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State Law Mandating Reporting From ERISA Group Health Plans Found Not Preempted by ERISA

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An Illinois district court found that an Arkansas state law requiring Employee Retirement Income Security Act (ERISA) plans to report certain prescription drug compensation-related information regarding their pharmacy benefit managers (PBMs) was not preempted by ERISA. See *Central States, Southeast and Southwest Areas Health and Welfare Fund et al. v. McClain*. Arkansas Insurance Department Rule 128 (Rule 128) provides state-level regulation of PBMs and mandates that health benefit plans and health care payors disclose certain information regarding the compensation programs of PBMs (the reporting requirement). Information obtained from the reporting requirement is used to determine if the pharmacy compensation programs are "fair and reasonable." If a pharmacy compensation program is deemed unfair or unreasonable, the commissioner may require the health benefit plan to pay an additional pharmacy dispensing fee (the dispensing fee requirement). Rule 128 prohibits health benefit plans from requiring subscribers (participants in self-funded ERISA health plans) to pay dispensing costs beyond the designated copay, coinsurance, and deductible amounts. A health care payor is defined to include health insurers, health maintenance organizations, and any other entity that provides or administers a self-funded benefit plan.

Despite Rule 128's express reference to self-funded plans and imposition of a reporting requirement similar to one the Supreme Court found to be preempted by ERISA in *Gobeille*, the district court found that neither the reporting requirement nor the dispensing fee requirement were preempted by ERISA.

Court's Analysis on ERISA Preemption

Central States, Southeast and Southwest Areas Health and Welfare Fund is a self-funded multiemployer welfare benefit plan governed by ERISA. The plaintiff argued that Rule 128 is preempted by ERISA because the rule: (i) imposes requirements directly on ERISA plans rather than simply regulating PBMs; (ii) governs a central matter of plan administration; and (iii) dictates plan design by prohibiting ERISA plans from requiring their Arkansas participants pay a higher amount for their prescription drugs to offset the higher dispensing fees.

In considering the plaintiff's arguments, the court indicated that there are two categories of state laws that ERISA preempts — those that have a "reference to" ERISA plans and those that have an "impermissible connection with" ERISA plans. With respect to the argument that the reporting requirement refers to ERISA plans, the court found that the plaintiffs failed to state a claim because Rule 128 does not *exclusively* target ERISA plans. Instead, it applies to all health care payors, which includes health benefit plans, whether or not those plans fall within ERISA's coverage, and other payors.

The court also rejected the argument that both the reporting requirement and the dispensing fee requirement have an impermissible connection with ERISA. With respect to the reporting requirement, the court held that because the reporting requirement's purpose is incidental to Rule 128's stated purpose of ensuring fair reimbursement for pharmacist and pharmacy services, the reporting requirement was not preempted by ERISA because it does not impede ERISA plan administration.

With respect to the dispensing fee requirement, the court determined that state laws affecting costs or incentives, but not mandating substantive coverage schemes, are not preempted by ERISA. The court characterized Rule 128 as a cost regulation statute, not a mandate on plan design, and held that its provisions do not compel plans into a specific coverage scheme. Additionally, the court noted that while Rule 128 prevents health benefit plans from requiring subscribers to pay dispensing costs outside of copays, coinsurance, and deductibles, it does not prohibit plans from increasing these amounts to offset any increased dispensing fees they must pay.

Analysis and Best Practices Going Forward

The court's analysis of ERISA preemption of the reporting rule in particular seems to take Supreme Court precedent a step further than expected. For instance, the court cited *Gobeille* to support its finding that a state law must "exclusively" apply to ERISA plans in order to be preempted by ERISA. However, the state reporting requirement analyzed in *Gobeille*, which the Supreme Court found to be preempted, also applied to other payors and was not "exclusive" in the way this district court seemed to require for ERISA preemption. State laws are very rarely written to apply "exclusively" to ERISA plans, but they have still been found to relate to ERISA plans.

Similarly, the court analyzed whether the reporting requirement was "incidental to" the purpose of Rule 128, but the well-established standard is generally whether a state law is incidental to plan administration. Specifically, the standard states, "ERISA pre-empts a state law that has an impermissible "connection with" ERISA plans, meaning a state law that "governs . . . a central matter of *plan administration*" or "interferes with nationally uniform *plan administration*." *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 320, 136 S. Ct. 936, 943 (2016). As a result, the court's ruling lacks analysis regarding whether the reporting requirement interferes with nationally uniform plan administration or governs a central matter of administration.

We anticipate group health plans with participants in Arkansas will be tracking the costs incurred under the dispensing fee requirement and considering passing through the costs to the participants in Arkansas using a geographic differentiation in the plan for annual copays, coinsurance, and deductibles. Ultimately, we would expect the cost of health care coverage to increase due to the dispensing fee requirement.

If the court's holding in this case is upheld and adopted by other jurisdictions, ERISA self-funded group health plans could be subject to a patchwork of state reporting schemes that would make plan administration increasingly difficult and complex, which is the exact opposite of the purpose of ERISA — to enable plan sponsors to have a uniform set of rules to follow to administer their plans across the U.S. and keep costs of administration down (thereby encouraging employers to offer plans in the first place). As we have seen since the state law PBM cases started, states are increasingly trying to enact laws targeting ERISA plans by careful drafting of state laws to include references to "all" health plans and "all" payors and imposing additional costs on operation. Protectionist laws such as this one lose sight of the objective of PBMs — to work to negotiate the best reimbursement rates with a view toward driving down the costs of prescription drug coverage — and pose the risk of inserting the government

into the role of pricing health care, instead of allowing market forces to establish pricing.

Plan sponsors should continue to monitor developments in this case, including a potential appeal. In the meantime, plan sponsors who initially chose to forgo reporting under Rule 128 based on the reasonable assumption that the reporting component of the law would be held to be preempted by ERISA should consider whether to wait for an appeal (and with any luck, a Supreme Court decision of preemption) or to conservatively comply with the reporting requirement now unless and until there are future developments in this area.

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