No. 25-452

IN THE

Supreme Court of the United States

UNITEDHEALTHCARE INSURANCE COMPANY, ET AL.,

Petitioners,

v.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The Supreme Court Of The State Of Nevada

BRIEF OF THE AMERICAN BENEFITS COUNCIL, THE ERISA INDUSTRY COMMITTEE, AMERICA'S HEALTH INSURANCE PLANS, INC., AND THE NEVADA ASSOCIATION OF HEALTH PLANS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

The American Benefits Council (the "Council") is a national non-profit organization dedicated to protecting and fostering employer-sponsored benefit plans. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

The ERISA Industry Committee ("ERIC") is a national non-profit business trade association representing approximately 100 of the nation's largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families.

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and care more affordable, accessible, and equitable for everyone. AHIP's members offer health and supplemental benefits through employer-provided coverage, the individual insurance market, and public

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* states that no counsel for a party authored this brief in whole or in part, 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. Pursuant to Supreme Court Rule 37.2, counsel for *amici* timely notified counsel for the parties of the intent to file this brief.

programs such as Medicare and Medicaid. Combined, AHIP's members provide healthcare coverage, services, and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's healthcare and health insurance systems work.

The Nevada Association of Health Plans ("NvAHP") is a trade association for its member companies providing commercial health insurance and government programs to Nevadans. NvAHP's primary goal is to create a statutory and regulatory environment that permits Nevada's health insurance plans to meet the needs of consumers, employers, and public purchasers. NvAHP is a unified voice advocating for issues important to Nevada's health plans. In addition, its mission is to ensure the growth and development of a high-quality, affordable healthcare delivery system for Nevadans that emphasizes prevention and strong patient-provider relationships.

The Council, ERIC, AHIP, and NvAHP regularly participate as *amici* in cases, like this one, that will have far-reaching effects on the design and administration of employee benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Those cases frequently include ERISA preemption cases. *E.g.*, *Rutledge v. PCMA*, No. 18-540 (U.S. Apr. 1, 2020); *Gobeille v. Liberty Mut. Ins. Co.*, No. 14-181 (U.S. Oct. 20, 2015). NvAHP also participated as an *amicus* in the proceedings below.

Amici support United's petition for certiorari because it presents a question of profound nationwide importance that has divided federal and state appellate courts. Healthcare providers have filed a

growing number of suits asserting that ERISA's express-preemption provision, Section 514(a), does not preempt state-law causes of action that force ERISA plans to reimburse out-of-network healthcare providers at a rate *different* from the rate specified in the terms of the governing plans. Some courts have embraced that position. These misguided decisions threaten significant disruption to America's employer-sponsored health benefits system, which has for decades delivered high-quality, affordable healthcare to many millions of employees and their families.

Plan terms governing maximum covered charges for out-of-network services—and the corresponding cost-sharing requirements for plan members—are an essential feature of employer-sponsored health benefits. Those terms encourage providers to join networks, and those networks in turn are designed to ensure that plan beneficiaries receive safe and cost-effective care. If providers can use state law to negate the plan terms that hold these networks together—a litigation strategy that the decision below endorses—the quality of healthcare will decline and costs and premiums will increase. Preventing those outcomes and protecting employers' ability to offer high-value, affordable healthcare is critically important to *amici* and their members.

SUMMARY OF ARGUMENT

"Nothing in ERISA requires employers to establish employee benefits plans." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Instead, ERISA offers numerous protections that are designed to encourage employers to offer those plans. *Conkright v. Frommert*, 559 U.S. 506, 517 (2010). One of the most important protections is ERISA Section 514(a),

which broadly preempts "any and all State laws"—including state-law causes of action—that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). This provision and other features of ERISA are designed to give employers "large leeway to design … plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003).

Because of these guarantees, many employers voluntarily offer health benefit plans to attract and retain talented, healthy workers. Employers carefully design these plans with the goal of delivering high-quality, affordable care. A critical plan-design element is the provider network, which consists of healthcare providers that have contracted with the plan to offer services to plan members at lower rates than those providers charge others. Plans set high standards for these networks to ensure that in-network providers are delivering care that is safe and effective.

To maintain these provider networks, employer plans need to encourage plan members to choose in-network providers—otherwise providers would have no incentive to join networks. One important way plans do this is by having members contribute a greater portion of the provider's charges when they choose to seek out-of-network treatment. Members pay higher cost-sharing amounts for such treatment. And plans typically limit the "allowed" amount they agree to cover for given out-of-network services. Plan members thus have a powerful incentive to use in-network providers, rather than out-of-network providers who may bill them for excessive charges that could exceed the amounts allowed by their plans. Collectively, these cost-related terms are essential to

provider networks and the delivery of high-value care. They are also a foundational feature of ERISA plans.

Given the centrality of these plan terms, it should not be controversial that ERISA preempts state-law causes of action that seek to override them. Respondents' unjust enrichment claim sought exactly that: to extract from the plans (through their claims administrator) higher amounts than the plans were obligated to pay to Respondents under plan terms. And Respondents succeeded: The jury awarded them $2.65 million more than plan terms required the plans to pay for the relevant treatment. Pet. App. 7a.

The Nevada Supreme Court nonetheless concluded that ERISA does not preempt this stark displacement of plan terms—and interference with critical aspects of plan design. It thus joined other state and federal courts that have misread this Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and *Rutledge v. PCMA*, 592 U.S. 80 (2020), as exempting from preemption all state laws regulating the amounts that plans pay for treatment of their members. Neither decision allows such regulation. Those cases concerned laws that this Court characterized as regulating the *total* cost that providers are paid *from all sources*, without compelling plans to cover any particular portion of that total. Respondents' unjust enrichment claim goes further by seeking to saddle employer plan sponsors (through their claims administrator)—and ultimately their plan enrollees (through higher premiums)—with the full amount billed, thus establishing a de facto new plan term for out-of-network payments. *Travelers* and *Rutledge* are thus inapposite.

Rutledge was not a sea change in ERISA preemption. Instead, it simply reaffirmed *Travelers*'s longstanding "logic" that incidental effects on a plan's operating costs, standing alone, do not trigger ERISA preemption. 592 U.S. at 88. State (and federal) courts should not be permitted to use these cases as a foothold to override employers' decisions about how much of their employees' treatment to cover. This case presents an ideal vehicle (Pet. 30-31) for this Court to resolve the conflict among the lower courts and clarify that its precedents do not authorize this interference with the design and function of ERISA-covered benefit plans.

ARGUMENT

I. The Allocation Of Costs Set Forth In A Health Plan Is An Essential Feature Of Plan Design

Employer-sponsored benefits—the prevailing method of providing health benefits in the United States—seeks "to provide quality care at reduced costs to the public." J. Scott Andresen, *Is Utilization Review the Practice of Medicine? Implications for Managed Care Administrators*, 19 J. Legal Med. 431, 431-32 (1998). Plans and their employer sponsors achieve this goal in various ways, and those mechanisms are reflected in the terms of the plan.

One of the most important ways that employer-sponsored plans ensure high-quality, low-cost care is through networks of providers that offer the best care at the best price. But plans cannot maintain these networks if they are compelled to reimburse out-of-network providers at the same rate as in-network providers (much less a higher rate). Adherence to plan terms that limit the extent of out-of-network coverage—including cost-sharing and allowed-cost

terms that limit the portion of providers' charges that plans agree to pay—is thus a central aspect of plan administration.

A. Employer-sponsored health plans are a major feature of American healthcare. The plan beneficiaries are employees and their families, and they contribute to the plan by paying monthly premiums. The terms of these plans describe what services are covered, limitations and exclusions on coverage, the maximum "allowed" charges that plans agree to cover for services, and plan members' cost-sharing obligations for those allowed charges.

Employer-sponsored health plans generally follow one of two models: "insured" or "self-funded." *See Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324 (11th Cir. 2014). For both types of plans, a plan administrator is typically responsible for processing benefits claims, *see N. Cypress Med. Ctr. Operating Co., Ltd. v. Aetna Life Ins. Co.*, 898 F.3d 461, 468 (5th Cir. 2018), which involves interpreting the terms of the plan to determine whether a given service is covered and the allowed charges. In the "insured" model, the plan administrator uses its own funds to pay claims. *Id.* For "self-funded" plans, the employer is ultimately responsible for paying claims and bears the financial risk of covering the healthcare costs of its employees. *Id.* Most plans at issue here are self-funded. Pet. 6.

B. ERISA gives plan sponsors "large leeway to design … plans as they see fit." *Black & Decker*, 538 U.S. at 833. Employers use that flexibility to develop mechanisms that ensure their members receive high-quality, safe, and affordable care. The mechanisms that are most effective at achieving this goal—which are all closely related and nearly ubiquitous across

plans—are provider networks, allowed charges, and cost-sharing requirements.

Plans routinely contract with selected healthcare providers "to create exclusive 'provider networks.'" *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). Providers in these networks "agree to render health-care services" to plan beneficiaries "at discounted rates and to comply with other contractual requirements" in exchange for "the benefit of patient volume higher than that achieved by nonnetwork providers." *Id.* By routing plan beneficiaries to in-network providers, plans ensure that beneficiaries receive quality care at lower cost. *See* Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 Ariz. St. L.J. 875, 917-20 (1995).

Provider networks "pla[y] a central role in insurance systems that ai[m] to contain costs while maximizing value for consumers and employers." Eline M. van den Broek-Altenburg & Adam J. Atherly, *The Relation Between Selective Contracting and Healthcare Expenditures in Private Health Insurance Plans in the United States*, 124 Health Pol'y 174, 175 (2020). Indeed, numerous studies show that carefully designed provider networks are associated with higher quality of care. *E.g.*, Olena Mazurenko et al., *The Impact of Narrow and Tiered Networks on Costs, Access, Quality, and Patient Steering: A Systematic Review*, 79 Med. Care Rsch. & Rev. 607, 608 (2022). Research has also established that carefully designed provider networks "resul[t] in lower prices" for services. van den Broek-Altenburg & Atherly, *supra*, at 175. This happens in at least two ways: (1) plans select the most "efficient providers" to join their

networks; and (2) the promise of more patients leads in-network providers to accept "lower negotiated prices" for their services. Daniel Polsky, *Provider Networks and Health Plan Premium Variation*, 56 Health Serv. Rsch. 16, 17 (2021). The upshot of these lower prices is substantial savings on premiums for plan members—up to hundreds of dollars per year. *See* van den Broek-Altenburg & Atherly, *supra*, at 175.

Provider networks depend, in turn, on plan terms that allocate responsibility for providers' charges between patients and the plan. A plan's ability to negotiate preferred rates with in-network providers depends on the plan being able to credibly offer those providers a higher volume of patients. *N. Cypress*, 898 F.3d at 469. Plans therefore must be able to provide meaningful financial incentives for their beneficiaries to use in-network providers. *See* John L. Utz, *Network Viability and the Emboldened Out-of-Network Provider*, 23 No. 2 ERISA Litig. Rep. 11 (2015). One way plans do this is by capping the allowed amount that the plan agrees to cover for a given service received from an out-of-network provider. Pet. 23. While out-of-network providers can bill plan members any rate the member is willing to accept, providers that bill more than allowed charges typically must collect the difference from the member. This incentivizes members to seek and receive care from in-network providers.

Relatedly, cost-sharing obligations—which include "copayments, deductibles, [and] co-insurance"—often require beneficiaries to contribute a higher share of the plan's allowed charges when they obtain services from out-of-network providers. *N. Cypress*, 898 F.3d at 469 & n.2. For example, if the

member receives a service from an in-network provider, the member might be required to pay a coinsurance rate of 10%, whereas if the member receives the service from an out-of-network provider, the member might be required instead to pay a 25% coinsurance rate.

Cost-sharing requirements incentivize plan members "to seek out providers with lower fees"—*i.e.*, in-network providers that offer lower negotiated rates and better care. *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991). Studies have found "robust" evidence that higher deductibles, for example, "are effective at reducing" the "use of low-value services that offer little or no clinical benefit." Brendan Rabideau et al., *Effects of Employer-Offered High-Deductible Plans on Low-Value Spending in the Privately Insured Population*, 76 J. Health Econ. 1, 1-3, 18-20 (2021).

Adherence to these plan terms governing costs—both allowed charges and cost-sharing obligations—is essential to maintaining provider networks. Plan sponsors carefully calculate and set these terms to encourage members to seek in-network care and to maximize incentives for high-quality providers to join networks. If out-of-network providers could circumvent these terms—and extract from the plan *more* than what plan terms dictate—providers would have little incentive to join networks and employers would lose their ability to design networks that are appropriate for the plan. That undermines efforts to keep costs down and provide high-quality care to plan members.

Self-funded employer plans bear these costs directly, and fully insured plans pay higher premiums reflecting these costs. Those consequences are

directly harmful to plan members and are also antithetical to ERISA's goal of "'encourag[ing]'" employers "to establish benefit plans." *Conkright*, 559 U.S. at 516-17. Plan members and their families thus benefit enormously from strict adherence to plan terms governing allowed charges and cost-sharing requirements.

ERISA also "commands that a plan shall 'specify the basis on which payments are made to and from the plan.'" *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quoting 29 U.S.C. § 1102(b)(4)). This requires plan sponsors to engage in a periodic budgeting process, in which they weigh anticipated contributions against predicted benefit expenses. Employers have a significant stake in designing plans in a way that promotes financial stability over time, because they want employees and their families to have strong and reliable coverage.

II. The Reading Of *Rutledge* That Some Courts Have Adopted Undermines Plan Network Design And ERISA

Out-of-network providers have long sought to use the courts, and state law, to extract 100% of their billed charges from plans. *See* Pet. 5-6 n.2 (collecting several suits filed before *Rutledge*). These suits involve different types of services and causes of action, but they all share a common theory: State law should override plan terms that govern allowed charges for out-of-network services. This litigation has only intensified in the wake of *Rutledge*. Several courts (like the Nevada Supreme Court here) have misread *Rutledge* and *Travelers* as endorsing providers' theory that state law may supplant ERISA plan terms. If left unchecked, this profound misinterpretation of *Rutledge* and *Travelers* threatens employers'

longstanding reliance on benefit designs that allow them to provide affordable, high-quality coverage for their employees.

A. In the five years since *Rutledge* was decided, providers have filed an exponentially increasing number of suits seeking higher reimbursement amounts from plans. *E.g.*, Pet. 5-6 n.2. The pattern is by now familiar: Providers refuse to agree to the preferred rates that are required for in-network providers; plan administrators reimburse those out-of-network providers according to the plan terms governing allowed charges; and those out-of-network providers bill amounts in excess of allowed charges and then sue plans under state law to recover their full billed charges. *See*, *e.g.*, *AMISUB (SFH), Inc. v. Cigna Health & Life Ins. Co.*, 681 F. Supp. 3d 842, 847 (W.D. Tenn. 2023); *Molina Healthcare of Tex., Inc. v. ACS Primary Care Physicians Sw., PA*, 2024 WL 3608192, at *2-3 (Tex. App. Aug. 1, 2024); *United Healthcare Servs., Inc. v. Hosp. Physician Servs. Se., P.C.*, 2024 WL 3852337, at *3 (N.D. Ga. Aug. 16, 2024) ("TeamHealth's CEO told United that TeamHealth was good at the litigation route and had a template to file a complaint in every state.").

Some of these suits have succeeded, despite ERISA's preemption provision. One of the earliest post-*Rutledge* decisions is illustrative. Providers claimed a plan administrator was required to reimburse them at the "usual and customary rate" under Florida law rather than according to plan terms. *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1289 (S.D. Fla. 2021). In rejecting the plan administrator's ERISA preemption argument, the court invoked (at 1298-99) *Rutledge*'s statements

that ERISA generally "does not pre-empt state rate regulations that merely increase costs," 592 U.S. at 88, and that "cost uniformity was almost certainly not an object of pre-emption," *id.* (quoting *Travelers*, 514 U.S. at 662). The court reasoned that *because* the state-law claims "fundamentally regard[ed] the rate at which third-party providers are reimbursed and the way that reimbursement rate is calculated," those claims were not preempted. 526 F. Supp. 3d at 1299.

The decision below applied the same rationale. According to the Nevada Supreme Court, there can be no ERISA preemption as to "the rate of reimbursement for emergency services" "because 'cost uniformity was almost certainly not an object of pre-emption.'" Pet. App. 12a (quoting *Travelers*, 514 U.S. at 662). In other words, merely because the providers here were suing over a cost-related issue (allowed charges), ERISA preemption was not implicated, notwithstanding that the suit sought to override the *plan terms* setting those charges.

These suits have covered the field in terms of the kinds of medical services at issue and the types of state-law causes of action that providers invoke. *See*, *e.g.*, *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc.*, 2021 WL 4651504, at *1 (S.D. Fla. Sept. 21, 2021) (unjust enrichment, breach of contract, promissory estoppel, and Florida statutory claims regarding emergency and non-emergency services); *Epic Reference Labs v. Cigna*, 2021 WL 4502836, at *1 (D. Conn. Sept. 30, 2021) (suit seeking $32 million in additional reimbursement for testing services at out-of-network laboratories); *cf. United Healthcare Servs., Inc.*, 2024 WL 3852337, at *1-2 (denying motion to dismiss in action "seeking declaratory relief relating to the reimbursement of … out-of-network claims" for

"emergency and non-emergency medical services"). But at their core, these cases raise the same question: Can providers leverage state law to nullify plan terms that govern a plan's allowed charges for out-of-network services? *Cf. United Healthcare Servs., Inc.*, 2024 WL 3852337, at *4 ("[T]he controversy is whether United is obligated to pay 100% of the amounts billed by [providers], or whether United may pay an amount that is consistent with the Plans.").

The proliferating lawsuits that have advanced the plan-nullification theory pose a crisis for ERISA and the provider networks upon which employers rely to provide affordable and effective benefits for their employees. If out-of-network providers can use state law to force plans to shoulder providers' charges in excess of allowed amounts, members lose a significant incentive to choose in-network providers. That, in the aggregate, reduces the volume of members using in-network providers, thereby undercutting providers' incentives to join networks and maintain network standards for quality and affordability of care. Moreover, if state law permits providers to charge excessive amounts free from market constraints, providers have even less incentive to join networks unless plans agree to pay them more, thus driving up healthcare costs and member premiums.

Unsurprisingly, then, out-of-network providers that have succeeded in the courts continue to pursue "the litigation route" rather than engage in meaningful negotiations to join plan networks. *United Healthcare Servs., Inc.*, 2024 WL 3852337, at *3. This dilemma ultimately harms patients, who are forced to obtain costlier, lower-quality care.

B. Decisions like the one below have other significant ramifications for ERISA-covered plans. By

elevating state law above plan terms, these decisions impose liability outside of the ordinary framework for determining benefits due under ERISA. *Cf.* 29 U.S.C. § 1132(a)(1)(B) (authorizing suit "to recover benefits due … under the terms of [the] plan"). That undermines several aspects of plan design and administration beyond just provider networks and cost-sharing.

First, many ERISA-covered plans grant "discretionary authority" to claims administrators to interpret plan terms, including terms governing allowed charges. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). These delegations are common in ERISA-covered employer-sponsored plans because a plan administrator's discretion—and the "deference" that courts afford to exercises of that discretion—promotes "efficiency, predictability, and uniformity" in plan administration. *Conkright*, 559 U.S. at 518. Thus, under the ERISA framework, the determination of allowed charges for out-of-network services would be based on the plan administrator's interpretation of the applicable plan terms, and would be reviewed deferentially by a court under an abuse-of-discretion standard where the plan has granted such discretion to the administrator. *See N. Cypress*, 898 F.3d at 483.

Routing ERISA claims through state law undercuts that discretionary authority. Under the decision below, for example, allowed charges are instead decided *de novo* by a jury, based on what it deems to be a "reasonable" amount. Pet. App. 7a, 20a-21a. Because a plan's discretion to interpret plan terms normally applies to *all* plan terms—not just those governing allowed charges—the reasoning of decisions like the one below threatens to dilute

efficiency, predictability, and uniformity in all facets of plan administration.

Second, ERISA authorizes only plan members to sue for benefits due. *See* 29 U.S.C. § 1132(a)(1)(B). Plan members can sometimes assign their claims—and thus the right to sue—to providers under a separate contract. But plans retain authority to prohibit such assignments through "anti-assignment clauses," which courts generally recognize as "enforceable" when used in ERISA plans. *Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445, 453, 455 (3d Cir. 2018). Plans use these provisions to "decrease their exposure to out-of-network claims, and encourage providers to come in network," lowering the cost of coverage for employers and plan beneficiaries. *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 228 (3d Cir. 2020). But under the logic of decisions like the one below, providers could sue under state law to recover benefits (in the form of ordinary damages) without obtaining an assignment from the beneficiary, even if the beneficiary's plan has an anti-assignment clause.

Third, although ERISA does not specify a statute of limitations for bringing a claim for benefits under 29 U.S.C. § 1132(a)(1)(B), limitations periods imposed by plans are enforceable, *see Heimeshoff v. Hartford Life & Acc. Ins. Co.*, 571 U.S. 99, 102 (2013), as are plan provisions requiring plan members to exhaust their administrative remedies before filing suit, *cf. id.* at 108. Plans rely on these requirements to provide certainty and repose, lowering the risk of unexpected expenses and thus making it easier and more attractive for employers to provide greater benefits to their employees. By suing under state laws that do

not honor plan terms in the same way that ERISA's framework does, providers could sue long after any plan limitations periods have expired, and without having to adhere to plan exhaustion requirements.

This Court's intervention is thus sorely needed to stem a tide of litigation that threatens to subvert provider networks and other important features of ERISA plan design.

III. *Rutledge* Was A Narrow Decision That In No Way Endorses A Dismantling Of ERISA-Covered Employer-Sponsored Benefits

The case for preemption here is straightforward. The $2.65 million in damages awarded on Respondents' unjust enrichment claim overrides the ERISA plan terms that specified what portion of the cost the plans would cover for out-of-network services. That state-law judgment plainly "relate[s] to" ERISA plans. 29 U.S.C. § 1144(a). Nothing in *Rutledge* or *Travelers* is to the contrary.

A. Respondents' unjust enrichment claim is preempted under well-established principles. A state law "relates to" an ERISA plan, and is therefore preempted, "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). Both prongs provide independently sufficient grounds for preemption here.

The unjust enrichment claim "has an impermissible 'connection with' ERISA plans" because it "'governs … a central matter of plan administration,'" *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016)—namely, "the payment of benefits," *Egelhoff*, 532 U.S. at 148. Respondents' claim directly interferes with this central aspect of

plan administration because it requires payment of benefit amounts that are different than the amounts specified in the plans. *See De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997) (ERISA preempts laws regulating a plan's "method of calculating … benefits"). Preemption is especially clear here because a plan's cost-allocation terms—displaced by the state-law judgment below—are important components of plan design and administration. *Supra* at 6-11.

Indeed, ERISA expressly *requires* a plan's fiduciaries to operate the plan "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). That includes the plan's written specification of the basis on which amounts are payable as benefits. *Id.* § 1102(a)(1), (b)(4). By requiring plan fiduciaries to pay providers an amount far in excess of what the plan document specifies, the Nevada Supreme Court's state-law judgment literally requires the fiduciaries to disobey an unambiguous congressional command. That judgment turns the Supremacy Clause upside down, defying the most venerable principle governing the relationship between state and federal law in a republic with dual sovereignties, *see Ware v. Hylton*, 3 U.S. (3 Dall.) 199 (1796)—a principle honored by ERISA's express-preemption provision.

Respondents' unjust enrichment claim also depends on an impermissible "reference to" ERISA plans because "'the existence of ERISA plans is essential to'" the claim's "'operation.'" *Gobeille*, 577 U.S. at 319-20. According to the Nevada Supreme Court, Respondents were entitled to judgment on this claim because they purportedly conferred a "benefit"

on United by satisfying United's "contractual duty" under its ERISA plans "to pay reasonable rates for out-of-network emergency care" to plan members. Pet. App. 18a-21a. Claims that are premised on this type of benefit—a provider's satisfaction of "the insurer's duty to its insured *under the terms of the ERISA plan*"—"entail an impermissible 'reference to' … ERISA plans" because they depend on "the existence of an ERISA plan." *Plastic Surgery Ctr., P.A.*, 967 F.3d at 239-42 (brackets omitted); *accord Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 386-87 (5th Cir. 2011). The unjust enrichment claim is thus squarely preempted.

B. Several lower courts, including the Nevada Supreme Court, have reached the opposite conclusion by casting causes of action like the one here as analogous to the rate regulations exempted from preemption in *Travelers* and *Rutledge*. *See*, *e.g.*, Pet. App. 12a; *Fla. Emergency Physicians*, 526 F. Supp. 3d at 1288-89. But these courts have misread *Travelers* and *Rutledge*, which involved laws that this Court described as merely regulating the *total* compensation due to providers, rather than specifically compelling plans or their agents to cover any particular portion of that cost in contradiction to plan terms.

Travelers upheld a New York law that "require[d] hospitals to collect surcharges *from patients*." 514 U.S. at 649 (emphasis added). As New York explained to this Court, these "assessments [we]re not imposed upon ERISA plans," and "the law d[id] not require any ERISA plan … to pay any benefit, any level of benefit, or any particular amount of a patient's hospital bill." Br. for Pet'rs 18-19, *Travelers*, 1994 WL 646144 (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 10 n.10, *Travelers*, 1994 WL 721247 (U.S. Dec. 29, 1994). Unlike Respondents' unjust enrichment claim, then, the law in *Travelers* did not require the *plans* themselves to pay any particular amount for the provider's services.

The Arkansas law in *Rutledge* was—according to this Court—even "less intrusive than the law at issue in *Travelers*," so "[t]he logic of *Travelers* decide[d] th[at] case." 592 U.S. at 88. The Court upheld an Arkansas law that it characterized as regulating the total amount paid to pharmacies for prescription drugs through the mix of funding sources determined by a plan—including reimbursements from plans (through their pharmacy benefit managers (PBMs)) *and* payments by patients at the point of sale. *Id.* at 84, 90. The law, this Court explained, did not demand that plans or their PBMs pay any particular rate, but instead merely set "a floor" for the total "cost" of the covered prescription drugs—that is, "how much" a PBM "*and its beneficiary* … owe[d]," collectively. *Id.* at 90 (emphasis added).

ERISA preemption did not reach *this* specific "form of cost regulation." 592 U.S. at 88. Nothing in the Arkansas law would have prevented a plan, by its terms, from leaving its beneficiary to pay at the pharmacy counter all mandated costs above a fixed amount covered by the plan. Instead, as the Court saw it, the law simply ensured that pharmacies ultimately received sufficient reimbursement from all sources "to cover [their] acquisition cost[s]." *Id.* at 85. This Court thus emphasized that the law did not "require plan administrators to structure their benefit

plans in any particular manner," *id*. at 89, and it reaffirmed that state laws "requiring payment of specific benefits" *by plans* or their agents are among the "primar[y]" targets of ERISA preemption, *id.* at 86-87; *see also Travelers*, 514 U.S. at 658 (§ 514(a) preempts state laws that "mandat[e] employee benefit structures or their administration").

Respondents' cause of action unmistakably *does* dictate the amount that the plans themselves must pay to providers. It requires United (and thus the plans) to reimburse Respondents at the rate a Nevada jury deemed "reasonable," Pet. App. 21a, 26a, rather than according to the terms of the governing ERISA plans. This claim is therefore very different from the narrow form of rate regulation assessed in *Travelers* and *Rutledge*.

Several decisions, including the decision below, have entirely failed to grapple with this critical distinction. Instead, they have reflexively invoked this Court's statements that ERISA preemption generally does not reach "state law[s] that merely increase costs," *Rutledge*, 592 U.S. at 91, that "cost uniformity was almost certainly not an object of pre-emption," *id.* at 88 (quoting *Travelers*, 514 U.S. at 662), and that the laws in *Rutledge* and *Travelers* were "merely a form of cost regulation," *id.* But these "'general'" pronouncements "should be read 'as referring in context to circumstances similar to the circumstances then before the Court.'" *Turkiye Halk Bankasi A.S. v. United States*, 598 U.S. 264, 278 (2023).

Read in context, *Rutledge*'s statements about state laws that "merely increase costs … for ERISA

plans," 592 U.S. at 88 (citing *De Buono*, 520 U.S. at 816), refer to laws that "ha[ve] only an incidental impact on" the costs of operating a plan, *De Buono*, 520 U.S. at 810. The paradigmatic example is a "tax of general application," such as "a gross receipts tax on the income of medical centers operated by ERISA funds." *Id.* at 809-10. Such laws indirectly "increas[e] the cost of providing benefits" without forcing plans to pay any particular amounts for services. *Id.* at 816. Here, by contrast, Respondents' unjust enrichment claim is *directly* regulating the amounts that plans must pay and overriding plan terms, not just making plans more expensive to operate.

Rutledge embraces this distinction because the particular "form of cost regulation" evaluated there, 592 U.S. at 88—regulation of the total cost of the underlying service—has only incidental effects on costs to plans. If a law increases the total cost of treatment, and that happens to increase the cost to the plan (because, for example, the plan has agreed to cover the full cost of treatment), that law is not preempted because the effect on what the plan pays is incidental. Plans are still free to choose to pay only part (or none) of the total cost. That is far different from the type of regulation at issue here: laws that seek to directly change "the amount paid" by *plans* and their administrators. *Am.'s Health Ins. Plans*, 742 F.3d at 1331 (emphasis omitted).

The practical "effect[s]" of these two distinct regulatory schemes are also starkly different. *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). Plan terms governing allowed charges and cost-sharing reflect the amounts that plan sponsors have budgeted for

payments to and from the plan. *See* 29 U.S.C. § 1102(b)(4). State laws that increase the costs of certain services might limit an employer's budgetary options for future plan years, but they can be anticipated in the ongoing budget forecasting process. By contrast, state laws exposing plans and employers to the risk of unpredictable payments in excess of budgeted amounts undercut incentives to offer such plans. Indeed, those laws are indifferent to a plan's continued existence—here, for example, state law neither required nor permitted the jury to account for how its damages award might interfere with an employer's ability to offer benefits.

Rutledge thus did not endorse the notion that state law overrides plan terms whenever cost is implicated in some way. That reading of *Rutledge* has no discernible limiting principle and would severely erode ERISA employer-sponsored coverage, given that employer-sponsored plan terms governing benefit payments are an important means of maintaining provider networks and ensuring that beneficiaries receive the best and most cost-effective care. This Court surely did not intend that result.

After all, as this Court has unanimously stated, "'[t]he plan … is at the center of ERISA.'" *Heimeshoff*, 571 U.S. at 108. State laws that override plan terms thus should fall comfortably within the *heartland* of ERISA preemption. Many federal and state appellate courts have recognized this inescapable conclusion, yet the Nevada Supreme Court and other courts have seen matters differently. Pet. 11-20. This case presents an excellent vehicle to make clear that *Rutledge* and *Travelers* were not intended to relegate plan terms to an afterthought, much less threaten

significant disruption to the employer-sponsored benefits system on which American families rely for high-quality, affordable care.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted.

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