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Before the Committee on Insurance, Texas House of Representatives:

The U.S. Supreme Court's 2020 Decision in *Rutledge v. Pharmaceutical Care Management Association* and Its Impact on the Texas Insurance Market

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Chairman Oliverson, Vice-Chair Vo, and members of the committee thank you for providing me with an opportunity to testify before the House Committee on Insurance about the U.S. Supreme Court's 2020 decision in *Rutledge v. Pharmaceutical Care Management Association* and its impact on the Texas insurance market. As you know, *Rutledge* held that States can regulate pharmacy benefits managers (PBMs) even when they are serving plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA).

I am testifying today on behalf of the National Community Pharmacists Association (NCPA). Founded in 1898, NCPA serves as the national voice for independent pharmacy, representing 19,400 pharmacies, which, in turn, employ more than 215,000 individuals nationwide.

Thanks in part to this Committee's hard work, Texas is a leader in enacting commonsense laws that regulate pharmacy benefit managers (PBMs). But to date, Texas has applied these laws only when PBMs are serving plans subject to regulation by the Texas Department of Insurance—and the Department does not regulate self-funded ERISA plans. As I will explain, *Rutledge* clears a path for Texas to regulate PBMs even when they are serving ERISA plans—and that makes good sense from a policy perspective, because the PBM-function does not vary depending on which type of plan a PBM serves.

I will focus my testimony on three things: (1) the need for State regulation of PBMs, (2) the contours of the Supreme Court's decision in *Rutledge*, and (3) why Texas can extend its existing laws to PBMs when they are serving ERISA plans.

1. The Need for State Regulation of PBMs

PBMs are powerful intermediaries who sit between patients and health plans. PBMs enter into contracts with benefit plans and insurers to provide beneficiaries with access to prescription drugs. PBMs deliver this access by contracting separately with pharmacies to create networks where beneficiaries can fill their prescriptions.

PBMs should be in a position to realize efficiencies for the plans and insurers with whom PBMs contract, including ERISA plans. PBMs process claims on behalf of plans and insurers, and by aggregating the demand of all of the plans and insurers with whom PBMs contract, PBMs are able to extract price concessions from large pharmaceutical manufacturers. Notably, the three largest PBMs claim to provide PBM services for more than 268 million Americans—which amounts to over eighty percent of all Americans with healthcare benefits. The three largest PBMs also own or are owned by large health insurers, and these vertically integrated corporations own some of the largest retail, mail order, and specialty pharmacies in the country.

PBMs are under no obligation to act in the best interests of the plans and patients they purport to serve—and their business structure creates inherent conflicts of interest on many levels. For example, a PBM has a financial incentive to steer patients to pharmacies in which it has an ownership interest, a practice this committee has studied and addressed in previous legislation. A PBM's incentives also differ, depending on whether it is serving an employer- or government-sponsored plan (where that plan must pay the PBM's costs) or the PBM works for an affiliated insurer (where the PBM's affiliate bears the costs).

Similarly, a PBM's self-interest can deprive plans and insurers of the economic benefits that should come from a PBM's market power. Take, for example, a PBM's power to negotiate discounts with pharmaceutical manufacturers. That should result in lower costs for plans and insurers—but sometimes the opposite occurs. *See, e.g.*, Joanna Shepherd, *Pharmacy Benefit Managers, Rebates, and Conflicts of Interest in the Market for Prescription Drugs*, 38 Yale Law & Pol'y Rev. 360 (2020). PBMs have demanded hidden rebates from manufacturers in order to place drugs on the PBMs' lists of approved medications. *See id.* at 361-62. All things being equal, the plan would benefit from the lowest possible cost for the medicine in question. But PBMs benefit from the drug that scores them the most profit. To illustrate this conflict, a generic drug might have a list price of $10 and generate only $5 in profit for the PBM, whereas a branded drug might have a list price of $20 but would result in $10 in profits for the PBM because the manufacturer has agreed to pay the PBM a secret rebate. In this scenario, the PBM would profit more by preferring the branded drug—even though it costs patients more in copayment obligations. Relatedly, pharmaceutical manufacturers have claimed that they have been punished by PBMs for *lowering* drug costs, because it means there is less room for the manufacturer to provide a hidden rebate to the PBM. *See id.* at 362.

Separately, PBMs have had a negative effect on pharmacy. Because the three largest PBMs control over eighty percent of the market for beneficiaries with prescription-drug coverage, pharmacies have limited bargaining power when negotiating with PBMs. Refusing to accept a PBM's contract could mean that a

pharmacy cannot serve the majority of patients in a pharmacy's community. As a result, PBM-pharmacy contracts generally grant PBMs unilateral authority to dictate the amount of reimbursement paid to pharmacies for drugs, require pharmacies to fill and dispense prescriptions regardless of the amount the pharmacy is reimbursed, and impose a variety of other restrictions on the practice of pharmacy. PBMs have routinely used their position to steer patients to pharmacies that they themselves own, even if it means the plan sponsor ultimately pays a higher net cost. And PBMs have prevented pharmacists from dispensing certain prescription drugs, even when a pharmacist is licensed to do so, in order to steer patients to mail-order pharmacies owned by PBMs. This is especially prevalent when it comes to "specialty drugs," which is a term coined by the PBMs themselves and is another way to steer high-reimbursement drugs to pharmacies the PBMs themselves own.

Evidence suggests that PBM reimbursement practices have driven more than sixteen percent of independent rural pharmacies out of business. Abiodun Salako *et al.*, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis (July 2018). The States of Ohio, Oklahoma, Arkansas, and Florida have also found evidence that PBMs reimburse pharmacies that they own more than unaffiliated pharmacies, leaving plans and patients to pay the difference.

In response to these and other practices, nearly all States and the District of Columbia have enacted laws regulating PBMs. These laws tend to regulate how

PBMs interact with pharmacies, benefit plans and insurance companies, the State's Medicaid program, and the State's benefit plan for State employees.

2. The Supreme Court's Decision in *Rutledge v. PCMA*

For many years, there was substantial uncertainty about whether States could regulate third-party service providers, like PBMs, when they were serving plans subject to regulation by ERISA. A federal statute, ERISA regulates private employer- and union-sponsored welfare benefit plans, including prescription drug plans. In one early case, the U.S. Court of Appeals for the Fifth Circuit, which includes Texas, held that ERISA preempts State insurance laws because they might have a tangential effect on ERISA plans. *See Texas Pharm. Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997). As a result, many States, like Texas, decided to regulate PBMs only when they were serving non-ERISA plans.

The Supreme Court's recent decision in *Rutledge v. Pharmaceutical Care Management Association* rejected the logic that underpins those earlier decisions. In *Rutledge*, the Supreme Court considered a challenge to an Arkansas law that regulates PBMs. Act 900, as Arkansas's law is known, regulates the amounts PBMs reimburse pharmacies for generic drugs; requires PBMs to provide a reasonable administrative appeal procedure, and to update and disclose their reimbursement lists to pharmacies; and allows pharmacies to decline to dispense drugs to beneficiaries when a PBM intends to reimburse the pharmacy less than the pharmacy's cost to acquire the drug. Ark. Code Ann. § 17-92-507. The Pharmaceutical Care Management Association (PCMA), a trade association representing the eleven

largest PBMs, claimed that ERISA preempts Act 900. A unanimous Supreme Court disagreed.

According to the Supreme Court, ERISA preempts State laws that have a "connection with" or "reference to" ERISA plans. *Rutledge*, 141 S. Ct. at 479. A State law has a "connection with" ERISA plans when it "governs a central matter of plan administration or interferes with national uniform plan administration." *Id.* at 480. A State law has a "reference to" ERISA plans if and only if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Id.* at 479, 481.

The Supreme Court held that Act 900 did not have a forbidden "connection with" ERISA plans. *Id.* at 480-81. In so holding, the Court emphasized that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Id.* Rather, ERISA is "primarily concerned with preempting [State] laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status." *Id.* at 480. Thus, the Supreme Court has deemed preempted State laws that dictate eligibility or benefits contrary to the terms of an ERISA plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (eligibility); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983) (benefits); *accord Rutledge*, 141 S.Ct. at 480. Act 900 does none of these things. The Court explained that the main part of Arkansas's law was a form of "cost regulation," which does not force ERISA plans "to adopt any particular

scheme of substantive coverage." *Id.* at 480. Similarly, the Court held the law's "enforcement mechanisms"—the appeal, update, and decline-to-dispense provisions—simply regulate the relationship between PBMs and third-parties that sell access to the "medical benefit[s]" that plans ultimately provide to their beneficiaries. *Id.* at 482-83. The Court emphasized that State law has traditionally governed the relationship between plans and those third-parties who sell goods and services to the plan. *See id.*

The Court also held that Act 900 did not make a prohibited "reference to" ERISA plans. *Id.* at 481. "Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan." *Id.* And "ERISA plans are likewise not essential to Act 900's operation," because "Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage." *Id.*

To summarize, *Rutledge* clarifies that States may regulate PBMs even when they serve ERISA plans, and ERISA preemption is concerned primarily with State laws only when they "requir[e] payment of specific benefits" or "bind[] plan administrators to specific rules for determining beneficiary status.'" *Rutledge*, 141 S. Ct. at 480. Typical State laws regulating PBMs do neither of these things—even if they are extended to apply to PBMs when they are serving ERISA plans.

3. *Rutledge* Makes Clear that Texas May Extend Its Existing Laws to Apply to PBMs Even When They Are Serving ERISA Plans.

As I noted at the beginning of my testimony, Texas has been a leader in enacting commonsense laws that regulate PBMs. So far, however, Texas has not

extended these laws to apply to PBMs when they are serving ERISA plans. *See* Tex. Ins. Code § 1369.552. *Rutledge* makes clear that Texas has the authority to do so.

As I will explain below, following *Rutledge*, the U.S. Court of Appeals for the Eighth Circuit considered a North Dakota law that includes provisions similar to those enacted by the Texas legislature, but North Dakota's law also applies to PBMs serving ERISA plans. In *PCMA v. Wehbi*, the Eighth Circuit explicitly held that ERISA does not preempt North Dakota's law. 18 F.4th 956 (8th Cir. 2021). That decision should give Texas comfort that it can extend its existing laws to apply to PBMs serving ERISA plans.

As you know, Texas has enacted a number of laws to reform the PBM industry. Most notably, last session, the Legislature unanimously passed House Bill 1763, which Governor Abbott then signed into law. Among other things, House Bill 1763 amended the Insurance Code to—

- Prohibit PBM claw backs that reduce the amount paid to a pharmacy weeks or months after a prescription is filled, Tex. Ins. Code § 1369.553;
- Ensure patient choice by allowing local pharmacies to mail and deliver prescriptions if requested by the patient, Tex. Ins. Code § 1369.557;
- Prevent self-dealing by prohibiting PBMs from steering patients to PBM-owned specialty pharmacies by requiring accreditation or certifications above those required by State and federal law, Tex. Ins. Code § 1369.558;
- Prohibits PBMs from paying affiliated retail or mail-order pharmacies more than they pay other pharmacies in a network, Tex. Ins. Code § 1369.554; and
- Clarifies that pharmacists must have access to PBM contracts handled through a pharmacy services administrative organization (PSAO), Tex. Ins. Code § 1369.556.

As noted, these provisions apply only to PBMs serving plans subject to regulation by the Texas Department of Insurance, and that does not include ERISA plans. Tex. Ins. Code § 1369.552.

Under the logic of *Rutledge*, however, there is little doubt that Texas can extend these provisions to PBMs when they serve ERISA plans. As noted above, in *PCMA v. Wehbi*, the Eighth Circuit considered a North Dakota law that includes provisions similar to those enacted by Texas. Among other things, North Dakota's law—

- Limits the types of fees that PBMs can impose on pharmacies, N.D. Cent. Code § 19-02.1-16.1(2);
- Permits pharmacies to mail and deliver prescriptions if requested by their patients, N.D. Cent. Code § 19-02.1-16.1(8), (9);
- Prohibits PBMs from imposing accreditation or recertification standards more onerous than State and federal licensing standards, N.D. Cent. Code § 19-02.1-16.1(11); N.D. Cent. Code § 19-02.1-16.2(4);
- Prevents self-dealing by PBMs related to affiliated pharmacies, N.D. Cent. Code § 19-02.1-16.2(2), (3); and
- Allows a pharmacy that belongs to a PSAO to receive a copy of the contract the PSAO has entered with a PBM on the pharmacy's behalf, N.D. Cent. Code § 19-02.1-16.1(6).

Unlike Texas's law, however, North Dakota extended these provisions to apply to PBMs even when they are serving ERISA plans. *See* N.D. Cent. Code § 19-02.1-16.1(1) (cross-referencing N.D. Cent. Code § 19-03.6-01); N.D. Cent. Code § 19-02.1-16.2(1) (same). Yet after faithfully applying the Supreme Court's decision in *Rutledge*, the Eighth Circuit held that ERISA does not preempt North Dakota's laws. *Wehbi*, 18 F.4th at 968-69.

Although Texas does not sit within the Eighth Circuit, that court's decision should give the legislature comfort that it may extend its existing laws to apply to PBMs serving ERISA plans. Like North Dakota's laws, Texas's laws "do not 'requir[e] payment of specific benefits' or 'bind[] plan administrators to specific rules for determining beneficiary status.'" *Id.* at 968 (quoting *Rutledge*, 141 S. Ct. at 480).

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In the wake of *Rutledge*, there is growing consensus that States should exercise their authority to regulate PBMs—regardless of the type of plan that the PBM is serving. Even before the Supreme Court decided *Rutledge*, the federal government, forty-six States, including Texas and the District of Columbia filed briefs with the Supreme Court arguing that States have robust authority to regulate PBMs.

As a result, there has been a recent surge of State-level regulation of PBMs, and the push for such regulation has straddled the political divide. Red States and Blue States—from Arkansas to California, and everywhere in between—have enacted or are considering legislation to further regulate PBMs. Texas should do the same by extending its existing laws to regulate PBMs when they are serving ERISA plans.

I am happy to answer any of the Committee's questions.