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

**BRIEF OF AMICI CURIAE AARP AND
AARP FOUNDATION SUPPORTING
NEITHER PARTY**

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STATEMENT OF INTEREST[1]

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families, with a focus on financial stability, health security, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works to end senior poverty by helping vulnerable older adults build economic opportunity and social connectedness.

Among other things, AARP and AARP Foundation seek to achieve affordable and accessible health care, including access to lower-cost prescription drugs. Concerned that a growing number of older Americans cannot afford insurance and the rising costs of many health care products and services, AARP has sought legislative reforms—both in state legislatures and Congress—to lower costs and increase the quality of health care. To these ends, AARP has urged all state governments to enact laws that, among other things, promote drug price

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[1] Pursuant to the Court's Rule 37.6, amici state that this brief was not authored in whole or in part by any party or its counsel and that no person other than amici, its members, or its counsel contributed any money that was intended to fund the preparation and submission of this brief. Pursuant to this Court's Rule 37.2(a), Counsel for Petitioner and Respondent have consented to the filing of this amicus brief.

transparency. AARP and AARP Foundation have also advocated for accessible, high-quality health care through participation as amici curiae in state and federal courts, including this Court.[2]

INTRODUCTION AND SUMMARY OF ARGUMENT

Older adults in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans.[3] 29 U.S.C. §§ 1001 *et seq*. Unfortunately, contrary to ERISA's purpose, a statute that was designed to safeguard employee benefits too frequently has been used to *deprive* employees of benefits and protections states create for them. Attempts to use ERISA to undercut health care regulation are contrary to this Court's recognition that such regulation is a traditional area of state concern. *See generally N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (*Travelers*), 514 U.S. 645, 654-55 (1995); *Boyle v. Anderson*, 68 F.3d

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[2] *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) (ERISA preemption).

[3] As part of its advocacy efforts to ensure that participants and beneficiaries receive the benefit of ERISA's protections to the greatest extent possible, AARP has participated as amicus curiae in numerous cases involving the breadth of ERISA's preemption clause. *See, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *Cal. Div. of Labor Stds. Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86 (1993).

1093, 1102 (8th Cir. 1995) (ERISA preemption challenge to MinnesotaCare health reforms).

Here, the Court of Appeals' decision would extend this Court's preemption jurisprudence past the Constitutional breaking point. Even in cases interpreting ERISA's express preemption provision, the Court has emphasized the need to "avoid [ ] the clause's susceptibility to limitless application." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936, 943 (2016). Thus, decisions have scrupulously avoided interpreting the clause to trammel core state authority to regulate health care costs, particularly when the state law in question focuses on a third-party provider rather than on plans themselves. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997). Here, finding that ERISA preempts state laws such as those enacted by Arkansas and the majority of other states participating here as amici would set a far-reaching precedent that would undermine state authority well beyond Congress's intent in passing ERISA.

Crucially, the Court should avoid blessing a standard that could curtail states' ability to address skyrocketing prescription drug costs—the single largest health care expense for consumers with private commercial insurance.[4] While taking no position herein on the wisdom of any given state law

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[4] Kristine Grow, *Prescription Drugs are Largest Single Expense for Consumer Premium Dollar* AM.'S HEALTH INS. PLANS (AHIP) (Mar. 2, 2017), https://www.ahip.org/prescription-drugs-are-largest-single-expense-of-consumer-premium-dollars/.

regulating pharmacy benefit managers ("PBMs"), we vigorously advocate for states to be able to regulate parties *other than ERISA plans* to promote pricing transparency and other measures that will lower those prohibitive costs. Accordingly, we urge the Court to reverse the Court of Appeals' decision and correct the Circuits' course on preemption of state law.

ARGUMENT

I. The Court of Appeals' Overly Broad Preemption Standard Abrogates States' Authority to Regulate Matters Related to Health and Safety.

As an overarching principle cabining the preemption of state law, the Court has stressed that the "historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *accord Arizona v. United States*, 567 U.S. 387, 399-400 (2012). The Court has always recognized the careful balance between federal power and states' authority to protect their citizens. The Court of Appeals upset that balance by inviting a "potentially boundless doctrine" that ignores established constitutional limits on federal authority. *See Wyeth v. Levine*, 555 U.S. 555, 587 (2009) (Thomas, J., concurring in the judgment) (internal quotation omitted).

ERISA only preempts "State laws insofar as they . . . relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). A state law "relate[s] 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). A state law has a "reference" to ERISA plans if it "acts immediately and exclusively upon ERISA plans" or if "the existence of ERISA plans is essential to the law's operation." *Cal. Div. of Labor Stds. Enf't v. Dillingham Constr., N. A., Inc.*, 519 U.S. 316, 325 (1997). 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. "A state law also might have an impermissible connection with ERISA plans 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.'" *Id.* (citation omitted). The Court has stated that those "formulations ensure that ERISA's express pre-emption clause receives the broad scope Congress intended while avoiding the clause's susceptibility to limitless application." *Id.*

Thus, the Court must consider whether preemption "was the clear and manifest purpose of Congress." *Wyeth*, 555 U.S. at 565; *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)) ("'the purpose of Congress is the ultimate touchstone' of pre-emption analysis.").

A. ERISA Does Not Supplant The States' Traditional Power To Regulate Health Care.

State and local governments have several reasons to assert their police powers to enact programs to ensure that their citizens have affordable, quality health coverage: to improve the quality and life expectancy for individual citizens; to stabilize the labor pool and maintain productivity in the business community; to maintain and increase access to health care facilities and other resources; and to promote the general well-being of the community at large. *See* Karen Davis, The Commonwealth Fund, *The Costs and Consequences of Being Uninsured*, MED. CARE RES. AND REV. 60 (2) (June 2003), http://goo.gl/A4CXTL. The power of state and local governments to enact laws designed to ensure the health and welfare of the state's residents and workers is well established and within the traditional police power of state and local governments. *See Sherlock v. Alling*, 93 U.S. 99, 103 (1876) (states' traditional role to regulate "subjects relating to the health, life, and safety of their citizens"); *Huron Portland Cement Co. v. City of Detroit*, 362 U.S. 440, 442 (1960) ("promoting the health and welfare of the city's inhabitants . . . clearly falls within the exercise of even the most traditional concept of what is compendiously known as the police power").

Indeed, the well-settled authority of states to regulate in certain areas has evolved into a presumption that, when federal laws overlap with areas traditionally within the local police power, both

local and federal law may have concurrent application. *See Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 205 (1983); *Huron Portland Cement Co*., 362 U.S. at 442. In *Pacific Gas*, the Court rejected the contention that a federal law concerning the regulation of new nuclear power plants preempted state regulation of "all things nuclear," explaining "the States retain their traditional responsibility in the field of regulating electrical utilities for determining questions of need, reliability, cost, and other related state concerns." 461 U.S. at 205. Thus, federal preemption of one aspect of nuclear power did not preclude state regulation of peripheral matters within the traditional realm of local police power where the federal law did not clearly intend to displace state law so broadly. Furthermore, *Huron* noted that "[i]n the exercise of [their police power], the states and their instrumentalities may act . . . concurrently with the federal government." 362 U.S. at 442. These decisions demonstrate how crucial it is to analyze the Congressional purpose in enacting the federal statute.

The Court also has conscientiously applied this presumption where the state uses its historic police powers to regulate in matters of health and safety that are at the heart of the state's authority and obligation to protect its residents. *See Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (federal blood plasma regulations promulgated by the Food and Drug Administration do not preempt county laws imposing additional requirements beyond the federal law). The Court has not treated ERISA otherwise. *E.g.*, *Travelers*, 514 U.S. at 661 (courts

"start with the assumption that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress").

Accordingly, the Court generally has held that ERISA does not preempt state laws regulating in the health care arena.[5] *See id.* ("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."); *De Buono*, 520 U.S. at 814-15 (finding state tax on hospitals not preempted because ERISA does not supplant presumption that state law is not preempted); *Dillingham*, 519 U.S. at 325 (prevailing wage statute is within state's traditional power to regulate). "[I]f ERISA were concerned with any state action—such as medical-care quality standards or hospital workplace regulations—that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach." *Dillingham*, 519 U.S. at 329; *accord Egelhoff*, 532 U.S. at 147. Consequently, state laws regulating third-party providers should be treated no differently than these other health care regulations.

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[5] Applying the historic presumption in claims of ERISA preemption makes particular sense because health plans were not the main focus of Congress's concern during the enactment of ERISA. *See generally* ABA Section of Labor and Emp't Law, EMPLOYEE BENEFITS LAW, at lxviii-lxix (Jeffrey Lewis et al. eds., 3d ed. 2012).

B. The Court of Appeals' Preemption Standard Reaches Too Far by Encompassing State Laws that Have a Completely Different Purpose and Effect than ERISA.

By finding that ERISA preempted a state law that applies exclusively to PBMs, which work with all plans whether employer-sponsored or otherwise, the Court of Appeals applied to ERISA's preemption clause the "uncritical literalism" this Court has soundly rejected. *Travelers*, 54 U.S. at 656. The proper approach is to consider "'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." *Dillingham*, 519 U.S. at 325 (citing *Travelers*, 514 U.S. at 656, 658-59).

"ERISA does not guarantee substantive benefits." *Gobeille*, 136 S. Ct. at 943. Instead, ERISA "seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Id.* (citing *Travelers*, 514 U.S. at 651). Congress enacted this regime primarily to address "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989).

In contrast, state laws regulating PBMs have at most "incidental" effects on plan administration. *See Gobeille*, 136 S.Ct. at 946 (citing *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806

(1997)). Such laws do not mandate employee benefit structures or their administration, *e.g.*, *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (workers' compensation law prohibiting termination of health benefits of workers receiving workers' compensation benefits is preempted), forbid a method of calculating pension benefits that federal law permits, *e.g.*, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-525 (1981) (preempted state law eliminating federally permitted integration of pension benefits with Social Security), or require employers to provide certain benefits, *e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (preempted state law requiring the provision of pregnancy benefits); *Metro. Life Ins. v. Mass.*, 471 U.S. 724 (1985) (preempted state law requiring plans to include minimum mental health benefits).

Nor do these laws bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself. *E.g., Boggs*, 520 U.S. at 841-42; *Egelhoff,* 532 U.S. at 147-48. The states' laws do not expressly refer to ERISA or ERISA plans. *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 828-830 (1988) (an explicit reference to ERISA in defining the scope of the state law's application is preempted); *Greater Washington Bd. of Trade*, 506 U.S. at 130-131 (same). And, these laws do not provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits—instead, laws like Arkansas's allow *pharmacies* to appeal to *PBMs*. *E.g., Aetna Health Inc. v. Davila*, 542 U.S. 200, 217-18 (2004); *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 54

(1987); *see also generally Travelers*, 514 U.S. at 668 (recognizing that laws having direct effects on plans are preempted). As the United States argues in urging the Court to grant certiorari, "The Arkansas law regulates only the relationship between PBMs and pharmacies. It does not regulate plans themselves or their relationships with PBMs, pharmacies, or plan participants. Like the New York law in *Travelers*, the Arkansas law "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 PBM for services." Br. for the U.S. as Amicus Curiae on Petition for Writ of Certiorari at 12-13.

ERISA polices the behavior of plan administrators and fiduciaries and ensures participants receive the benefits to which they are entitled. State laws governing PBMs work to influence the future behavior of health care market players. While Arkansas's law and others like it may incidentally affect the administration of ERISA plans in some ways, they are not the type of state laws that Congress intended ERISA to preempt.

II. Preserving States' Ability to Address Exorbitantly High Prescription Drug Costs is Vitally Important, Especially to the Growing Population of Older Adults.

It is indisputable that the prices of prescription drugs have been increasing for years. The cost is passed along to consumers with health coverage through increased health care premiums, deductibles,

and other forms of cost-sharing, as well as to state and federal budgets. Prescription drugs are the single largest health care expense for consumers with private commercial insurance.[6] Rising prescription drug costs also "account for more than 22 percent of every [commercial] premium dollar–outpacing physician, inpatient, and outpatient hospital services."[7]

Drug prices are greatly exceeding the growth of the incomes of many older adults with calamitous consequences. In 2017, the average annual retail price for 754 brand name, generic, and specialty prescription drugs used to treat chronic conditions was almost $20,000 per year. However, the average Social Security retirement benefit was only $16,848, and the median annual income of a Medicare beneficiary was just over $26,000.[8] According to AARP research data, in 2016, twenty-eight percent of Americans stopped taking a prescription drug as

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[6] Kristine Grow, *Prescription Drugs are Largest Single Expense for Consumer Premium Dollar* AM.'S HEALTH INS. PLANS (AHIP) (Mar. 2, 2017), https://www.ahip.org/prescription-drugs-are-largest-single-expense-of-consumer-premium-dollars/.

[7] *Id.*

[8] Stephen Schondelmeyer & Leigh Purvis, *Trends in Retail Prices of Prescription Drugs Widely Used by Older Americans, 2017 Year-End Update* 1-2, AARP PUBLIC POL'Y INST. (Sept. 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/09/trends-in-retail-prices-of-prescription-drugs-widely-used-by-older-americans.doi. 10.26419-2Fppi.00073.003.pdf.

prescribed due to cost.[9] When drug' prices rise so high that people can no longer afford to purchase necessary medication, it can irreparably harm their health and even put their lives at risk.

In order to protect their residents, as well as state budgets, "[b]oth Democrat and Republican leaders have shown a willingness to pursue strong measures that not only help consumers but also protect state taxpayer dollars."[10] Last year, at least 33 states enacted laws to address drug affordability and access.[11] An overview of state laws to rein in costs are multifaceted, and frequently include drug price transparency.[12]

Health economists and other experts are convinced that significant cost containment cannot occur without widespread and sustained transparency in health care prices.[13] As a result, states have sought

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[9] *Id.*

[10] Steven Findlay, KHN Kaiser Health News, *States Pass Record Number of Laws to Reel in Drug Prices* (Sept. 9, 2019), https://khn.org/news/states-pass-record-number-of-laws-to-reel-in-drug-prices/.

[11] *Id.*

[12] PEW, *States Use Various Approaches to Manage Drug spending* (Feb. 8, 2017), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/02/states-use-various-approaches-to-manage-drug-spending.

[13] *See, e.g.*, Robert Wood Johnson Found., *How Price Transparency Can Control the Cost of Healthcare* (Mar. 2016), https://rwjf.ws/2x0DFGZ.

to employ their traditional police and regulatory powers to improve the transparency and operation of prescription drug markets.[14] *See Automated Med. Labs., Inc.,* 471 U.S. at 715 (emphasizing presumption against preempting state use of traditional police power).

Amici take no position herein on whether Arkansas's law or ones like it are an effective strategy for addressing prescription drug costs. Instead, we simply urge the Court not to extend longstanding preemption doctrine in a way that forecloses the states from using their police power to rein in health care and prescription drug costs, even if those methods incidentally affect ERISA plans through their regulation of third parties. The Court of Appeals' ruling extends ERISA's preemption clause far past this breaking point, so it must be reversed.

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[14] *See, e.g.,* Nat'l L. Rev. *Growing Number of States Enact Drug Pricing Transparency Laws* (Jan. 23, 2020); Br. for Amici Curiae for the States of Cal., et al. Supporting Pet. for Cert., at 8-11; 18.

CONCLUSION

For all these reasons, amici respectfully submit that the Court should reverse the decision of the Eighth Circuit in this case.

Respectfully Submitted,

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