In a win for patients and physicians, state lawmakers can continue to legislate certain aspects of how pharmacy benefits managers (PBMs) operate in their states, the U.S. Supreme Court recently ruled.

As the Litigation Center of the American Medical Association and State Medical Societies and Arkansas Medical Society explained in a brief to the high court, it’s important to let states govern these entities because PBMs increasingly play a pivotal role in prescription-drug pricing for drug benefits administration.

Without laws like the one that was challenged in Arkansas, PBMs could operate with minimal transparency when it comes to drug pricing and other decisions, the AMA Litigation Center brief told the Supreme Court in the case, Rutledge v. Pharmaceutical Care Management Association. That would make it tough for physicians to determine which treatments a particular payer preferred, what level of cost-sharing their patients would bear, and whether medications were subject to sometimes unreasonable utilization-management requirements.

“This lack of transparency in patients’ drug coverage can interfere with sound medical practice and may lead to delays in and other disruption to necessary medical treatment,” the brief says. “Thus, the ability of patients and their physicians to have the information and even the latitude they need to make key decisions regarding medication has been hampered by the sort of practices that state legislation of PBMs can properly address.”

The Supreme Court’s unanimous decision overturned an opinion from the 8th U.S. Circuit Court of Appeals that said the federal Employee Retirement Income Security Act of 1972 (ERISA) preempted the Arkansas law.

Find out more about the cases in which the AMA Litigation Center is providing assistance and learn about the Litigation Center’s case-selection criteria.
Law targets patient, doctor worries

The case arose after the Pharmaceutical Care Management Association (PCMA) challenged a 2015 Arkansas law that aimed to address concerns that PBMs were often setting rates too low to cover pharmacies’ costs. That, in turn, would put many pharmacies out of business. State lawmakers—like their counterparts in other states that have pursued legislative remedies—were especially concerned about what the practice would mean for rural and independent pharmacies and their patients.

For generic drugs, the Arkansas law requires PBMs to:

- Tether reimbursement rates to pharmacies’ acquisition costs by updating their maximum allowable cost (MAC) lists when drug wholesale prices increase.
- Provide administrative appeal procedures for pharmacies to challenge MAC reimbursement prices below the pharmacies’ acquisition costs. If the pharmacy couldn’t have acquired the drug at a lower price from its typical wholesaler, a PBM must increase its reimbursement rate to cover the cost.
- Let a pharmacy decline to sell a drug to a beneficiary if the relevant PBM will reimburse the pharmacy at less than its acquisition cost.

Court: ERISA doesn’t preempt law

The PCMA argued—and the 8th U.S. Circuit court of Appeals agreed—that the state law fell under a framework the U.S. Supreme Court established in an earlier case, Gobeille v. Liberty Mutual Insurance Co., to determine whether ERISA can preempt a law. That says a state law is not allowed under ERISA if it “acts immediately and exclusively upon ERISA plans” or if “the existence of ERISA plans is essential to the law’s operation.” State law also is not allowed if it governs “a central matter of plan administration” or “interferes with nationally uniform plan administration.”

The AMA Litigation Center brief argued and the U.S. Supreme Court agreed that the Arkansas law did not fit into that preemption.
“ERISA does not preempt a state law that merely increases costs, however, even if plans decide to limit benefits or charge plan members higher rates as a result,” the U.S. Supreme Court ruled. “In sum, [the law] amounts to cost regulation that does not bear an impermissible connection with or reference to ERISA.”

Reversing the lower court’s decision was a positive outcome for patients and physicians because allowing it to stand would have undermined Congress’ intent and swept “so broadly as to invalidate all manner of traditional state health care regulation that has some indirect effect on ERISA plans, no matter how remote,” the AMA Litigation Center brief told the court.