No. 23-1213

In the Supreme Court of the United States

GLEN MULREADY, IN HIS OFFICIAL CAPACITY AS INSURANCE COMMISSIONER OF OKLAHOMA, ET AL., PETITIONERS

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

In 2019, Oklahoma enacted the Patient's Right to Pharmacy Choice Act, Okla. Stat. tit. 36, §§ 6958 *et seq.*, which regulates various practices by pharmacy benefit managers (PBMs). PBMs "serve as intermediaries between prescription-drug plans and the pharmacies that beneficiaries use." *Rutledge* v. *Pharmaceutical Care Mgmt. Ass'n*, 592 U.S. 80, 83-84 (2020). Respondent, a trade group for PBMs, brought this suit to challenge Oklahoma's 2019 law, arguing as relevant here that four provisions are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* Respondent also argued that one of the four provisions, which requires a PBM to accept into its preferred tier of pharmacies any willing provider that meets standard terms and conditions, is also preempted by Part D of the Medicare statute, 42 U.S.C. 1395w-101 *et seq.* The questions presented are:

1. Whether the court of appeals erred in finding the four challenged provisions of Oklahoma's 2019 law to be preempted by ERISA as applied to ERISA-covered employee benefit plans providing for prescription drug benefits.

2. Whether the court of appeals erred in finding the any-willing-provider provision of Oklahoma's 2019 law to be preempted by 42 U.S.C. 1395w-112(g) as applied to prescription drug plans under Medicare Part D.

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This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

A. Background

This case concerns the preemptive effect of two federal laws—the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and Part D of the Medicare statute, 42 U.S.C. 1395w-101 *et seq.*—on an Oklahoma law regulating intermediaries in the insurance industry known as pharmacy benefit managers (PBMs).

1. ERISA is designed to "protect * * * the interests of participants in employee benefit plans and their bene-

ficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). The statute governs both pension plans and "employee welfare benefit plan[s]," *i.e.*, plans that, "through the purchase of insurance or otherwise," provide medical, disability, or certain other benefits, including prescription-drug benefits. 29 U.S.C. 1002(1).

ERISA generally preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a)" of Title 29. 29 U.S.C. 1144(a). This Court has held that "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). A state law has an "impermissible connection" with an ERISA plan when it "'governs a central matter of plan administration or interferes with nationally uniform plan administration.'" *Rutledge* v. *PCMA*, 592 U.S. 80, 87 (2020) (citation omitted).

ERISA's express preemption provision is subject to several exceptions. As relevant here, the preemption provision does not "exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). That "savings clause" generally "returns to the States the power to enforce those state laws that 'regulate insurance,'" such as when a plan or plan sponsor contracts with an insurer to pay for and administer the benefits owed under an ERISA plan. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990).

The savings clause is subject to its own exception in the so-called deemer clause, which provides that no plan covered by ERISA "shall be deemed to be an insurance

company * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies" or "insurance contracts." 29 U.S.C. 1144(b)(2)(B). Under the deemer clause, when a plan or plan sponsor does *not* obtain insurance from a third party and instead "self-insures" or "self-funds" the benefits owed under an employee benefit plan, States may not deem the plan itself to be engaged in the business of insurance for purposes of applying state insurance laws. See *FMC Corp.*, 498 U.S. at 61-62; *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 732-733, 747 (1985).

2. Medicare is a federally funded health insurance program for the elderly and disabled. The traditional Medicare program encompasses hospital insurance (Part A) and outpatient medical insurance (Part B). In 2003, Congress added Part D to the Medicare statute, establishing a program of optional prescription-drug coverage for Medicare beneficiaries. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (2003 Act), Pub. L. No. 108-173, Tit. I, 117 Stat. 2071-2176 (42 U.S.C. 1395w-101 *et seq.*). Under Part D, private health insurance companies, called plan sponsors, enter into contracts with the Centers for Medicare and Medicaid (CMS) to offer prescription drug plans to Medicare beneficiaries. 42 U.S.C. 1395w-112.

When Congress created Part D, it incorporated by cross-reference a preemption provision from Part C of the Medicare statute relating to Medicare Advantage plans, which are not at issue here. See 2003 Act § 232(a), 117 Stat. 2208. Taking into account the cross-reference, the preemption provision states that any federal standards established under Part D for plans or plan sponsors "shall supersede any State law or regulation (other

than State licensing laws or State laws relating to plan solvency) with respect to" such plans or plan sponsors. 42 U.S.C. 1395w-26(b)(3); see 42 U.S.C. 1395w-112(g).

3. Health benefit plans—including plans covered by one or both of ERISA and Medicare Part D—frequently rely on PBMs to provide access to a network of pharmacies to fill prescriptions. Pet. App. 4-5. PBMs contract with pharmacies to establish pharmacy networks and contract with health benefit plans to provide access to those networks. See *Rutledge*, 592 U.S. at 83-84. In a typical arrangement, the PBM operates as an intermediary between the plan and participating network pharmacies: "When a beneficiary of a prescription-drug plan goes to a pharmacy to fill a prescription, the pharmacy checks with a PBM to determine that person's coverage and copayment information. After the beneficiary leaves with his or her prescription, the PBM reimburses the pharmacy for the prescription, less the amount of the beneficiary's copayment." *Id.* at 84.

"Depending on a plan's goals" for coverage, a PBM can tailor the available network of pharmacies in various ways. Pet. App. 5. One common design choice is to establish "two-tier[s]" of participating pharmacies, such as "standard and preferred." *Ibid.* Generally, a "preferred" pharmacy has agreed to "accept lower reimbursements" from a PBM in exchange for "higher customer volumes." *Ibid.* To provide higher volume, the PBM offers discounts to plan beneficiaries, such as lower copayments, as an incentive to direct their business to the preferred pharmacy. *Ibid.*

The Medicare statute provides that a prescription drug plan offered to Medicare beneficiaries under the Part D program "shall permit the participation" in its network of pharmacies "of any pharmacy that meets the

terms and conditions under the plan." 42 U.S.C. 1395w-104(b)(1)(A). The statute also provides that a plan may "reduce coinsurance or copayments" for particular network pharmacies. 42 U.S.C. 1395w-104(b)(1)(B).

CMS's regulations require Part D plans to allow for network participation by "any willing pharmacy" that meets the terms and conditions of a standard contract established by the plan. 42 C.F.R. 423.505(b)(18); see 42 C.F.R. 423.120(a)(8). But, consistent with Section 1395w-104(b)(1)(B), the regulations do not impose any similar obligation with respect to participation as a preferred pharmacy, thus allowing Part D plans to use differential cost-sharing (such as reduced copayments) to grant some network pharmacies preferred status. See 70 Fed. Reg. 4194, 4254 (Jan. 28, 2005).

Neither Medicare Part D nor ERISA requires any health plan to use a PBM. As a practical matter, however, PBMs are "ubiquitous" in the market. Pet. App. 5; see Federal Trade Commission, Interim Staff Report, *Pharmacy Benefit Managers* 5 (July 2024) (explaining that the six largest PBMs "manage 94 percent of prescription drug claims in the United States").

B. Oklahoma's 2019 Law

In 2019, Oklahoma enacted the Patient's Right to Pharmacy Choice Act, Okla. Stat. tit. 36, §§ 6958 *et seq.*, to "establish * * * standards and prohibitions on restrictions of a patient's right to choose a pharmacy provider," *id.* § 6959. This appeal concerns four provisions in the 2019 law. See Pet. App. 8.

Network access standards. The 2019 law requires that a PBM adhere to certain "retail pharmacy network access standards," which require ensuring that at least one in-network pharmacy and one preferred pharmacy are sufficiently close to a specified percentage of bene-

ficiaries in urban, suburban, and rural areas—for example, that "[a]t least ninety percent (90%) of covered individuals residing in an urban service area live within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy network." Okla. Stat. tit. 36, § 6961(A)(1); see *id.* § 6960 (relevant definitions).

Any willing provider. The 2019 law requires PBMs to admit to their preferred tier of in-network pharmacies any pharmacy that "is willing to accept the terms and conditions that the PBM has established for other providers as a condition of preferred network participation status." Okla. Stat. tit. 36, § 6962(B)(4).

Probation status. The 2019 law prohibits PBMs from denying, limiting, or terminating a contract with a pharmacy based on the pharmacy's employment of a pharmacist who is placed on "probation status" with the Oklahoma Board of Pharmacy, if the pharmacist still maintains an "active license to dispense" despite being on probation status. Okla. Stat. tit. 36, § 6962(B)(5).

Discount prohibition. The 2019 law states that health insurers and PBMs may not use "discounts in cost-sharing or a reduction in copay or the number of copays" to create incentives for covered individuals to choose between one in-network pharmacy and another—for example, by providing for reduced copays when using an in-network mail-order pharmacy as compared to an in-network retail (*i.e.*, brick-and-mortar) pharmacy. Okla. Stat. tit. 36, § 6963(E).

C. The Present Controversy

The Pharmaceutical Care Management Association (PCMA), a trade association representing the interests of PBMs, brought this action in the Western District of Oklahoma against the Oklahoma agency responsible for administering the 2019 law and the State's insurance

commissioner (collectively, Oklahoma). Pet. App. 2, 11. PCMA contended that numerous provisions in the 2019 law are preempted by ERISA or Medicare Part D. See *id.* at 11-12, 56. The district court "entered a mixed judgment for both sides," finding some of the challenged provisions preempted and others not. *Id.* at 13; see *id.* at 54-70. PCMA appealed, and its appeal focused solely on the four provisions of the 2019 law discussed above. *Id.* at 8-13.

At the court of appeals' invitation, the United States participated in the appeal as an amicus curiae. C.A. Order 1-2 (Jan. 25, 2023). The United States took the position that three of the challenged provisions—the retail network access standards, the requirement to admit any willing provider to preferred network status, and the prohibition on using discounts to create incentives for beneficiaries to prefer some in-network pharmacies over others—satisfy this Court's test for "connection with" preemption under ERISA. U.S. C.A. Amicus Br. 11 (citation omitted). The United States also took the position, however, that ERISA's savings clause would permit Oklahoma to apply those three provisions to PBMs acting as or for insurance companies under contract to ERISA plans, although ERISA's deemer clause would foreclose applying the provisions to self-insured ERISA plans. *Id.* at 17-21. By contrast, the United States argued that the probation-status provision is not preempted under ERISA because it has only a *de minimis* impact. *Id.* at 9-11. The United States also argued that the any-willing-provider provision is preempted under the Medicare statute as applied to Part D plans. *Id.* at 22-26.

The court of appeals reversed and remanded, concluding that all four of the challenged provisions in the

2019 law are preempted by ERISA as applied to ERISA plans and that the any-willing-provider provision is also preempted by the Medicare statute as applied to Medicare Part D plans. Pet. App. 1-51. As a threshold matter, the court rejected Oklahoma's argument that the 2019 law is exempt from ERISA preemption on the theory that it "regulates PBMs, not health plans." *Id.* at 17. The court explained that whether a state law has an impermissible "connection" with ERISA plans depends on the "'nature of the effect of the state law on ERISA plans,'" and that a state law can be preempted even when it "nominally" regulates only third-party administrators that ERISA plans rely on, rather than the plans themselves. *Ibid.* (citation omitted); see *id.* at 18-21, 31.

On the merits, the court of appeals determined that the network access standards, the discount prohibition, and the any-willing-provider provision "relate to" ERISA plans. 29 U.S.C. 1144(a). The court explained that those three provisions "curtail and eliminate certain widely-employed plan structures and impose alternative benefit designs." Pet. App. 23 (brackets omitted). For example, the network access standards effectively "dictate which pharmacies must be included in a PBM's network." *Id.* at 25. "[O]n top of that," the court explained, the any-willing-provider provision "requires that those pharmacies be invited to join the PBM's preferred network" if they meet the applicable terms and conditions. *Ibid.* And the court observed that the discount prohibition "requires that cost-sharing and copayments be the same for all network pharmacies—whether retail or mail-order; standard or preferred." *Id.* at 26. Thus, the court concluded, "[e]ach provision either directs or forbids an element of plan structure or benefit design." *Ibid.*

The court of appeals also held that the provision concerning pharmacists placed on probation is preempted by ERISA. Pet. App. 37. The court observed that ERISA plans that "want to promote patient safety" by excluding from network participation any pharmacy that employs a pharmacist placed on probation status are forbidden from making that network-design choice. *Ibid.* And, unlike the United States, the court saw no basis for distinguishing the probation-status provision from the other challenged provisions on the basis of its *de minimis* impact. *Id.* at 34-37.

The court of appeals declined to address whether or to what extent ERISA's savings clause permits Oklahoma to apply any of the four challenged provisions to PBMs. Pet. App. 38-40. In the court's view, Oklahoma had "not preserve[d] a savings-clause argument" in the district court or on appeal. *Id.* at 39.

On Medicare Part D, the court of appeals understood the Medicare statute to codify a form of "field preemption," under which CMS regulations establishing standards for Part D plans occupy the field and leave no room for state law. Pet. App. 43 (citation omitted); see *id.* at 41-47. The court noted that the Eighth Circuit had likewise treated the preemption provision in Part D as establishing a "field-preemption standard rather than a conflict-preemption one," while expressing disagreement with how the Eighth Circuit had applied the field-preemption standard in a prior case. *Id.* at 47 (discussing *PCMA* v. *Wehbi*, 18 F.4th 956, 970-976 (8th Cir. 2021)).

The court of appeals made clear, however, that the "result would be the same" even if Part D's preemption provision is understood to codify a form of conflict preemption, as Oklahoma contended. Pet. App. 49. The

court explained that CMS's regulations impose on Part D plans an obligation to admit to their network of participating pharmacies any willing provider that meets standard terms and conditions, but that the regulations impose no similar requirement for participation in a preferred tier within the network—thus leaving Part D plans and their sponsors discretion to decide which pharmacies would receive preferred status and on what terms. *Id.* at 49-50. The 2019 law's any-willing-provider provision would eliminate any such discretion, which the court held would conflict with the federal scheme. See *ibid.*

DISCUSSION

The court of appeals held that four provisions in Oklahoma's Patient's Right to Pharmacy Choice Act, Okla. Stat. tit. 36, §§ 6958 *et seq.*, are preempted by ERISA, as applied to ERISA-covered employee benefit plans for prescription drugs, because the provisions address central matters of plan administration. Petitioners contend (Pet. 18-25) that the Tenth Circuit's ERISA holdings conflict with this Court's decision in *Rutledge* v. *PCMA*, 592 U.S. 80 (2020), and with the Eighth Circuit's decision in *PCMA* v. *Wehbi*, 18 F.4th 956 (2021). Those contentions are unsound. The Tenth Circuit faithfully adhered to this Court's precedent, and the Eighth Circuit's decision in *Wehbi* does not necessarily indicate any divergence of approach to ERISA preemption. In addition, this case would be a suboptimal vehicle for addressing ERISA preemption because neither the Tenth Circuit nor the district court addressed whether the challenged provisions of the Oklahoma law are exempt from preemption in some applications under ERISA's savings and deemer clauses.

The court of appeals also held that the any-willing-provider provision in Oklahoma's 2019 law is preempted by the Medicare statute as applied to Medicare Part D prescription drug plans. That holding is correct and does not warrant further review. Petitioners contend (Pet. 29-34) that the Part D preemption analysis in the decision below is also in conflict with *Wehbi*. But both the Tenth Circuit here and the Eighth Circuit in *Wehbi* understood the Medicare statute to codify a form of field preemption for the Part D program, and in any event the Tenth Circuit correctly explained that the particular provision at issue here would be preempted even under petitioners' narrower approach. The petition for a writ of certiorari should be denied.

I. THE ERISA PREEMPTION QUESTION DOES NOT WARRANT FURTHER REVIEW

A. ERISA Preempts State Laws That Govern Central Matters Of ERISA Plan Administration, Even When The Laws Do So By Regulating Third Parties Such As PBMs

1. ERISA generally preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a)" of Title 29, 29 U.S.C. 1144(a), which includes an employee benefit plan providing for prescription drug benefits. This Court has recognized two ways in which a state law may "relate to" ERISA plans so as to trigger federal preemption. *Ibid.* "First, ERISA pre-empts a state law if it has a 'reference to' ERISA plans." *Gobeille* v. *Liberty Mut. Ins. Co.*, 577 U.S. 312, 319 (2016) (citation omitted). "Second, ERISA pre-empts a state law that has an impermissible 'connection with' ERISA plans[.]" *Id.* at 320 (citation omitted).

Only "connection with" preemption is at issue here. See Pet. App. 16. To determine whether such a connec-

tion exists, "this Court asks whether a state law 'governs a central matter of plan administration or interferes with nationally uniform plan administration.'" *Rutledge*, 592 U.S. at 87 (quoting *Gobeille*, 577 U.S. at 320). That test is satisfied when, for example, state law "require[s] providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits," or when state law "bind[s] plan administrators to specific rules for determining beneficiary status." *Id.* at 86-87. In contrast, state laws "that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage" are not preempted. *Id.* at 88.

The court of appeals correctly applied those principles to the three provisions in Oklahoma's 2019 law specifying network access standards, prohibiting the use of discounts to encourage beneficiaries to select one in-network pharmacy over another, and requiring that any willing provider be accepted into a network's preferred tier (if it has one). Pet. App. 21-33. As the court explained, each of those provisions "either directs or forbids an element of plan structure or benefit design." *Id.* at 26.

For example, the sponsor of an ERISA-covered drug plan may decide, given the geographic dispersion of the beneficiaries covered by the plan, that it would be desirable for beneficiaries to have available to them a low-cost option for filling prescriptions by mail. Ordinarily, a plan could seek to provide that option by negotiating with a mail-order pharmacy to grant the pharmacy preferred status, under which the pharmacy would accept lower rates of reimbursement in exchange for higher volumes of business, secured by offering beneficiaries

discounts (*e.g.*, lower copayments) when using the mail-order pharmacy. See p. 4, *supra*; cf. Pet. App. 27.

The challenged provisions of Oklahoma's 2019 law would impede any such network design. The discount prohibition would forbid using lower cost-sharing to create an incentive for beneficiaries to prefer the mail-order option over other options. Pet. App. 25-26. The any-willing-provider provision would require the plan to accept into preferred status any in-network pharmacy that meets standard terms and conditions, thus undermining the plan's ability to give preferential treatment to a mail-order option. *Id.* at 26. And the network access standards would require the plan to make available retail pharmacy options within specified areas, even if the best judgment of the plan sponsor is that beneficiaries would be better off if the network were designed to favor a discounted mail-order option. See *id.* at 25, 27.

2. Petitioners contend (Pet. 25-27) that the court of appeals erred in equating state regulation of PBMs with state regulation of ERISA plans. Petitioners are correct that the challenged provisions in the 2019 law by their terms generally operate on PBMs. See Okla. Stat. tit. 36, § 6961(A) (network access standards for "[p]harmacy benefits managers"); *id.* § 6962(B)(4) (any-willing-provider requirement for any "PBM"); *id.* § 6963(E) (discount prohibition for any "health insurer or PBM").

This Court's precedent makes clear, however, that a state law may be impermissibly related to ERISA plans even when the law regulates only third parties with whom the plans contract. Thus, in *Gobeille* v. *Liberty Mutual Ins. Co.*, *supra*, this Court held that a Vermont information-disclosure law had a "connection with" ERISA plans, even when the law operated on a third-party administrator. 577 U.S. at 320 (citation omitted);

see *id.* at 317-318, 326. Likewise, in *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355 (2002), the Court held that an Illinois law mandating independent review of certain benefit denials was "related to" ERISA plans where the law regulated health maintenance organizations under contract to ERISA plans—although the Court ultimately found the law not preempted by operation of ERISA's savings clause. See *id.* at 361, 365-370; see also, *e.g.*, *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329, 332-333 (2003); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 733, 735, 739 (1985).

Petitioners contend (Pet. 26) that the 2019 law is "fundamentally different" from the state laws at issue in prior cases, but petitioners' proffered distinctions sound only in the degree of potential interference with ERISA plan administration. The salient point, which the court of appeals correctly understood, is that "state laws can relate to ERISA plans even if they regulate only third parties." Pet. App. 18. And contrary to petitioners' suggestion (Pet. 27), other courts of appeals have reached the same conclusion when confronted with analogous state laws. See, *e.g.*, *Wehbi*, 18 F.4th at 966-967; *PCMA* v. *District of Columbia*, 613 F.3d 179, 188 (D.C. Cir. 2010). As the D.C. Circuit explained, a state law that forbids PBMs from adopting common network design choices and cost-sharing arrangements may "function as a regulation of an ERISA plan itself." *District of Columbia*, 613 F.3d at 188 (citation omitted).[1]

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[1] The parties dispute whether the 2019 law also operates directly on ERISA plans in some circumstances. Compare Br. in Opp. 12, with Cert. Reply Br. 4-5. As originally enacted, the 2019 law defined a PBM as any person "that performs pharmacy benefits management." Okla. Stat. tit. 36, § 6960(3) (2019). That definition could be

3. The court of appeals was mistaken in concluding that the probation-status provision in the 2019 law also has an impermissible "connection with" ERISA plans. See Pet. App. 33-38. That provision appears to have only a modest impact on the structure and design of plan benefits, limiting a plan's choices about how to design a pharmacy network only to the limited extent of forbidding an arrangement in which a participating pharmacy is terminated from the network if it employs a pharmacist who is placed on probation status by state regulators (but who is still eligible to dispense). See U.S. C.A. Amicus Br. 9-11; p. 6, *supra*.

The court of appeals saw "no footing for a *de minimis* test" in the context of ERISA preemption of state laws governing "plan administration." Pet. App. 36. But this Court has instructed that a state law has an impermissible connection with ERISA plans when the state law "governs a *central* matter of plan administration." *Rutledge*, 592 U.S. at 87 (emphasis added; citation omitted). As the modifier "central" implies, some state laws that have only an attenuated impact on plan administration are not preempted. See *ibid.* (observing that "not every state law that affects an ERISA plan * * * has an impermissible connection").

Nonetheless, the question whether the probation-status provision is preempted is not sufficiently important to warrant this Court's review in its own right. Among other considerations, nothing in the decision below forbids Oklahoma from using probation status as a means of rehabilitating pharmacists. See Pet. App. 38

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read to encompass a plan that contracts directly with pharmacies, without a PBM. U.S. C.A. Amicus Br. 16-17. In any event, as set forth above, a state law may be preempted by ERISA even when it operates on ERISA plans by regulating third-party administrators.

n.17 (noting the State's interest in rehabilitation). The only thing the State may not do is require PBMs acting for ERISA plans *not* to treat probation as a reason for terminating a pharmacy's network participation.

B. Petitioners Identify No Sound Basis For Further Review

1. Petitioners contend (Pet. 18-22) that the decision below is inconsistent with this Court's decision in *Rutledge* v. *PCMA*, *supra*. But the court of appeals fully considered petitioners' *Rutledge*-based arguments and persuasively explained why that decision does not support petitioners' position. Pet. App. 28-32. Petitioners identify no error in that reasoning, let alone anything to justify the suggestion that the Tenth Circuit "[f]lout[ed]" *Rutledge* or "ignored [its] clear message." Pet. 2, 18 (emphasis omitted).

In *Rutledge*, this Court considered an Arkansas law regulating "the price at which [PBMs] reimburse pharmacies for the costs of drugs covered by prescription-drug plans." 592 U.S. at 83. The law was designed to ensure that, when a pharmacy fills a prescription for a drug and is reimbursed by a PBM acting as an intermediary for a health plan, the PBM's rate of reimbursement for the drug is at least equal to the wholesale cost paid by the pharmacy. *Id.* at 84. PCMA argued that the Arkansas law had an impermissible "connection with" ERISA plans, but this Court disagreed. *Id.* at 89. The Court instead viewed the state law as "merely a form of cost regulation," like the state law the Court held was not preempted in *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). *Rutledge*, 592 U.S. at 88. The Court acknowledged that PBMs could seek to "pass [any] increased costs on to plans," but explained that ERISA

does not preempt state laws that "merely increase costs * * * for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Ibid.* And the Court emphasized that Arkansas's rate regulation did not "require plan administrators to structure their benefit plans in any particular manner." *Id.* at 89.

The same cannot be said here. Oklahoma's 2019 law is more than merely "cost regulation." *Rutledge*, 592 U.S. at 89. Oklahoma is seeking to regulate the composition and terms of participation for the networks of pharmacies that PBMs construct and administer for plans. And as explained above (at pp. 12-13), at least three of the challenged provisions "directly affect central matters of plan administration," *Rutledge*, 592 U.S. at 89, because they regulate central aspects of the structure and cost-sharing terms of the pharmacy networks utilized by ERISA-covered plans.

Petitioners contend (Pet. 2) that *Rutledge* should be understood to mean that "state efforts to regulate PBMs are unlikely to be preempted" by ERISA. But petitioners overlook the Court's focus in *Rutledge* on "cost regulation," 592 U.S. at 88, rather than *all* forms of PBM regulation. Indeed, if it were true that a state law necessarily lacks a prohibited connection with ERISA plans if the law directly regulates only PBMs rather than health plans, much of the Court's reasoning in *Rutledge* would have been superfluous. The Court could have rejected PCMA's preemption arguments in *Rutledge* on that basis alone, rather than going on to explain why the indirect economic effects of the Arkansas law on ERISA plans did not suffice to warrant a finding of preemption. See *id.* at 88-90.

2. Petitioners contend (Pet. 22-25) that the Tenth Circuit's ERISA holding with respect to the fourth chal-

lenged provision of the Oklahoma law, the probation-status provision, conflicts with the Eighth Circuit's decision in *PCMA* v. *Wehbi*, *supra*. In *Wehbi*, the Eighth Circuit addressed a North Dakota law that prohibited PBMs from imposing, as a condition of network participation, pharmacy accreditation requirements "inconsistent with" or "more stringent than" applicable state and federal licensing standards for pharmacies. 18 F.4th at 965-966. The Eighth Circuit determined that those provisions did "not meet the connection-with standard" for ERISA preemption, observing that they would cause at most "modest disuniformity in plan administration." *Id.* at 968. The Eighth Circuit also observed that the "economic effects" of those provisions on ERISA plans would be "*de minimis*." *Ibid.*

In the United States' view, the probation-status provision in Oklahoma's 2019 law is not preempted by ERISA for similar reasons, and the Tenth Circuit was mistaken to conclude otherwise. See pp. 15-16, *supra*. But any tension between *Wehbi* and the decision below does not warrant further review. In *Wehbi*, North Dakota had effectively forbidden PBMs from imposing greater accreditation standards than federal or state law, whereas Oklahoma here seeks to forbid PBMs from attaching harsher consequences to probation status than the State wishes. Petitioners fail to show that those different forms of state regulation necessarily have the same degree of effect on plan administration, or that a decision finding one preempted would necessarily dictate a result with respect to the other. Indeed, the Tenth Circuit here stated that it would have reached the same conclusion even using what it called "a *de minimis* test" derived from *Wehbi*. Pet. App. 37.

C. The Court Of Appeals' Decision Not To Address The Savings Clause Weighs Against Further Review

The United States contended as an amicus below that although the network access, probation-status, and discount-prohibition provisions in Oklahoma's 2019 law "relate to" ERISA plans, 29 U.S.C. 1144(a), ERISA's savings clause would permit some applications of those provisions to PBMs. U.S. C.A. Amicus Br. 17-22. When a PBM is acting as or for an insurer for an ERISA plan, state regulation of the PBM can fall within the State's authority to enforce laws "regulat[ing] insurance." 29 U.S.C. 1144(b)(2)(A); see *Kentucky Ass'n*, 538 U.S. at 335-339 & n.1 (holding that the savings clause permitted enforcement of state law regulating health maintenance organizations acting for ERISA plans).

The court of appeals declined to address the savings clause because, in its view, petitioners "did not preserve a savings-clause argument." Pet. App. 39. The court stated that petitioners did not develop any savings-clause argument in the district court; the district court "never discussed the issue"; and petitioners did not pursue it on appeal "as an alternative reason to affirm." *Ibid.*; cf. Pet. C.A. Br. 35 n.7.

To be sure, petitioners contend (Pet. 28; Cert. Reply Br. 8) that the court of appeals was mistaken to treat the savings-clause argument as having been waived or forfeited. But whether or not petitioners adequately preserved the argument below, neither the court of appeals nor the district court passed on the issue. Because the lower courts did not address the savings clause, they also had no occasion to address the deemer clause.

This case would therefore be a suboptimal vehicle for addressing ERISA preemption. If this Court were to grant review and decide only whether the challenged

provisions "relate to" ERISA plans, 29 U.S.C. 1144(a), the Court would be addressing only half the equation. And if the Court were to address the savings and deemer clauses, the Court would be doing so without the benefit of any prior analysis from a lower court. Cf. *Cutter* v. *Wilkinson*, 544 U.S. 709, 718 n.7 (2005) (emphasizing that this Court generally sits as a "court of review, not of first view").

II. THE MEDICARE PART D PREEMPTION QUESTION ALSO DOES NOT WARRANT FURTHER REVIEW

The second question presented in the petition also does not warrant certiorari. The court of appeals correctly held that the any-willing-provider provision in the 2019 law is preempted by the Medicare statute as applied to Medicare Part D prescription drug plans. That holding does not conflict with any decision of this Court or another court of appeals, and petitioners identify no other sound reason for further review.

Under the Medicare statute, the federal standards applicable to Part D plans and plan sponsors "supersede any State law or regulation" with respect to such plans or plan sponsors. 42 U.S.C. 1395w-26(b)(3); see 42 U.S.C. 1395w-112(g). Here, the relevant CMS regulation requires that Part D plan sponsors "agree to have a standard contract with reasonable and relevant terms and conditions of participation whereby any willing pharmacy may access the standard contract and participate as a network pharmacy." 42 C.F.R. 423.505(b)(18). Unlike the any-willing-provider provision in Oklahoma's 2019 law, the CMS regulation does *not* require that a Part D plan sponsor permit any willing provider to participate as a *preferred* pharmacy (to the extent the plan has both preferred and nonpreferred tiers).

The rulemaking record demonstrates that the omission of any analogous requirement to grant preferred status to all willing providers was deliberate. See 70 Fed. Reg. at 4254. CMS explained that it was seeking to strike a balance in implementing two adjacent statutory provisions: one requiring that Part D plans "permit the participation of any pharmacy that meets the terms and conditions under the plan," and another authorizing Part D plans to "reduce coinsurance or copayments" at "in-network pharmacies." 42 U.S.C. 1395w-104(b)(1)(A) and (B). CMS interpreted those two provisions to "permit[] cost-sharing discounts for preferred pharmacies," *i.e.*, to allow Part D plans to "vary their cost sharing" among in-network pharmacies as an "appropriate contracting tool" to construct a preferred tier and potentially "lower costs" for beneficiaries. 70 Fed. Reg. at 4254. Part D plans would have substantially less flexibility to do so if they were required to make any cost-sharing discounts for the preferred tier available to all willing providers. See *ibid.* Under the plain text of the Medicare statute, those federal standards for Part D plans "supersede" the state law at issue here. 42 U.S.C. 1395w-26(b)(3).

Petitioners contend (Pet. 29-34) that the Tenth Circuit's Medicare preemption holding parted ways, again, with the Eighth Circuit's analysis in *Wehbi*, *supra*. But both circuits construed the express preemption provision for the Part D program as codifying a form of "field preemption." Pet. App. 43; see *Wehbi*, 18 F.4th at 971 (reviewing the statutory history and concluding that certain amendments in 2003 "expand[ed] the scope of express Medicare preemption from conflict preemption to field preemption," including for Part D). The Tenth Circuit did express disagreement with what it perceived

to be an overly "fastidious approach" in *Wehbi* to defining the relevant field occupied by particular federal standards. Pet. App. 47. But the Tenth Circuit made clear that it otherwise "share[d] *Wehbi*'s view" of Part D preemption. *Ibid.*

In any event, the Tenth Circuit also made clear that it would have reached the same result "even under Oklahoma's narrower approach." Pet. App. 49. As explained above, the federal standards give Part D plans discretion to use cost-sharing discounts as a contracting tool to create preferred networks. That discretion would be significantly undermined, if not eliminated, if Part D plans were required to admit any willing provider into a network's preferred tier.

Petitioners acknowledge (Pet. 33) the Tenth Circuit's alternative reasoning but speculate that the Tenth Circuit's discussion of field preemption will have more prospective significance as "the law of the circuit moving forward." At this time, however, petitioners fail to show any square conflict warranting further review. Nothing in *Wehbi* suggests that, if presented with the kind of federal-state conflict that the Tenth Circuit correctly identified here, the Eighth Circuit would reach a different result. And any arguable tension between the two circuits regarding the scope of Part D preemption is recent and shallow. No further review is warranted.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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