No. 18-540

IN THE

Supreme Court of the United States

LESLIE RUTLEDGE,
in her official capacity as
Attorney General 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 NATIONAL COUNCIL OF INSURANCE LEGISLATORS AS *AMICUS CURIAE* SUPPORTING PETITIONER

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INTERESTS OF *AMICUS CURIAE*[*]

The *amicus curiae* National Council of Insurance Legislators ("NCOIL") is a legislative organization with the nation's 50 States as members. NCOIL is represented principally by State legislators serving on committees that regulate insurance and financial institutions. NCOIL works to preserve State jurisdiction over insurance as established by the McCarran-Ferguson Act 75 years ago, and it serves as an educational forum for public policymakers and interested parties.

NCOIL asserts the prerogative of legislators in making State insurance policy. As a part of that work, NCOIL educates State legislators on current and longstanding insurance issues. NCOIL also promulgates model laws on, among other things, State healthcare and insurance, including model laws regulating pharmacy-benefit managers. As a legislative organization focused on State powers in the area of healthcare insurance, NCOIL is well suited to speak to ERISA preemption's negative impact on State innovation and the legal and policy reasons why the scope of ERISA preemption should not be expanded further.

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[*] Counsel for each party has consented in writing to the filing of this brief. No counsel for a party in this case authored this brief in whole or in part. No counsel for a party nor any party in this case made a monetary contribution intended to fund the preparation or submission of this brief. The only person or entity—other than *amicus*, its members, or its counsel—that made such a monetary contribution was the Independent Pharmacy Cooperative, which made its contribution through the Insurance Legislators Foundation, NCOIL's educational and research arm.

SUMMARY OF ARGUMENT

States are the laboratories of democracy. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). Perhaps nowhere is that more true—and necessary—than in the evolving and challenging space of healthcare-insurance regulation.

Today, however, the preemption provision of the Employee Retirement Income Security Act of 1974 threatens State innovation in a way that Congress never intended. Congress passed ERISA to protect employer-provided retirement and health plans. It included a preemption provision, 29 U.S.C. § 1144(a), to ensure that ERISA's framework governed over State laws. Yet that provision's "unhelpful" and blanket language has led courts to extend it too far, thwarting State laws that do not directly regulate ERISA plans, stem their administration or enforcement, or invade the areas of ERISA's fundamental concerns. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

This case is about one such decision. The United States Court of Appeals for the Eighth Circuit held below that Arkansas's Act 900, Ark. Code § 17-92-507, which regulates pharmacy-benefit managers, was preempted under ERISA. In so doing, the Eighth Circuit paid only passing lip service to this Court's command that when States operate "in fields of traditional state regulation" there is an "assumption" that such laws are not preempted absent a "clear and manifest purpose of Congress" to the contrary. *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). This Court should reiterate that command and reverse.

Claims of ERISA preemption usually challenge two related areas of State power: (1) the healthcare of residents and (2) the business of insurance.[1] That States are the primary regulators of these areas is long-recognized in tradition and statute. The McCarran-Ferguson Act of 1945, for example, explicitly reserved for the States control over the business of insurance. 15 U.S.C. §§ 1011, 1012(a), (b). ERISA itself repeated that reservation by adding the so-called "saving clause," which exempts from preemption State laws relating to insurance. 29 U.S.C. § 1144(b)(2)(A). And the Patient Protection and Affordable Care Act of 2010 expanded the States' role in regulating healthcare and insurance. Indeed, after 2010, the lines between healthcare regulation *per se* and insurance regulation *per se* have become so intertwined that, for States to make an legislative impact, they must account for both plan coverage and insurance costs in passing reforms. Viewed as a whole, the upshot is Congress's intent to protect, not preempt, the vast majority of State laws regulating healthcare insurance.

A sweeping view of ERISA preemption, like the Eighth Circuit's, does not respect the States' role. That is particularly troubling given the healthcare challenges facing Americans. Premiums, unexpected bills, and rising pharmaceutical costs present major stumbling blocks to many households. In the face of

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[1] The facts of this case do not directly deal with State insurance regulation. But State control over that matter is both impacted by and frequently the subject of this Court's ERISA-preemption decisions. *See, e.g.*, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985).

those challenges, States should be encouraged to enact reforms—not discouraged by the looming threat of overbroad ERISA preemption.

As it stands, ERISA preemption has already hampered much of the States' ability to innovate. This owes in large part to the growth of employer self-funded plans, which fall outside of ERISA's saving clause and are thus subject to preemption. When ERISA was passed, self-funded plans accounted for a sliver of the market. But today, 61 percent of all covered workers have self-funded plans. Though Congress did not envision a dwindling role for States in exercising their traditional powers over healthcare and insurance, ERISA preemption has caused just that. This Court should not compound the problem by extending the scope of ERISA preemption further.

Congress can, when it specifically determines that such action is in the national interest, make policy decisions and pass laws that apply nationwide standards for healthcare and insurance regulation. But ERISA is not that law. Interpreting ERISA's preemption provision broadly discourages, if not forecloses, State innovation at a time when it is most needed.

ARGUMENT

I. The States Have—and Require—Broad Authority to Regulate Healthcare Insurance.

In deciding claims of ERISA preemption, this Court starts from the "presumption that Congress does not intend to supplant state law." *Travelers Ins.*, 514 U.S. at 654. "Indeed," this Court has explained, when federal law enters "fields of traditional state

regulation," courts work "on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Claims of ERISA preemption often implicate two core—and increasingly overlapping—areas of "traditional state regulation": local healthcare and the business of insurance. Nothing in ERISA's text or history signals a "clear and manifest purpose" to disrupt the States' general control over those areas. *See id.* at 661. As a result, the presumption against preemption applies. The Eighth Circuit's contrary decision, which adopts a far-reaching concept of ERISA preemption that disregards State authority, should be reversed.

A. States Regulate Healthcare and Insurance, and ERISA Did Not Displace That Authority.

The "regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cty. v. Automated Med. Labs. Inc.*, 471 U.S. 707, 719 (1985). This tradition dates back to the founding. *See Gibbons v. Ogden*, 22 U.S. 1, 79 (1824) (referencing "the acknowledged power of a State[ ] to provide for the health of its citizens"). And since then this Court has repeatedly recognized "the historic primacy of state regulation of matters of health and safety." *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996); *see also, e.g.*, *Dillingham*, 519 U.S. at 330–32; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 & n.10 (1997). As such, "federalism

concerns" dictate respect for local healthcare regulation unless Congress clearly meant to displace it. *Medtronic*, 518 U.S. at 485; *see also Travelers Ins.*, 514 U.S. at 654–55.

The same is true for State control of local insurance. This Court recognized that control as early as *Paul v. Virginia*, 75 U.S. 168, 183 (1868). And after *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), casted doubt on that conclusion, Congress passed the McCarran-Ferguson Act of 1945. *See, e.g.*, *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 499–500 (1993). McCarran-Ferguson declares that "continued regulation and taxation by the several States of the business of insurance is in the public interest." 15 U.S.C. § 1011. It reserves for the States control over the "business of insurance, and every person engaged therein." *Id.* § 1012(a). McCarran-Ferguson's purpose, therefore, is abundantly clear: "limit congressional preemption" of State insurance laws. *Am. Ins. Ass'n v. Garamendi*, 539 U.S. 396, 428 (2003).

With the States' general authority over healthcare and insurance established, ERISA entered the picture in 1974. ERISA did not purport to overhaul healthcare or insurance regulations. As the name suggests—the Employee *Retirement Income Security* Act—the law sets minimum standards for most voluntarily established retirement and health plans. *See generally The Employee Retirement Income Security Act of 1974: The First Decade*, An Information Paper Prepared for Use by the Special Committee On Aging, S. Prt. 98-221, 1–32 (2d Sess. 1984). To that end, ERISA specifically protects:

> participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b); *accord Conkright v. Frommert*, 559 U.S. 506, 516 (2010) ("Congress enacted ERISA to ensure that employees would receive the benefits they had earned.").

These are the "fundamental area[s] of ERISA regulation." *See Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016); *see also Travelers Ins.*, 514 U.S. at 651 ("reporting and disclosure mandates …, participation and vesting requirements…, funding standards…, and fiduciary responsibilities for plan administrators" are ERISA's methods for carrying out its employee protections). When State laws "intrude[ ]" upon those areas, they risk preemption. *Gobeille*, 136 S. Ct. at 945–46. Also preempted are State laws that directly regulate ERISA plans, dictate terms or beneficiaries, or alter ERISA's remedy and enforcement schemes. *Accord Egelhoff v. Egelhoff*, 532 U.S. 141, 147–48 (2001); *De Buono*, 520 U.S. at 814–15; *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98–100 (1983). And that scope of ERISA preemption is sensible, as far as it goes. ERISA entails "a uniform administrative scheme," and State laws that interfere with that scheme, or otherwise invade ERISA's fundamental

areas of concern, can be fairly deemed preempted. *Egelhoff*, 532 U.S. at 148.

Not among ERISA's "fundamental areas" is a concern for standard-setting on providers, insurers, third-party suppliers and coordinators, or the products plans consume. *Accord Metro. Life Ins.*, 471 U.S. at 732 (ERISA "contains almost no federal regulation of the terms of benefit plans"). For that reason, this Court has recognized that State laws targeted "only [at] the health care industry" carry the "starting presumption" against ERISA preemption. *De Buono*, 520 U.S. at 813–14 & n.10. As to insurance more specifically, ERISA itself exempts from preemption "any law of any State which regulates insurance." 29 U.S.C. §§ 1144(b)(2)(A). That provision, known as the "saving clause," generally protects, like McCarran-Ferguson, State authority over insurance regulation. In fact, this Court has suggested that the saving clause is, in some ways, broader than McCarran-Ferguson. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337 ("ERISA's saving clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they 'regulate.'") (emphases in original); *see also id.* at 340–41.

The saving clause is limited by the provision that follows, the so-called "deemer clause." The deemer clause states that "employee benefit plan[s]"—that is, self-insured or self-funded plans—are not companies engaged in insurance for purposes of the saving

clause.[2] 29 U.S.C. § 1144(b)(2)(B); *see also FMC Corp.*, 498 U.S at 61; *Metro. Life Ins.*, 471 U.S. at 735 n.14, 747. Critically, however, Congress could not have intended the deemer clause to subvert the saving clause and its general protection for State insurance regulations. In the 1970s, when Congress enacted ERISA, only about seven percent of employees had coverage through self-funded plans. Jon R. Gabel, *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny*, 18 Health Affairs 62, 70 (1999).[3] It follows that, to the extent ERISA's enactors "thought about the effect [of ERISA] on health plans, they probably would have believed that the insurance savings clause in ERISA's preemption provisions would have been sufficient to address any future problems" between State regulation and ERISA's preemptive sweep. Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J. L. Med. & Ethics 660, 661 (2008).

B. The Affordable Care Act Merges Healthcare and Insurance Regulation for the States.

Congress did not intend to reform healthcare or insurance with ERISA. But it did with the Affordable Care Act.[4] Enacted in 2010, the Act sets nationwide

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[2] A self-funded plan, unlike an "insured plan" or a "fully insured plan," is a plan that pays the benefits rather than an insurance carrier.

[3] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.6.62.

[4] As is true with McCarran-Ferguson and the saving clause, this case does not squarely concern the Affordable Care Act. The Act's effect on healthcare insurance, however, is notable in assessing the impact of a broad view of ERISA preemption.

healthcare standards for, among other things, insurance affordability and plan coverage.[5] 42 U.S.C. §§ 300gg-1–300gg-63. Yet the law, by large measure, relies on the States to implement its framework. *See* Alan Weil & Raymond Scheppach, *New Roles for States in Health Reform Implementation*, 29 Health Affairs 1178, 1178–79 (2010).[6] States, for example, must oversee insurance markets and run insurance exchanges. 42 U.S.C. § 18031. They must also set up and conduct risk-adjustment review programs. *Id.* § 18063. Still more, as was true before 2010, States are the primary regulators of most forms of healthcare coverage—like HMOs, PPOs, and, after the Act, affordable-care organizations (or ACOs)—plus providers, hospitals, medical suppliers, coordinators, and insurers.

Going a step further, the Affordable Care Act affirmatively guarantees "state flexibility." *Id.* §§ 18041–18054. It does so by disavowing express preemption, *id.* § 18041(d), and including a "waiver for state innovation" so long as minimum standards are met, *id.* § 18052. Such waivers, which appear in Congress's other major healthcare regimes, like Medicaid (but not ERISA), protect federalism. They endorse State authority over healthcare and insurance and allow States to craft their own regulations consistent with national policy. *See, e.g.*, Elizabeth Y.

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[5] The Affordable Care Act carves out ERISA self-funded plans from certain standards. 29 U.S.C. § 1185d(b); 42 U.S.C. § 300gg-16(a).

[6] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0448.

McCuskey, *Agency Imprimatur & Healthcare Reform Preemption*, 78 Ohio St. L. J. 1099, 1153–57 (2017).

The Affordable Care Act thus recognizes, as McCarran-Ferguson and the saving clause recognize, the key role for States in regulating healthcare and insurance. But the Act also alters fundamentally *how* States regulate. Congress's overhaul brought about a flood of standards, programs, and rules aimed "to increase the number of Americans covered by health *insurance* and decrease the cost of health *care*." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (emphases added). Congress, in other words, viewed plan coverage and insurance costs as intertwined, believing that new requirements for expanded and better coverage would, with State oversight, lower insurance costs.

Several provisions reflect this union of coverage and costs. The Affordable Care Act, for example, contemplates State involvement in the application of medical-loss ratios. 42 U.S.C. § 300gg-18(b)(2). Such regulations mandate that insurers spend a certain percentage of premiums on care or improving care; otherwise those insurers must issue rebates. *Id.* §§ 300gg-18(a)–(b). Medical-loss ratio laws, therefore, govern the relationship among insurers, providers, and policyholders, by controlling the amounts owed *from* insurers *to* policyholders when certain amounts have not been paid *to* providers. The Affordable Care Act also contemplates the use of tools like shared-savings programs and gainsharing. *Id.* §§ 1395jjj, 1395cc-3. These regulations likewise frame arrangements among certain insurers, providers, and policyholders. So, too, do numerous reform programs promoted by

the Affordable Care Act for States to control, such as those relating to the curbing of waste, abuse, and fraud in the healthcare system. *See, e.g.*, *id.* §§ 1320a-7, 18041, 18083.

In short, the current regime not only assumes States' rights over healthcare and insurance—it marries the two, for as long as the Affordable Care Act remains the law.

C. The Eighth Circuit's Decision Below Disregards This Critical Context.

On balance, two facts are clear: (1) States maintain control over healthcare and insurance regulation, limited only by clear congressional intent; and (2) States, in exercising that control, operate under a regime that has increasingly blurred the lines among regulations of plans, providers, and insurers.

The Eighth Circuit's decision below is not in keeping with the first fact. The decision treated this Court's "presumption" against preemption as an afterthought. *See* Pet. App. 5a–7a; *Travelers Ins.*, 514 U.S. at 654–55. And it ignored the settled principle that ERISA does not preempt "traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330.

The Eighth Circuit's decision does not account for the second fact either. Its interpretation of ERISA preemption, sweeping as it is, makes it even more difficult for States to regulate. If ERISA preempts, as the Eighth Circuit thought, State laws that "implicitly refer[ ]" to ERISA plans and laws that are well beyond ERISA's fundamental areas of concern (as rate regulation is, *see Travelers Ins.*, 514 U.S. at 667 & n.6),

then States are further hamstrung in regulating the overlapping relationships among plans, providers, and insurers. *See* Pet. App. 5a–7a.

This Court should therefore reject the Eighth Circuit's interpretation of ERISA preemption and reinforce the presumption against preemption when it comes to the States' exercise of traditional authority.

II. An Expansive View of ERISA Preemption Frustrates State Authority.

The need for clarity on the limits of ERISA preemption is especially necessary today. The evolving structure of healthcare and insurance markets expands the threat ERISA preemption poses to State solutions. And it does so at a time when those solutions are required, given rising healthcare costs and inadequate care.

A. The Nation's Healthcare and Insurance Challenges Are Well Known.

Consider first the healthcare challenges facing Americans, which are unfortunately well known. "The cost of health care affects every aspect of the U.S. health systems." *Data Note: Americans' Challenges with Health Care Costs*, Kaiser Family Foundation, June 11, 2019.[7] A few statistics suffice to demonstrate the problem:

- Fifty-eight percent of people who spend more than $100 per month on prescriptions have difficulty affording their medication.

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[7] https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/.

- About half of adults admit that they or a family member put off visiting a provider or skipped treatment due to costs.
- The problem is even worse for households with serious medical conditions. Sixty-four percent of those households admit to putting off care, and in 23 percent of cases, conditions were worse as a result.
- Twenty-nine percent of adults admit to having not taken their medications as prescribed due to costs.
- More than one in four adults say they or a family member had difficulty paying medical bills in the past year, and half of that group reported that their bills have a "major impact" on their family.

Id. These challenges extend even to those with employer-sponsored coverage. About half of Americans with employer-sponsored coverage report that they or a family member skipped or postponed receiving care or obtaining prescriptions in the past year due to costs. *Id.* And almost 24 million Americans with employer-sponsored coverage spend a large share of their income on premiums or out-of-pocket costs. *How Much U.S. Households with Employer Insurance Spend on Premiums and Out-of-Pocket Costs: A State-By-State Look*, The Commonwealth Fund, May 23, 2019 (considering a "large share" of income to be 5 percent for those with low income and 10 percent otherwise).[8]

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[8] https://www.commonwealthfund.org/publications/issue-briefs/

There is serious room for improvement. Compared to many other countries, "the United States ranks last or near the bottom on measures related to health indicators, such as access, efficiency, and equity." *State Health Systems Innovations*, National Conference of State Legislatures, May 23, 2019.[9]

B. A Broad View of ERISA Preemption Threatens States Working to Address These Challenges.

As noted, this Court's decisions have generally held that ERISA preemption is appropriate if State law "intrudes" upon a fundamental area of ERISA concern, *Gobeille*, 136 S. Ct. at 945–46, or otherwise requires benefits, *Shaw*, 463 U.S. at 97–98, dictates beneficiaries, *Egelhoff*, 532 U.S. at 148–49, or alters ERISA's contemplated remedies and means of enforcement, *see Aetna Health Inc. v. Davila*, 542 U.S. 200, 221 (2004). This Court should not expand ERISA preemption any further. A broader interpretation would further undercut States' ability to enact reform and address the nation's pressing healthcare challenges.

The Eighth Circuit's decision below is an example of a broad interpretation of ERISA preemption frustrating State advancement in healthcare reform. *See* Pet. App. 5a–7a. Another is the rejection of "play or pay" laws, which require (or strongly encourage) by various means employers to offer or contribute to

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2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket.

[9] https://www.ncsl.org/research/health/state-health-systems-innovations.aspx.

healthcare coverage. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 190–97 (4th Cir. 2007) (holding a Maryland law preempted); *Retail Indus. Leaders Ass'n v. Suffolk Cty.*, 497 F. Supp. 2d 403, 416–18 (E.D.N.Y. 2007) (holding a similar county ordinance preempted); *but see Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 546 F.3d 639, 651–661 (9th Cir. 2008) (holding a similar county ordinance not preempted); *see also* Mary Ann Chirba-Martin, *ERISA Preemption of State "Play or Pay" Mandates: How PPACA Clouds an Already Confusing Picture*, 13 J. Health Care L. & Pol'y 393 (2010).

But more important than the particular laws that have already been struck down, a broad view of ERISA preemption hampers State innovation in a fundamental way: it creates a growing disincentive for States to pass reforms. Preemption looms over efforts to regulate healthcare insurance. Commentators, for example, have recognized preemption's challenge to State laws that combat surprise, out-of-network medical bills. Loren Adler *et al.*, *State Approaches to Mitigating Surprise Out-of-Network Billing*, USC-Brookings Schaeffer Initiative for Health Policy, 38 (2019)[10] (noting that the "unpredictab[ility]" of "ERISA preemption"). The same is true for iterations of different price-transparency laws, *see* Jaime S. King & Erin C. Fuse Brown, *ERISA as a Barrier for State Health Care Transparency Efforts*,

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[10] https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf.

UC Hastings Law: Legal Studies Research Paper Series 7, 10–11 (2019),[11] and even experiments with single-payer insurance, *see* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Pa. L. Rev. (forthcoming 2020).[12]

To avoid the too-broad view of ERISA preemption, States are often forced to sacrifice meaningful reform with workarounds to circumvent preemption. The workarounds are not easy. Under *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828 (1988), even laws that exempt ERISA plans from their reach are subject to preemption. *Accord Pharm. Care Mgmt. Ass'n v. Gerhart*, 852 F.3d 722, 728 (8th Cir. 2017) (stating that a law that "specifically exempts [self-funded] ERISA plans from an otherwise generally applicable statute" is in "reference to" ERISA plans). And even if a State thinks it has done enough to evade ERISA preemption, protracted litigation often awaits. States thus face grave uncertainties in dedicating the resources and political capital necessary to pass new healthcare-insurance reforms.

The problem has only grown over time. When Congress passed ERISA, State authority over healthcare insurance for employer plans was largely preserved. This owed to ERISA's saving clause, which protects State insurance regulation over all plans but self-funded ones. As noted, in the 1970s, only seven

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[11] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3214173.

[12] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3395462.

percent of workers had self-funded plans, leaving the vast majority of employer and non-group insureds subject to State control. Gabel, *Job-Based Health Insurance,* 18 Health Affairs at 70. Not so today. Since the 1970s, the number of covered workers with self-funded plans has ballooned to 61 percent in 2019. *2019 Employer Health Benefits Survey*, Kaiser Family Foundation (2019).[13] This has left increasingly little for States to regulate. And nothing in ERISA suggests that Congress envisioned such a result. When ERISA passed, "no member of Congress" could "seriously have foreseen a time when … ERISA—a law primarily meant to regulate pensions—would have become such a stumbling block to national health reform." Borzi, *There's "Private" and Then There's "Private"*, 36 J. L. Med & Ethics at 663.

The Affordable Care Act's sea change puts States in a precarious position as well. As explained, the Act's set of nationwide standards, programs, and rules conflates the lines between strictly insurance and healthcare regulation. States are left to carry out much of this framework and more. While the Act provides timetables and State-innovation waivers to protect State regulation, it makes no mention of ERISA preemption. *See* Mallory Jensen, *Is ERISA Preemption Superfluous in the New Age of Health Care Reform?*, 2011 Colum. Bus. L. Rev. 464, 501–03 (2011). States, therefore, continue to risk ERISA preemption in attempting to exercise control of healthcare insurance after the Act.

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[13] https://www.kff.org/report-section/ehbs-2019-summary-of-findings/.

The troubling condition of American healthcare and the States' already-curbed role in regulating modern markets militate against any further expansion of this Court's ERISA-preemption jurisprudence.

CONCLUSION

This Court should reverse the judgment below.

Respectfully submitted,

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