

Publications

The Supreme Court Narrows ERISA Preemption in *Rutledge v. PCMA*

ATTORNEYS & PROFESSIONALS

Jon Breyfoglejbreyfogle@groom.com

202-861-6641

Lisa Campbelllcampbell@groom.com

202-861-6612

Tamara Killiontkillion@groom.com

202-861-6328

Seth Perrettasperretta@groom.com

202-861-6335

Ryan C. Temmertemme@groom.com

202-861-6659

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In the recently-decided *Rutledge v. Pharmaceutical Care Management Association* (“PCMA”), the Supreme Court found 8–0 (Justice Barrett did not take part) that ERISA **did not** preempt an Arkansas state law that established statutory minimum and other standards for pharmacy benefit managers’ (“PBMs”) payments to network pharmacies. No. 18-540, 2020 WL 7250098, at *2 (U.S. Dec. 10, 2020) (hereinafter “*Rutledge*”). The Court’s holding in *Rutledge* could reverberate beyond the facts of this case: it has the potential to undermine various quality-increasing and cost-reducing measures previously employed by self-funded employer plans. Below, we briefly summarize the *Rutledge* case, analyze the Court’s decision, and discuss its implications.

I. Background

Rutledge concerns PBMs, which were described by the Court as “a little-known but important part of the process by which many Americans get their prescription drugs.” *Id.* at *2. In broad strokes, PBMs facilitate payments between prescription drug plans to pharmacies. *Id.* The level of reimbursement provided to the pharmacy by the PBM does not necessarily match the amount of expense experienced by the pharmacy. At particular issue in *Rutledge* was a practice by which PBMs and pharmacies negotiate contract amounts with a maximum allowable cost (“MAC”) for each prescription drug that may become out of step with the wholesale price, should the wholesale price change.

The Arkansas statute at issue in *Rutledge*, Act 900, is premised on a concern that pharmacies are not fully reimbursed by PBMs for prescription drugs. As described by the Court, Act 900 contains three primary enforcement mechanisms: more closely tethering of reimbursement rates to pharmacy costs by requiring updates when prices increase; requiring administrative appeal procedures for pharmacies to challenge MAC prices; and, allowing pharmacies to decline to sell drugs on which they will lose money. *See* Ark. Code § 17-92-507(c)(2); *Id.* at § 17-92-507(c)(4)(A)–(C); *Id.* at § 17-92-507(e).

ERISA section 514(a) provides that ERISA preempts “any and all State laws insofar as they . . . relate to any employee benefit plan covered by ERISA.” For example, the Supreme Court has explained that a “law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, 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)(emphasis added). Two lines of precedent on ERISA preemption were counterpoised by *Rutledge: New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), which found a state hospital surcharge **was not** preempted, and the more recently decided *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016), which found that a state all-payer claims database was preempted. Both the district court and the Eighth Circuit found that Act 900 **was** preempted by ERISA.

II. The *Rutledge* Decision

Justice Sotomayor, writing for a unanimous Court, found that “[t]he logic of *Travelers* decides this case” and, therefore, Act 900 was not preempted by ERISA. *Rutledge* at *4. Justice Sotomayor explained that “ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.” *Id.* She went on “[i]ndeed, Act 900 is less intrusive than the law at issue in *Travelers*, which created a compelling incentive for plans to buy insurance from the blues instead of other insurers. Act 900, by contrast, applies equally to all PBMs and pharmacies in Arkansas.” *Id.*

In a short opinion announced a little over two months after oral arguments, Justice Sotomayor briskly rejected counter-arguments from PCMA including: that enforcement provisions in Act 900 directly affected central matters of plan administration (finding no requirements for plan structure); that Act 900 mandated a particular pricing methodology (finding that it merely establishes a floor for benefits, not a central plan administration); that Act 900 affects central matters of plan administration in its appeal procedure, allowing pharmacies to decline to dispense, and in its enforcement mechanisms creating operational inefficiencies (finding, respectively, no burden from the appeal procedure, the fault lies with the PBM, and that inefficiencies alone do not trigger preemption).

Justice Thomas filed a concurrence about as long as the majority opinion, in which he reiterated his ongoing concerns about the Supreme Court’s ERISA preemption decisions. He again noted his disagreement with the Court’s “relates to” jurisprudence, which he believes casts far too wide a preemptive net and criticized recent attempts by the Court to “narrow” its test as confusing. While he joined the majority opinion in full, he believed that the case should have been easily resolved because nothing in ERISA “governs the same matter as Act 900.” *Rutledge* at *7.

III. Possible Implications

The *Rutledge* decision narrows ERISA preemption and we are concerned that it opens the door for increased legislation by states to independently regulate the payments made by intermediaries on behalf of self-insured ERISA-covered group health plans. Following *Rutledge*, there is the potential for more widespread adoption of similar legislation by states targeting other payment practices, not only by PBMs, but also by other group health plan service providers, like third-party administrators (“TPAs”) that manage employer health and behavioral health benefits. Legislation of the sort could have a chilling effect on strategies currently used by employers, TPAs and PBMs to manage benefit costs for self-funded plans. Indeed, it seems likely that *Rutledge* may embolden states to take more direct steps, possibly inviting states to try to regulate the amounts a TPA must pay for out-of-network services, payments to certain types of providers relative to others, or other cost containment strategies that TPAs commonly employ on behalf of self-insured ERISA health plans. Of course, there will still be preemption arguments to be made if this occurs, but it will be interesting to see how courts draw lines in light of this new decision.

Groom will be monitoring these changes as they develop, so please check back here for updates or reach out to us with any questions you may have.

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