Case No. 18-2926

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,
Plaintiff-Appellant,

v.

DIRK WILKE, in his official capacity as the interim State Health Officer of North Dakota; MARK J. HARDY, in his official capacity as the Executive Director of the North Dakota Board of Pharmacy; GAYLE D. ZIEGLER, in her official capacity as President of the North Dakota Board of Pharmacy; and WAYNE STENEHJEM, in his official capacity as the Attorney General of North Dakota,
Defendants-Appellees.

On Appeal from the United States District Court
for the District of North Dakota
The Honorable Daniel L. Hovland
(No. 1:17-cv-141-DLH)

BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* SUPPORTING PLAINTIFF-APPELLANT AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, *amicus curiae* the Chamber of Commerce of the United States of America certifies that it has no parent corporation and no publicly held corporation owns ten percent or more of its stock.

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IDENTITY AND INTEREST OF *AMICUS 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, such as health plans similar to the plans at issue here. 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, including cases, like this one, with the potential to significantly affect the design and administration of employee benefit plans.

The ERISA preemption issues presented in this case are critically important to the Chamber and its members. The Chamber is united in its commitment to the strong ERISA preemption principles long recognized by the Supreme Court's jurisprudence. Given "the centrality of pension and welfare plans in the national

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party contributed money intended to fund its preparation or submission. No person other than *amicus*, its members, and its counsel contributed money intended to fund the preparation or submission of this brief. All parties consented to the filing of this brief.

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). 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." *Id.*

The North Dakota laws at issue in this case, N.D. Cent. Code §§ 19-02.1-16.1 and 19-02.1-16.2, frustrate Congress's aims by requiring plan administrators to structure the provision of prescription-drug benefits under different substantive and administrative rules in North Dakota than in other states, where other members of the same plans reside. These rules include requirements dictating how plans can structure the pharmacy provider networks through which patients receive benefits, N.D. Cent. Code §§ 19-02.1-16.1(3), (8)-(9), (11), 19-02.1-16.2(4)-(5), and

restrictions on a plan's cost-sharing design, *id.* § 19-02.1-16.1(4). The laws also saddle plans with several disclosure and recordkeeping requirements. *Id.* §§ 19-02.1-16.1(4)-(5), (7), (10), 19-02.1-16.2(2). As PCMA argues, these provisions "bind plan sponsors to particular choices concerning benefit design and otherwise deal with the subject matters covered by ERISA," and are therefore preempted. PCMA Replacement Br. 22.

To evade the inexorable conclusion that these laws impermissibly trench on core concerns of ERISA, North Dakota invokes the Supreme Court's recent decision in *Rutledge v. PCMA*, 141 S. Ct. 474 (2020), which held that ERISA does not preempt an Arkansas law regulating prescription drug pricing methodology. *See* Suppl. Br. for Pet'rs, *Wilke v. PCMA*, No. 20-683 (U.S. Dec. 18, 2020). North Dakota claims that *Rutledge* undoes this panel's prior conclusion that North Dakota's laws are preempted, *id.* at 1-2, and requires affirmance of the district court's holding, Add.16-17, that those laws escape preemption because they apply to "*PBMs*" instead of "*plan[s]*," N.D. Initial Br. 29-30.

This Court should reject these arguments, which misapprehend *Rutledge* and contravene well-settled preemption precedent unaffected by that decision. The Supreme Court's unanimous opinion in *Rutledge* indicates that it is a narrow decision relying exclusively on longstanding caselaw, not a sea change in ERISA preemption. 141 S. Ct. at 481. *Rutledge* was about the particular category of "rate"

regulation, and apart from that type of regulation the decision did not weaken in any way the well-established restrictions on states' authority to regulate in core areas of concern under ERISA. Indeed, *Rutledge* reaffirmed precedent holding that ERISA preempts state laws "requir[ing] providers to structure benefit plans in particular ways," *id.* at 480, or otherwise "dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). *Rutledge* also confirmed that ERISA preemption analysis applies equally when a state law regulates core plan functions by imposing requirements on third parties that "administer benefits for ERISA plans," rather than the plans themselves. 141 S. Ct. at 479.

To hold otherwise would contravene ERISA's plain text and controlling 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 benefits that can be provided and administered in a uniform manner from state to state. A ruling upholding North Dakota's laws would sanction a patchwork of state requirements that would preclude uniform national coverage, 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 "requir[e] the tailoring of plans and employer conduct to the peculiarities

of the law of each jurisdiction"—an outcome "fundamentally at odds with the goal of uniformity" that underlies ERISA preemption. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

ARGUMENT

The Supreme Court has long held that "[a] law 'relates to' an employee benefit plan," and thus 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.*, 577 U.S. 312, 320 (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).

The Supreme Court recently decided *Rutledge v. PCMA*, 141 S. Ct. 474 (2020), on narrow grounds that reaffirmed the "logic" of these well-established

precedents. *Id.* at 481. *Rutledge* limited ERISA preemption in a specific category of state "rate regulation," which is not presented in this case. By contrast, binding precedent continues to dictate that ERISA preempts state laws—such as North Dakota's here—that regulate plan design or benefit structure, or that mandate disclosure by plans. *Rutledge* also reaffirmed that traditional ERISA preemption analysis applies with full force to state laws purporting to regulate third-party administrators acting on ERISA plans' behalf (such as PBMs) instead of plans themselves.

This Court should therefore decline North Dakota's invitation to recast the narrow decision in *Rutledge* as a break from traditional, broad ERISA preemption. An expansive reading of *Rutledge* would harm plans and patients alike by crippling ERISA's preemption provision and undermining uniform national coverage and plan administration. The Court should reject those arguments and hold the challenged laws preempted.

I. *Rutledge* Does Not Save North Dakota's Laws From Preemption

A. *Rutledge* Addressed A Narrowly Defined Category Of "Rate Regulation" Not Presented Here

Rutledge was a narrow decision addressing a particular form of cost regulation—concerning the maximum allowable cost ("MAC") pricing for prescription drugs—that is not presented in this challenge to North Dakota's very different laws. *Rutledge* involved Arkansas's MAC law, which set a floor for the

total amount paid to pharmacies for dispensing prescription drugs through the mix of funding sources determined by a plan—including both reimbursements from PBMs on plans' behalf, and copayments by patients in accordance with plan terms. *Rutledge*, 141 S. Ct. at 478, 482. Critically, Arkansas's law left plans free to determine who should bear what portion of these costs, and did not require plans or their agents to pay any particular amount or provide a particular benefit. *Id.* at 482.

The Supreme Court resolved *Rutledge* in a short and narrow unanimous decision. Relying exclusively on its prior decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), the Court held that Arkansas's MAC law was not preempted under ERISA's "connection-with" prong because it "amounts to nothing more than cost regulation." 141 S. Ct. at 481. Indeed, the Court expressly refrained from breaking any new ground in *Rutledge*, because Arkansas's law was actually "less intrusive than the law at issue in *Travelers*," so that "[t]he logic of *Travelers* decide[d] th[e] case." *Id.*

Importantly, the Court did not adopt a blanket exception from preemption for *all* state laws that concern "cost" (or PBMs) in any way. Indeed, the Court recognized that state laws "requiring payment of specific benefits" by plans or their agents are among the "primar[y]" targets of ERISA preemption. 141 S. Ct. at 480. Rather, in addressing Arkansas's MAC law regulating the total amount of pharmacy reimbursements from all sources, the Court used "cost regulation" in a narrow sense,

referring to state laws that "merely increase costs" by "'indirect economic influence,'" without "forcing plans to adopt any particular scheme of substantive coverage" or "requir[ing] plan administrators to structure their benefit plans in any particular manner." *Id.* at 480, 482-83.

The Court's controlling precedent in *Travelers* was similarly limited and confirms *Rutledge*'s own narrow scope. *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, 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, *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, *Travelers*, 1994 WL 721247, at 10 n.10 (U.S. Dec. 29, 1994). Because the law imposed no "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 division of total costs among payers simply was not at issue.

Travelers, like *Rutledge*, upheld the state law at issue only after determining that the law "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." *Travelers*, 514 U.S. at 659-60, 668. The Court made clear that if the law *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; *accord Rutledge*, 141 S. Ct. at 480. Like *Rutledge*, *Travelers* confirms that state "rate regulation" is subject to ordinary preemption analysis based on its "effects" on ERISA plans. 514 U.S. at 658.

In short, *Rutledge* is not a sea change in ERISA preemption, but a straightforward application of *Travelers*. Both precedents concern a narrow category of regulations specifying the total costs due to providers from all sources, without compelling plans to pay particular amounts or provide particular benefits.

These narrow holdings have no bearing in this case because, unlike the law in *Rutledge*, the North Dakota laws at issue do not regulate MAC pricing and are not "rate regulations" in the limited sense in which the Supreme Court has used that term. North Dakota itself has stated that its laws are "distinguishable," "unlike," and "differ markedly from" the Arkansas laws at issue in *Rutledge*, as "North Dakota's laws do not regulate the methodology for reimbursing pharmacies." N.D. Initial Br.

2, 14, 26, 31; *accord* Add.15 (district court recognizing the same). Indeed, in response to a direct question from this panel at oral argument regarding "the Supreme Court's [then-pending] review of *Rutledge*"—"would the result of that case have an impact on the issues before this Court?"—counsel for North Dakota unequivocally stated that Arkansas's law is "completely distinguishable and for those reasons it *doesn't have any bearing on connection-with* [ERISA] preemption" of North Dakota's laws, or on any issue in "the rest of th[is] case" besides reference-to preemption. Recording 26:51-27:10, http://media-oa.ca8.uscourts.gov/OAaudio/2019/10/182926.mp3 (emphasis added).

The courts that have addressed *Rutledge* have confirmed that "the Court did not disturb" prior precedents establishing "'connection with'" preemption. *Fast Access Specialty Therapeutics, LLC v. UnitedHealth Grp., Inc.*, 2021 WL 1238869, at *13-14 (S.D. Cal. Apr. 2, 2021); *see also Mabry v. ConocoPhillips Co.*, 2021 WL 189144, at *11 n.140 (D. Alaska Jan. 19, 2021) (adhering to prior circuit precedent because it is "not clearly inconsistent with" *Rutledge*). Because North Dakota is correct that its laws are "fundamentally different" from Arkansas's MAC-pricing regulation, Recording 17:05-27, *Rutledge* does not alter prior precedent establishing that North Dakota's laws are preempted because they have an impermissible connection with ERISA plans.

B. *Rutledge* Preserves The Limits On States' Regulation Of Plan Structure And Disclosures

The targeted analysis in *Rutledge* did not disturb precedents broadly prohibiting state regulation in areas that have a "connection with" ERISA plans—including (1) laws regulating plan design and benefit structure and (2) laws imposing disclosure requirements on plans.

1. *Rutledge* reaffirmed that "ERISA is … primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits … or by binding plan administrators to specific rules for determining beneficiary status." 141 S. Ct. at 480 (citing *Shaw*, 463 U.S. 85, and *Egelhoff*, 532 U.S. 141). The Court also reiterated that preemption may apply where "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Rutledge*, 141 S. Ct. at 480 (quoting *Gobeille*, 577 U.S. at 320).

This longstanding category of preempted benefit regulation encompasses a wide variety of state laws. For example, absent an express exception to preemption, states may not restrict plans' choice of provider networks by forcing them to contract with "any willing provider." *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332-34 (2003). As the Sixth Circuit held in a decision affirmed by a unanimous Supreme Court, such laws "'relate to' employee benefit plans" within the meaning of ERISA's preemption clause, *id.* at 333, because they impermissibly "mandat[e]

benefit structures," *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 362-63 (6th Cir. 2000); *accord CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 648-49 (5th Cir. 1996).[2]

States also may not intrude on plan design choices concerning the "method of calculating … benefits" or payment of benefits. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997). For example, a state may not "prohibi[t] plans from being structured in a manner requiring reimbursement in the event of recovery from a third party" or "requir[e] plan providers to calculate benefit levels in [one state] based on expected liability conditions that differ" from conditions in other states. *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990). ERISA also preempts state regulation of a "plan's 'system for processing claims and paying benefits.'" *Egelhoff*, 532 U.S. at 150. At bottom, "the payment of benefits" is "a central matter of plan administration" that ERISA preemption squarely protects from state regulation. *Id.* at 148.

In sum, ERISA preempts state laws that "mandat[e] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. Such state regulation

[2] The question presented in *Miller* was whether the state law was "saved from pre-emption" under ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A)—making clear that the law would *otherwise* be preempted. 538 U.S. at 334. The savings clause is irrelevant here because North Dakota waived any such argument, as this panel correctly held. *PCMA v. Tufte*, 968 F.3d 901, 906 (8th Cir. 2020).

of plan benefit levels is directly 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] plan[s]," *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (emphasis added). Congress well understood that employers are not "require[d] … to establish employee benefit plans" at all, *id.*, 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). So ERISA leaves plan sponsors "large leeway" to decide what benefits to offer. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). But state laws dictating the substantive terms for covered benefits abrogate that leeway, and are accordingly preempted. Nothing in *Rutledge* undercuts this foundational principle.

2. ERISA also preempts state regulations in the interrelated areas of disclosure, reporting, and recordkeeping. The Supreme Court held in *Gobeille* that ERISA preempted a Vermont law imposing reporting requirements on plans and their third-party administrator agents. 577 U.S. 317, 320. The Court stressed that ERISA primarily operates by mandating "procedures" that are "intended to be uniform," and that "ERISA's reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive." *Id.* at 321. The Court reaffirmed that

"reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA." *Id.* at 323. Thus, Vermont's reporting regime both "intrude[d] upon 'a central matter of plan administration' and 'interfere[d] with nationally uniform plan administration.'" *Id.* (quoting *Egelhoff*, 532 U.S. at 148). Preemption was "necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Id.* *Rutledge* did not address reporting, disclosure, or recordkeeping and thus did nothing to disturb the broad preemption principles of *Gobeille* and its predecessors.

C. North Dakota's Laws Trench On Core Matters Of Plan Design And Administration

North Dakota's laws are impermissibly "connected with" ERISA plans under the preemption principles that *Rutledge* reaffirmed. To give just a few examples:

1. Sections 16.1(11) and 16.2(4) improperly dictate how ERISA plans must design their pharmacy provider networks. They do so by prohibiting PBMs from requiring pharmacies to meet heightened "accreditation standards" in order to participate in a plan's provider network. N.D. Cent. Code. §§ 19-02.1-16.1(11), 19-02.1-16.2(4). These provisions evidently require plans to provide prescription drug benefits in North Dakota according to a certain structure, *i.e.*, through less exclusive networks consisting of pharmacies that need not comply with heightened credentialing standards that plans may impose in other states. For patients, less

exclusive networks and lower standards translate into higher premiums and potential safety concerns with the drugs they receive through these networks. *See* PCMA Replacement Br. 9-10.

North Dakota's network regulations are analogous to the "any willing provider" statutes held to be impermissibly "connected with" ERISA plans in *Miller* and related cases. Those statutes "impair[ed plans'] ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails." *Miller*, 538 U.S. at 332. These state restrictions "frustrate[d plans'] efforts at cost and quality control, and … ultimately den[ied] consumers the benefit of their cost-reducing arrangements with providers." *Id.* The laws were therefore "connected with" ERISA plans because they denied plans "the right to structure their benefits in a particular manner." *CIGNA*, 82 F.3d at 648; *accord Nichols*, 227 F.3d at 362-63.

2. Section 16.1(4) impermissibly regulates plan cost-sharing requirements by mandating that patients' copayments cannot "excee[d] the cost of the medication." N.D. Cent. Code § 19-02.1-16.1(4). Unlike the "rate regulation" permitted by *Rutledge*—which concerned the *total* amounts paid to pharmacies—Section 16.1(4) regulates the division of pharmacy costs among payors, prohibiting plans from determining the respective shares of costs borne by patients, plans, and plan agents

(PBMs). In this way, Section 16.1(4) impermissibly intrudes on plans' cost-sharing, an integral component of benefit structure that allows plans to incentivize efficient and effective treatment. *See* PCMA Replacement Br. 26; *supra* at 6-8.

3. North Dakota's laws imposing plan-related disclosure requirements are also squarely preempted under *Gobeille*. Because "reporting, disclosure, and recordkeeping" are themselves "fundamental components of ERISA's regulation of plan administration," North Dakota's disclosure requirements necessarily intrude on a "'central matter of plan administration'" and are accordingly preempted. *Gobeille*, 577 U.S. at 323. That is particularly true here because North Dakota's laws specifically require disclosure of information on matters of core ERISA concern. Section 16.1(10), for example, directs PBMs acting on plans' behalf to provide pharmacies with information related to their pharmacy networks, such as the "group number for each pharmacy network established or administered by a [PBM]." N.D. Cent. Code § 19-02.1-16.1(10). Pharmacy network information is integral to plan administration, since pharmacy networks are central to the overall structure of how prescription drug benefits get disbursed to patients. *See* PCMA Replacement Br. 8-10, 23-25*; cf. PCMA v. Gerhart*, 852 F.3d 722, 731 (8th Cir. 2017) (holding that ERISA preempts state law requiring PBM disclosures to network pharmacies).[3]

[3] Just as *Rutledge* did not disturb *Gobeille*, it also did not disturb the portion of *Gerhart* addressing this disclosure requirement and relying on *Gobeille*, which

Additionally, Section 16.1(4) requires disclosure to providers of the "adjudicated cost" on claims paperwork—information that pertains directly to the "'processing of claims and disbursement of benefits,'" which is likewise a "central matter of plan administration." *Egelhoff*, 532 U.S. at 148-49.

II. ERISA Preemption Applies Equally To State Laws Targeting Third-Party Agents Of ERISA Plans

North Dakota is not aided by the superficial fact that its challenged laws, like those in *Rutledge*, involve regulation of PBMs. To the contrary, *Rutledge* reaffirmed the longstanding principle that state laws interfering with plan administration are preempted equally whether they regulate plans or third parties, such as PBMs, that act on their behalf.

In this case, the district court asserted that ERISA does not preempt state laws that impose obligations "on PBMs" rather than "on ERISA plans." Add.16-17. The district court was wrong at the threshold to suggest that North Dakota's laws even make this distinction—in reality, its laws regulate *any* "third-party payer," including ERISA plans. *E.g.*, N.D. Cent. Code § 19-02.1-16.1(2); *see* PCMA Replacement Br. 31. But the district court's more fundamental error was thinking that the distinction matters. To the contrary, the district court's attempt to cabin ERISA

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remains good law in this Circuit. *See Brown v. First Nat'l Bank in Lenox*, 844 F.2d 580, 582 (8th Cir. 1988) ("[O]ne panel of this Court is not at liberty to overrule an opinion filed by another panel.").

preemption to laws acting directly on plan sponsors themselves (rather than their agents) departs significantly from the long-established analytical framework that *Rutledge* reaffirmed.

Under the precedents of this Court and the Supreme Court, ERISA preempts state laws interfering with plan administration and design regardless of whether the administration is carried out by the plan or by a third party. What matters is the "aspect of plan administration" or design regulated, *Gobeille*, 577 U.S. at 324, and the "nature of the effect … on ERISA plans," *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997), 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 Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). A state can no more interfere with plan administration carried out through a plan's "third-party administrators," *Gerhart*, 852 F.3d at 731, 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. 577 U.S. at 317. The position suggested by the district court in this case—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 341 (Ginsburg, J.,

dissenting), and was rejected by the majority, *id.* at 317. And in *Gerhart*, this Court relied on *Gobeille* to hold preempted an Iowa state law that imposed "duties and restrictions … on PBMs in their role as third-party administrators for ERISA plans" that were "inconsistent with ERISA's central design." 852 F.3d at 731.

Rutledge endorsed prior precedent on this point. Although Arkansas's MAC-pricing law purported to "regulat[e] PBMs" rather than plans, 141 S. Ct. at 481, the Court applied standard ERISA preemption doctrine. The Court concluded that this particular Arkansas law did not actually "'gover[n] a central matter of plan administration or interfer[e] with nationally uniform plan administration,'" *id.* at 480, and so was not preempted. But the Court did not dispute this Court's previous judgment that a PBM-regulating law that *did* intrude on those areas *would* be subject to connection-with preemption. *See id.* at 479 (citing *Gerhart*, 852 F.3d at 726, 731). Notably, the United States submitted a brief urging that state regulation is not preempted where it "imposes obligations on PBMs, not plans." Br. for U.S. as Amicus Curiae, *Rutledge*, 2020 WL 1190622, at 27 (U.S. Mar. 2, 2020). But at oral argument, the government conceded that ERISA preemption "focuse[s] on *what* is being regulated"—*i.e.*, "plan administration"—rather than "who." Tr. 26:24-27:12, perma.cc/AC87-RS4Q (emphasis added). In keeping with that concession, the Court declined to endorse any third-party exception to ERISA preemption.

Other circuits 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. *PCMA 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*, 577 U.S. at 320, 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 loophole, the district court turned 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 interpretation of the statute, *see Varity*, 516 U.S. at 502-03, and preclude an interpretation of ERISA's preemption provision that differentiates between regulation of plans and regulation of their agents.

In light of this authority, North Dakota has conceded that ERISA "could" "sometimes" preempt "regulation of a PBM exercising [administrative] functions" on plans' behalf. N.D. Initial Br. 27; *see also id.* at 33 (recognizing that *Gobeille* and *Gerhart* held preempted laws regulating "third parties"). Despite conceding that it is *not* dispositive whether a state law regulates "*PBMs*" rather than "*plan[s]*,"

North Dakota has also relied on this false distinction at virtually every turn in its effort to resist preemption. *Id.* at 29-31 (arguing that North Dakota's accreditation, conflicts-of-interest, and claw-back requirements "ha[ve] nothing to do with plan administration" because they merely "limit a PBM's ability" to take certain actions); *id.* at 30 (same for mail-order restrictions, because they "are included in 'PBM-pharmacy contracts,' not plan documents"); *id.* at 32-33 (same for disclosure requirements, because they merely "requir[e] *PBMs* to disclose *PBM-controlled*" information).

North Dakota wrongly assumes a distinction between "pharmacy contracts" and "plan documents," N.D. Initial Br. 30, even though such contracts often form *part* of the plan. And more fundamentally, these muddled arguments contravene controlling precedent, which holds that ERISA preemption *always* applies equally to state laws "limit[ing]" third-party agents' "ability" to engage in plan administration on plans' behalf. *Cf. id.* at 29. This Court should reject the district court's erroneous reliance on the distinction between PBMs and the plans for which they provide administrative services.

III. North Dakota's Narrow Approach To Preemption Would Undermine Uniform Coverage And Plan Administration In Areas Far Beyond This Case

Invoking *Rutledge* to justify North Dakota's laws here could threaten basic preemption principles and significantly undermine Congress's objectives across

many contexts extending well beyond this case. "ERISA's goal, [the Supreme] 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), including by "ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions," *Rutledge*, 141 S. Ct. at 480. Allowing states to dictate the structure of plan benefits and disclosures, as North Dakota seeks to do, would subject ERISA plans to a thicket of conflicting state rules that will defeat Congress's objectives, preclude plans from offering uniform national coverage, and raise costs of plan administration. The resulting burden on plans will ultimately harm participants and beneficiaries by barring them from accessing the full range of benefits offered in other states, *see* PCMA Replacement Br. 8-10, and 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. Katherine Keisler-Starkey et al., *Health Insurance Coverage in the United States: 2019* at 5 (Sept. 15, 2020), https://www.census.gov/library/publications/2020/demo/p60-271.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. ERISA accordingly employs broad preemption of related state laws as a principal means to accomplish Congress's "primar[y]" goal of "'ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefits law.'" *Rutledge*, 141 S. Ct. at 480. The statute prohibits states from "requir[ing] providers to structure benefit plans in particular ways," *id.*, because such "conflict in substantive [benefits] law" is "[p]articularly disruptive" and "fundamentally at odds with the goal of uniformity that Congress sought to implement," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Preemption also serves the related "congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators" of complying with divergent state laws—"burdens ultimately borne by the beneficiaries" in the form of higher premiums or reduced benefits. *Egelhoff*, 532 U.S. at 150 (alterations in original).

North Dakota's laws undermine uniform coverage and plan administration in these ways. Under these laws and the growing patchwork of similar state-specific PBM regulations, "plans and employer[s]" are forced to "tailo[r]" their benefit coverage "to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. Contrary to Congress's objectives, "[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 coverage restrictions and network requirements that apply to pharmaceutical benefit coverage in each state. *Egelhoff*, 532 U.S. at 148-49 (footnote omitted).

The 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.

Additionally, limiting ERISA preemption to laws regulating activities carried out by plans themselves, as the district court held, would discourage the efficient and increasingly widespread division of labor that third-party administrators facilitate. *See* Add.16-17. This would inevitably raise plan costs and reduce the funds available for benefit coverage, contrary to Congress's "goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators." *Egelhoff*, 532 U.S. at 150 (alterations in original). Further, a patchwork of state laws restricting third-

party administrators could reduce the number of third parties that are available 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). 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. *E.g.*, 29 U.S.C. §§ 1002(21), (38), 1102(a), (b)(2). ERISA directly regulates some of these entities, such as fiduciaries. *Id.* § 1104. Allowing states to interfere with plans' delegation to these entities would frustrate Congress's scheme.

Plan sponsors today (and in particular the large multi-state employers most affected by preemption) increasingly rely on third-party agents of many different types to help administer ERISA plans. Sixty-seven percent of the numerous workers covered by health plans are covered by completely or partially self-funded plans, many of which rely on third parties for plan administration. Kaiser Family Found., *2020 Employer Health Benefits Survey: Summary of Findings*, https://www.kff.org/report-section/ehbs-2020-summary-of-findings/ (Oct. 8, 2020). In particular, approximately 74% of large employers and 56% of smaller employers directly

engage PBMs to manage and administer their prescription drug benefit plans. Pharm. Benefit Mgmt. Inst., *2018 Trends in Drug Benefit Design* 12 (2018). Today, "nearly all States and the District of Columbia have enacted laws regulating PBMs," Petition for a Writ of Certiorari, *Wilke v. PCMA*, No. 20-683, at 7 (U.S. Nov. 13, 2020), with various states concededly "tak[ing] different approaches to regulating PBMs," California Amicus Br., *Rutledge*, 2020 WL 1372774, at 33. 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*, 577 U.S. at 326-27. 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 PBMs, third parties play a vital role in many aspects of modern plan administration, all of which are threatened by a "third-party" exception from ERISA preemption. Claims administrators, for example, apply plan terms to determine whether and the extent to which benefits are covered. *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 HMO, Inc. v. Moran*, 536 U.S. 355, 373 (2002). Provider networks contract with insurers to provide various services. *See Miller*, 538 U.S. at 332. Moreover, the district court's purported third-party exception would affect not only health plans, but all ERISA employee benefit plans, opening the door, for example, for states to limit retirement plans—while claiming merely to regulate plan service providers—by telling plan service providers which funds to include in their lineup. It is therefore essential that this Court 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.

North Dakota's unduly narrow approach to ERISA preemption thus threatens to disrupt uniform national coverage and plan administration, reduce efficiency, and increase plan costs in areas extending far beyond this particular case.

CONCLUSION

The Court should reaffirm the broad scope of ERISA preemption established by the statute's plain language and relevant precedent. *Rutledge* does not change the longstanding principles that ERISA preempts state laws, like North Dakota's, that impermissibly regulate plan design and benefit structure or impose plan-related disclosure requirements, whether those laws act directly on plans or on third-party agents (such as PBMs) engaged in plan administration on plans' behalf. The Court should reverse the district court's judgment and remand with instructions to enter judgment in favor of PCMA declaring that ERISA preempts Sections 16.1 and 16.2 to the maximum extent advocated by PCMA.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that pursuant to Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B), this brief is proportionately spaced, has a typeface of 14 point in Times New Roman font, and contains 6,495 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f), according to the word count feature of the Microsoft Word word-processing system used to generate this brief.

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CIRCUIT RULE 28A(h) CERTIFICATION

Pursuant to Circuit Rule 28A(h), the undersigned hereby certifies that I have filed electronically a non-scanned PDF version of this brief. I hereby certify that the file has been scanned for viruses and that it is virus-free.

/s/ Helgi C. Walker
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CERTIFICATE OF SERVICE

In accordance with Fed. R. App. P. 25, I hereby certify that I electronically filed the foregoing with the Clerk of Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system on May 17, 2021. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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