No. 18-540

IN THE
Supreme Court of the United States

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas,
Petitioner,

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,
Respondent.

On Writ of Certiorari
To the United States Court of Appeals
For the Eighth Circuit

BRIEF OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether Arkansas's statute regulating PBMs' drug-reimbursement rates is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

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INTEREST OF *AMICUS CURIAE*[1]

The National Association of Chain Drug Stores ("NACDS") is a non-profit, tax-exempt organization incorporated in Virginia. Chains operate over 40,000 pharmacies, and NACDS' over 80 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 157,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and health care affordability.

Amicus and its members have a strong interest in this case. The Arkansas law at issue is one of numerous state laws that help protect the health and safety of their citizens by promoting the economic viability of their trusted community pharmacies. The unregulated reimbursement practices of pharmacy benefit managers (PBMs) have caused thousands of pharmacies to close, leaving many communities without front-line health care providers. *Amicus*'s members include pharmacies who depend on state laws like Arkansas's to ensure fair treatment. *Amicus* does not suggest that ERISA preemption is never, or even rarely, warranted; to the contrary, *amicus*'s members rely on ERISA preemption

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[1] Counsel for all parties have consented to the filing of this *amicus* brief. Pursuant to this Court's Rule 37.6, *amicus* states that this brief was not authored in whole or in part by counsel for any party, and that no person or entity other than *amicus*, its members, or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

to ensure that employee health care plans are subject to one, rather than fifty-one, regulatory schemes. But ERISA preemption has its limits, and Arkansas's statute falls outside those limits. ERISA does not disable states from protecting the interests of pharmacies and the communities they serve merely because the state law may have incidental economic effects on health care plans.

SUMMARY OF ARGUMENT

This Court's cases establish that ERISA does not preempt Arkansas's statute. The statute does not make any reference to ERISA—to the contrary, it applies to all pharmacy benefit plans, regardless of whether they are ERISA plans. Nor does it have a meaningful connection to ERISA plans—rather, it regulates the economic relationship between Pharmacy Benefit Managers (PBMs) and pharmacies, neither of which are ERISA plans. Under this Court's precedents, any incidental effect Arkansas's law will have on the relationship between PBMs and ERISA plans is insufficient to trigger ERISA preemption.

Arkansas's statute also serves sound policy interests unrelated to the goal of ERISA preemption. The statute is designed to mitigate a health care crisis: the rampant closure of pharmacies. Pharmacies not only dispense medications, but also provide front-line health care like immunizations, tobacco cessation, hormonal contraceptive therapies, blood pressure and glucose testing, flu shots, and information to customers on a variety of health-related matters. When a pharmacy closes in a rural area, local residents may have no alternative health care provider nearby, leading to the

risk of noncompliance with medication regimens and poor health outcomes. Arkansas's statute prevents PBM contracts from reimbursing pharmacies at low rates that do not cover the costs of purchasing and dispensing expensive prescription medications, which presently results in pharmacies taking a loss for dispensed prescriptions. In addressing such losses, Arkansas's legislature has chosen to ensure that pharmacies can keep their doors open to patients. That is a laudable legislative goal—and it in no way undercuts the core purpose of ERISA preemption, which is to protect ERISA plans from inconsistent state administrative burdens.

The Court should uphold Arkansas's statute under its current ERISA preemption jurisprudence and make no changes to that jurisprudence. Specifically, the Court should reject any invitation to narrow the scope of ERISA preemption or apply any kind of presumption against preemption. This Court's decisions interpreting ERISA's preemption provision correctly interpret the statutory text, and have proved clear and administrable in practice. Finally, Congress's repeated amendments to surrounding provisions, and express statements that ERISA's preemption provision would stay intact, establish that Congress has ratified current law.

ARGUMENT

Under a straightforward application of this Court's precedents, Arkansas's law is not preempted. It does not refer to ERISA plans, has only an attenuated connection to ERISA plans, and serves laudable policy goals unrelated to the purposes of ERISA. The Court should resolve this case narrowly and leave those

precedents intact, rather than using this case as a vehicle to make broad changes to preemption law.

I. ERISA Does Not Preempt Arkansas's Law.

For both doctrinal and practical reasons, ERISA does not preempt Arkansas's law.

A. This Court's ERISA Preemption Precedents Resolve This Case.

Arkansas's statute is indistinguishable from statutes that this Court has already found not to be preempted under ERISA. Resolving the case therefore requires no more than a straightforward application of this Court's precedents.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has interpreted this phrase to require preemption of two categories of state laws. First, "ERISA pre-empts a state law if it has a 'reference to' ERISA plans." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (internal quotation marks omitted). "To be more precise, where a State's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation, that 'reference' will result in pre-emption." *Id.* (internal quotation marks and alterations omitted). By contrast, if a state statute regulates a class of plans that "need not necessarily be ERISA plans," it does not make "reference to" ERISA for purposes of ERISA preemption. *Cal. Div. of Labor Standards Enf't v. Dillingham Const., N.A., Inc.*, 519 U.S. 316, 325 (1997); *accord N.Y. State Conf. of Blue Cross & Blue Shields*

Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) ("The surcharges are imposed upon patients and HMO's, regardless of whether the commercial coverage or membership, respectively, is ultimately secured by an ERISA plan, private purchase, or otherwise, with the consequence that the surcharge statutes cannot be said to make 'reference to' ERISA plans in any manner.").

Second, ERISA preempts "a state law that has an impermissible 'connection with' ERISA plans." *Gobeille*, 136 S. Ct. at 943. That standard is satisfied when a state law "governs a central matter of plan administration" or "interferes with nationally uniform plan administration," or when "acute, albeit indirect, economic effects" of the state law "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." *Id.* (quotation marks and alterations omitted).

Arkansas's law does not fall within either category of preemption. First, Arkansas's law does not make "reference to" ERISA. Arkansas's law imposes certain legal obligations on any entity that "administers or manages a pharmacy benefits plan or program," defined to include any "plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in th[e] state." Ark. Code Ann. § 17-92-507(a)(7), (a)(9). Because that definition includes both ERISA and non-ERISA plans, *Dillingham* and *Travelers* establish that it does not make "reference to" ERISA.

In reaching a contrary conclusion, the Eighth Circuit followed its own prior case law holding that a state law

makes "implicit reference to ERISA" because the definition of a pharmacy benefits plan "include[s]" plans subject to ERISA regulation. Pet. App. 6a. This holding is directly contrary to *Dillingham* and *Travelers*, and the Court may resolve this case merely by reciting and applying the rule in those cases.

Second, Arkansas's statute does not have a "connection with" ERISA plans. This Court has held that the "connection with" requirement is not satisfied merely because a law may have an incidental economic effect on an ERISA plan's negotiations with a third party. In *Travelers*, this Court unanimously held that a statute that regulated hospital rates for in-patient care was not preempted by ERISA. The Court recognized that the statute would have "an indirect economic effect on choices made by insurance buyers, including ERISA plans." 514 U.S. at 659. But because the law did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself," or "preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one," it was not preempted. *Id.* at 659-60. The Court explained that the law might "affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges." *Id.* at 660. The Court adhered to *Travelers* in *Dillingham*, finding that a statute that "alters the incentives, but does not dictate the choices, facing ERISA plans" was not preempted. 519 U.S. at 334; *accord De Buono v. NYSA-ILA Med. & Clinic Servs. Fund*, 520 U.S. 806, 816 (1997) ("Any state tax, or other law, that increases the cost of providing

benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute.").

Those precedents establish that Arkansas's law is not preempted. As in *Travelers* and *Dillingham*, Arkansas's law does not impose any legal obligations on ERISA plans. Nor does it force ERISA plans to adopt any particular scheme of coverage or restrict ERISA plans' choice of insurers or plan administrators. Perhaps the Arkansas statute will affect the economics of operating a PBM, which in turn will have an incidental effect on the prices that PBMs ultimately charge ERISA plans. But under *Travelers* and *Dillingham*, that type of economic effect is not sufficient to establish ERISA preemption.

Arkansas's statute does not refer to ERISA plans, and does no more than incidentally affect ERISA plans' contractual negotiations with third parties. This Court's cases squarely hold that such a statute is not preempted. That is all the Court needs to say to decide this case.

B. Arkansas's Statute Achieves Laudable Policy Goals Unrelated to ERISA.

Arkansas's statute serves the important purpose of protecting patient access to care by ensuring that PBMs' reimbursement rates cover pharmacies' costs of providing prescription medications. That purpose is entirely consistent with the purpose of ERISA preemption: protecting ERISA plans, which are neither PBMs nor pharmacies, from the burden of simultaneously complying with 51 regulatory programs.

Arkansas's statute addresses a genuine health care crisis: the rampant closure of pharmacies, especially in rural areas. In fact, independent data sources have reported that the number of retail pharmacies in the United States dropped by almost 2,000 over the past two years.[2] Moreover, several pharmacy chains have announced plans to close hundreds of additional pharmacies.[3] Pharmacy closures have disproportionately affected rural areas. Six hundred thirty rural communities that had at least one pharmacy in March 2003 had no retail pharmacy in March 2018.[4]

Pharmacy closures are harmful to patients because pharmacies serve as front-line health care providers. In addition to providing medications, pharmacies offer

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[2] National Association of Chain Drug Stores, The Pharmacy Reimbursement Crisis, https://www.nacds.org/pdfs/pharmacy/2020/Pharmacy-Reimbursement-2020.pdf (last visited Feb. 24, 2020) (showing that the number of U.S. retail pharmacies dropped from 58,706 in December 2017 to 56,788 in December 2019 according to IQVIA, an industry group that collects pharmacy data, and that a net 995 pharmacy profiles closed in 2018 and a net 695 pharmacy profiles closed in 2019 according to the National Council for Prescription Drug Programs, a national group that assigns identification numbers to pharmacies for billing purposes).

[3] Christine Blank, *Chains Closing Stores, Opening Fewer*, Drug Topics (Aug. 7, 2019), https://www.drugtopics.com/latest/chains-closing-stores-opening-fewer.

[4] Abiodun Salako et al., *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, Rural Policy Brief, RUPRI Ctr. for Rural Health Pol'y Analysis, Brief No. 2018-2 (July 2018), https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf.

immunizations, tobacco cessation, hormonal contraceptive therapy, blood pressure and glucose testing, flu shots, and information to customers on a variety of health-related matters. When a pharmacy closes in a rural area, the frequent result is that the rural area has no front-line health care provider at all. Thus, if a patient in such a rural area wishes to obtain medications or basic health care testing, the patient may have to drive an hour or more out of their way and take time out of work. If the patient is unable or unwilling to do so, the patient may not comply with medication regimens or may not get tested, and poor health care outcomes may result.[5]

One of the reasons for the mass closure of pharmacies is that PBMs can reimburse pharmacies at low rates that do not cover the costs of purchasing and dispensing expensive prescription medications, causing the pharmacies to take a loss for dispensed prescriptions. Some background on PBMs' operating practices is necessary to understand why.

Pharmacies buy drugs from drug manufacturers and distributors. To make a profit, pharmacies must recoup those costs from the patients who purchase the drugs. But in most cases, the patients do not pay the full cost of the drugs; rather, they pay a co-pay, and the rest comes

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[5] Dima M. Qato, et al., *Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults*, JAMA Network Open 12 (Apr. 19, 2019) (finding "pharmacy closures are associated with persistent, clinically significant declines in adherence to cardiovascular medications among older adults in the United States.").

from a health care plan. But pharmacies ordinarily do not interact directly with health care plans. Rather, they interact with middlemen—PBMs.

Arkansas's statute, and others like it, address certain practices by PBMs that can drive pharmacies out of business. Presently, PBMs can reimburse pharmacies for dispensing drugs at rates that do not cover pharmacies' costs of purchasing those drugs. As a result of these practices, pharmacies can and do receive reimbursements from the PBM that are less than the cost of obtaining the drug in the first place.

At least 38 states, including Arkansas, regulate PBMs' pricing practices to help ensure that pharmacy reimbursement covers the cost to provide patient services and care. Arkansas's law does not regulate PBMs in their capacity as claim-processors of claims submitted to health care plans. Nor does Arkansas's law impose any restrictions on PBMs' contracts with health care plans. Instead, Arkansas's statute imposes certain rules designed to ensure that PBMs reimburse pharmacies at rates that cover the pharmacies' cost of acquiring the drugs. Ark. Code Ann. § 17-92-507(c)(4)(C)(iii), (e). In addition, Arkansas requires PBMs to disclose their Maximum Allowable Cost ("MAC") lists (*i.e.*, lists setting the maximum amount it will reimburse a pharmacy for a particular drug). *Id.* § 17-92-507(a)(1), (c)(1). It further requires PBMs to update their MAC lists when drug prices go up, and to allow pharmacies to challenge prices on MAC lists when they are below acquisition costs. *Id.* § 17-92-507(c)(2), (c)(4)(B). And it bars PBMs from charging lower prices

to their affiliates than to other pharmacies. *Id.* § 17-92-507(d).

These policy goals are entirely disconnected from the goal of ERISA preemption: ensuring that ERISA plans do not face burdensome administrative requirements. As this Court has explained, "[r]equiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators — burdens ultimately borne by the beneficiaries." *Gobeille*, 136 S. Ct. at 944 (quotation marks and alterations omitted). In the absence of ERISA preemption, the already-complex process of processing claims would become a nightmare: "A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). ERISA preemption ensures that employees' health care spending goes to health care, rather than administrators and lawyers.

Applying ERISA's preemption provision to Arkansas's statute would be like fitting a square peg in a round hole. Arkansas's statute does not increase administrative burdens on ERISA plans, either in intent or in effect. Rather, it regulates the economic relationship between two parties, neither of which are ERISA plans: PBMs and pharmacies.

Arkansas's statute does impose certain administrative requirements on PBMs, such as

requiring PBMs to maintain an appeal procedure for pharmacies challenging reimbursement rates. At the certiorari stage, Respondent characterized those requirements as indirect administrative burdens on ERISA plans themselves. Respondent is incorrect. This appeal procedure has nothing to do with the ERISA plans with which the PBMs contract. The whole premise of PBMs' business model is that their reimbursement rates are *different* from the amount they charge ERISA plans. Regulating those reimbursement rates regulates the PBMs, not the ERISA plans.

In reality, Respondent is not seeking centralized *federal* regulation; it is seeking *no* regulation. The federal government regulates ERISA plans in myriad ways. The purpose of ERISA preemption is to ensure that ERISA plans have one, rather than fifty-one, regulators. But the federal government does not regulate PBMs under ERISA, because PBMs are not ERISA plans. Thus, under Respondent's theory, PBMs fall within a strange sweet spot—not enough like ERISA plans to be subject to federal regulation, but sufficiently "related" to ERISA plans to be free from state regulation. The Court should not adopt that unlikely interpretation.

II. The Court Should Not Make Any Changes to its Broader ERISA Preemption Jurisprudence.

In past years, members of this Court have suggested that the Court should rethink its ERISA preemption jurisprudence. *See, e.g.*, *Gobeille*, 136 S. Ct. at 947-49 (Thomas, J., concurring); *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 152-53 (2001) (Scalia, J., concurring); 532 U.S. at 153 (Breyer, J., dissenting). The

Court should decline that invitation and leave current law intact. First, the Court's decisions correctly interpret ERISA's preemption provision. Second, the Court's approach has proven administrable in practice. Third, Congress has repeatedly declined to amend ERISA's preemption provision, while making other amendments to ERISA—demonstrating that Congress has ratified this Court's decisions. Congress is free to change its mind, but until it does so, the Court should leave current law where it stands.

A. This Court's ERISA Preemption Cases Are Correct.

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has recognized that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" *Travelers*, 514 U.S. at 655 (quoting Henry James, *Roderick Hudson* xli (New York ed., World's Classics 1980)). As previously explained, this Court has therefore construed "relate to" to encompass only those statutes that have a "reference to," or a sufficiently close "connection with," ERISA plans.

In *Gobeille*, Justice Thomas opined that this Court has "abandoned efforts to give its text its ordinary meaning," and instead has "adopted atextual but what [it] thought to be 'workable' standards to construe § 1144." 136 S. Ct. at 948 (Thomas, J., concurring). In *amicus*'s view, however, this Court's decisions reflect an interpretation of, rather than a gloss on, the words

"related to." This Court has repeatedly recognized that "the venerable maxim *de minimis non curat lex* ('the law cares not for trifles') is part of the established background of legal principles against which all enactments are adopted, and which all enactments (absent contrary indication) are deemed to accept." *Wis. Dep't of Revenue v. William Wrigley, Jr., Co.*, 505 U.S. 214, 231 (1992). Thus, ERISA's preemption provision is properly construed to exclude statutes with only a *de minimis* relationship to ERISA plans. Rather, under bedrock principles of statutory interpretation, a statute is preempted only if its relationship to ERISA is sufficiently proximate.

The "reference to" and "connection with" tests identify the categories of state statutes with a sufficiently proximate relationship to ERISA plans. Hence, they reflect an *interpretation* of the phrase "relate to," not a judge-driven effort to adopt workable standards. More specifically, this Court's cases reflect that a statute can be "related to" ERISA in two ways—on its face, or as applied. The "reference to" test covers the first type of relationship: if on its face, a statute refers to ERISA, it is "related to" ERISA. The "connection with" test covers the second type of relationship: if as applied, a statute effectively regulates ERISA plans, it is "related to" ERISA. By contrast, if a state statute neither refers to ERISA, nor regulates ERISA plans or dictates their choices, then the statute's connection to ERISA is so attenuated that it is not "related to" ERISA within the meaning of § 1144.

This Court's recognition of those two types of preemption aligns with ERISA's purpose. The

"reference to" test recognizes that if a state statute specifically singles out ERISA plans, then it likely reflects disagreement with the scope of federal regulation—otherwise, there would be no need for the state to target *only* ERISA plans. A statute that is intended to undermine federal regulatory choices is a classic candidate for preemption. The "connection with" test recognizes that some state statutes can sufficiently affect ERISA plans that they are tantamount to the sorts of regulations of those plans that the federal government might otherwise promulgate—and under ERISA, those regulations fall within the federal government's exclusive prerogative.

The Court should reject the invitation to "interpret[] the 'relate to' clause as a reference to [the Court's] ordinary pre-emption jurisprudence." *Egelhoff*, 532 U.S. at 152-53 (Scalia, J., concurring). That interpretation would render ERISA's broadly-worded preemption provision entirely superfluous, because "ordinary pre-emption" principles exist regardless of whether a statute includes an express preemption clause. As this Court has recognized, "[t]here is no doubt that Congress may withdraw specified powers from the States by enacting a statute containing an express preemption provision." *Arizona v. United States*, 567 U.S. 387, 399 (2012). In addition, "State law must also give way to federal law in at least two other circumstances." *Id.* The first is field preemption, which arises when there is a framework of regulation "so pervasive that Congress left no room for the States to supplement it or where there is a federal interest so dominant that the federal system will be assumed to

preclude enforcement of state laws on the same subject." *Id.* (internal quotation marks and ellipses omitted). The second is conflict preemption, which arises when state laws "conflict with federal law." *Id.* ERISA is so comprehensive and reticulated that, even without an express preemption provision, ordinary field preemption principles would apply; in addition, conflict preemption principles apply to all federal laws with or without express preemption provisions. Thus, to interpret ERISA as merely incorporating ordinary preemption provisions would render ERISA's express preemption provision—perhaps the broadest preemption provision in the U.S. Code—wholly superfluous.

Moreover, interpreting ERISA's preemption provision in light of ordinary preemption principles would effectively overrule *Gobeille*. In *Gobeille*, the state attempted to avoid preemption by invoking this Court's cases that had "addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law, in particular state laws regulating a subject of traditional state power." 136 S. Ct. at 946 (internal quotation marks omitted). But the Court held that "ERISA, however, certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Id.* (internal quotation marks omitted). Thus, "ERISA pre-empts a state law that regulates a key facet of plan administration even if the state law exercises a traditional state power." *Id.* *Gobeille* is correct: nothing in the text of ERISA's preemption provision suggests putting a thumb on the scale in favor of state regulation. In this case,

Arkansas's statute is not preempted because the statutory phrase "relate to any employee benefit plan"—construed in light of ordinary statutory interpretation principles—does not extend to a statute that regulates PBMs' pricing practices. Supplementing those principles with atextual presumptions is unwarranted and unnecessary to resolve this case in favor of Arkansas.

B. This Court's ERISA Preemption Cases Provide a Clear and Administrable Standard.

Over the past two decades, ERISA preemption cases have rarely arisen in this Court—a testament to the fact that this Court's most recent articulation of the scope of ERISA preemption is clear and straightforward to apply.

Between the 1970s and 1990s, this Court heard a steady stream of ERISA preemption cases. Indeed, Justice Scalia's concurrence in *Dillingham*, urging the Court to reconsider its ERISA preemption jurisprudence, was driven by his frustration that such cases appeared to be unending: "Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more ERISA pre-emption cases so far this Term), suggesting that our prior decisions have not succeeded in bringing clarity to the law." *Dillingham*, 519 U.S. at 334-35 (Scalia, J., concurring) (footnotes omitted). Justice Scalia lamented that "[t]oday's opinion is no more likely

than our earlier ones … to bring clarity to this field." *Id.* at 335.

Justice Scalia's prediction proved wrong. ERISA preemption cases have largely stopped. In the past 15 years, the Court has heard only two ERISA preemption cases: *Gobeille* and this case.

The flow of cases has stopped largely because the "reference to" and "connection with" tests, have, in practice, proved easy to apply. The "reference to" test can be applied mechanically—one must simply look to the face of the state statute and check whether it refers to ERISA. Likewise, the "connection with" test has been straightforward to apply—one must analyze whether the statute imposes legal obligations on ERISA plans, or effectively dictates its choices. If the state statute regulates third parties and does not effectively dictate the choices of ERISA plans, it is not preempted, regardless of whether or to what extent there may be incidental economic effects on ERISA plans.

True, there were many ERISA preemption cases before *Dillingham*—but that is because the law was in flux during that period. As Justice Scalia observed in his concurrence, "the criteria set forth" in some of the Court's earlier ERISA cases were subsequently "abandoned," because they adopted a case-by-case approach to relatedness that was "doomed to failure." 519 U.S. at 335 (Scalia, J., concurring). *Dillingham*'s clear test has stabilized the law.

Indeed, even the two cases the Court has taken in the past 15 years—*Gobeille* and this case—reveal the unusual clarity of this Court's jurisprudence. In

Gobeille, the Second Circuit held that the statute at issue was preempted under ERISA. The Court granted certiorari even without a circuit split in view of "the important issue" presented, and affirmed the Second Circuit. 136 S. Ct. at 943, 947. Thus, no appellate court ever reached a conclusion inconsistent with Court's holding in *Gobeille*. In this case, although there is a circuit split, the Eighth Circuit found preemption only by reciting a legal rule that is squarely at odds with this Court's unambiguous ERISA preemption holdings. There is no evidence that this Court's modern test for ERISA preemption, when applied properly, results in any difficult or borderline cases.

The Court should not unsettle a test that is working well. Both states and employers have come to rely on the clarity of this Court's cases. States know what types of laws are in and out of bounds and do not have to face the burden of defending their laws against Supremacy Clause challenges. Employers have certainty that ERISA plans will not be subject to direct state regulation, and need not face the risk that a federal court might put a thumb on the scale against preemption. At the same time, employers have certainty that state laws like Arkansas's will be upheld. This enables them to negotiate agreements with third parties under the assumption that the laws will be enforced, rather than gambling on whether a federal court will invalidate them. When a pharmacy negotiates with a PBM, or when an employer sets up a health care plan, they need legal clarity to assess the economic consequences of their decisions. That legal clarity currently exists, and should continue to exist.

C. Congress Has Ratified This Court's Decisions.

ERISA's preemption provision is now 46 years old. Congress has had numerous opportunities to amend it, and has repeatedly declined to do so. In fact, in some cases, Congress has gone out of its way *not* to amend ERISA's preemption provision. That is a powerful signal to the Court that Congress approves of this Court's ERISA preemption jurisprudence, and that the Court's jurisprudence should stay where it is.

"*Stare decisis* … is a foundation stone of the rule of law." *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2409 (2015) (internal quotation marks omitted). It "promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Id.* (quotation marks omitted). "What is more, *stare decisis* carries enhanced force when a decision … interprets a statute. Then, unlike in a constitutional case, critics of our ruling can take their objections across the street, and Congress can correct any mistake it sees." *Id.* And *stare decisis* applies with even greater force when Congress has "repeatedly amended" the relevant laws, but "spurned multiple opportunities to reverse" the decision sought to be overruled. *Id.* at 2409-10.

ERISA is a subject of constant legislative churn, with new amendments, and amendments to the amendments, enacted unceasingly. Indeed, Section 1144, which governs preemption of state law, has been amended nine times since 1974. For instance, in the most recent amendment, Congress added a new subsection (e)

governing preemption of "automatic contribution arrangements." Pension Protection Act of 2006, Pub. L. No. 109-280, § 902(f), 120 Stat. 780, 1039 (codified at 29 U.S.C. § 1144(f)). Yet Congress has left the language at issue here—"relate to any employee benefit plan"—unchanged since ERISA's enactment in 1974.

Not only has Congress declined to amend § 1144(a), but Congress has repeatedly enacted statutes explicitly saying that it was *not* amending § 1144(a). Congress regularly enacts various types of health care and pension legislation, and when it does so, Congress is careful to make clear that ERISA preemption remains intact. For instance, when Congress amended laws governing state income taxation of pension income, it stated: "Nothing in this section shall be construed as having any effect on the application of section 514 of the Employee Retirement Income Security Act of 1974 [*i.e.*, 29 U.S.C. § 1144]." 4 U.S.C. § 114(e). Likewise, when Congress enacted new legislation related to state regulation of health insurers, it stated: "Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans." 29 U.S.C. § 1191(a)(2); *see also*, *e.g.*, 29 U.S.C. § 1185b(e)(2) (health care coverage for breast cancer patients); 42 U.S.C. § 1397ii(a)(2) (state children's health insurance programs); 42 U.S.C. § 300gg-62(b)(1) (individual health insurance coverage). In other cases, Congress provided that a new statute modifies the scope of ERISA

preemption only in a carefully targeted way. *See, e.g.*, 42 U.S.C. § 666(c)(3).[6]

The fact that Congress has repeatedly amended ERISA and its surrounding provisions, while going out of its way to leave § 1144(a) intact, demonstrates that Congress has ratified this Court's interpretation of § 1144(a). Indeed, this Court has frequently found that Congress ratified judicial interpretations even when the argument for ratification was weaker than it is here. For instance, the Court has found that Congress can ratify this Court's interpretation of a statute merely by leaving the statute intact while amending surrounding provisions. *See, e.g.*, *Forest Grove Sch. Dist. v. T.A.*, 557 U.S. 230, 244 n.11 (2009) ("When Congress amended IDEA without altering the text of § 1415(i)(2)(C)(iii), it implicitly adopted [the Supreme Court's] construction of the statute."). It has even adopted the same view with respect to interpretations of a statute by federal

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[6] That provision states: "Notwithstanding subsection (d) of section 514 of the Employee Retirement Income Security Act of 1974 (relating to effect on other laws), nothing in this subsection shall be construed to alter, amend, modify, invalidate, impair, or supersede subsections (a), (b), and (c) of such section 514 as it applies with respect to any procedure referred to in paragraph (1) and any expedited procedure referred to in paragraph (2), except to the extent that such procedure would be consistent with the requirements of section 206(d)(3) of such Act (relating to qualified domestic relations orders) or the requirements of section 609(a) of such Act (relating to qualified medical child support orders) if the reference in such section 206(d)(3) to a domestic relations order and the reference in such section 609(a) to a medical child support order were a reference to a support order referred to in paragraphs (1) and (2) relating to the same matters, respectively."

appellate courts. *See, e.g.*, *Tex. Dep't of Hous. & Cmty. Affairs v. Inclusive Cmtys. Project, Inc.*, 135 S. Ct. 2507, 2520 (2015) ("Congress' decision in 1988 to amend the FHA while still adhering to the operative language in §§ 804(a) and 805(a) is convincing support for the conclusion that Congress accepted and ratified the unanimous holdings of the Courts of Appeals finding disparate-impact liability."). Here, not only has Congress amended surrounding provisions without amending § 1144(a), but Congress has repeatedly enacted statutes specifically stating that ERISA's preemption provision was staying intact.

The Court should therefore adhere to its longstanding ERISA preemption jurisprudence. Under that jurisprudence, ERISA's preemptive scope is broad—but not broad enough to require preemption here.

CONCLUSION

The judgment of the Eighth Circuit should be reversed.

Respectfully submitted,

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