No. 18-540

IN THE
Supreme Court of the United States

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State 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 THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND THE AMERICAN BENEFITS COUNCIL AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") expressly preempts "any and all State laws" that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). The Eighth Circuit held that this provision preempts Arkansas's Act 900, which sets the prices ERISA plans pay and the procedures they must follow to reimburse pharmacies for drugs dispensed to plan participants and beneficiaries. The Eighth Circuit concluded that Act 900 is preempted because it unlawfully interferes with the administration of prescription-drug benefits on behalf of an ERISA-governed employee benefit plan.

The question addressed by *amici* is whether Arkansas can avoid preemption—despite Act 900's undisputed impact on plan administration—by casting the Act's onerous restrictions as a matter of "rate regulation" and "necessary incidents to that regulation," and by purporting to impose these restrictions on third-party administrators acting as agents for ERISA plans, rather than on the plans themselves.

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INTEREST OF *AMICI CURIAE*[1]

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every economic sector, and from every region of the country. Many of the Chamber's members maintain, administer, or provide services to employee benefits programs governed by ERISA. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus* briefs in cases that raise issues of concern to the nation's business community.

The American Benefits Council (the "Council") is a national non-profit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 440 members are primarily large, multi-state employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health

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[1] The parties consented to the filing of this brief. Pursuant to Rule 37.6, counsel for *amici* represents that this brief was not authored in whole or in part by counsel for a party and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

plans covering virtually all Americans who participate in employer-sponsored programs.

The Chamber and the Council frequently participate as *amici curiae* in cases with the potential to significantly affect the design and administration of employee benefit plans. Many of these organizations' members offer their employees the opportunity to participate in health plans similar to the plans at issue here.

The ERISA preemption issues presented in this case are critically important to the Chamber, the Council, and their members. Members of both the Chamber and the Council hold differing views on the subject matter of the law at issue in this case—the efficacy of pharmacy benefit managers ("PBMs") and maximum allowable cost ("MAC") pricing. Indeed, certain aspects of the PBM model stand at odds with the interests of many plan sponsors. But *amici* are united in their commitment to the strong ERISA preemption principles long recognized by this Court's jurisprudence. Given "the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force," *Boggs v. Boggs*, 520 U.S. 833, 839 (1997), the protection of uniform plan administration is essential to the interests of employers and their plans' participants and beneficiaries.

SUMMARY OF THE ARGUMENT

ERISA Section 514(a) expressly preempts "any and all State laws" that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). The plain language of this express-preemption provision is broad, and it operates to block states from forcing plans to "design" and administer "their programs in an environment of

differing state regulations." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990); *see also Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147-48 (2001). Congress enacted this bar because allowing such a hodge-podge of different regulations in different states would "complicate the administration of nationwide plans" and produce "inefficiencies that employers might offset with decreased benefits." *FMC Corp.*, 498 U.S. at 60.

The Arkansas statute at issue in this case, Act 900, frustrates Congress's aims by requiring administrators to process claims for prescription-drug benefits under different substantive and procedural rules—and pay higher amounts—in Arkansas than in other states, where other members of the same plans reside. These rules include requirements that benefit managers continually update the MAC lists specifying the amounts at which PBMs reimburse pharmacies for drugs prescribed to plan members, Ark. Code Ann. § 17-92-507(c)(2), and administrative appeal procedures allowing pharmacies to challenge reimbursements they consider too low, *id.* § 17-92-507(c)(4)(A)-(B). The law also imposes a rule of decision requiring a PBM, as claims administrator, to grant certain appeals, increase reimbursement for the claims at issue and any other affected claim, and adjust its MAC list going forward. *Id.* § 17-92-507(c)(4)(C)(i), (iii). Finally, the law permits pharmacies unilaterally to decline to dispense a requested drug, notwithstanding a patient's benefits claim and the pharmacy's contractual obligations to the PBM, if the PBM's reimbursement falls below a specified threshold. *Id.* § 17-92-507(e). As the court of appeals recognized, these provisions "interfer[e] with national uniform plan administration" of ERISA

plans, and are therefore preempted by ERISA. Pet. App. 5a.

To evade the inexorable conclusion that Act 900 impermissibly treads on this core concern of ERISA, Arkansas and the United States as *amicus* posit a series of limitations on ERISA preemption. Arkansas suggests that its interventions into this sphere avoid preemption because they are only "ordinary state rate regulation and necessary incidents to that regulation." Pet. Br. 13. The United States argues that Act 900 also is not preempted because it applies to third parties that administer pharmacy benefits for ERISA plans, and "thus regulate[s] PBM administration, not ERISA plan administration." U.S. Br. 27.

This Court should reject these artificial limitations, which would eviscerate ERISA preemption. State regulation of the rates that ERISA plans agree to pay to provide coverage to their members is not an exception to ERISA preemption; it is at the core of what ERISA preempts because calculating benefits is a central plan function. Nor is there any blanket exemption from preemption for requirements imposed as incidents to an otherwise legitimate state purpose. Indeed, as this Court recently reaffirmed, "ERISA pre-empts a state law that regulates a key facet of plan administration *even if the state law exercises a traditional state power*." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016) (emphasis added). *Gobeille* likewise confirms that ERISA preemption applies equally when a state law regulates core plan functions by imposing requirements only on a plan's "third-party administrator" or agent, rather than the plan itself. *Id.* at 942.

To hold otherwise would contravene ERISA's plain text and this Court's precedents, and would open significant gaps in ERISA's preemptive scope for all employee benefit plans, posing a serious threat to the ability of plan sponsors to offer nationwide employee benefit plans that can be administered in a uniform manner from state to state. A ruling upholding Act 900 would sanction a patchwork of state requirements that would decrease efficiency and increase plan costs—not just in the PBM context, but in numerous others involving different kinds of benefits and plans, different aspects of plan administration, and different kinds of third-party administrators. The result would be to "undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Gobeille*, 136 S. Ct. at 944 (quoting *Egelhoff*, 532 U.S. at 149-50).

This Court should reject the unduly narrow, counter-textual approach to ERISA preemption offered by Arkansas and the United States, and affirm the decision of the court of appeals holding Act 900 preempted.

ARGUMENT

This Court has long held that "[a] law 'relates to' an employee benefit plan," and so is preempted by ERISA, "if it has a [(1)] connection with or [(2)] reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). As elaborated over more than three and a half decades, the first branch of this two-part framework establishes that "a state law … has an impermissible 'connection with' ERISA plans" if it "governs … a central matter of plan administration," "interferes with nationally uniform plan administration," or imposes "acute, albeit

indirect, economic effects" that "'force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). This "connection with" preemption ensures fidelity to "[o]ne of the principal goals of ERISA": "to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

Arkansas and the United States ask this Court to depart from these settled principles by chiseling a trio of novel, non-textual exceptions out of the statutory scope of ERISA preemption. Arkansas claims that no state law is preempted that imposes "rate regulation," broadly defined as "regulations that limit" the rates paid for "goods and services [plans] provide beneficiaries." Pet. Br. 13. Arkansas also seeks a free pass from preemption for any laws "incidental" to a permissible objective of state regulation, "even if those [laws] bear on benefits or claims processing" by ERISA plans. *Id.* at 14. And the United States suggests that states may regulate plan administration so long as they "direct" their laws at agents acting on plans' behalf, instead of the plans themselves. U.S. Br. 27.

These propositions lack foundation in ERISA's text or this Court's precedent. If adopted, they will harm plans and their members by crippling ERISA's preemption provision and undermining uniform plan administration. The Court should reject these arguments and affirm the decision below.

I. ARKANSAS'S AND THE UNITED STATES' PROPOSED EXCEPTIONS TO ERISA PREEMPTION CONTRAVENE ERISA AND THIS COURT'S PRECEDENT

Arkansas's and the United States' narrow approaches to ERISA preemption depart from longstanding precedent in ways that would significantly undercut the broad scope of preemption expressly established by Congress and enforced by this Court. Arkansas's novel exception to preemption for laws "incidental to rate regulation," and the United States' exception for laws "directed at" third parties acting as plans' agents, lack support in statutory text or precedent. To the contrary, this Court's precedents establish that states cannot regulate the structure and administration of plan benefits under the guise of "rate regulation," that ERISA preemption admits of no exception for state laws "incidental" to broader regulatory objectives, and that ERISA preemption protects activities of plan administration equally whether carried out by plans or their agents.

A. STATES CANNOT REGULATE THE STRUCTURE OF PLAN BENEFITS UNDER THE GUISE OF "RATE REGULATION"

Arkansas's defense of Act 900 starts from the mistaken premise that under *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), "ERISA does not preempt rate regulation," meaning regulation of "the rates at which third-party plan administrators reimburse providers of healthcare benefits." Pet. Br. 23. Respondent ably explains why Act 900 is not "rate regulation," because it directly

regulates the administration of benefits and the integrally related process of reimbursement on behalf of and under a plan. Resp. Br. 36-40. This Court should not only reject Arkansas's "rate regulation" argument as applied to Act 900 in particular, but should also resist Arkansas's broader invitation—which finds no support in *Travelers*—to carve a vast exception from ERISA preemption for "rate regulation" in the expansive sense that Arkansas uses that term here.

State regulation of the rates that ERISA health benefit plans agree to pay for treatment of their members is at the core of what ERISA preempts. *Travelers* itself recognized that "ERISA pre-empt[s] state laws that mandat[e] employee benefit structures or their administration," including any law that "force[s] an ERISA plan to adopt a certain scheme of substantive coverage." 514 U.S. at 658, 668. A state ordinarily may not require an ERISA plan "to pay employees specific benefits," *Shaw*, 463 U.S. at 97, 108 (sick leave), or "cover a specified illness or procedure," *Met. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728, 735 n.14 (1985) (minimum mental-health-care benefits), much less set the dollar amount that a plan must pay for the benefits it elects to cover.[2]

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[2] *Shaw* and *Met. Life* recognized enumerated statutory exceptions to these rules—exceptions not applicable or invoked here—but they each found preemption outside the scope of these exceptions. *Shaw* held that New York could mandate sick-leave benefits through disability insurance plans "exempt from ERISA" under 29 U.S.C. § 1003(b)(3), but could not "require an employer to alter its ERISA plan" to provide those benefits. 463 U.S. at 108. *Met. Life* held that Massachusetts could mandate minimum-health-care benefits for insured plans under an exception to preemption for laws "regulat[ing] insurance," 29

Instead, ERISA preempts laws regulating a plan's "method of calculating … benefits." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997) (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981)). "[T]he payment of benefits" is "a central matter of plan administration" that ERISA preemption squarely protects from state regulation. *Egelhoff*, 532 U.S. at 148.

State regulation of plan benefit levels is antithetical to ERISA's statutory scheme. "Congress' primary concern" in enacting ERISA was to ensure that employers *pay* the benefits due to their employees, *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)—not to "mandate what kind of benefits employers must provide if they choose to have [benefits] plans," *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Congress well understood that employers are not "require[d] … to establish employee benefit plans," *ibid*., and that undue regulation would only "discourage employers from offering [such] plans in the first place," *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). ERISA thus leaves plan sponsors "large leeway" to decide what benefits to offer. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). State laws telling ERISA plans how much to pay for covered benefits directly undercut that leeway.

Congress also enacted ERISA to enable plan administrators "to calculate uniform benefit levels nationwide," *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), in light of the "increasingly interstate" scope of many employee benefits plans, 29 U.S.C. § 1001(a). Congress thus elected federal rather than state regulation to avoid a jumble of "[d]iffering, or even

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U.S.C. § 1144(b)(2)(A), but not for self-funded plans to which the exception does not apply, 471 U.S. at 735 & n.14.

parallel, regulations from multiple jurisdictions" that could prevent plans from offering the same benefits in different states. *Gobeille*, 136 S. Ct. at 945. Regulations requiring plans to calculate payments for health benefits differently from state to state are incompatible with that scheme.

Nothing in *Travelers* saves laws like Act 900 from preemption, even supposing that they could accurately be called "rate regulation." *Travelers* upheld a New York law that "require[d] hospitals to collect surcharges *from patients*." 514 U.S. at 649 (emphasis added). As the state told this Court, these "assessments [we]re not imposed upon ERISA plans" or their agents, and "the law d[id] not require any ERISA plan or third party payor to pay any benefit, any level of benefit, or any particular amount of a patient's hospital bill." Br. for Pet'rs Cuomo, *et al.*, *Travelers*, 1994 WL 646144, at 18-19 (U.S. Nov. 16, 1994). Indeed, "at least one commercial insurer … made the determination that its plan terms d[id] not permit payment" of the surcharge. Reply Br. for Pet'rs Cuomo, *et al.*, *Travelers*, 1994 WL 721247, at 10 n.10 (U.S. Dec. 29, 1994). Because the statute did not impose any "substantive coverage requirement binding plan administrators," the principal ground for preemption asserted in this Court was that the law improperly influenced plans' choice of insurers because the surcharge for some insurers' patients was greater than for others' patients. 514 U.S. at 658-59, 664. Regulation of the rates paid by ERISA plans and their administrators and agents simply was not at issue.

Even as to the type of "rate regulation" at issue in *Travelers*—regulating hospitals' charges to patients—the Court did not adopt a blanket rule precluding

preemption. Arkansas makes much of the Court's statement in a footnote that "ERISA was not meant to pre-empt basic rate regulation." 514 U.S. at 668 n.6. But the Court's point was to *reject* a categorical *bar* on state rate regulation, not to *adopt* a categorical *safe harbor*. As the Court explained in the body of the opinion, ERISA cannot be read to universally "bar any state regulation of hospital costs." *Id.* at 664. But that does not mean that *every* such regulation survives preemption. To the contrary, the Court upheld New York's surcharge only after determining that the statute "affect[ed] only indirectly the relative prices of insurance policies," and "d[id] not bind plan administrators to any particular choice" or "preclude uniform administrative practice or the provision of a uniform interstate benefit package." *Id.* at 659-60, 668. The Court made clear that if the statute *had* "force[d] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[ed] its choice of insurers," it "might indeed be pre-empted." *Id*. at 668. *Travelers* thus confirms that state "rate regulation"—even in the sense used in that case—is subject to the ordinary test for preemption based on its "effects" on ERISA plans.

In this case, Arkansas's Act—unlike the law in *Travelers*—impermissibly mandates plans' benefit calculations because it binds plans and their administrators to pay specified amounts for benefits using particular reimbursement processes. *See* Resp. Br. 36-40. Rather than simply regulating the prices paid by consumers for goods and services in the healthcare market, with only indirect influence on plan decisions, the law directly dictates the substantive and procedural rules governing a plan's "'system for processing claims and paying benefits.'" *Egelhoff*, 532 U.S. at 150. It even prevents plans from

guaranteeing coverage by allowing pharmacists to decline to dispense drugs. The law thus effectively negates the benefit at issue—the patient's right to receive medication according to the cost-sharing and reimbursement terms set out in the plan. Under state-specific PBM restrictions like Arkansas's, "[p]lan administrators cannot make payments simply [as] specified by the plan documents. Instead they must familiarize themselves with state laws so that they can determine" the specific procedures and rules of decision that apply to pharmaceutical benefit coverage in each state. *Id.* at 148-49. No "rate regulation" exception countenances this "direct regulation of a fundamental ERISA function." *Gobeille*, 136 S. Ct. at 946.

B. THERE IS NO EXCEPTION FROM PREEMPTION FOR STATE REGULATION OF ERISA PLAN BENEFITS "INCIDENTAL" TO OTHER REGULATORY OBJECTIVES

Arkansas's second flawed limitation on ERISA preemption is that "ERISA does not preempt necessary incidents to otherwise permissible laws." Pet. Br. 25 (heading). Arkansas claims this purported exemption saves Act 900's "enforcement mechanisms"—*e.g.*, requiring plans to regularly update their MAC lists, Ark. Code Ann. § 17-92-507(c)(2), and hear appeals challenging reimbursement decisions, *id.* § 17-92-507(c)(4)—"because they are necessary and incidental to Arkansas's otherwise permissible rate regulation." Pet. Br. 24-25.

Arkansas's argument falters at every step. There is nothing "otherwise permissible" about Act 900's purported "rate regulation." *See supra* at 10-12. But

even assuming *arguendo* that a state could enact a "permissible" rate-regulation measure in this area, the supposedly "incidental" provisions of Act 900 would still violate ERISA in light of their interference with uniform plan administration. Resp. Br. 40-41.

Arkansas's novel premise that states can "regulate the structure or management of plan beneficiaries' benefits" to advance "otherwise permissible laws," Pet. Br. 25 (heading) (emphasis omitted), gets ERISA preemption exactly backward. ERISA's express preemption provision, Section 514(a), defines the scope of preemption by a law's relation to the *federal* interest at stake—ERISA-governed "employee benefit plan[s]"—not the state's objective in interfering with those interests. 29 U.S.C. § 1144(a). The provision does not distinguish among state laws that meet this criterion, but broadly "supersedes *any and all*" of them. *Ibid*. (emphasis added). Congress's use of the "'expansive'" term "any" leaves "no warrant to limit the class of provisions of law" preempted by the statute. *Republic of Iraq v. Beaty*, 556 U.S. 848, 856 (2009). The Court "must give effect to this plain language." *Shaw*, 463 U.S. at 97.

The only exceptions to ERISA's categorical test for preemption—that is, the only laws that may avoid preemption "even if" they "regulate the structure or management of plan beneficiaries' benefits," Pet. Br. 25—are specifically enumerated in Section 514(b). They include, for example, laws that "regulat[e] insurance, banking, or securities," 29 U.S.C. § 1144(b)(2), and "qualified domestic relations orders," *id.* § 1144(b)(7). Arkansas does not invoke any of these exceptions. And there is no statutory exception for statutory provisions that are "incidental" to rate regulation or any other non-

enumerated statutory purpose. Where, as here, "'Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent.'" *TRW Inc. v. Andrews*, 534 U.S. 19, 28 (2001).

Outside of the enumerated statutory exceptions to ERISA preemption, this Court has consistently recognized that state laws relating to ERISA plans are preempted regardless of whether the state claims they are "incidental to" an otherwise permissible state scheme. "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 330 (1997). A "law that regulates a key facet of plan administration" is therefore preempted "even if the state law exercises a traditional state power." *Gobeille*, 136 S. Ct. at 946 (citing *Egelhoff*, 532 U.S. at 151-52). Such a law "cannot be saved by invoking [a] State's traditional power[s]" because the "purpose" of a state law cannot "transform [its] direct regulation of 'a central matter of plan administration' into an innocuous and peripheral set of additional rules." *Ibid*. (citation omitted). Instead, "[u]nder th[e] 'broad common-sense meaning'" of ERISA's preemption provision, "a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987)).

Travelers—the linchpin of Arkansas's "incident to rate regulation" defense—illustrates the point: Whatever its purpose, a law is only "otherwise

permissible" under ERISA, Pet. Br. 25, if it "does not bind plan administrators to any particular choice" or "preclude uniform administrative practice or the provision of a uniform interstate benefit package." 514 U.S. at 659-60, 668; *see supra* at 10-12. If a "necessary" or "incidental" component of the law fails this test, the law is not "otherwise permissible."

Arkansas rests its contrary view on nothing more than a single, inapposite sentence in *Gobeille*. Pet. Br. 25-26. *Gobeille* held that Congress "intended to pre-empt state reporting laws … that operate with the purpose of furthering public health," including the Vermont law at issue in the case. 136 S. Ct. at 946. Arkansas points to the Court's speculation that the "analysis *may* be different" if a state imposed "incidental reporting" to facilitate "enforcement" of an otherwise valid state law, such as the state tax upheld in *De Buono*. *Ibid*. (emphasis added). But the Court made clear it was not reaching this issue because "that [was] not the law before the Court." *Ibid*. Even assuming *arguendo* that a different analysis applied, nothing in *Gobeille* suggests that the analysis would show that *all* "incidental reporting" requirements—let alone all "necessary incidents" to other types of "otherwise permissible laws," Pet. Br. 25 (heading)—survive preemption. To the contrary, *Gobeille* confirms that a reporting law *may* be preempted even if it "operate[s] with the purpose of furthering public health"—an otherwise permissible objective. 136 S. Ct. at 946.

To be sure, there may be some state recordkeeping requirements that exert such a tenuous and incidental *effect* on plan administration that they do meet the ordinary standard to trigger preemption. That may have been true in *De Buono*—although *De*

Buono "did not explicitly concern reporting requirements" and those requirements "drew no comment from the Court." *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 557 (6th Cir. 2016). But what matters is "the *effect* of the state law on ERISA plans," *Gobeille*, 136 S. Ct. at 943 (emphasis added), not whether it is incidental to an otherwise lawful statute.

In short, to claim that a state law is "necessary and incidental" to an "otherwise permissible … regulation," Pet. Br. 24-25, is not a defense to ERISA preemption. Each provision of Act 900 must stand or fall on its own terms.

C. ERISA PREEMPTION APPLIES EQUALLY TO STATE LAWS TARGETING THIRD-PARTY AGENTS OF ERISA PLANS

The United States proposes a third, equally baseless limitation on ERISA preemption. Rather than embrace Arkansas's meritless exception for "incidental" regulations, the United States argues that ERISA does not preempt Act 900 because Act 900 "imposes obligations on PBMs, not plans." U.S. Br. 27. The United States is wrong at the threshold that the Act even makes this distinction—in reality, the Act reaches *any* "entity," including a plan, that "administers or manages a pharmacy benefits plan," Ark. Code Ann. § 17-92-507(a)(7); *see also* Resp. Br. 46-47. But the government's more fundamental error is thinking that the distinction matters. To the contrary, the government's attempt to cabin ERISA preemption to laws "'directed at … plan sponsors'" themselves—rather than at their agents, U.S. Br. 27—departs significantly from the long-established analytical framework for ERISA preemption.

Under this Court's precedents, ERISA preempts state laws regulating central plan administration regardless of whether the administration is carried out by the plan or by a third party. What matters is the "aspect of plan administration" regulated, *Gobeille*, 136 S. Ct. at 945, and the "nature of the effect … on ERISA plans," *Dillingham*, 519 U.S. at 325, not the entity nominally regulated. That is the only mode of preemption analysis that sensibly accounts for the "administrative realities of employee benefit plans" with which ERISA is concerned. *Fort Halifax*, 482 U.S. at 9. A state can no more interfere with plan administration carried out through a plan's agent than with administration by the plan itself.

Gobeille confronted this question directly, concluding that ERISA preempted Vermont's reporting law even though that law imposed direct requirements only on the respondent plan's "third-party administrator," Blue Cross. 136 S. Ct. at 942. The position now advanced by the government—that a state law avoids preemption if its "burden of compliance falls on" a plan's third-party administrator—garnered only two dissenting votes, *id.* at 955 (Ginsburg, J., dissenting), and was rejected by the majority, *id.* at 942.

The lower courts have likewise recognized that "ERISA's overarching purpose of uniform regulation of plan benefits overshadows [any] distinction" based on which entity is the "focus" of a state law. *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014). The concerns underlying ERISA preemption are "equally applicable to agents … who undertake and perform administrative duties for and on behalf of ERISA plans," because "[t]o subject such companies to … differing state [regulations] would

create obstacles to the uniformity of plan administration" just as surely as differing obligations imposed on plans themselves. *Kollman v. Hewitt Assocs., LLC*, 487 F.3d 139, 148 (3d Cir. 2007).

At a minimum, a state law restricting third-party administrators "constrains" the plan "by forcing it to decide between administering its pharmaceutical benefits internally upon its own terms or contracting with a [third party] to administer those benefits upon the terms laid down" by the state. *Pharm. Care Mgmt. Ass'n v. D.C.*, 613 F.3d 179, 188 (D.C. Cir. 2010) (joined by Kavanaugh, J.). Just as ERISA preempts a law that "effectively restrict[s] [an ERISA plan's] choice of insurers," *Gobeille*, 136 S. Ct. at 943, it assuredly preempts a law that effectively restricts a plan's reliance on third-party administrators. And a state law that forces plans either to follow a state scheme, or to alter their terms or administration to avoid it, "is not any less of a regulation of … ERISA plans simply because there are two ways of complying with it." *Egelhoff*, 532 U.S. at 150. Regulation of third-party plan administration thus impermissibly restricts plan sponsors from delegating administrative functions, which is itself a structural choice reserved to plans under ERISA.

Ultimately, "[a]rtificial entities" such as ERISA plans "may act only through their agents." *Braswell v. United States*, 487 U.S. 99, 110 (1988). A loophole from preemption for state laws that act on plan agents rather than the plan itself is potentially limitless. By embracing that limitless loophole, the government's brief turns foundational agency principles on their head. The law traditionally makes no distinction between the acts of the principal and the acts of the agent. Instead, authorized acts of an agent are

traditionally treated as acts of the principal, *see* Restatement (Second) of Agency § 7 (1958), and an authorized agent typically enjoys a "privileg[e]" to engage in whatever conduct "his principal is privileged to have an agent do," *id.* § 345. These background common-law principles, extant at the time of ERISA's adoption, inform the Court's interpretation of the statute, *see Varity*, 516 U.S. at 502-03 (citing *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323 (1992)), and preclude an interpretation of ERISA's preemption provision that differentiates between regulation of a plan and regulation of its agents.

II. THE PROPOSED EXCEPTIONS TO PREEMPTION WOULD UNDERMINE UNIFORM PLAN ADMINISTRATION IN AREAS EXTENDING FAR BEYOND THIS CASE

The approaches urged by Arkansas and the United States, if adopted, would dismantle basic ERISA preemption principles and significantly undermine Congress's objectives across a variety of contexts extending well beyond this case. "ERISA's goal, this Court has emphasized, is 'uniform national treatment of [plan] benefits.'" *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 17 (2004) (quoting *Patterson v. Shumate*, 504 U.S. 753, 765 (1992)). Artificially cabining the broad scope of ERISA preemption, as Arkansas and the United States suggest, would subject ERISA plans to a thicket of conflicting state rules that will defeat Congress's objective, increase uncertainty, and raise the costs of plan administration. The resulting burden on plans will ultimately harm participants and beneficiaries by "lead[ing] those employers with existing plans to reduce benefits, and those without

such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11.

More than 178 million Americans, or 55% of the U.S. population, receive health insurance through employment-based benefit plans. Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2018* at 3 (Nov. 8, 2019), https://www.census.gov/library/publications/2019/demo/p60-267.html. Congress enacted ERISA to safeguard "the continued well-being and security" of the "millions of employees and their dependents [who] are directly affected by these plans." 29 U.S.C. § 1001(a).

By the time of ERISA's enactment, "the operational scope and economic impact of such plans [was] increasingly interstate," 29 U.S.C. § 1001(a), and today most plans operate across multiple states, *see* Resp. Br. 31. ERISA accordingly employs broad preemption of related state laws as a principal means to accomplish the "congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 150 (alterations in original) (quoting *Ingersoll-Rand*, 498 U.S. at 142).

Arkansas's Act 900 undermines uniform plan administration in this way. Under Act 900 and the growing patchwork of similar state-specific PBM regulations, "[p]lan administrators cannot make payments simply [as] specified by the plan documents. Instead they must familiarize themselves with state statutes so that they can determine" the specific procedures and rules of decision that apply to pharmaceutical benefit coverage in each state. *Egelhoff*, 532 U.S. at 148-49. By increasing plan cost and uncertainty, these obstacles to uniform nationwide administration threaten to force plans to

modify their terms, including by potentially reducing coverage for prescription drugs or other benefits. Resp. Br. 26-32, 34-35.

The administrative burdens imposed by conflicting state laws are no mere theoretical concern. They have concrete consequences for the many Americans who depend on ERISA plans. Evidence shows that "each one percent increase in … plans' costs … results in a potential loss of insurance coverage for about 315,000 individuals." Health Economics Practice, Barents Group, LLC, *Impacts of Four Legislative Provisions on Managed Care Consumers*: 1999-2003, at iii (1998). The cumulative effect of "[r]equiring ERISA administrators to master the relevant laws of 50 States" is to massively increase the costs of maintaining and operating a multi-state employee benefits plan. *Egelhoff*, 532 U.S. at 149.

Arkansas's and the United States' proposed limitations on ERISA preemption would exacerbate the "serious administrative problems" resulting from exposure to "50 or more potentially conflicting" state regimes that ERISA was enacted to prevent. *Gobeille*, 136 S. Ct. at 949 (Breyer, J., concurring).

In particular, limiting ERISA preemption to laws regulating activities carried out by plans themselves, as the United States suggests, would discourage the efficient and increasingly widespread division of labor that third-party administrators facilitate. *See* Resp. Br. 46. This would inevitably raise plan costs and reduce the funds available for benefit coverage—a particularly perverse way in which to honor "the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries." *Gobeille*, 136 S. Ct. at 957 (quoting *Egelhoff*, 532 U.S.

at 149-50). Further, a patchwork of state laws restricting third-party administrators could reduce the number of third parties that are able and willing to administer plan benefits, increasing plan costs and decreasing choice. Congress intended ERISA to "induc[e] employers to offer benefits by assuring a predictable set of liabilities," and "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (second and third alterations in original) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002); *Varity*, 516 U.S. at 497). Many provisions of ERISA expressly contemplate that plan sponsors may need to rely on third parties to carry out the complex functions of plan administration. *See*, *e.g.*, 29 U.S.C. §§ 1002(16)(A), (21), (38), 1102(a). ERISA directly regulates some of these entities, such as fiduciaries. *Id.* § 1104. Allowing states to interfere with plans' delegation to these entities would frustrate the scheme enacted by Congress.

Plan sponsors today (and in particular the large multi-state employers most affected by ERISA preemption) increasingly rely on third-party agents of many different types to help administer ERISA plans. 61% of the many workers covered by a health plan are covered by completely or partially self-funded plans, many of which rely on third parties for plan administration. Kaiser Family Found., *Employer Health Benefits: 2019 Annual Survey* 11 (2019). And, as relevant to this case, approximately 74% of large employers and 56% of smaller employers directly engage PBMs to manage and administer their prescription drug benefit plans. Pharmacy Benefit Mgmt. Inst., *2018 Trends in Drug Benefit Design* 12

(2018). Today, Arkansas is one of 40 states to pass laws trenching on this area of plan administration, Resp. Br. 19, with various states concededly "tak[ing] different approaches to regulating PBMs," California Br. 33. These regulatory regimes vary substantially between states. Resp. Br. 26-32. Moreover, direct conflict between state laws is not the only burden ERISA guards against. Rather, "the central design of ERISA … is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements." *Gobeille*, 136 S. Ct. at 947. If allowed to take root, this mish-mash of varying state regulation will only grow and threaten to wipe out the efficiency gains that uniform plan administration offers large, nationwide plans and their participants and beneficiaries.

Beyond the PBMs at issue in this case, third parties play a vital role in many aspects of modern plan administration, all of which would be threatened by a "third-party" exception from ERISA preemption. Claims administrators, for example, apply plan terms to determine eligibility for benefits coverage. *See Met. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008). These administrators may in turn engage external reviewers to provide independent administrative appeals of benefits coverage decisions. *See Rush Prudential*, 536 U.S. at 373. Healthcare provider networks contract with insurers to provide a variety of services to plans, participants, and beneficiaries. *See Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). Moreover, the United States' purported third-party exception would open the floodgates to state regulation of the panoply of third parties involved in plan administration (fiduciary and otherwise),

allowing unwarranted avoidance of ERISA preemption. For example, the proposed exception could allow states to require third-party administrators to pay minimum reimbursement rates for certain facilities, providers, items, or services, undermining strategies—such as provider networks and centers of excellence—that many plan sponsors have adopted to improve health plan quality and reduce costs. And such an exception would affect not only health plans, but all ERISA employee benefit plans—opening the door, for example, for states to tell retirement plan service providers which index funds to include in their plan offerings, while claiming to regulate service providers rather than plans. It is therefore essential that this Court clearly confirm that states may not avoid ERISA preemption by the simple expedient of imposing impermissible restrictions on plan service providers in lieu of plans themselves.

Arkansas's proposed exemptions from preemption for "rate regulation" and its "necessary incidents" would also provide a roadmap for widespread state evasion of ERISA preemption principles. Because reimbursement processes are integral to the design and administration of benefits plans, states would be able to parlay their asserted authority over rate regulation into a license to intrude on nearly any conceivable aspect of ERISA plan operation. Resp. Br. 19. Moreover, Arkansas's proposed exception from preemption for any laws "incidental to" an otherwise permissible purpose could conceivably apply to many state regimes other than the purported "rate regulation" at issue here. This would destabilize longstanding preemption doctrine and open up vast gaps in ERISA's uniform national scheme. Allowing state regulation of benefit administration to shelter

under an expansive "incident to rate regulation" exception to preemption would expose plans to conflicting state obligations imposing "direct regulation of … fundamental ERISA function[s]" properly reserved for federal protection under Section 514(a). *Gobeille*, 136 S. Ct. at 946.

Arkansas's and the United States' unduly narrow approaches to ERISA preemption thus threaten to disrupt uniform plan administration, reduce efficiency, and increase plan costs in areas extending far beyond the particular circumstances of this case.

CONCLUSION

The Court should reject Arkansas's and the United States' proposed limitations on ERISA preemption and affirm the judgment of the court of appeals.

Respectfully submitted.

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