19-CV-977-J

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,

Plaintiff,

V.

GLEN MULREADY, in his official capacity as Insurance Commissioner of Oklahoma, and

OKLAHOMA INSURANCE DEPARTMENT,

Defendants.

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Other Authorities

STATEMENT OF UNDISPUTED FACTS

1. For years, in laws that are not challenged here, Oklahoma has licensed pharmacy benefit managers under standards set by state law, and it has regulated the relationship between pharmacies and pharmacy benefit managers. *See* OKLA. STAT. tit. 59, §§ 357-360.

2. "Pharmacy benefit managers (PBMs) are a little-known but important part of the process by which many Americans get their prescription drugs." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 478 (2020). As described by this Court:

> In simple terms, health insurance plans providing drug benefits often use a pharmacy benefit manager (PBM) to act as an intermediary in ensuring beneficiaries can use their drug benefits to obtain prescriptions. PBMs create pharmacy networks and then contract with pharmacies in those networks to provide prescriptions to beneficiaries. When a pharmacy dispenses the prescription, it then files a claim with the PBM. The PBM processes that claim and notifies the pharmacy how much the plan will pay and how much the beneficiary must pay. Afterwards, the PBM reimburses the pharmacy according to the contract between the PBM and pharmacy. The contract between the PBM and the pharmacy determines the reimbursement rate, not the insurance plan. The PBM then bills the insurance plan according to its contract with the insurance plan, and the insurance plan pays the prescription benefit to the PBM.

Order, July 9, 2020, Doc. 48 at 1-2 (citations omitted); *see also Rutledge*, 141 S. Ct. at 478 (describing how "PBMs serve as intermediaries between prescription-drug plans and the pharmacies that beneficiaries use."); Ex. 1, Rep. of Debra L. Billingsley ¶ 16-18 (executive director of the Oklahoma Pharmacists Association); Ex. 2, Report of Ronald White, D.Ph. ¶ 15 (former pharmacist, health plan consultant, and PBM pharmacy auditor); Ex. 3, Report of Justin Wilson, Pharm.D. ¶ 13 (pharmacist and Oklahoma Pharmacy Board member).

3. While health insurance plans often choose to contract with PBMs, no law requires them to do so. Ex. 4, PCMA Resp. to Req. for Adm. (Nov. 12, 2020), Resp. No. 4.

4. PBMs are not fiduciaries to health insurance plans, and they have opposed efforts to make them fiduciaries. Ex. 5, PCMA Prod., PCMA0000153-154, 252-262; *see also* Ex. 1, Billingsley ¶ 27 (citing Br. of PCMA et al. as Amici Curiae 21, *Doe v. Express Scripts*, No. 18-346, 2018 WL 3185904, at *10-11 (2d Cir. June 20, 2018)); Ex. 6, Depo. of Kim Caldwell, at 31-32; Ex. 7, Depo. of Michael Zucarelli, at 54-57.

5. Rather, the contracts between PBMs and health insurance plans are the result of arms-length negotiations. Ex. 4, PCMA Adm., Resp. No. 3.

6. In other words, PBMs have their own profit motive, apart from health plans. Ex. 1, Billingsley ¶ 22-23, 26; Ex. 3, White ¶ 18, 25, 35-37; Ex. 7, Zucarelli Depo. at 54-57.

7. Health plans are aware of this profit motive and take it into account when contracting with PBMs. Ex. 7, Zucarelli Depo. at 54-57. Indeed, PCMA's expert witness, a consultant for health plans, testified that PBMs (among others) are "a business that's out to get your money … they're all looking to make a profit on the commercial health plan sponsor." *Id.* at 56-57.

8. Because PBMs "potentially could manipulate" things "if they know the clients and consultants aren't keeping in check," and because PBMs make mistakes, PBMs need oversight and accountability. Ex. 7, Zucarelli, Depo. at 81-83.

9. PBMs administer drug benefits for approximately 2,462,000 Oklahomans: approximately 1,742,700 who receive prescription drug coverage through an employer, 209,300 with non-group prescription drug coverage, and 510,000 who receive coverage through Medicare Part D. Ex. 8, PCMA Resp. to Interr. (Nov. 12, 2020), Resp. No. 18.

10. Three PBMs control approximately 80-85% of the multi-billion dollar market for pharmacy benefit management services. Ex. 1, Billingsley ¶¶ 19-20; Ex. 3, Wilson ¶ 20.

11. Independent pharmacies have little to no bargaining power in regard to contract negotiations with PBMs. Ex. 1, Billingsley ¶¶ 19-21; Ex. 2, White ¶¶ 17, 28; Ex. 3, Wilson ¶¶ 15, 31-32; Ex. 6, Caldwell Depo. at 79-82.

12. In addition to administering pharmacy benefits, many PBMs own or are affiliated with pharmacies—including retail, mail-order, and specialty pharmacies—that compete against the same independent and retail pharmacies that they contract with for benefit management services. Ex. 1, Billingsley ¶¶ 32-34, Ex. 2, White ¶¶ 18, 20, 24, 26; Ex. 3, Wilson ¶¶ 14, 20; Ex. 7, Zucarelli Depo. at 55-56.

13. Recently, the White House Council of Economic Advisors opined that PBMs "exercise undue market power against manufacturers and against health plans and beneficiaries they are supposed to be representing, thus generating outsized profits for themselves." Ex. 9, CEA, White Paper, Reforming Biopharmaceutical Pricing at Home and Aboard (Feb. 2018).

14. PBMs have often reimbursed pharmacies for drugs at rates lower than what the pharmacies paid for the drugs. Ex. 1, Billingsley ¶¶ 24-25; Ex. 3, Wilson ¶¶ 26-29; Ex. 7, Zucarelli Depo. at 160-162; *cf.* Ex. 2, White ¶ 28.

15. In several other states, PBMs have been found to have reimbursed the pharmacies they own at higher rates than other pharmacies they do not own. Ex. 1, Billingsley ¶ 34; Ex. 10, Ark. Ins. Dep't Exam., at 1.

16. PBMs have frequently incentivized and even mandated that patients use or switch to pharmacies owned by the PBMs or affiliated with the PBMs, including mail-order pharmacies. Ex. 1, Billingsley ¶¶ 32-33, Ex. 2, White ¶¶ 18, 20, 24, 26; Ex. 3, Wilson ¶¶ 20-25; *see also* Ex. 7, Zucarelli Depo. at 59-63 (describing "mandatory mail" as something that can be "abrasive"

to patients "for obvious reasons"); *id.* at 128, 151-56 (noting that there is a "high prevalence" of using PBM-owned pharmacies). In doing so, they have discouraged the use of in-person pharmacies that PBMs are not affiliated with. Ex. 7, Zucarelli Depo. at 137.

17. In certain instances, PBMs will offer "extremely important" and binding "guarantees" to health plans if the plans will agree to use the PBMs' own pharmacies. Ex. 7, Zucarelli Depo. at 163-64; *see also* Doc. 1, ¶ 23 (discussing PBM "guarantees" more generally).

18. Some patients, of course, "want to shop at a pharmacy that they've been shopping at for a long time" rather than be forced or encouraged to switch pharmacies. Ex. 6, Caldwell Depo. at 48; Ex. 3, Wilson ¶ 22; Ex. 7, Zucarelli Depo. at 28-29.

19. At least one prominent PBM distributes ID cards to patients with the PBM's name (and only its name) on the front, a practice that has confused patients into thinking that they must use that particular PBM's pharmacies. Ex. 3, Wilson ¶ 25; Ex. 7, Zucarelli Depo. at 128-29.

20. PBMs have also been charging pharmacies various retroactive fees. Ex. 1, Billingsley ¶¶ 30-31, 51-54; Ex. 3, Wilson ¶ 30.

21. Similarly, some PBMs have retroactively reduced reimbursements post-processing in connection with pharmacy quality and performance incentives or pharmacy submission errors. Ex. 8, PCMA Interr., Resp. No. 24.

22. PBMs often exclude pharmacies from increasingly important preferred networks without explanation, which has led to patients complaining about being forced to avoid their local pharmacy. Ex. 1, Billingsley ¶ 50; Ex. 2, White ¶¶ 20, 24, 32; Ex. 3, Wilson ¶ 19; *see also* Ex. 7, Zucarelli Depo. at 108-11.

23. Independent community pharmacies have been squeezed financially in recent years, with their profit margins dropping to the point that they have to find "creative" ways and new business models just to stay viable. Ex. 1, Billingsley ¶¶ 51-52, 59-60; Ex. 3, Wilson ¶ 26; Ex. 7, Zucarelli Depo. at 49-53, 178-79.

24. Independent pharmacists in Oklahoma attribute much of this "squeeze" to PBMs and the various PBM practices listed above. Ex. 1, Billingsley ¶¶ 51-52, 59-60; Ex. 3, Wilson ¶ 26. The lack of transparency from PBMs, in particular, "fuels" much of the pharmacists' concerns. Ex. 7, Zucarelli Depo. at 73-74; Ex. 3, Wilson ¶ 35, 41; *see also* Ex. 5, PCMA Prod. PCMA0000207 (PCMA opposing "the wrong kind of transparency").

25. Others, such as one of PCMA's experts, believe that "we have too many brick-and-mortar [pharmacy] locations trying to cut into a piece of the pie." Ex. 6, Caldwell Depo. at 46.

26. Whatever the case, drug prices are not falling under the current PBM-dominated system. *See, e.g.*, Ex. 2, White ¶ 32; Ex. 5, PCMA Prod. PCMA0000154, 312 (attributing the "rising drug prices" to drug manufactures).

27. In response to these PBM practices, nearly every state has enacted laws regulating PBMs. *See* Ex. 1, Billingsley ¶ 35; Ex. 7, Zucarelli Depo. at 41-43, 65-70. This includes Oklahoma. *See* Undisputed Fact No. 1.

28. The state laws regulating PBMs are not uniform. Ex. 6, Caldwell Depo. at 31; Ex. 7, Zucarelli Depo. at 65; Brief for Calif., *Rutledge*, 2020 WL 1372774 at *14-21 (cataloguing the variety of State approaches).

29. In 2019, the Oklahoma Legislature unanimously passed the Patient's Right to Pharmacy Choice Act. *See* Ex. 11, House & Senate Votes, HB 2632.

30. As described by the Court (Doc. 48 at 2-3), the Act, among other things, provides that:

- PBM networks must be designed so that a set percentage of network beneficiaries live within a set geographical distance from a pharmacy in the network. OKLA. STAT. tit. 36, § 6961(A).

- PBMs cannot bar a pharmacy from being a preferred participant in a pharmacy network if the pharmacy is willing to accept the terms and conditions the PBM has established for other pharmacies. *Id.* § 6962(B)(4).

- PBMs cannot "[d]eny, limit, or terminate a pharmacy's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy." *Id.* § 6962(B)(5).

- PBMs cannot require beneficiaries to use pharmacies directly or indirectly owned by the PBM. *Id.* § 6961(C).

- If a PBM lists one pharmacy on promotional materials it must list all pharmacies participating in its networks. *Id.* § 6961(D).

- PBMs cannot give incentives or discounts to beneficiaries for purchasing at specific pharmacies. *Id.* § 6963(E).

- PBMs cannot charge pharmacy service fees for adjudicating a claim. *Id.* § 6962(B)(2).

- PBMs cannot reimburse a pharmacy in an amount less than the PBM reimburses pharmacies it owns or with which it is affiliated. *Id.* § 6962(B)(3).

- PBMs cannot retroactively deny or reduce a reimbursement after determining a claim is covered, except for fraud or error. *Id.* § 6962(B)(6).

- PBMs must pay reimbursements for services even if PBMs terminates the pharmacy from the network. *Id.* § 6962(B)(7).

- Health insurers are required to monitor PBMs. *Id.* § 6963(A)-(B).

31. When the Act was being deliberated, Rep. Regina Goodwin (D-Tulsa) stated: "[M]y pharmacist there in Tulsa, Oklahoma has really been ringing the phone saying he needs this, he's independent . . . it's this kind of legislation that helps the little guy . . . ." *See* Audio/Video,

Okla. House 1st Reg. Sess., 57th Legis., Day 22, March 11, at 3:57:20 PM, *available at* https://www.okhouse.gov/Video/Default.aspx.

CASE HISTORY

Plaintiff Pharmaceutical Care Management Association (PCMA), a trade association of PBMs, brought suit in October 2019, claiming that the Pharmacy Choice Act is preempted by the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq.* (ERISA) and Medicare Part D, and that certain regulations violated the Oklahoma Administrative Procedures Act (OAPA). *See* Doc. 1. Defendants temporarily stayed enforcement of the law and regulations, due to PCMA and Defendants' mutual belief that "the U.S. Supreme Court's [then-forthcoming] decision in *Rutledge* will substantially inform core issues in Count 1 (ERISA Preemption) of [this] dispute." Doc. 25 at 2. Specifically, Defendants and PCMA agreed that *Rutledge v. PCMA* was "likely to clarify the legal standards under which this present case should be evaluated." *Id.* at 3.

Due to the COVID-19 pandemic, however, the Supreme Court delayed hearing the *Rutledge* case, and Defendants then moved to lift the stay and notified PCMA and this Court of its intent to enforce the Act. Doc. 27. In response, PCMA sought a preliminary injunction against the challenged provisions, arguing—as they do in their complaint—that these provisions are preempted under ERISA and Medicare Part D, and that certain regulations are in violation of the OAPA. Doc. 31.

This Court denied the preliminary injunction for all the provisions challenged under ERISA, and for all but two provisions challenged under Medicare Part D, holding that PCMA was unlikely to succeed on the merits of those claims. Doc. 48 at 13. This Court also held that

PCMA was unlikely to succeed on its challenge against two out of the three challenged regulations. Doc. 48 at 13-15. PCMA then filed an interlocutory appeal with the Tenth Circuit, Doc. 50, and sought an emergency injunction of the Act pending appeal. Emergency Motion, *PCMA v. Mulready*, No. 20-6107 (10th Cir. July 17, 2020). After reviewing the parties' submissions, the Tenth Circuit declined to issue such an injunction because PCMA had "not made a sufficient showing to warrant imposition of an injunction pending appeal," Order, *PCMA v. Mulready,* No. 20-6107, at 2 (10th Cir. Aug. 17, 2020), and PCMA thereafter voluntarily dismissed its interlocutory appeal. Doc. 60. The Act then took effect, with the exception of the enjoined provisions, and Defendants have been working ever since to enforce it and respond to complaints about PBMs. *See, e.g.*, Ex. 2, White ¶¶ 29-32.

Several months later, the Supreme Court finally decided *Rutledge,* where PCMA had challenged an Arkansas law regulating "the price at which [PBMs] reimburse pharmacies for the cost of drugs." 141 S. Ct. at 478. In addition, the Arkansas law included certain enforcement mechanisms that require PBMs to provide a reasonable administrative appeal procedure and to update and disclose their reimbursement lists to pharmacies; it also 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. *See* Ark. Code Ann. § 17-92-507. In a unanimous decision, the Supreme Court reversed the Eighth Circuit and held that the law was not preempted because it had "neither an impermissible connection with nor reference to ERISA." 141 S. Ct. at 478.

With the guidance provided by the unanimous *Rutledge* decision, confirming the correctness of this Court's earlier ruling, Defendants now move for summary judgment.

ARGUMENT

Summary judgment should be entered for Defendants pursuant to Rule 56 because "there is no genuine issue of material fact" and Defendants are "entitled to judgment as a matter of law." *Bones v. Honeywell Int'l, Inc.*, 366 F.3d 869, 875 (10th Cir. 2004).

I. PCMA does not have standing to challenge the provisions of the Pharmacy Choice Act that regulate health insurers but not PBMs.

At the outset, a federal court must assure itself of standing. That inquiry is claim-specific. Thus, though PCMA may have standing to assert some claims, this does not necessarily give rise to standing for the rest. *See Lewis v. Casey*, 518 U.S. 343, 358 n.6 (1996); *Rosen v. Tn. Comm'r of Fin. & Admin.*, 288 F.3d 918, 928 (6th Cir. 2002) ("[S]tanding is a claim-by-claim issue."). Here, PCMA does not have standing on all of its claims.

The complaint refers in passing to the Act's "Health Insurer Monitoring Requirement." Doc. 1 at 16. Separately, it also purports to challenge other provisions of the Act that regulate only health insurers. *Id.* PCMA does not have standing to challenge these provisions, which impose obligations exclusively upon a "health insurer." Under Oklahoma law, a PBM is an entity distinct from a health insurer that provides "pharmacy benefits management" for health insurers and other entities. OKLA. STAT. tit. 36, § 6960(1), (3). PCMA is made up exclusively of PBMs. As a result, PCMA lacks standing to vindicate the rights of health insurers.[1]

[1] Even if PCMA were to have standing to vindicate the rights of health insurers, their claims would fail for the reasons discussed below.

II. Except for one provision, federal law does not preempt the provisions of the Pharmacy Choice Act at issue.

As to the merits, PCMA has taken a scattershot approach to this litigation, challenging nearly a dozen provisions of the Pharmacy Choice Act under theories of preemption related to ERISA and Medicare Part D. Their haphazard approach has landed on a single provision of the Pharmacy Choice Act that actually acts with respect to a Part D standard and is thus preempted by Medicare Part D, but—as this Court concluded even without the benefit of *Rutledge*—none are preempted by ERISA.

A. Defendants are entitled to judgment as a matter of law on PCMA's ERISA preemption claims.

ERISA preempts only state laws that regulate with respect to the core functions of ERISA. Because the challenged provisions of the Pharmacy Choice Act do not concern central matters of plan administration as contemplated by ERISA, ERISA does not preempt them. Defendants are therefore entitled to judgment as a matter of law on PCMA's ERISA preemption claims.

1. ERISA preempts only state laws that regulate the core functions of ERISA.

ERISA is a federal law designed to prevent private employee benefit plans and their fiduciaries from misusing plan assets. By its text, ERISA's provisions "shall supersede any and all State laws insofar as they may … relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). The "relate to" language of this preemption clause, though facially broad, does not modify "the starting presumption that Congress does not intend to supplant state law." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995); *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997).

"[A] state law relates to an ERISA plan if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quotations omitted). While "connection with" and "reference to" are separate grounds for preemption, at issue here is only whether Oklahoma's laws have an "impermissible connection" with an ERISA plan.

A state law has an impermissible "connection with" an ERISA plan if it "governs a central matter of plan administration or interferes with nationally uniform plan administration." *Rutledge*, 141 S. Ct. at 480 (citations omitted). Ways in which state laws can govern central matters of plan administration include mandating that a plan provide certain benefits, *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983), dictating to a plan who is eligible for coverage, *Egelhoff*, 532 U.S. at 14748, "eliminat[ing] [a] method for calculating pension benefits" expressly contemplated under federal law, *Alessi v. Raybestos-Manhattan*, 451 U.S. 504, 524 (1981), or "prohibit[ing] plans from being structured in a manner requiring reimbursement in the event of recovery from a third party," *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990). A law can interfere with nationally uniform plan administration when it exposes plans to potentially divergent obligations related to "a principal and essential feature of ERISA." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 325 (2016).

But "[c]rucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Rutledge*, 141 S. Ct. at 480. "ERISA [is not] concerned with any state action … that … potentially affect[s] the choices made by ERISA plans" such as "medical-care quality standards" or "hospital workplace regulations." *Calif. Div. of Lab. Standards Enf't v. Dillingham Const.*, 519 U.S. 316, 329 (1997). ERISA regulates certain employer-sponsored pension and

welfare benefit plans, but it "does not guarantee substantive benefits." *Gobeille*, 577 U.S. at 320. "The statute, instead, seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Id.* at 320-21. The Supreme Court uses ERISA's object and policy as a guide:

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

Dillingham, 519 U.S. at 326-27 (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)).

In recent decades, the Supreme Court has declined to stretch ERISA's preemptive effect beyond its existing domain to state laws "quite remote from the areas with which ERISA is expressly concerned—'reporting, disclosure, fiduciary responsibility, and the like.'" *Id.* at 330 (citations and quotations omitted). To the Court, "[a] reading of [state law] resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling.'" *Id.* at 330-32 (quoting *Travelers*, 514 U.S. at 665).

Within this framework, in *Rutledge*, the Supreme Court held that "ERISA does not preempt state rate regulations"—an area where ERISA has nothing to say. *Rutledge*, 141 S. Ct. at 480. On the other hand, in *Gobeille*, the Supreme Court held preempted a Vermont law that required health plans to disclose and "report detailed information about claims and plan members" to the State—an area with which ERISA is expressly concerned. *Gobeille*, 577 U.S. at 323. That distinction is key. Even before *Rutledge*, this Court recognized that "the *Gobeille* Court premised its decision on the fact that the state law related to specific action that ERISA regulated." Doc. 48 at 8. This Court's recognition was confirmed by Justice Thomas in his

concurrence in *Rutledge*, who pointed out that "since *Travelers* every state law this Court has held pre-empted involved a matter explicitly addressed by ERISA provisions." *Rutledge*, 141 S. Ct. at 485 (Thomas, J., concurring).

Even though the disclosure in *Gobeille* was achieved through a third-party administrator, the state law at issue in that case in fact regulated ERISA health plans themselves with respect to "a central aspect of plan administration." It was thus held preempted. But state laws that regulate only the relationship between two of the plan's external providers can have no more than an "indirect economic influence" on plan choices and therefore cannot be said to be "a regulation of an ERISA plan itself." *Travelers*, 514 U.S. at 659. These state laws are "alter[ing] the incentives, but … not dictat[ing] the choices, facing ERISA plans." *Dillingham*, 519 U.S. at 334.

Thus, although insurers provide services to ERISA plans, the Supreme Court has confirmed that "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans." *Travelers*, 514 U.S. at 663 (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741 (1985)). Similarly, in *Rutledge*, the Supreme Court approved of Arkansas's decline-to-dispense provision—even though, as applied to ERISA plans, that provision authorized pharmacies to decline to provide an ERISA benefit to ERISA-covered beneficiaries—because that provision regulated the relationship between two service providers: PBMs and pharmacies. 141 S. Ct. at 482. It, therefore, did "not require plans to provide any particular benefit to any particular beneficiary in any particular way." *Id.*

If that were not the case, ERISA would preempt the state regulation of doctors, lawyers, accountants, and pharmacists in so far as they provide services to ERISA plans. And

ERISA's preemptive reach would include such substantive areas that the Supreme Court has already held not preempted, such as "medical-care quality standards," "hospital workplace" conditions, and "hospital rates." *Dillingham*, 519 U.S. at 328-29. Indeed, if it "were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course." 514 U.S. at 655. That is a result "no sensible person could have intended." *Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring).

2. The provisions of the Pharmacy Choice Act at issue do not regulate core functions of ERISA.

ERISA does not preempt the Pharmacy Choice Act. The Act regulates the rates at which PBMs reimburse pharmacies and the relationship between PBMs and pharmacies—including network access standards and the marketing of services that PBMs provide. The chief concern here is protecting patient choice from the anti-competitive practices of the PBMs that not only control pharmacy access to patient consumers, but also compete with those same pharmacies. *See* Undisputed Facts Nos. 10-24, 29-31.

ERISA was never intended to thwart States' attempts to regulate PBMs in this way. Because the provisions of the Act regulate only the relationship between PBMs and pharmacies—and not ERISA plan administration—they do not have an impermissible connection with ERISA plans. PBMs are neither health plans nor health plan fiduciaries. *See* Undisputed Facts Nos. 2-8. They are service providers to health plans. Service providers, and PBMs in particular, are not subject to meaningful regulation under ERISA. In other words, ERISA has nothing to say about the activities of PBMs that the State is regulating—including many the anti-steering provisions designed to deal with PBM self-dealing. The State licenses PBMs and is entitled to regulate their interactions with pharmacies, and ERISA says nothing

to interfere with that State prerogative. Whatever the Act's downstream effects on health plans may be, they are not enough to establish an impermissible connection. To hold otherwise would be to declare that PBMs are unable to be regulated at all, given that virtually everything they do indirectly affects health plans in some way.

Contrary to PCMA's contention, *Gobeille* is of little relevance here. In *Gobeille*, a plan sued to enjoin a Vermont law that compelled both plans and third-party administrators acting on behalf of plans to "report detailed information about claims and plan members" to further a State-run healthcare database. 577 U.S. at 323. The Supreme Court deemed this law preempted because it exposed *plans* to potentially divergent obligations related to reporting and disclosure, "a principal and essential feature of ERISA." *Id.* at 325. Unlike the Vermont law in *Gobeille*, the Pharmacy Choice Act does not impose concrete mandates regarding "principal and essential feature[s] of ERISA." *Id.* Rather, it regulates the rates that PBMs reimburse pharmacies for dispensing drugs and the quality of the networks that PBMs must maintain. And unlike in *Gobeille*, no plan is suing to enforce the terms of ERISA. Rather, PCMA is suing on behalf of PBMs, third-party service providers, in order to protect their business model—a model that profits at the expense of plans. *See* Undisputed Facts Nos. 6-8. None of the provisions PCMA challenges here interferes with plan administration or any other area regulated by ERISA.

(1) Network access standards

PCMA's challenge to the Pharmacy Choice Act's network access and quality standards must fail. These standards aim to (1) improve patient access to retail pharmacies including preferred pharmacies, (2) prohibit PBMs from discriminating against pharmacies willing to

accept the terms and conditions for preferred pharmacy status or employ a pharmacist on probation status with the State Board of Pharmacy, and (3) curtail the practice of steering patients away from their preferred pharmacies and to a pharmacy affiliated with the PBM. *See* OKLA. STAT. tit. 36, §§ 6961(A)-(C), 6962(B)(4)-(5), 6963(E). PCMA claims that these standards regulate central matters of plan administration and threaten uniformity. They do not.

The Act's network access and quality standards do not regulate core matters of ERISA plan administration. These standards regulate the quality of the pharmacy networks that PBMs sell to ERISA and non-ERISA plans alike. For example, the Act requires PBMs to meet retail pharmacy geographic standards. OKLA. STAT. tit. 36, § 6961(A). ERISA has "nothing to say" about such standards. *Dillingham*, 519 U.S. at 330. In *De Buono*, the Supreme Court held that ERISA does not preempt state laws regulating hospitals—including an ERISA-ran hospital—because such activity is not regulated by ERISA. *See* 520 U.S. at 815-16. ERISA does not preempt state "medical-care quality standards" and "hospital workplace regulations"—even though those state laws might affect the goods and services that ERISA plans purchase or provide for their beneficiaries. *See, e.g., Dillingham*, 519 U.S. at 329. Likewise, in *Rutledge*, the Supreme Court held that ERISA does not preempt a state law that empowered pharmacies to decline to provide ERISA-covered benefits to beneficiaries. If ERISA does not preempt a state law that outright empowers pharmacies to decline to provide drugs or that sets "medical-care quality standards," then it certainly doesn't preempt state pharmacy-network quality standards.

Many of the Act's provisions are designed to protect against PBM self-dealing. OKLA. STAT. tit. 36, § 6961(C). *See also* Undisputed Facts No. 12, 16-17, 19. Again, ERISA has nothing to say about this and does not wholly preclude states from regulating third parties that sell their services to ERISA plans. No doubt the "downstream effect[s]" may come into play as a health plan weighs its "shopping options," but these indirect economic effects cannot be the basis for preemption. *See* Doc. 48 at 7. Thus, in *Travelers*, the Supreme Court confirmed that "laws that regulate only the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans." *Travelers*, 514 U.S. at 663 (quoting *Metro. Life*, 471 U.S. at 741). The same must be true for PBMs.

Indeed, as it relates to plan choices, Oklahoma's standards are less restrictive than the enforcement mechanisms at issue in *Rutledge*. *Cf. Rutledge*, 141 S. Ct. at 481 ("Indeed, 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."). Take the any-willing-provider provision for instance. It simply prohibits PBMs from discriminating against pharmacies willing to meet the terms and conditions needed to join a preferred pharmacy network. *See* OKLA. STAT. tit. 36, § 6962(B)(4). It does not place mandates on health insurers, nor does it regulate the terms and conditions that PBMs set for a provider—PBMs can place the bar wherever they want, however high they want. This is "a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Travelers,* 514 U.S. at 662.

Nor do the network access provisions threaten the national uniformity of plan administration contemplated by ERISA. On this score, this Court has already held that PCMA has simply "conflate[d] PBMs with ERISA plans" and "it is the PBM's own operations,

independent of the ERISA plans, that are subject to differing laws and regulations." Doc. 48 at 7. And, as in *Travelers*, "if the state law interferes with national uniformity but ERISA does not address the matter, [the Supreme Court] ha[s] held that the matter in question does not require uniformity." *Rutledge*, 141 S.Ct. at 485, n. 2 (Thomas, J., concurring) (quoting *Travelers*, 514 U.S. at 662). Consistent with this, this Court previously rejected PCMA's argument, noting that the case they relied upon—the *Gobeille* case—regulated the "core functions" of an ERISA plan. Doc. 48 at 7. Such regulation of core ERISA functions is not the case here. Thus, the Act's network access standards are not preempted by ERISA.

(2) Claims-processing provisions

PCMA's challenge to the Act's claims-processing provisions must also fail. "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." *Rutledge*, 141 S. Ct. at 480. *Rutledge* confirmed that in *Travelers* the Supreme Court held "ERISA was not meant to pre-empt basic rate regulation." 514 U.S. at 667 n.6. As this Court and the Supreme Court recognized, rate regulations do "not bind plan administrators to any particular choice." *Id.* at 659; Doc. 48 at 8. And they do not "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one." *Travelers*, 514 U.S. at 660. Instead, they "simply bear[] on the costs of benefits and the relative costs of competing insurance to provide them." *Id.*

The claims-processing provisions at issue here are basic rate regulations. They do not dictate choices on ERISA health plans. Far from it, like the surcharge in *Travelers* and the reimbursements in *Rutledge*, the rate regulations here are not "so acute that it will effectively

dictate plan choices." *Rutledge*, 141 S. Ct. at 481. They merely regulate the amounts that PBMs pay pharmacies for dispensing prescription drugs, the reimbursements that PBMs provide to pharmacies, and the fees that they charge. *See* OKLA. STAT. tit. 36, § 6962(B)(2)-(3), (6)-(7); *cf. Rutledge*, 141 S. Ct. at 482 ("Requiring PBMs to reimburse pharmacies at or above their acquisition costs does not require plans to provide any particular benefit to any particular beneficiary in any particular way."). ERISA has nothing to say about these regulations, and thus the matters covered by these regulations are not core plan concerns.

As to uniformity, while the Act might affect cost, "cost uniformity was almost certainly not an object of pre-emption." *Travelers*, 514 U.S. at 662. Thus, even if there are increased cost and in fact "PBMs … pass … increased costs on to plans," that is not enough to trigger preemption. *Rutledge*, 141 S. Ct. at 481. In the end, any discussion of "operational inefficiencies"—which are speculative at best—and the indirect effects on health plans are largely irrelevant to the purely legal question of ERISA preemption. *Rutledge*, 141 S. Ct. at 483. The Supreme Court has made clear that "[a]ny state ... law[] that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted." *De Buono*, 520 U.S. at 816.

(3) Promotional Materials

Finally, PCMA's challenge to the promotional materials rule must fail. *See* OKLA. STAT. tit. 36, § 6961. This Court has correctly held that the disclosures required by ERISA and the promotional materials regulated by the Act are different. Doc. 48 at 8-9. "That is, the Act regulates how PBMs can advertise and entice members to use certain providers, while ERISA's

disclosure requirements deal with information ERISA plans must disclose to members." *Id.* The Court went on to say, "recognizing this distinction, the provision addressing promotional materials neither relates to a central matter of plan administration, nor does it undermine the uniform regulation of ERISA plans." *Id.* at 9. As with other provisions, "[t]hat makes sense because ERISA has nothing to say about those activities." *Rutledge*, 141 S.Ct. at 485, n. 2 (Thomas, J. concurring); *see also Dillingham*, 519 U.S. at 327 (holding a law regulating "a hazard with which ERISA is unconcerned" is not preempted).

B. Except for one provision, Defendants are entitled to judgment as a matter of law on PCMA's Medicare Part D preemption claims.

Defendants are also entitled to judgment as a matter of law on PCMA's Medicare Part D preemption claims. Medicare Part D preempts only state laws that overlap with a Part D standard. Because the challenged provisions of the Pharmacy Choice Act do not overlap with a Part D standard (except for one provision), Medicare Part D does not preempt them.

1. Medicare Part D preempts only state laws that regulate with respect to a standard established under Part D.

Medicare Part D is a public-private partnership through which private companies sponsor Medicare-funded prescription drug benefits, subject to Part D regulations. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066. Part D borrows its preemption clause from Part C. *See* 42 U.S.C. §§ 1395w-26(b)(3), 1395w-112(g). Thus, the preemption clause governing Part D provides: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Part D plans] which are offered by [Part D sponsors] under this part." 42 U.S.C. § 1395w-26(b)(3) (Part C

preemption); *id.* § 1395w-112(g) (Part D incorporating by reference Part C preemption). So, simply put, PCMA must show that the provisions of the Act that it challenges regulate "with respect to" a "standard[] established under" Part D that "supersede[s]" state law.

While "[t]he Tenth Circuit has not addressed the scope of Medicare Part D," Doc. 48 at 9, "[t]he term "supersede" … suggests a replacement or substitution instead of a blanket pre-emption." *Rutledge*, 141 S. Ct. at 483-84 n. 2 (Thomas, J., concurring); *see also District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 135-36 (1992) (Stevens, J., dissenting) (noting the word "supersede" is "often overlooked"). Thus, every court to address Medicare Part D preemption has required an overlapping federal standard. *See Rutledge*, 891 F.3d at 1113 (Part D preempts State laws "when (1) Congress or the Centers for Medicare and Medicaid Services (CMS) has established 'standards' in the area regulated by the state law; and (2) the state law acts 'with respect to' those standards."); *Do Sung Uhm v. Humana*, 620 F.3d 1134, 1148 n. 20, 1157-58 (9th Cir. 2010) (preempting consumer protection claim involving marketing materials because CMS had on-point standards). In fact, CMS—the federal agency charged with administering Part D—has consistently required overlapping federal standards for preemption, stating that "although the Congress included broad preemption rules . . . we d[o] not believe that the Congress intended for each and every State requirement applying to [Part D plans] to become null and void." CMS, *Medicare Program; Medicare Prescription Drug Benefit*, 70 Fed. Reg. 4,194, 4,319 (Jan. 28, 2005); *see also* Doc. 48 at 11 ("Because there is no overlap between Part D and Act's regulations … , Plaintiff is not likely to succeed on this claim.").

2. Except for one provision, the provisions of the Pharmacy Choice Act at issue do not regulate with respect to standards established under Part D.

(1) Promotional Materials

Against this legal backdrop, this Court was correct that 42 C.F.R. § 423.2262 overlaps with OKLA. STAT. tit. 36, § 6961(D)—the law and standards relating to pharmacy promotional materials. The Medicare Part D standard regulating marketing communication expressly applies to both Part D sponsors and downstream entities, like PBMs, 42 C.F.R. § 423.2260, and it also regulates the same pharmacy marketing materials, 42 C.F.R. § 423.2263(b)(6). Notably, the provision of the Act and the Part D standard can potentially diverge. And thus there is overlap. Defendants, therefore, concede that the promotional materials provision of the Act as applied to PBMs providing services to Part D sponsors are preempted by Medicare Part D. At the same time, this goes to show that Medicare Part D clearly delineates between Part D sponsors and PBMs, and when the law wants sponsors and PBMs to be treated the same, it expressly says so.

(2) Geographic restrictions on standard networks

For the same reason, Defendants were wrong to concede at the preliminary injunction phase the preemption of the "[s]tandards for convenient access to network pharmacies." 42 C.F.R. § 423.120. While both the federal standard and the Act have provisions that set access standards, the federal standard applies only to Part D sponsors while the Act applies only to PBMs. This distinction is key. To be licensed by the State, PBMs must meet certain criteria, one of those being that the PBM can ensure certain standards for convenient access to network pharmacies. The Act's convenient access standards apply only to a PBM's network pharmacies

for the purposes of state licensing. The Medicare Part D standard does not overlap with state licensing standards for PBMs. Rather, Medicare Part D mandates access standards for "a Part D sponsor (as defined in § 423.4 of this part)." 42 C.F.R. § 423.120(a)(1).

As it is, the Part D sponsor can contract with a PBM in Oklahoma for pharmacy management services that under its license already meets the federal access standard. Thus, there is no overlap—that is, overlap need be with respect not only to *what* is being regulated but also *who* is being regulated. Moreover, the Act will never subject the Part D sponsor to conflicting standards. If the State were to set less stringent standards, the PBM would have to exceed those to contract with a Part D sponsor anyway. On the other hand, if the State were to set more stringent standards, that wouldn't conflict either because the federal standards merely set a floor as they are couched in terms of "at least." 42 C.F.R. § 423.120(a)(1)(i-iii). While Defendants now ask this Court to hold this provision not preempted by Medicare Part D, we acknowledge that the exercise is largely academic in that any PBM that enters a contract with a Part D sponsor must meet the same standards either way.

* * *

This Court has previously held that PCMA's remaining preemption claims based on Medicare Part D are unlikely to succeed on the merits. As set forth below, there is no reason to change course now. There is no overlap between any Part D standard and the following state-law provisions that PCMA challenges:

(3) Network Structures

As to the use of preferred networks, 42 C.F.R. § 423.120(a)(9) does not overlap with OKLA. STAT. tit. 36, §§ 6961, 6962(B)(4)-(5), or 6963(E). The federal standard permits a Part

D plan to "reduce copayments or coinsurance for covered Part D drugs obtained through a preferred pharmacy." The Act does not address when a Part D plan may reduce copayments or coinsurance for preferred pharmacies. And no part of the Act prohibits the use of preferred networks. Ex. 12, Defs' Prod. OK-003809-3811. It instead addresses access to and composition of PBM pharmacy networks and prevents PBMs from forcing (or steering) beneficiaries to use PBM-affiliated pharmacies.

(4) Preferred Network Admission

As to preferred network admissions, 42 C.F.R. § 423.120(a)(8) does not overlap with OKLA. STAT. tit. 36, § 6962(B)(4). To begin with, as this Court noted, "[t]he Part D regulations … do not reach PBMs's requirements for pharmacies to join their networks, rather those regulations only deal with Part D plans' requirements." Doc. 48 at 11. "PBMs do not fall under any of th[e] categories" enumerated in the definition of Part D sponsors. Doc. 48 at 10-11 (citing 42 C.F.R. § 423.4). Furthermore, the Oklahoma provision prohibits a PBM from denying a pharmacy preferred status if that pharmacy meets the PBM's requirements for that status. The federal standard only prohibits a Part D sponsor from denying a pharmacy entry into its network if that pharmacy meets Part D standards. Part D standards for standard networks are distinct from PBM standards for preferred networks both in terms of types of standards and types of networks.

(5) Negotiated Drug Prices

As to negotiated drug prices, 42 U.S.C. § 1395w-102(d) does not overlap with OKLA. STAT. tit. 36, § 6962(B)(3) or (B)(6). The Part D standard ensures consumers have access to negotiated prices for drugs by imposing requirements on a Part D plan sponsor or Medicare

Advantage organization. Oklahoma's laws do not block access to negotiated prices. As part of the Act's many anti-steering provisions, they (1) prohibit a PBM from reimbursing pharmacies that it owns more than other pharmacies and (2) address when a PBM can retroactively deny or reduce reimbursement during claim adjudication. The state law certainly doesn't replace negotiated prices. And this standard of Medicare Part D was not meant to preempt every state law that might affect price.

(6) Service Fees

As to service fees for claim adjudication, 42 U.S.C. § 1395w-111(i) does not overlap with OKLA. STAT. tit. 36, 6962(B) (2). Oklahoma law prohibits PBMs from charging fees to pharmacies for the submission of a claim, enrollment in a pharmacy network, or development of a claims processing service. In contrast, the federal standard addresses the Secretary of Health and Human Services' responsibility to preserve competition, including the Secretary's abstention from negotiations between drug manufacturers, pharmacies, and Part D plan sponsors. None of these items concern fees charged for claim adjudication.

(7) Compliance Monitoring

As to compliance monitoring, 42 C.F.R. § 423.505(i)(5) does not overlap with OKLA. STAT. tit. 36, § 6963 (A)-(B) and Okla. Admin. Code § 365:25-29-9(c)(1). The federal standard governs contracts entered between Part D sponsors and CMS requiring the sponsors to "retain[] the right to approve, suspend, or terminate" a delegation of "selection of its prescription drug providers to another organization." In contrast, the Act sets forth a health insurer's responsibility to ensure compliance with the Pharmacy Choice Act. To that end, the Insurance Department rule requires an insurer to approve contracts between a PBM and any

retail pharmacy network providers beforehand. In sum, the federal standard addresses contracts between a Part D plan sponsor and a third party, whereas the Oklahoma law addresses contracts between a PBM (not a Part D sponsor) and a completely different third party—that is, a pharmacy. Again, "the Part D regulation and the Act deal with completely different matters." Doc. 48 at 12.

(8) Compliance Monitoring

As to PCMA's claims that Part D's requirement that Part D sponsors assert their network providers are in compliance with state pharmacy laws preempts the Act's requirements that PBMs not terminate contracts with pharmacies that employ pharmacists on probation and that PBMs pay claims to terminated pharmacies, 42 C.F.R. § 423.153(c), does not overlap with any of the provisions that PCMA challenges. Oklahoma law does not address any topic covered by 42 C.F.R. § 423.153(c). Nor does any provision of state law interfere with Part D sponsors' duty to assert compliance with state law on the part of their network providers. Indeed, how could a federal requirement to assert compliance with state pharmacy law possibly mean a specific state pharmacy law is invalid? Like this Court, Defendants cannot "conceive of how those provisions overlap." Doc. 48 at 12.

III. Defendants are entitled to judgment as a matter of law on PCMA's state law claims.

The Court does not have supplemental jurisdiction over PCMA's claims that are grounded in the Oklahoma Administrative Procedures Act ("OAPA"). OKLA. STAT. tit. 75, § 306(A). These claims are state law claims that are not "so related to claims [of ERISA and Medicare Part D preemption] that they form part of the same case or controversy under Article III of the United States Constitution." 28 U.S.C. § 1367(a). Even if it is held that these claims

form part of the same case or controversy, the Court should decline to exercise supplemental jurisdiction under 28 U.S.C. § 1367(c)(4) because there is an independently compelling reason for declining jurisdiction. In any event, PCMA's OAPA claims are meritless and Defendants are entitled to judgment as a matter of law.

A. The Court does not have supplemental jurisdiction over PCMA's state administrative claims.

For starters, the legal question presented by the state OAPA claims, although loosely related to the subject matter of the federal preemption claim, would not involve the same analysis as the one required to resolve the ERISA and Medicare Part D claims. The ERISA and Medicare Part D claims involves issues of preemption under federal law, not appropriate administrative rulemaking under Oklahoma law. Thus, these claims present an independent state law claim with independent legal determinations. Supplemental jurisdiction is thus improper here.

B. Even if supplemental jurisdiction were proper, the Court should decline to exercise it.

Even if supplemental jurisdiction were proper, the Court should decline to exercise it because there is a compelling reason for doing so. *United Mine Workers of Am. v. Gibbs*, 383 U.S. 715, 726 (1966) ("It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right."). Oklahoma has strongly set forth in statute a policy that rules "are presumed to be valid until declared otherwise by a district court of this state or the Supreme Court." OKLA. STAT. tit. 75, § 306(C). Moreover, under the process set forth in state law, "[t]he validity or applicability of a rule may be determined in an action for declaratory judgment in the district court of the county of the residence of the person seeking relief or, at

the option of such person, in the county wherein the rule is sought to be applied." OKLA. STAT. tit. 75, § 306(A); *cf. Misischia v. Pirie*, 60 F.3d 626, 631 (9th Cir. 1995) ("A litigant cannot use supplemental jurisdiction to have a federal judge instead of a state judge perform the judicial review of a state administrative agency decision which the state statute assigns to a state court.").

Here, adjudicating the OAPA claims would intrude on the State's role of interpreting its own laws without any counterbalancing benefit that typically would weigh in favor of exercising supplemental jurisdiction. *See Quackenbush v. Allstate Ins. Co.,* 517 U.S. 706, 716 (1996) (doctrine of abstention calls for federal courts to respect independence of state governments, especially when exercising equitable powers); *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 172-73 (1997) (in deciding whether to exercise supplemental jurisdiction, court should consider and weigh values of judicial economy, convenience, fairness, and comity).

C. If this Court exercises supplemental jurisdiction, Defendants are entitled to a judgment as a matter of law on PCMA's state law claims.

If this Court exercises supplemental jurisdiction, PCMA's OAPA claims must fail. PCMA asserts that three administrative rules—the so called Promotional Materials Rule, the Contract Approval Rule, and the Specialty Drugs Rule—violate the Oklahoma Administrative Procedure Act. PCMA claims that they are inconsistent with or exceed statutory authority. That is incorrect.

In Oklahoma, "[s]tatutory construction by agencies charged with the law's enforcement is given persuasive effect especially when made shortly after the statute's enactment." *Cox v. State*, 87 P. 3d 607, 616 (Okla. 2004). Rules "are presumed to be valid until declared otherwise

by a district court of this state or the Supreme Court." OKLA. STAT. tit. 75, § 306(C). Moreover, an "agency has, by implication and in addition to the powers expressly given by … statute, such powers as are necessary for the due and efficient exercise of the powers expressly granted, or such as may be fairly implied …." *Okla. Pub. Employees Ass'n v. Okla. Dep't of Cent. Servs.*, 55 P.3d 1072, 1084 (Okla. 2002).

PCMA first claims that the Promotional Materials Rule is inconsistent with the statute. The statute says "[PBMs] shall not in any manner on any material … include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers *participating in the preferred and nonpreferred pharmacy and health networks*." OKLA. STAT. tit. 36, § 6961(D) (emphasis added). PCMA says this rule is inconsistent because it does not contain this italicized language. Defendants disagree and continue to read the law and the rule as the same—that is, the rule refers only to network participants, even if it doesn't explicitly say so. Under this rule, PBMs do not need to list every healthcare provider in existence.

Defendants recognize that the Court rejected this earlier, noting that "a strict reading of the regulation could lead to an absurd result, [but] this is not a situation where two reasonable readings of the regulation exist." Doc. 48 at 14. In some situations, however, a court may deviate from a literal reading that would lead to an absurd result even if the language is unambiguous. *Dalton v. I.R.S.*, 77 F.3d 1297, 1299 (10th Cir. 1996) ("If unambiguous statutory language is not defined, we give the language its common meaning, provided that the result is not absurd … ."). We respectfully request that the Court do so here.

Next, the Contract Approval Rule sets forth an efficient means to make sure that insurers "monitor" and "ensur[e]" the compliance of each contract covered under this section

meets the requirements of the Act—which PCMA acknowledges they must do. *See* OKLA. STAT. tit. 36, § 6963; Okla. Admin. Code § 365:25-29-9(c)(1); Doc. 31 at 18. Under the Act, an insurer must "monitor" each contract and "ensur[e]" that it is in compliance. Thus, if an insurer finds a contract not in compliance, it must have some recourse. Rather than allowing noncompliant contracts to be entered into, the regulation requires approval beforehand without having to go back and undo a noncompliant contract and thus provides for the efficient administration of the Act.

Finally, PCMA asserts that the Specialty Drugs Rule is inconsistent with the Act. The rule says "[t]he act draws no distinction between regular or specialty drugs." Okla. Admin. Code § 365:25-29-7.1(a)(2). PCMA asserts that a single mention of specialty drugs in OKLA. STAT. tit. 36, § 6961(C) "draw[s] [a] distinction" creating an inconsistency. Doc 31 at 18. But PCMA offers no further explanation on this point. A closer look shows that, far from drawing a distinction, the provision makes explicit *the lack thereof* in the Act's prohibition on PBMs forcing patients to use pharmacies owned by the PBM. OKLA. STAT. tit. 36, § 6961(C). There is no APA violation here.

CONCLUSION

Summary judgment should be entered for Defendants on the claims set forth above.

Respectfully submitted,

s/ *Randall Yates*

RANDALL J. YATES
ZACH WEST
Assistant Solicitors General

OFFICE OF ATTORNEY GENERAL
STATE OF OKLAHOMA
313 N.E. 21st Street
Oklahoma City, OK 73105
Direct: (405) 522 – 4448
Randall.Yates@oag.ok.gov
Zach.West@oag.ok.gov

Counsel for Defendants