No. 22-6074

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,

Plaintiff-Appellant

v.

GLEN MULREADY, in his official capacity as Insurance Commissioner of Oklahoma; OKLAHOMA INSURANCE DEPARTMENT,

Defendants-Appellees

On Appeal from the United States District Court
for the Western District of Oklahoma
No. 5:19-CV-00977-J (Judge Bernard M. Jones)

BRIEF OF *AMICUS CURIAE* ASSOCIATION OF FEDERAL HEALTH ORGANIZATIONS SUPPORTING APPELLANT AND IN SUPPORT OF REVERSAL

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FED. R. APP. P. 26.1 DISCLOSURE STATEMENT

In accordance with Fed. R. App. P. 26.1, *Amicus Curiae* Association of Federal Health Organizations states that it is an unincorporated association and has no parent corporation and that no publicly held corporation owns 10% or more of its stock.

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GLOSSARY OF ABBREVIATIONS

ERISA: Employee Retirement Income Security Act

FEHBA: Federal Employees Health Benefits Act

FEHBP: Federal Employees Health Benefits Program

PBM: pharmacy benefits manager

STATEMENT OF THE *AMICUS CURIAE*

The Association of Federal Health Organizations ("AFHO") is an organization of entities that serve as carriers of health benefit plans under the Federal Employees Health Benefits Program ("FEHBP"). Collectively, the plans of AFHO's member carriers provide health benefits to over 75% of the roughly eight million federal and postal employees, annuitants, and eligible dependents who receive health coverage under the FEHBP. *See* U.S. Gov't Accountability Office, *Federal Employees Health Benefits Program: Enrollment Remains Concentrated Despite More Plan Offerings, and Effects of Adding Plan Types Are Uncertain* (Accessible Version) 22 (Oct. 5, 2017), https://www.gao.gov/products/gao-18-52. Many of the plans are national in scope, covering enrollees in all U.S. states and territories. All of the plans for which AFHO's members are carriers contain terms that are the same for all jurisdictions in which the respective plans operate.

Health benefit plans under the FEHBP are governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914. FEHBA, in turn, contains a preemption provision designed to ensure "uniform administration of the program, free from state interference, particularly in regard to coverage, benefits, and payments." *Coventry Health Care of Mo., Inc. v. Nevils*, 137 S. Ct. 1190, 1197 (2017); *see* 5 U.S.C. § 8902(m)(1) ("The terms of any contract under

this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans."). Given the similar "relates to" language in FEHBA's preemption provision and the express preemption provision in the Employee Retirement Income Security Act ("ERISA"), courts have held that "precedent interpreting the ERISA provision . . . provides authority for cases involving the FEHBA provision." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 393-94 (9th Cir. 2002); *see* 29 U.S.C. § 1144(a) (ERISA's preemption clause providing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). Accordingly, AFHO's members have an interest in decisions, such as the impending one in this case, that will determine the applicability of ERISA's preemption provision, as the ERISA precedents may be persuasive in the FEHBA-preemption context.

AFHO agrees with Appellant in this appeal: ERISA preempts the provisions of the Oklahoma Patient's Right to Pharmacy Choice Act ("Act") challenged by Appellant – namely, 36 O.S. § 6961(A)-(B) (referenced as the "Retail-Only Pharmacy Access Standards" by Appellant, *see* Appellant's Br. at 15-16 (Doc. 010110720841 (filed Aug, 4, 2022)); 36 O.S. § 6962(B)(4) (referenced as the "Any Willing Provider Provision" by Appellant, *see* Appellant's Br. at 16); 36 O.S.

§ 6962(B)(5) (referenced as the "Probation-Based Pharmacy Limitation Prohibition" by Appellant, *see* Appellant's Br. at 16); and 36 O.S. § 6963(E) (referenced as the "Cost-Sharing Discount Prohibition" by Appellant, *see* Appellant's Br. at 16). AFHO files this brief in order to emphasize that: (1) the Court's decision, if it rejects preemption, will have debilitating consequences for employee benefit plans that operate nationally or in multiple states; (2) the Act is readily preempted under traditional ERISA-preemption rubrics, as reinforced by *Rutledge v. Pharmaceutical Care Management Ass'n*, 141 S. Ct. 474 (2020); (3) an affirmance would create a split with numerous other Circuits; and (4) there currently exists no presumption against ERISA preemption, which likewise reinforces that ERISA preempts the Act.

Counsel for the *amicus* has contacted counsel for Appellant and for Appellees, respectively, and they indicated that Appellant and Appellees consent to the filing of this brief.

STATEMENT PURSUANT TO FED. R. APP. P. 29(4)(E)

Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for the *amicus* state that no party's counsel authored this brief in whole or in part and that no person other than the *amicus*, its members, or its counsel contributed money that was intended for preparing or submitting this brief.

ARGUMENT

I. APPLICATION OF LAWS LIKE THE ACT WOULD HAVE SERIOUS, NEGATIVE RAMIFICATIONS FOR NATIONAL AND MULTISTATE EMPLOYEE BENEFIT PLANS

The Oklahoma statute is among a growing number of state laws aimed at regulating pharmacy benefits managers ("PBMs") and pharmacy-level transactions associated with healthcare coverage. In *Rutledge*, which is the Supreme Court's recent ERISA preemption decision upholding an Arkansas PBM regulation, various states participated as *amici* and identified forty-four states that, in just the "past five years," have "enacted or amended statutes addressing PBMs." Br. for Cal., 44 Other States, & D.C. as *Amici Curiae* in Supp. of Pet'r in *Rutledge v. Pharm. Care Mgmt. Ass'n*, No. 18-540, 2020 U.S. S. Ct. Briefs LEXIS 4272, at *29 (Mar. 2, 2020). Since *Rutledge*, some of these states, as well as new ones, have aggressively sought to expand or enact additional PBM-regulating measures.[1]

[1] *E.g.*, S.B. 227, Act No. 2021-341, Reg. Sess. (Ala. 2021), 2021 Bill Text AL S.B. 227 (May 6, 2021); S.B. 1356, 55th Leg., 1st Sess. (Ariz. 2021), 2021 Bill Text AZ S.B. 1356 (Apr. 9, 2021); H.B. 1804, Act No. 665, 93rd Gen. Assemb. (Ark. 2021), 2021 Bill Text AR H.B. 1804 (Apr. 12, 2021); H.B. 1881, Act No. 1103, 93rd Gen. Assemb. (Ark. 2021), 2021 Bill Text AR H.B. 1881 (May 3, 2021) (codified as amended in Ark. Code Ann. § 23-92-601 - 23-92-606 (2022)); H.B. 1237, 73rd Gen. Assemb. (Colo. 2021), 2021 Bill Text CO H.B. 1237 (June 7, 2021); H.B. 244, Act No. 192, 2021 Reg. Sess. (La. 2021), 2021 Bill Text LA H.B. 244 (June 11, 2021); H.B. 601, 44th Gen. Assemb., 2021 Reg. Sess. (Md. 2021), 2021 Bill Text MD H.B. 601 (May 18, 2021); S.B. 2799, 2021 Reg. Sess. (Miss. 2021), 2021 Bill Text MS S.B. 2799 (Apr. 20, 2021); S.B. 395, 67th Reg. Sess. (Mont. 2021), 2021 Bill Text Mont. S.B. 395 (May 12, 2021); H.B. 1492, 67th Leg. Assemb. (N.D. 2021), 2021 Bill Text ND H.B. 1492 (Apr. 21, 2021) (codified

As to their ramifications for employee benefit plans providing healthcare coverage, including drug benefits, these state laws fall on a continuum: on the one end are state statutes that may simply constitute an added cost of doing business, whereas on the other end are state laws the compliance with which would be exceedingly burdensome for employee benefit plans. The Arkansas law at issue in *Rutledge* fell on the former part of the continuum (the less-onerous end). For one thing, the Arkansas law, as described by the Supreme Court, was "merely a form of cost regulation." *Rutledge*, 141 S. Ct. at 481. By principally requiring that PBMs reimburse pharmacies at certain rates, but not mandating "plans . . . provide any particular benefit to any particular beneficiary in any particular way," the most Arkansas's law would do is "increase[] costs" for ERISA plans; and, even then, "only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract." *Id.* at 482, 481.

Moreover, the Arkansas law most immediately affected third parties administering pharmacy benefits and pharmacies, not the "'principal ERISA

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as amended in N.D. Cent. Code §§ 19-02.1-16.5, 43-15-25.3 (2022)); H.B. 6477, 2021-22 Leg. Sess. (R.I. 2021), 2021 Bill Text RI H.B. 6477 (July 6, 2021); H.B. 1398, 111th Leg. (Tenn. 2021), 2021 Bill Text TN H.B. 1398 (May 26, 2021); S.B. 3, 105th Leg. Sess., 2021-22 Reg. Sess. (Wis. 2021), 2021 Bill Text WI S.B. 3 (Mar. 26, 2021) (codified as amended in scattered sections of Wis. Stat. § 632 (2022)); H.B. 2263, 85th Leg., 1st Reg. Sess. (W. Va. 2021), 2021 Bill Text WV H.B. 2263 (Apr. 9, 2021) (codified as amended in scattered sections of W.Va. Code §§ 5, 33 (2022)).

entities, the employer, the plan, the plan fiduciaries and the beneficiaries as such.'" *Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 990 (10th Cir. 1999) (quoting *Hospice of Metro Denver, Inc. v. Grp. Health Ins. of Okla. Inc.*, 944 F.2d 752, 756 (10th Cir. 1991)). That is, on its face, the Arkansas measure regulated entities – *i.e.*, PBMs – that *Rutledge* characterized as "serv[ing] as intermediaries between prescription-drug plans and the pharmacies that beneficiaries use," rather than the ERISA plans themselves. Indeed, nothing in the Arkansas law stopped "prescription-drug plans [from] reimburs[ing] PBMs" for their plan's drug costs at a rate that "differ[ed] from . . . a PBM's reimbursement to a pharmacy." *Id.* at 478. Nor was the Arkansas law overtly aimed at ERISA-plan beneficiaries, as it regulated PBM relationships *with pharmacies*, not PBM relationships with the customers of pharmacies. *See id.* at 478-79.[2]

[2] This is not to say that only direct regulation of ERISA plans and their beneficiaries triggers ERISA preemption. Quite to the contrary, ERISA's "pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 98 (1983)); *see* 29 U.S.C. § 1144(c)(2) (defining a "State" whose laws are subject to ERISA's preemption clause as any state or any of its political subdivisions or instrumentalities "which purports to regulate, directly *or indirectly*, the terms and conditions of employee benefit plans covered by [ERISA]") (emphasis added). However, whereas the courts have "virtually taken it for granted" that ERISA preempts direct regulation of ERISA plans, *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988), whether ERISA preempts a state law arguably not directed to ERISA plans entails a more detailed inquiry into "the nature of the effect of the state law

In contrast, the provisions Appellant challenges in the Act are of an entirely different nature, registering near the pole of the continuum for state laws that are highly burdensome for employee benefit plans. The Act does not simply concern a PBM's reimbursement to a pharmacy; in fact, pharmacy reimbursement rates are hardly mentioned in the provisions Appellant contests. Instead, as Appellant's brief explains in detail, "the challenged provisions in the Act work in tandem to restrict *pharmacy networks*," which are "a fundamental component of plan benefit design." Appellant's Br. at 25 (emphasis added). "[T]hese network restrictions serve to eliminate or dramatically curtail common plan mechanisms – including limited preferred pharmacy networks, specialty pharmacy networks, and preferred mail-order options – that reward workers and their families for using pharmacies of higher quality and cost efficiency." *Id.*

Equally important, while Arkansas's statute operated directly on PBMs (again, labelled by the Supreme Court as intermediaries) and pharmacies, the Oklahoma provisions more broadly encompass key ERISA parties. For instance, the Act is not limited solely to stand-alone PBMs that "contract with . . . healthcare plans and programs." *Rutledge*, 141 S. Ct. at 481 n.1. The Act's definition of "pharmacy benefits manager" includes "a person that performs pharmacy benefits

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on ERISA plans." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (internal quotation marks and citation omitted).

management" and "any other person acting for" him or her via contract or an employment relationship, with pharmacy benefits management then not separately defined. 36 O.S. § 6960(4). An ERISA plan that chooses itself to administer its pharmacy-benefits program seemingly is within the statute's confines. Also potentially within the Oklahoma law's confines is an ERISA plan assisting an ostensibly separate PBM with pharmacy benefits management, such as by determining appeals of pharmacy-benefits disputes or by establishing the criteria through which the PBM does its work.

Similarly, the Act addresses PBMs' (and plans') relationships with beneficiaries (another chief ERISA party), not just with pharmacies – as the statute's very name imparts (*i.e.*, "*Patient's* Right to Pharmacy Choice Act," 36 O.S. § 6958 (emphasis added)). The Act's network access provisions are all keyed on the number of "covered individuals" within a certain area. 36 O.S. § 6961(A). Further, the Act mandates that "patients" must have access to pharmacies with ownership unconnected to a PBM. *Id.* § 6961(C). More generally, the Act commands that "an individual" shall have a "choice" of "a retail pharmacy or a mail-order pharmacy," *id.* § 6963(E), and that PBMs shall not "restrict an individual's choice of in-network provider for prescription drugs" or incentivize use of certain pharmacies through discounts or reductions in cost-sharing "to individuals." *Id.* § 6963(D); *see id.* § 6959 ("purpose of the [Act] is to establish

minimum and uniform access to a provider and standards and prohibitions on restrictions of *a patient's* right to choose a pharmacy provider") (emphasis added).[3]

If they were to apply, laws like Oklahoma's pose especially acute problems for employee benefit plans that operate nationally or multistate. To comply, the plans would need to establish different operational features in each state on the subjects associated with drug benefits that these laws address. And because these state laws may – and, in the case of the Act, do – dictate plan terms and structures, such as the provider networks they adopt and the cost-sharing terms to which beneficiaries shall be subject, *see infra* pp. 13-15, the plan's terms would, in effect, be subject to variation state-by-state. "Application of differing state . . . laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990).

Plus, the unique features necessary in each state could increase the available benefits in particular states, notwithstanding that the participants' payroll contributions for coverage under the plan might be designed to be uniform throughout the nation. The "'lack of uniformity of [administration and] benefits

[3] The Act also has provisions ordering certain disclosures from PBMs directly to "self-funded employer plans," illustrating another instance in which the Oklahoma law immediately extends beyond intermediary PBMs and pharmacies to ERISA plans and their beneficiaries. 36 O.S. § 6962(D)(2)-(3).

for enrollees in the same plan . . . would result in enrollees in some States paying a premium based, in part, on the cost of benefits provided only to enrollees in other States.'" *Helfrich v. Blue Cross & Blue Shield Ass'n*, 804 F.3d 1090, 1099 (10th Cir. 2015) (FEHBP plan) (quoting H.R. Rep. No. 95-282, at 4 (1977)). Or if a plan seeks to retain its nationwide uniformity, it will be forced to adopt the most exacting state's requirements across the board. Put in real terms, to administer a nationally uniform ERISA plan, a plan sponsor might need to codify nationally in the ERISA plan's terms Oklahoma's expansive (and expensive) provider-network requirements and limits on beneficiary cost-sharing.

These problems would not be confined to a small set of plans. Approximately 163 million individuals obtain healthcare coverage through employer plans, the vast majority governed by ERISA and almost certainly involving multistate private employers. *See* Kaiser Family Foundation, *Health Ins. Coverage of the Total Population* (2020).[4] Additionally, the 163 million total comprises the eight million FEHBP enrollees, the majority of whom are in national plans. *See supra* p. 1. Each of these ERISA and FEHBP plans – if state laws such

[4] https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?dataView=1&currentTimeframe=0&selectedDistributions=employer&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Aug. 10, 2022).

as Oklahoma's applied – would be denied the advantages of uniformity in plan administration, terms, and beneficiary financial contribution.

II. THE ACT READILY SUCCUMBS TO ERISA PREEMPTION UNDER THE STANDARD ERISA PREEMPTION TESTS

ERISA preemption was designed to neutralize the difficulties for national and multistate plans that the Oklahoma law creates. With preemption, Congress ensured that "employee benefit plan regulation would be 'exclusively a federal concern.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). It sought to give employers "large leeway" – *i.e.*, discretion free from state interference – to "design . . . welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003); *see* 5 U.S.C. § 8902(d) (FEHBA giving federal government final authority over federal-employee plans). With ERISA, Congress immunized employee benefit plans from state regulation because localized regulation, if allowed, would introduce inefficiencies and litigation risks that could discourage employers from offering plans in the first place. *See Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-23 (2016).[5]

[5] To be sure, Congress anticipated some state variability under ERISA in *insured* ERISA plans, considering that it saved state insurance regulations from preemption. *See* 29 U.S.C. § 1144(b)(2)(A). However, the Act's provisions do not constitute insurance regulations, given, at a minimum, that they are, in part, aimed at those administering drug benefits, including PBMs, who carry no insurance risk. *See Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 338 (2003); *id.* at 336 n.1;

Summing up its standards, the Supreme Court has said "ERISA pre-empt[s] state laws that mandate[] employee benefit plan *structures* or their administration." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) ("*Travelers*"). Confirming that test, *Rutledge* reiterated that "ERISA is . . . primarily concerned with preempting laws . . . requir[ing] providers [here, meaning employers] to structure benefit plans in particular ways." 141 S. Ct. at 480. As another "shorthand," the Supreme Court "asks whether a state law 'governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.* (quoting *Gobeille*, 577 U.S. at 320). In these instances, the state law has "an 'impermissible connection' with" ERISA plans, *id.* (quoting *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997) ("*Dillingham*")), and, therefore, "relate[s] to" them and activates ERISA's preemption provision, 29 U.S.C. § 1144(a).

Am.'s Health Ins. Plans v. Hudgens, 742 F.3d 1319, 1333 (11th Cir. 2014). Because statutes like Oklahoma's are not saved state insurance laws, they prompt state variability beyond the level sanctioned by Congress even for insured plans. And ERISA's insurance savings clause cannot save from preemption the Act's application to self-funded ERISA plans or to their PBMs (or to FEHBP plans). *See* 29 U.S.C. § 1144(b)(2)(B) (self-funded plans shall not be "deemed to be an insurance company"); 5 U.S.C. § 8902(m)(1) (for FEHBP plans, FEHBA preempting state laws "relat[ing] to health *insurance* or plans") (emphasis added). In any event, Appellees have waived raising the application of ERISA's insurance savings clause. *See* Appellant's Br. at 39 n.14.

Based on these principles, as Appellant has ably shown, ERISA preempts the Act. *See* Appellant's Br. at 22-42. As Appellant has described, the Act's provisions intricately govern the pharmacy networks that plans and PBMs establish and maintain. *See id.* at 26-30. The existence of provider networks are a common and essential ingredient for a cost-effective health plan that any employer establishes. Through contracts with providers (including pharmacies), the plan and a PBM can extract terms from pharmacies that are beneficial for the plan's beneficiaries, in exchange for the steerage of beneficiaries to that provider and the guarantee of smooth, direct payment to the provider.

The centrality of networks to a health plan is nicely illustrated by FEHBA. FEHBA expressly recognizes them as a key feature of a health plan. The largest employee health benefit plan (of any type) in the United States – with about five million enrollees – is the FEHBA-governed "service benefit plan," which is called for in 5 U.S.C. § 8903(1). There, FEHBA authorizes the creation of "[o]ne Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering 2 levels of benefits, . . . under which payment is made by a carrier *under contracts with physicians, hospitals, or other providers of health services*." *Id.* (emphasis added). Hence, Congress, in the very description of the service benefit plan, referenced network contracting. ERISA generally leaves it to employers to decide exactly how to fashion their employee

health plans, and employers have by their election then promised in their plans, and have themselves, or through their PBMs, created comprehensive provider networks that Congress, in FEHBA, saw as fundamental to operating an employee health plan.

As noted earlier, for preemption purposes, "'the nature of the effect of the state law on ERISA plans'" matters. *Egelhoff*, 532 U.S. at 147 (quoting *Dillingham*, 519 U.S. at 325); *see supra* pp. 6-7 n.2. And when a state law would "'govern[] . . . a central matter of plan administration,'" the nature of its effect is too invasive to survive ERISA preemption. *Gobeille*, 577 U.S. at 320 (quoting *Egelhoff*, 532 U.S. at 148). Here, Oklahoma has attempted to control a chief facet of an employee health plan – *i.e.*, the establishment and terms of provider networks – and, accordingly, "[p]re-emption is necessary." *Id.* at 323. Preemption will "prevent the States from imposing novel, inconsistent, and burdensome [network] requirements on plans," requirements that otherwise would be at odds with "the uniform system of plan administration contemplated by ERISA." *Id.*

An aspect of the Act's network-access provisions particularly illustrating friction with ERISA is what Appellant has called the "Cost-Sharing Discount Prohibition." *See supra* p. 3. Here, the Act forecloses PBMs from "'requir[ing] or incentiviz[ing]' the use of a particular pharmacy using any 'discounts in cost-sharing.'" Appellant's Br. at 16 (quoting 36 O.S. § 6963(E)). Among other things,

"the *Cost-Sharing Discount Prohibition* prohibits plans from offering beneficiaries incentives or rewards to use mail-order pharmacies, including specialty pharmacies." *Id.* at 27-28 (italics in original). Yet, cost-sharing – such as copayments or coinsurance – typically is established within the ERISA plan itself, to which beneficiaries refer in order to ascertain their rights and obligations. By regulating cost-sharing, Oklahoma has thereby bound "plan administrators to specific rules for determining" beneficiaries' obligations, so that its Act "is pre-empted." *Rutledge*, 141 S. Ct. at 480.

It bears emphasizing, again, that no such offending network-access provisions were at issue in *Rutledge* with Arkansas's PBM law. The Arkansas statute "amount[ed] to cost regulation," "requir[ing] PBMs to reimburse Arkansas pharmacies at a price equal to or higher than that which the pharmacy paid to buy the drug from a wholesaler." *Id.* at 483, 479. The Act amounts to much more and is preempted.

III. AN AFFIRMANCE OF THE DISTRICT COURT'S DECISION WOULD CREATE A CIRCUIT SPLIT

Appellant has shown that the Act, in regulating networks, "expressly eliminates limited preferred pharmacy networks by prohibiting plans from excluding pharmacies willing to meet the terms of the network." Appellant's Br. at 28 (describing "Any Willing Provider Provision" of the Act, 36 O.S. § 6962(B)(4)). If the Court upholds the district court's finding that ERISA does

not preempt this part of the Act, it will spawn a Circuit split with *every* Circuit to have addressed ERISA's preemption of state any-willing-provider statutes. All Circuits so far to have considered the question have deemed such state laws to "relate to" ERISA plans under ERISA's preemption provision. *See Prudential Ins. Co. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897 (8th Cir. 2005) (Arkansas law); *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000) (Kentucky law), *aff'd sub nom.*, *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Tex. Pharmacy Ass'n v. Prudential Ins. Co.*, No. 95-50807, 1997 U.S. App. LEXIS 12986 (5th Cir. Feb. 14, 1997) (Texas law); *CIGNA Healthplan of La., Inc. v. La. ex rel. Ieyoub*, 82 F.3d 642 (5th Cir. 1996) (Louisiana law); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500 (4th Cir. 1993) (Virginia law); *see also Cedra Pharmacy Houston, LLC v. UnitedHealth Grp., Inc.*, No. 17-CV-3800, 2019 U.S. Dist. LEXIS 55827, at *39 (S.D. Tex. Mar. 7, 2019) (following *Tex. Pharmacy Ass'n*), *report and recomm. adopted,* 2019 U.S. Dist. LEXIS 55285 (S.D. Tex. Mar. 29, 2019), *aff'd*, 798 F. App'x 826 (5th Cir. 2020).[6]

[6] The Sixth Circuit's "relate to" holding in *Kentucky Ass'n* was implicitly affirmed by the U.S. Supreme Court when it assumed Kentucky's any-willing-provider statutes "'relate to any employee benefit plan,' 29 U.S.C. § 1144(a)," in order to reach the issue of whether the Kentucky statutes were saved from preemption under ERISA's insurance savings clause. *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. at 333. As noted, the insurance savings clause has no application to the Act, and, anyway, Appellees have waived any argument under the insurance savings clause. *See supra* pp. 11-12 n.5.

The state laws at issue in these cases protected various types of providers, including pharmacies, or even applied just to pharmacies. *E.g.*, *Tex. Pharmacy Ass'n*, 1997 U.S. App. LEXIS 12986, at *3-*4. And they required those administering health plans both to accept entry into their provider networks any provider willing to abide by the network terms and meeting the necessary qualifications and to provide to the health plan's beneficiaries the opportunity – without penalty of lesser reimbursement – to obtain services from any provider willing and able to satisfy network entry conditions. *E.g.*, *Prudential*, 413 F.3d at 902; *CIGNA*, 82 F.3d at 645; *Stuart*, 995 F.2d at 501.

In reaching the conclusion that the state laws "relate[d] to" ERISA plans, the decisions rest on the "connection with" strand of ERISA preemption, with the *CIGNA* decision being indicative of the "connection with" analysis in the cases:

> The Supreme Court has emphasized that preemption is appropriate on this ground when statutes "mandate employee benefit structures or their administration." In the instant case, ERISA plans that choose to offer coverage by [preferred provider organizations ("PPOs")] are limited by the statute to using PPOs of a certain structure[,] i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

82 F.3d at 648 (quoting *Travelers*, 514 U.S. at 658); *accord Stuart*, 995 F.2d at 502 ("The statute restricts the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit

health plan to those preferred by the insurer."); *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d at 362-63 (same). The Sixth Circuit in *Kentucky Ass'n* emphasized that its "connection with" holding jibed with *Travelers* and should not yield to some notion that "the Supreme Court's post-*Travelers* case law may represent a 'sea change' in the 'relation to' analysis." 227 F.3d at 362; *see id.* at 361.

Taking no heed of these decisions, the district court upheld the Act's any-willing-provider provision, albeit by misconstruing it as somehow applying only to pharmacies already in an ERISA plan's network (though it is mystifying how a provision designed to ease entry into a network could apply only to entities already in the network). *See* Appellant's Br. at 37. No such limiting language appears in the Act's text, and this Court – consistent with the other Circuits' well-reasoned decisions – should hold that ERISA preempts a state any-willing-provider law.

IV. THERE NO LONGER IS A PRESUMPTION AGAINST EXPRESS PREEMPTION UNDER ERISA

Solidifying the case for preemption of the Act is that there no longer exists a presumption against preemption under ERISA's preemption provision. In its initial decision addressing the Act (where it denied a preliminary injunction), the district court said: "When addressing preemption claims, the Court begins with a presumption that Congress does not intend to supplant state law." *Pharm. Care Mgmt. Ass'n v. Mulready*, No. CIV-19-977-J, 2020 U.S. Dist. LEXIS 261290, at

*5 (W.D. Okla. July 9, 2020). The perfunctory analysis the district then provided on ERISA preemption – a few paragraphs – in its final decision in Appellee's favor suggests the district court ultimately was not dissuaded from placing a thumb on the scale at the start against ERISA preemption. Nonetheless, there is no presumption against preemption anymore, and the Court, respectfully, should now so declare, not just to ensure a correct result in this appeal but to set the lower courts straight in future ERISA-preemption litigation.

Undoubtedly, at an earlier time, the Supreme Court had instructed for ERISA's preemption section a "starting presumption that Congress does not intend to supplant state law . . . in fields of traditional state regulation." *Travelers*, 514 U.S. at 654-55. Contemporaneously, the Supreme Court's general trend was to extend to express-preemption situations (*i.e.*, situations involving a statutory provision expressly defining the scope of preemption) the "presumption against the pre-emption of state police power regulations" typically applied in ordinary conflict-preemption circumstances governed by the Constitution's Supremacy Clause. *Cipollone v. Liggett Grp.*, 505 U.S. 504, 518 (1992) (federal food and drug statute).

But the Supreme Court's thinking changed in the twenty years following *Travelers*, so that by the mid-2010s a majority of Justices had registered dissatisfaction with a presumption against preemption when Congress had included

a preemption command in the statute's express terms. *E.g.*, *CTS Corp. v. Waldburger*, 573 U.S. 1, 19-20 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.); *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 570 U.S. 1, 21 (2013) (Kennedy, J., concurring). Then, in *Gobeille*, in the ERISA context, the Court refused to recognize at all the existence of a presumption against preemption. *See* 577 U.S. at 325-26 ("*Any* presumption against pre-emption, *whatever* its force in other instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.") (emphasis added).

Ultimately, in *Puerto Rico v. Franklin California Tax-Free Trust*, the Supreme Court formally ruled that, where a "statute 'contains an express pre-emption clause,' we do not invoke any presumption against preemption but instead 'focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent.'" 579 U.S. 115, 125 (2016) (quoting *Chamber of Commerce v. Whiting*, 563 U.S. 582, 594 (2011)). Though *Franklin* was not an ERISA case, the Court in *Franklin* cited *Gobeille* in support of the proposition that there is no presumption against preemption if a statute contains an express preemption provision. *See id.* After *Franklin*, at least two Circuits have now rejected a presumption against preemption when applying ERISA's express preemption provision, determining *Travelers* to have been overtaken on the point.

See Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan, 938 F.3d 246, 259 (5th Cir. 2019) ("Given that *Franklin* specifically references *Gobeille* – an ERISA case – when holding that there is no presumption [against] preemption when the statute contains an express preemption clause, we conclude that holding is applicable here."); *see also Pharm. Care Mgmt. Ass'n v. Wehbi*, 18 F.4th 956, 967 (8th Cir. 2021) (same).

Finally, clinching the point that there is no presumption against preemption in ERISA express-preemption cases is *Rutledge*. The Court there conspicuously nowhere mentioned any presumption against preemption, notwithstanding that the Court otherwise relied heavily on *Travelers*. *See Rutledge*, 141 S. Ct. at 479-81.

All of this means that this Court should not tip the scale at the start against preemption when judging if ERISA preempts the Oklahoma statute, focusing solely on the preemption section's plain statutory text. *See FMC Corp.*, 498 U.S. at 58 (describing text of ERISA's preemption provision, though broad, as "plain"); *Rutledge*, 141 S. Ct. at 484 (Thomas, J., concurring) (reiterating that the terms of ERISA's preemption section are readily afforded a "reasonable," "ordinary" meaning).[7]

[7] ERISA's preemption provision was, from the start, a poor candidate for a presumption against preemption. When it enacted ERISA, Congress characterized the preemption provision as the statute's "'crowning achievement'" and revolutionary for its time. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)); *see Franchise Tax Bd. v. Constr. Laborers*

CONCLUSION

The Court should reverse the district court's decision that ERISA does not preempt the Act.

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Respectfully submitted,

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Vacation Tr., 463 U.S. 1, 24 n.26 (1983) (describing ERISA's as a "virtually unique pre-emption provision"). It would be odd for Congress to enact statutory language with such acclaim, only then to intend a presumption against application of that very statutory language.

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August 11, 2022 */s/ Anthony F. Shelley*
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