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 FOR EMPLOYERS HEALTH PURCHASING CORPORATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTERESTS OF *AMICUS CURIAE*[1]

Employers Health Purchasing Corporation ("EHPC") is a group purchasing organization that provides resources and advice to assist employer and union plans to provide access to high-quality health care benefits at a sustainable cost. EHPC represents more than 175 plan sponsors, headquartered in 34 states. EPHC's client organizations represent a broad spectrum of plan sponsors including manufacturers, unions, service organizations, retailers, political subdivisions, and universities. These organizations vary in size, ranging from 80 employees to more than 50,000 employees. The plans offered by EPHC's client organizations cover more than 1 million people in all 50 states. Among EHPC's client organizations, the average plan sponsor has participants that fill prescriptions in 33 different states, not including the plan sponsor's state of domicile. On average, more than 39% of all retail prescriptions are filled outside of an EHPC plan sponsor's state of domicile.

Plan sponsors choose to self-fund their health plans for a variety of reasons, including the ability to customize a plan to meet the specific needs of the sponsor's workforce, increased flexibility and control of the plan, and cost savings from reduced administrative and risk fees. Another fundamental reason that employers and unions choose to self-fund is the protection from disparate and potentially conflicting state regulation provided by the Employee

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus*, made a monetary contribution intended to fund its preparation or submission. Counsel for both parties have provided written consent to the filing of this brief, as required under Rule 37.3.

Retirement Income Security Act's ("ERISA") preemption of any state law relating to employer and union-sponsored health plans. By enacting ERISA, Congress intended to provide a nationally uniform scheme of regulation for multi-state employers to encourage them to offer benefit programs for their employees. The advantages of self-funding inure not only to employers and union groups, but also to employees and their dependents who participate in the health plan.

The lower the costs of administering a plan, the greater the benefits value a plan sponsor can provide to its participants. Compliance with state-specific regulations drives up the costs of plan administration. Thus, the more individual states can freely impose their own regulations on a benefit plan, the greater the cost of plan administration and the lower the benefits value to plan participants. Such increased costs contradict Congress's manifest purpose in enacting ERISA.[2] The Eighth Circuit correctly held that ERISA preempts Act 900. Overturning that decision would significantly weaken ERISA's broad preemption clause and open the door for each state to impose its own intrusive requirements associated with prescription drug benefits.

As an advocate for large self-funded employers who operate businesses in many different states, EHPC has a strong interest in seeing that its clients are protected from burdensome and conflicting state-

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[2] *See Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 944 (2016) ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries.").

enacted and enforced regulations. As a result of ERISA's preemption clause, EHPC clients subject to ERISA are able to offer more than 1 million plan participants benefits that are customized to their industry and workforce. Accordingly, EHPC supports affirming the decision below and urges the Court to enforce ERISA's broad preemption provision to ensure that core plan functions are subject exclusively to federal regulation.

INTRODUCTION AND SUMMARY OF ARGUMENT

Many self-funded employers and union groups choose to contract with a third-party administrator ("TPA") to process claims and control certain aspects of the self-funded health benefit plan. A TPA performs these functions on behalf of the plan sponsor. Act 900, the Arkansas law at issue in this case, attempts to regulate Pharmacy Benefit Managers ("PBMs"), which are TPAs that perform the administration of prescription drug benefits as part of a plan sponsor's health plan.

PBMs provide critical services that greatly reduce prescription drug spending by self-funded plans. One of the most significant ways that PBMs are able to secure competitive pricing is through the Maximum Allowable Cost ("MAC") payment model. MAC pricing provides an incentive for pharmacies to purchase and dispense the least costly generic drugs available on the market. The MAC price represents the upper limit or maximum amount that a PBM or plan will reimburse a pharmacy for generic drugs and multi-source brand name drugs (brand drugs with a therapeutic equivalent).

MAC pricing is one of several terms and conditions included in contracts between PBMs and retail

pharmacies. Larger retail chains generally contract directly with PBMs. Independent pharmacies often gain purchasing power by using a pharmacy services administrative organization to negotiate with PBMs on the independent pharmacies' behalf. See Staff of S. Comm. on Fin., 116th Cong., *A Tangled Web* 25 (June 2018), https://bit.ly/38YpdlK ("[I]n 2011 and 2012, at least 22 PSAOs were in operation and represented or provided services to up to 28,300 pharmacies, the majority of which were independent."). To streamline administration, most self-funded plan sponsors use a PBM to establish the network and payment levels for network pharmacies. *Id.* This network contracting impacts many aspects of the plan sponsors' drug benefit strategies such as tailoring access to meet participant needs and maximizing network cost containment strategies. Permitting any mechanism to circumvent this process eliminates vital tools used by plan sponsors to ensure appropriate access, economic viability, and consistency of the plan for the beneficiaries.

MAC pricing sets a single price for clinically equivalent products. Capping the amount that a plan will reimburse a pharmacy for a generic or multi-source brand medication incentivizes pharmacies to purchase medication from competitively priced manufacturers and wholesalers. See Adam Kautzner, Express Scripts, *MAC Pricing Keeps Generics Affordable* (Aug. 6, 2019), https://bit.ly/2Wn7EJy. MAC pricing is a contractual mechanism to ensure that pharmacies are held accountable in their drug procurement processes, which benefits both plan sponsors and plan participants. A pharmacy is discouraged from purchasing a higher-priced drug because it may not be reimbursed the full amount by the PBM; therefore, this mechanism creates

predictability and prevents excessive pharmacy profit margins to ensure the cost sustainability of the plan.

In addition, MAC prices are driven and negotiated based on a variety of factors including, but not limited to: the duration of a drug's generic status, the number of manufacturers making brand name or generic versions, availability and accessibility of the drug and whether there have been obstacles in the manufacturing process of the drug. See Acad. of Managed Care Pharmacy, *Maximum Allowable Cost (MAC) Pricing* (May 20, 2019), https://bit.ly/3a0lt4z.

Arkansas's Act 900 imposes administrative burdens on plan sponsors and onerous regulations on PBMs and how they administer and support plan sponsors' health plans. Notably, the Act:

- requires that PBMs reimburse pharmacies at or above the pharmacies' drug acquisition costs, Ark. Code Ann. § 17-92-507(a)(6);
- provides strict criteria where plans are required to update MAC pricing within 7 days of an increase in a pharmacy's acquisition cost, *id.* § 17-92-507(c)(2);
- necessitates disclosure of detailed plan information to pharmacies in the plan's network, *id.* § 17-92-507(c)(4)(C)(ii);
- dictates that plans must establish an appeals process for pharmacies to challenge reimbursement levels, including a minimum amount of time for pharmacies to file appeals and a maximum amount of time for plans to resolve appeals, *id.* § 17-92-507(c)(4)(A)(i);
- allows a pharmacy to reverse and rebill below-cost transactions if the pharmacy concludes that

the MAC rate is below the pharmacy's acquisition cost, *id.* § 17-92-507(c)(4)(C)(iii); and

- permits pharmacies to decline to dispense a participant's medication if the pharmacy believes that it may lose money on the sale of that particular prescription drug, *id.* § 17-92-507(e).

These requirements undermine the utility of MAC pricing, eliminate the incentive for pharmacies to competitively purchase drugs, drive up plan costs and reduce benefits' value to participants, undermine national uniformity of plan administration, and threaten participants' access to benefits. As such, Act 900 has an impermissible connection with employee benefits plans and is thus preempted by ERISA.

Act 900's restrictions on MAC pricing and imposition of administrative burdens directly impact plan design and the structure and management of prescription drug benefits and therefore "gover[n] . . . a central matter of plan administration." Act 900 also "interferes with nationally uniform plan administration" by subjecting plan sponsors to multiple, potentially conflicting state-imposed requirements. And Act 900 interferes with the protection of plan participants and their receipt of benefits—by driving up costs that will ultimately be borne by participants, allowing pharmacies to refuse to dispense required medications to participants, and creating the risk of disparate benefits based on where a plan participant seeks to fill their prescriptions—and thus runs counter to ERISA's objectives.

Act 900 is precisely the type of state regulation that Congress, in enacting ERISA, expressly intended to preempt. The Court of Appeals correctly held that Act 900 is preempted under Section 514 of ERISA, 29 U.S.C. § 1144. Reversing that decision would have a

lasting negative impact on ERISA plan sponsors, their participants and beneficiaries. EHPC urges the Court to affirm the Eighth Circuit's decision.

ARGUMENT

I. ACT 900 IS EXPRESSLY PREEMPTED BY ERISA.

Arkansas's Act 900 is expressly preempted by ERISA. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]" 29 U.S.C. § 1144(a). A state law "relates to" an ERISA plan and is preempted if it has "a connection with or reference to such a plan." *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)). To determine whether a state law impermissibly "relates to" an ERISA plan due to some "connection with" that plan, the Court "look[s] both to 'the objectives of the ERISA statute . . .' as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quoting *Cal. Div. of Labor Standards Enf't* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)).[3] A state law has an impermissible "connection with" ERISA plans where it "governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration." *Gobeille* v. *Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016)

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[3] Because it is clear that Act 900 operates "in connection" with ERISA plans, EHPC in this brief will only address that prong of this Court's test for whether a state law "relate[s] to" an employee benefit plan under 29 U.S.C. § 1144(a). EHPC does, however, agree with Respondent's argument that Act 900 also impermissibly "refers to" ERISA plans. *See* Respondent's Br. 48-49.

(omission in original) (quoting *Egelhoff*, 532 U.S. at 148). Act 900 does both.

Act 900 is preempted by ERISA because the state law attempts to mandate employee benefit structures and plan design—both central matters of plan administration. And Act 900 interferes with nationally uniform plan administration, contrary to Congress's intent that employee benefit plans be administered in a nationally uniform way in order to minimize administrative costs and burdens. As the court below correctly held, Act 900 is preempted.

A. Act 900 Governs Central Matters Of Plan Administration.

Act 900 has an impermissible connection with ERISA plans because it regulates plan design and the structure and management of prescription drug benefits provided by ERISA plans. Such functions are "a central matter of plan administration" and therefore, state regulation of these functions is expressly preempted by ERISA. *Egelhoff*, 532 U.S. at 148.

Act 900 regulates the use of MAC pricing. MAC pricing enhances market efficiency by eliminating the need to carry out an individual price assessment for each transaction processed at a pharmacy. MAC pricing was originally adopted by the Centers for Medicare and Medicaid Services after government audits revealed Medicaid reimbursements far exceeded a pharmacy's acquisition costs. Kautzner, *supra.*

MAC pricing is instrumental in structuring a pharmacy benefit plan because such pricing can efficiently reflect the average acquisition cost for a particular drug across dozens of purchasers. If states are permitted to manipulate MAC pricing, it will

decrease pharmacies' incentive to seek better-priced drugs and can even incentivize retail pharmacies to dispense more expensive brand drugs in the alternative. Eliminating cost-control incentives directly affects the composition of a health plan's drug formulary strategy.

In addition, Act 900 will undermine contracts that drive the composition of pharmacy retail networks under the plan and the scheme of payment to contracted pharmacies. This construct not only is the foundation for plan design decisions, such as the size of the retail network and participant cost-sharing, but also is foundational to the contract between the plan and the PBM.

Many plan sponsors utilize coinsurance at retail network pharmacies. This is a common benefit strategy to ensure that price increases and decreases are shared between plan sponsors and participants. MAC pricing drives consumer behavior and enables plan participants to choose more cost-effective therapies or lower cost pharmacies, which collectively preserve plan assets. These consumer actions benefit the greatest number of beneficiaries, a core tenet of ERISA. Act 900 will undermine plan designs by allowing network pharmacies either to refuse to fill a prescription or to reverse and re-bill at a higher rate. The effect of these actions will be to unfairly limit access, erode plan assets and harm beneficiaries, each of which runs counter to Congress's intent in enacting ERISA's intent.

Act 900 is therefore fundamentally different from the state law upheld in *Travelers*. There, a New York law required healthcare providers to collect surcharges from patients covered by a commercial insurer but not from patients covered by Blue Cross Blue Shield plans and certain exempt HMO plans.

Travelers, 514 U.S. at 649. Concluding that the law had "only an indirect economic effect on the relative costs of various health [plans]," the Court held that ERISA did not preempt the surcharges. *Id.* at 662.

Unlike the New York surcharges found to be mere rate regulation in *Travelers*, Act 900 has a *direct* economic effect on the costs of an ERISA health plan and impacts multiple aspects of plan design. Rather than a state setting the amount an insured patient must pay, Act 900 directly prescribes how an ERISA plan must calculate claim costs, process claim disputes, and provide administrative relief. Further, the challenged law in *Travelers* indirectly affected health care providers by requiring them to charge patients the relevant surcharge. *Id.* at 650. By contrast, Act 900 directly impacts and regulates plans by effectively setting a minimum reimbursement floor and mandating specific procedural requirements including updating MAC lists, establishing specific appeal procedures, and allowing pharmacies to rebill. The provisions in Act 900 impose burdensome requirements on plan sponsors, impacting both the plans that have directly contracted with pharmacies and plans that have delegated these responsibilities to PBMs to act on their behalf.

Petitioner argues that Act 900 regulates only the PBM-pharmacy relationship and not self-funded benefit plans themselves and thus, the regulation only impacts a *PBM*'s discretionary decisions. This argument ignores the functional reality that PBMs stand in the shoes of plan sponsors to perform functions such as network contract management, pharmacy reimbursement, and claims adjudication on behalf of plan sponsors. If a plan does not delegate these functions to the PBM, it would have to perform the functions itself. And, as described further below,

infra 15-16, cost increases that a state law may impose on a PBM will inevitably be passed on to the plan sponsor.

The restrictions and mandates of Act 900 thus apply not only to PBMs but also to the plans that contract with PBMs to administer their pharmacy benefits. Moreover, Act 900 applies whether the plan chooses to contract with a PBM or chooses to directly administer its drug benefits. The Arkansas law regulates "an entity that administers or manages a pharmacy benefits plan or program." Ark. Code Ann. § 17-92-507(a)(7). PBMs act as intermediaries in a similar fashion to the TPA that was subpoenaed for claims data in *Gobeille*. In *Gobeille*, the Court relied on ERISA's robust disclosure and record-keeping requirements to find that the state law imposing comparable requirements on a third-party administrator intruded on essential functions of plan administration. 136 S. Ct. at 945. Regardless of which entity bore the burden of compliance, the regulation intruded on "a central matter of plan administration." *Id.* The significance of this Court's prior ruling is clear; it does not matter whether a plan manages drug benefits itself or engages a PBM to perform this service on the plan's behalf. In either circumstance, the Act's requirements subject self-funded benefit plans to a state law, which is precisely the kind of "connection" that is expressly preempted by ERISA.

Imposing reimbursement requirements that undermine MAC methodology and impact multiple features of plan design affects "key facet[s] of plan administration" and is expressly preempted by ERISA. See *id.* at 946.

B. Act 900 Interferes With Nationally Uniform Plan Administration.

ERISA seeks to ensure that the benefits promised by an employer are more secure by mandating certain oversight systems and other standard procedures. Because ERISA self-funded plans are subject exclusively to federal regulation, these plans are able to streamline their operations by offering a uniform benefits scheme in all states in which they operate. Cigna, *Advantages and Myths of Self-Funding* (Dec. 2017), https://bit.ly/33oH5p5. This, in turn, allows plan administrators to tailor a plan design to best meet the needs of the employee population that benefits from that plan. *Id.* Without ERISA, multi-state employer-sponsored plans would find it nearly impossible to operate under a variety of conflicting state-based regulations.

Restrictions on MAC pricing interfere with the calculation and disbursement of benefits. See *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). Traditionally, MAC pricing allows plan sponsors to secure lower-cost therapeutic alternatives so that they are able to drive innovation in benefit designs for their plan participants. Act 900's stringent regulations on disclosure and implementation of MAC methodology eliminates a cost-containment mechanism and reduces competition. As a result of increased regulation, plan sponsors will be forced to modify their plan designs to offset the lost value of MAC pricing. Realistically, this offset will be achieved by reducing benefits or increasing participants' co-payments and premium contributions, not only in Arkansas, but across all participants throughout the U.S. Thus, the proposed regulations unfairly shift the cost to plan sponsors and their participants not only in Arkansas but also in

every other state in the country where a plan sponsor's plan participants and beneficiaries utilize the benefit.

A failure to uphold preemption here would subject ERISA self-insured health plans to 50 or more potential state pricing and reporting requirements. "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990). This Court has repeatedly struck down laws that provide ERISA plans with myriad conflicting state regulations. Forced compliance with these laws burdens fiduciaries and plan administrators in performing their ERISA mandated functions. See *Gobeille*, 136 S. Ct. at 945 ("Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.").

Some of Act 900's disclosure provisions would force plans to seek additional information from various providers, vendors, and third parties with whom they work, and would cause significant changes to claim recording and increased cost for the output of such data. See *id.* ("[R]eporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA."). If Act 900 is upheld, ERISA health plans with participants living or filling prescriptions in Arkansas would be forced to adopt Arkansas specific changes to their health plans. Further, if the Court holds that Act 900 is not preempted by ERISA, it will open the door to forcing plans to comply with state-specific laws for each state where participants purchase prescription drugs at retail pharmacies. See Respondent's Br. 27-31

(describing multitude of conflicting state laws governing pharmacy benefits). This slippery slope poses a serious threat to the viability of self-insured health benefit plans, which protect millions of employees throughout the nation.

C. Act 900 Is Contrary To ERISA's Purpose Of Protecting Plan Participants And Ensuring Receipt Of Benefits.

In evaluating whether a state law has an impermissible connection with ERISA plans and is therefore preempted, the Court considers "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," and "the nature of the effect of the state law on ERISA plans." *Gobeille*, 136 S. Ct. 943. Act 900 runs counter to ERISA's fundamental objective of protecting plan participants and ensuring that they receive contractually defined benefits, further confirming that it is preempted by ERISA.

Multiple features of ERISA embody the objective of protecting plan participants. For example, section 404(a) of ERISA provides an "exclusive purpose" rule. This rule mandates that the plan fiduciary—i.e., the plan sponsor—"discharge his [or her] duties with respect to a plan *solely* in the interest of the participants and beneficiaries," and for the "*exclusive purpose* of . . . providing benefits to participants and their beneficiaries; and . . . defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1) (emphases added).

The "exclusive purpose" standard reveals that plan fiduciaries must act solely in furtherance of plan participants' interests when administering an employer-sponsored health plan. The fiduciary obligations of ERISA are so robust that plan sponsors

are held to a higher standard of conduct than trustees under traditional state trust law. See *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996) ("After all, ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection.").

Further, in construing the standard by which fiduciaries must administer their health plan, the Court takes into consideration "competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits" and "its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Id.* Act 900's burdensome requirements create the exact regulatory environment ERISA was enacted to prevent and run counter to ERISA's participant-protective objectives.

First, Act 900 drives up the costs and burdens of plan administration by disrupting the pricing models set forth between the PBM and plan sponsor and by imposing additional significant procedural requirements on plans' administration of benefits. While hybrid variations exist, there are essentially two types of pricing models utilized by a plan sponsor and its PBM: pass-through and traditional.

Under a true pass-through model, the plan is charged the actual retail discounts and fees negotiated between the PBM and retail pharmacy. As the PBM cannot derive revenue from spread (the difference between what the PBM bills the plan and pays the retail pharmacy), the PBM usually charges a per claim administrative fee to the plan to cover the cost of its services. The plan does not receive any contractual guarantees, and is therefore at risk for whatever costs

are passed through. Thus, under Act 900, any state-required reimbursement in excess of the network contract between the PBM and pharmacy necessarily has a direct and negative impact on the plan—both in the increased costs it will incur and necessarily pass on to participants, and also in a dramatic loss in the predictability of its expenses.

Under a traditional model, negotiated retail discounts are set forth in the contract between the plan and the PBM. This benefits the plan by guaranteeing discounts to the plan and thereby providing stability and certainty around drug costs. While the PBM is at risk for not achieving its guarantees and does not charge an administrative fee, the PBM benefits in circumstances when its payment to the pharmacy is less than the price it has guaranteed in its contract with the plan. Any negative impact on the underlying economics between the pharmacy and the PBM creates negative pressure on the arrangement between the plan and the PBM, which must be addressed in retail network contract rates and other economic aspects of the arrangement between the PBM and plan.

Act 900 further drives up costs of administering the plan by imposing onerous procedural requirements, including frequent, mandatory updating of MAC lists and creation of appeal and rebill procedures. These requirements will further increase the cost of administering plans and impose additional burdens on plans with participants utilizing the plan in a multitude of states.

These costs will ultimately be borne by plan participants in one form or another. In order to ensure plan viability, these extra hurdles will force the plan to reevaluate plan design such as benefit coverage and participant cost-sharing, including participants' out of

pocket contribution, which will be especially felt by participants in high deductible health plans, who will bear the increased cost until their maximum-out-of-pocket amount is satisfied. Indeed, plan sponsors often elect MAC pricing because it provides the best coverage and value for participants. In stark contrast, Act 900 effectively requires plan sponsors to adopt pricing methodologies designed to benefit pharmacies, not plan participants.

Second, Act 900's "decline to dispense" provision will render plans unable to fulfill an ERISA plan's access requirements because the law permits a pharmacy to turn away a participant altogether if the pharmacy determines that it is in the pharmacy's best interest because it will lose (or not make enough) money on a given transaction. Ark. Code Ann. § 17-92-507(e). Limiting via state law a participant's access to his or her promised pharmacy benefits, which a provider is otherwise contractually obligated to provide, is disruptive and contrary to ERISA's purpose of advancing the best interests of plan participants.

Third, under Act 900, employees working for the same company who are a part of the same health plan would have access to unequal benefits due to conflicting directives of state law. This dynamic means that an Arkansas employee could potentially be denied a prescription that an employee enrolled in the same health plan who lives in another state would readily acquire. This harsh provision could force a plan participant to choose between traveling out of state to fill his or her prescription or being without his or her medication altogether. When a state law has the effect of making "certain benefits available in some states but not in others," that is the clearest evidence that it should be preempted. *Fort Halifax*, 482 U.S. at 9.

Viewed against "the objectives of the ERISA statute," Act 900's negative impact on participants and their access to benefits demonstrates that the Act is outside "the scope of the state law that Congress understood would survive." *Gobeille*, 136 S. Ct. at 943.

* * *

ERISA is intended to protect employee benefit plans from state laws that mandate benefit requirements, impose administrative burdens, bind employers to particular plan designs and preclude them from implementing uniform plan administration. ERISA strengthens an employee benefits system that serves the well-being of all American employees, regardless of the state in which they live.

ERISA preempts state regulation like Act 900 that impedes the legitimate goals of uniform plan administration. Congress intended for ERISA to prioritize plan participants and their beneficiaries by subjecting such plans exclusively to federal authority and shielding them from multiple potentially conflicting state regulations. Because Act 900 does serious violence to these paramount objectives of ERISA, the Act has more than a connection to the federal scheme and the Court of Appeals correctly held that the Act is preempted.

CONCLUSION

For the foregoing reasons, the Court should affirm the judgment of the Court of Appeals.

Respectfully submitted,

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