt a state law that regulates how pharmacy benefit managers (PBMs) reimburse pharmacies, the US Supreme Court has ruled (*Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540 (U.S. Dec. 10, 2020)).

State law sets PBM reimbursement standards

The case centers on an Arkansas law (Ark. Code Ann. § 17–92–507, 2015 Act 900) requiring PBMs to reimburse a pharmacy for generic drugs at a price at least equal to the wholesale invoice amount that the pharmacy paid for the drug inventory. The law also mandates that PBMs use updated "maximum allowable cost" (MAC) lists and permit appeals. In addition, pharmacies have a "decline to dispense" option when a particular transaction would cause them to lose money.

After a PBM industry association sued to block the law, the 8th US Circuit Court of Appeals held that the law is preempted because it interferes with the nationwide uniform administration of ERISA health plans.

Supreme Court finds no ERISA preemption

In a unanimous ruling, the high court overturned the 8th Circuit decision, finding "ERISA does not preempt a state law that merely increases costs." The Arkansas statute regulates only the relationship between PBMs and pharmacies. The law does not make "reference to" or have an impermissible "connection with" ERISA plans. Nor does the statute regulate plans themselves or their relationships with PBMs, pharmacies, or plan participants. Citing a 1995 case, *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (514 U.S. 645), the court reasoned "creating inefficiencies alone is not enough to trigger ERISA pre-emption."

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Employer considerations

Since the Arkansas law's enactment, many states have taken action to regulate PBMs. Some impose additional requirements beyond pharmacy reimbursement. Plan sponsors will need to work with PBMs to determine to what extent, if any, a given state's PBM standards may apply to a self-insured plan.

The Arkansas law has three major components. Under two key provisions, a PBM must work with pharmacies to ensure its MAC list reflects the latest pricing and must provide a means for pharmacies to appeal reimbursement. The third component gives network pharmacies the right to refuse to fill a prescription if their reimbursement won't cover their cost for the drug. Plan sponsors will need to ensure their PBMs are working with Arkansas pharmacies to comply with these requirements, without beneficiaries being refused service.

In the longer term, plan sponsors will need to seek protection from increasing claim costs if generic reimbursement rates rise, with cost increases passed along to sponsors. Plan sponsors also will want to understand what the implications are for other states' PBM laws and how this decision might lay the groundwork for future cases affecting healthcare claim costs.

Related resources

Non-Mercer resources

- *Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540 (U.S. Dec. 10, 2020)
- Ark. Code Ann. § 17–92–507, 2015 Act 900 (Arkansas Legislature, Feb. 26, 2015)
- State strategies to regulate pharmacy benefit managers (National Conference of State Legislatures, May 16, 2019)
- *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)

Mercer Law & Policy resources

- Top 10 compliance issues for health and leave benefits in 2021 (July 20, 2020)
- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)
- Roundup of selected state health developments, fourth-quarter 2019 (Jan. 21, 2020)
- Roundup of selected state health developments — first-quarter 2019 (May 8, 2019)