No. 25-5416

In the United States Court of Appeals
FOR THE SIXTH CIRCUIT

MCKEE FOODS CORPORATION,

Plaintiff-Appellee,

v.

BFP INC.,

Defendant,

and

CARTER LAWRENCE, in his official capacity as Commissioner of the Tennessee Department of Commerce and Insurance,

Defendant-Appellant.

On Appeal from the United States District Court for the Eastern District of Tennessee, No. 1:21-cv-279, The Honorable Charles E. Atchley, Jr.

BRIEF OF THE ERISA INDUSTRY COMMITTEE, AMERICA'S HEALTH INSURANCE PLANS, INC., THE AMERICAN BENEFITS COUNCIL, THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AND THE NATIONAL ASSOCIATION OF MANUFACTURERS AS AMICI CURIAE IN SUPPORT OF APPELLEE AND AFFIRMANCE

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DISCLOSURE OF CORPORATE AFFILIATIONS AND FINANCIAL INTEREST

Pursuant to Sixth Circuit Rule 26.1, each of the amici curiae makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

   No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

   No.

Dated: September 5, 2025

s/ Michael E. Kenneally
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INTEREST OF AMICI CURIAE[1]

The ERISA Industry Committee ("ERIC") is a national non-profit business trade association representing approximately 100 of the nation's largest employers in their capacity as sponsors of employee benefit plans for their workers, retirees, and families. ERIC frequently participates as amicus curiae in cases that have the potential for far-reaching effects on employee benefit plan design or administration.

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance industry. AHIP is committed to market-based solutions and public-private partnerships that make high-quality coverage and care more affordable, accessible and equitable for everyone. AHIP's members offer health and supplemental benefits through employer-provided coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Combined, AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans. That experience gives AHIP broad first-hand knowledge and a deep understanding of how the nation's health care and health insurance systems work.

[1] No counsel for a party authored this brief in whole or in part, and no party, party's counsel, or person other than the amici curiae, their members, or their counsel contributed money that was intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

The American Benefits Council ("the Council") is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees, and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans. The Council regularly participates as amicus curiae in cases affecting employee benefits plans.

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files amicus curiae briefs in cases, like this one, that raise issues of concern to the nation's business community.

The National Association of Manufacturers ("NAM") is the largest manufacturing association in the United States, representing small and large manufacturers in every industrial sector and in all 50 states. Manufacturing employs 13 million people, contributes $2.9 trillion to the U.S. economy annually, has the

largest economic impact of any major sector, and accounts for more than half of all private-sector research and development in the nation. The NAM is the voice of the manufacturing community and the leading advocate for a policy agenda that helps manufacturers compete in the global economy and create jobs across the United States.

This case presents an issue of profound importance to the amici curiae and their members. Many of the amici's members sponsor, provide, or help administer health plans that include prescription-drug benefits and are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. One crucial feature of ERISA is the freedom that it gives employers that sponsor employee health benefit plans by broadly preempting state regulation. Preemption creates a strong incentive for employers to establish, customize, and maintain employee health benefit plans. This incentive is particularly meaningful to employers that operate across multiple states. It allows such employers to provide a consistent set of excellent benefits to millions of Americans and their families without fear of diverging state regulations and burdens. The amici submit this brief to urge the Court to affirm the district court's proper application of fundamental ERISA preemption doctrine. It is critical—not just to the amici's members, but to all plan sponsors, plan administrators, and the many employees who benefit from employer-provided health coverage—that courts recognize and enforce ERISA's

preemption of state laws that interfere with the design and administration of ERISA-covered benefit plans.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress designed ERISA to be "a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To that end, ERISA includes a broad express preemption provision. It instructs that federal regulation of employee benefit plans "shall supersede any and all State laws insofar as they . . . relate to" ERISA-covered plans. 29 U.S.C. § 1144(a). Congress thus ensured that "employee benefit plan regulation would be exclusively a federal concern." *Davila*, 542 U.S. at 208 (citation and quotation marks omitted).

This expansive preemption regime serves a vital purpose. Nothing in ERISA requires employers to establish benefit plans. Accordingly, ERISA reflects a "careful balancing" of sometimes competing objectives—on the one hand regulating employee benefits plan while on the other encouraging "the creation of such plans." *Id.* at 215 (citation omitted). A patchwork of state regulation disrupts that balance, as the Supreme Court has repeatedly stressed. "Requiring ERISA administrators to master the relevant laws of 50 States . . . would undermine the congressional goal of minimizing the administrative and financial burden[s] on plan administrators—burdens ultimately borne by the beneficiaries." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 321 (2016) (citation, brackets, and quotation marks omitted). Without

strong preemption, employers would have to navigate an assortment of varying and potentially contradictory state regulations at great expense.

In addition, Congress deliberately designed ERISA to give employers "large leeway" to design benefit plans "as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). For plans that offer prescription-drug benefits, two critical design components are the pharmacy network and the benefit cost-sharing structure. Plan sponsors like McKee Foods Corporation ("McKee") design pharmacy networks that are appropriate for their employee population in terms of both service and cost. And plan sponsors use a variety of incentives, such as lower participant copays for filling prescriptions at in-network pharmacies, to provide cost-effective benefits and high-quality care through these plans.

The district court correctly held that ERISA preempts Tenn. Code Ann. §§ 56-7-3120, 56-7-3121, and 56-7-2359 (collectively, "the Tennessee Law"), insofar as those provisions apply to self-funded ERISA plans. The Tennessee Law is expressly preempted under controlling precedent because it interferes with central matters of prescription-drug benefit plan design and administration. Most obviously, it restricts employers' ability to design pharmacy networks for their plans, instead requiring them to admit "any willing pharmacy" into their networks—even if doing so would inhibit employers' efforts to control costs or would jeopardize the quality of care. As the Tenth Circuit recently explained (relying on this Court's earlier precedent),

any-willing-provider laws constrain plans' ability to structure benefits as they wish. *Pharm. Care Mgmt. Ass'n v. Mulready*, 78 F.4th 1183, 1198 (10th Cir. 2023), *cert. denied*, 2025 WL 1787716 (U.S. 2025); *see Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 355 (6th Cir. 2000), *aff'd sub nom. Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). The scope of a pharmacy network is one of the "key benefit designs" for a health plan that offers prescription-drug benefits. *Mulready*, 78 F.4th at 1198. Here, however, the Tennessee Law limits plans' ability to implement effective cost-savings measures and requires Tennessee-specific plan provisions, thus interfering with nationally uniform plan administration.

In addition to express preemption, ERISA impliedly preempts the Tennessee Law under principles of obstacle or conflict preemption. Such preemption applies "where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (citation omitted). By this measure, too, the Tennessee Law conflicts with ERISA. In restricting plan design choices and imposing significant administrative burdens, the Tennessee Law interferes with Congress's goal of allowing employers to design benefit plans to best fit their employee population without the challenge of conflicting state-by-state requirements. The Tennessee Law also conflicts with ERISA's fiduciary provisions, which require that plan fiduciaries administer a plan prudently and solely in the interest of participants. *See* 29 U.S.C. § 1104(a)(1). For

example, if a plan fiduciary determines (as McKee did here) that a pharmacy has engaged in fraud, deception, or unfair billing practices, or has otherwise acted in a way that harms plan participants, ERISA's fiduciary rules may require the plan to take appropriate remedial steps, which could include removing that pharmacy from the plan's network. But the Tennessee Law places ERISA plan fiduciaries between a rock and a hard place: either remove the fraudulent or unscrupulous pharmacies from their network and risk liability under the Tennessee Law or allow them to remain and face potential claims for breach of ERISA's fiduciary duties. For plans that address prescription-drug cost-sharing and copays in the governing plan documents, moreover, the anti-steering and cost incentive provisions of the Tennessee Law may also contradict plan terms, which conflicts with ERISA's fiduciary duty to administer the plan in accordance with its written terms. *See* 29 U.S.C. § 1104(a)(1)(D).

For all these reasons, the Tennessee Law is preempted. The Court should affirm the judgment of the district court.

ARGUMENT

States may not regulate the design of an ERISA plan's benefits. The challenged provisions of the Tennessee Law intrude directly into an employer's design of its pharmacy-provider network and benefit structure and therefore are preempted under settled law, as the district court recognized.

I. ERISA preemption is critical to encourage employers to offer benefits to employees.

Because ERISA relies on employers' voluntary decisions to offer benefits to their employees, the statute reflects "the public interest in encouraging the formation of employee benefit plans." *Davila*, 542 U.S. at 208 (citation omitted). An employer that chooses to provide a benefits plan "undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress therefore recognized that if administering a benefits plan was too burdensome, complicated, or expensive, or if it opened employers up to unacceptable litigation risk, many employers would simply choose not to offer benefits to their employees. *Conkright v. Frommert*, 559 U.S. 506, 517 (2010). Congress recognized, too, that if employers had to comply with specific benefits laws in every state in which they operate, the administrative headache and associated costs could prompt employers to offer less generous benefits. *See, e.g.*, *Gobeille*, 577 U.S. at 321; *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-50 (2001); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

As a result, ERISA includes an expansive express preemption provision. This provision generally preempts "any and all State laws insofar as they may now or

hereafter relate to any employee benefit plan described in [29 U.S.C. § 1003(a)]," including plans that provide prescription-drug benefits. 29 U.S.C. § 1144(a). This language is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). Congress used such broad language "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, thereby minimizing the administrative and financial burden of complying with conflicting directives and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 592 U.S. 80, 86 (2020) (citation, brackets, and quotation marks omitted).

II. The district court correctly held that the Tennessee Law is expressly preempted.

As the Supreme Court has construed 29 U.S.C. § 1144(a), a state law "relates to" an ERISA plan if it has either a "reference to" or "connection with" such a plan. *See*, *e.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); *Rutledge*, 592 U.S. at 86-87. Here, the district court had no need to examine the first possibility ("reference to") because the Tennessee Law has a clear "connection with" ERISA plans. State laws have such a connection if they "require providers to structure benefit plans in particular ways," "bind plan administrators to [a] particular choice" concerning the substance of plan benefits, "govern[] a central matter of plan administration," or "interfere[] with nationally uniform plan administration." *Rutledge*, 592 U.S. at 86-87 (citations omitted). Here, the Tennessee Law directly

interferes with ERISA plan design and administration and interferes with uniform administration under settled law. But before turning to the Tennessee Law, it helps to consider some basic background about employer-sponsored health benefit plans.

A. The provider network and amount of participant contributions are critical components of employer-sponsored health plans.

Most working-age American adults get their healthcare benefits through an employer-sponsored plan. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2023, at 4-5 (Sept. 2024), https://www2.census.gov/library/publications/2024/demo/p60-284.pdf. In raw numbers, that equates to about 154 million Americans. *See* KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2024 ANNUAL SURVEY 7 (2024), https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf. And approximately 75% of eligible workers offered health coverage through their employer accept it. *Id.* at 68.

Around 63% of covered workers are enrolled in health plans that are self-funded. *Id.* at 163. A plan is "self-funded" or "self-insured" when the plan and employer do not rely on third-party insurance to pay for plan benefits; the plan, rather than an insurer, bears the obligation to pay claims. *See, e.g.*, *FMC Corp.*, 498 U.S. at 54. The distinction between "self-funded" health plans and "insured" plans often matters under ERISA because the statute's so-called "savings clause" generally exempts state laws that regulate insurance from normal ERISA preemption. 29

U.S.C. § 1144(b)(2)(A). At the same time, however, the statute's "deemer clause" carves out self-funded ERISA plans from the savings clause. 29 U.S.C. § 1144(b)(2)(B); *FMC Corp.*, 498 U.S. at 61. As a result, "self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans." *FMC Corp.*, 498 U.S. at 61.

The design of a self-funded plan's prescription-drug benefits involves three primary components: (1) the prescription drugs and related services that are covered; (2) the pharmacies and service providers from whom covered prescriptions and services can be obtained, generally referred to as the pharmacy network; and (3) the cost-sharing arrangements between the plan sponsor and participants, including premiums, deductibles, and co-payments or "copays."[2]

A pharmacy network is a designated group of pharmacies that have contracted to provide prescriptions and related services to the plan's participants at pre-negotiated rates. Participants who use in-network pharmacies typically do so at lower costs compared to going out of network to a non-contracted pharmacy. By using pharmacy networks, plans can often obtain benefits and cost reductions that, in turn, are passed on to plan participants by requiring lower contributions to the cost

[2] For simplicity, this brief uses the term "participants" to include spouses, dependents, and generally anyone eligible to access health benefits provided by the plan.

of coverage, providing more generous benefits, or both. Pharmacies within a plan network contractually agree to accept discounted rates in exchange for increased volume. The plan and plan participants, in turn, benefit from the discounted rates. Having a pharmacy network also creates greater cost certainty and predictability: plans generally negotiate and thus know the cost of prescription drugs offered by in-network pharmacies. This allows plans to more accurately project prescription-drug costs. On the other hand, if plans cannot maintain a pharmacy network, the resulting decrease in cost certainty will induce plans to be more conservative with the services designated as covered, leading to diminished benefits for participants.

Pharmacy networks also increase administrative efficiency because pharmacies in a network generally agree to subject themselves to plan rules for claims processing, whereas without such an agreement the plan must be prepared to negotiate claims processing individually with each pharmacy. Finally, pharmacy networks allow plans to enhance quality for patients receiving pharmacy care. By screening, monitoring, and selecting which pharmacies are in-network, plans can ensure that only high-quality pharmacies are covered and can exclude pharmacies that do not meet the plan's standards.

For all these reasons, the vast majority of plans with prescription-drug benefits use pharmacy networks. Health-plan networks have been found to reduce costs to plan participants without negatively impacting the quality of services. *See* Daniel

Polsky & Bingxiao Wu, *Provider Networks and Health Plan Premium Variation*, 56 HEALTH SERVS. RSCH. 16, 17 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7839649/pdf/HESR-56-16.pdf (finding that a broader provider network correlated with more expensive premiums).

There are various ways to structure pharmacy benefits, networks, and participant cost-sharing. ERISA affords plan sponsors wide latitude to design these plan components to fit the needs of their employees and their families. *See, e.g.*, *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (discussing freedom of plan sponsors to design their employee benefit plans). A plan sponsored by a manufacturing company with a significant long-term/older employee population may have different considerations than a plan sponsored by a retail company with a younger and more transient workforce. An employer with geographically dispersed employees may design a wider pharmacy network, while an employer whose workforce is concentrated in a single region may see no reason to do so. While some employers opt for plans with broad pharmacy networks, others create plans with more tailored networks through which they can obtain larger discounts, thus providing participants benefits through fewer providers but at a lower cost.

Many plans work with pharmacy benefit managers ("PBMs") to help deliver prescription-drug coverage. *See Rutledge*, 592 U.S. at 83-84; *Mulready*, 78 F.4th at 1188-89. Common PBM functions include negotiating prices with drug

manufacturers and pharmacies, establishing drug formularies,[3] working with plan sponsors in their design of pharmacy networks, and processing prescription-drug claims. While PBMs assist with the administration of prescription-drug benefits, the plan sponsors ultimately decide how to design and structure the plan's benefits.

B. The Tennessee Law is preempted because it interferes with plan design and administration.

For three main reasons, the Tennessee Law intrudes on "a central matter of plan administration" and "interferes with nationally uniform plan administration." *Rutledge*, 592 U.S. at 86-87 (citations omitted).

1. The Tennessee Law requires that any willing pharmacy be included in a health plan's prescription-drug provider network. Tenn. Code Ann. § 56-7-2359. This Court has already ruled that a similar "any-willing-provider" statute in Kentucky had a "connection with" ERISA and therefore fell within ERISA's express preemption provision. *See Nichols*, 227 F.3d at 361-63. The law there prohibited health plans from discriminating against any provider in its geographic coverage area willing to meet the plan's terms and conditions. *Id.* at 355. This Court recognized that such laws "not only affect the benefits available by increasing the potential providers," but also "directly affect the administration of the plans." *Id.* at

[3] A drug formulary is a list of prescription medications that are covered by a prescription-drug plan and often includes cost information (tier, copay and/or deductible) and a list of drugs that are excluded from plan coverage.

363. Unlike the law here, however, the Kentucky statute sought to accommodate ERISA by excluding self-insured ERISA plans from its scope. *Id.* at 360-61, 366-67. This Court therefore determined (and the Supreme Court later agreed) that the state law fell within ERISA's preemption savings clause. *Id.* at 363-72; *see Miller*, 538 U.S. at 342.[4]

Tennessee has no answer to this Court's decision in *Nichols*. Below, the State argued that *Rutledge* abrogated *Nichols*. But the district court thoroughly refuted that argument, so the State now tries a different strategy. It suggests (at 36-37) that *Nichols* somehow supports the Tennessee Law because it held that Kentucky's any-willing-provider law fell within the savings clause. The problem with this reasoning, of course, is that the Kentucky legislature, "aware of its inability to regulate self-insured ERISA plans," properly excluded self-funded ERISA plans from the scope of its any-willing-provider law, taking ERISA's deemer clause (29 U.S.C. § 1144(b)(2)(B)) out of the picture. *Nichols*, 227 F.3d at 360. Here, in contrast, the Tennessee Law explicitly includes ERISA plans regardless of whether they are self-funded. Tenn. Code Ann. § 56-7-3102(1), (5).

[4] While the Supreme Court determined that the Kentucky law avoided preemption because it regulated insurance, *Miller*, 538 U.S. at 342, this Court's ruling that the Kentucky law "relates to" ERISA plans remains undisturbed.

The State ignores this feature of the statute in suggesting (at 49) that the law regulates PBMs only and therefore does not trigger the deemer clause. But even if the Tennessee Law did not expressly include ERISA plans within its coverage, the State's argument would still fail. This Court rejected a similar distinction between plans and health maintenance organizations ("HMOs") in *Nichols*, when it determined that Kentucky's any-willing-provider law could lawfully be enforced neither "against the employer who has a self-insured ERISA plan *nor against the administrator of such a plan, even if the administrator is an entity, such as an HMO*, which would be subject to the statute if it were acting not as a mere administrator but as an insurer of its own plan." *Nichols*, 227 F.3d at 366 (emphasis added). Tennessee may not "compel a change in [a self-funded ERISA] plan, regardless of the nature of the entity administering the plan." *Id.* Courts therefore reject the State's argument that the deemer clause is limited to only the plans themselves. *See id.* at 366-67; *Light v. Blue Cross & Blue Shield of Ala., Inc.*, 790 F.2d 1247, 1249 (5th Cir. 1986) (finding that ERISA preempted claims against administrator of self-insured medical-expense plan even though 29 U.S.C. § 1144(b)(2)(B) does not expressly refer to plan administrators). That approach comports with ERISA's broad statutory language as well. The preemption provision reaches state laws that "purport[] to regulate, *directly or indirectly*, the terms and conditions of [ERISA-covered] benefit plans." 29 U.S.C. § 1144(c)(2) (emphasis added). In any event,

the State has forfeited any savings-clause argument because it made no such argument below. Memorandum of Law in Support of Defendant Lawrence's Motion for Summary Judgment, R. 123, PageID #1931-38.

Changing tack, Tennessee says (at 38) that *Nichols* is "factually distinguishable" because it addressed HMOs rather than PBMs. But the State never identifies any difference that affects the ERISA-preemption analysis. In both contexts, the HMOs and PBMs perform functions on behalf of the ERISA plans, and the state laws infringe on employers' freedom to design and structure their health benefit plans and provider networks.

Beyond this Court's precedent in *Nichols*, Tennessee's position also runs headlong into the Tenth Circuit's recent decision in *Mulready*, which expressly relied on *Nichols* to conclude that Oklahoma's any-willing-provider law regulating PBMs and pharmacy-benefit networks was preempted. 78 F.4th at 1198-99. The Supreme Court declined to grant certiorari in *Mulready*, and the Solicitor General filed a brief expressing the United States' position that the Tenth Circuit had correctly held that Oklahoma's pharmacy-network access standards and any-willing-provider requirement were preempted. Br. for the United States as Amicus Curiae at 12, *Mulready v. Pharm. Care Mgmt. Ass'n*, No. 23-1213 (U.S.). Other circuits have reached similar conclusions confronting similar state laws. *See CIGNA Healthplan of La. v. Louisiana ex rel. Ieyoub*, 82 F.3d 642, 647-48 (5th Cir. 1996)

(ruling that Louisiana's any-willing-provider statute was preempted because the statute "den[ied] insurers, employers, and HMOs the right to structure their benefits in a particular matter . . . effectively requiring ERISA plans to purchase benefits of a particular structure"); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 501-02 (4th Cir. 1993) (ruling that Virginia's any-willing-provider law was preempted by ERISA because it regulated "the structure" of health-plan provider networks).

Plans cannot achieve employers' objectives if a pharmacy network must be open to *all* pharmacies. For example, it becomes impossible to achieve cost savings because the pharmacies in the network will not anticipate higher patient volume and will not accept lower reimbursements. Tennessee (at 41) dismisses the relevance of plans' "cost-cutting measure[s]." But as healthcare costs continue to soar, and drug costs become a larger part of healthcare expense, it is critical for plan sponsors to persuade pharmacies to offer lower costs and high-quality services by promising higher volume through an "in network" designation. The Tennessee Law removes a plan's ability to drive volume, which in turn means that pharmacies have little or no incentive to compete for that volume. *See Mulready*, 78 F.4th at 1189 ("preferred pharmacies have agreed to accept lower reimbursements from plans in exchange for higher customer volumes [and] achieve this higher volume by lowering the required copayments owed by customers filling their prescriptions.").

2. Another provision of the Tennessee Law, Tenn. Code Ann. § 56-7-3120, is preempted because it significantly limits cost-containment mechanisms to prescription-drug plans. This "anti-steering" provision restricts plans from offering lower copays to participants as an incentive to use in-network pharmacies, and it prohibits PBMs and covered entities from offering financial or other incentives for participants to use pharmacies owned by or financially beneficial to the PBM or covered entity. These statutory mandates hamper the ability of self-insured plans to control their own costs, "thereby hindering those plans from structuring their benefits as they choose." *Mulready*, 78 F.4th at 1199 (citing *Black & Decker*, 538 U.S. at 833, and holding that similar provisions in Oklahoma's PBM law were preempted by ERISA); *see also* Br. for the United States as Amicus Curiae, *Mulready*, *supra*, at 12 (agreeing with the Tenth Circuit that "prohibiting the use of discounts to encourage beneficiaries to select one in-network pharmacy over another . . . forbids an element of plan structure or benefit design" (citation omitted)).

McKee has already faced a complaint by a non-network pharmacy based on these provisions, challenging McKee's ability to offer lower-cost prescriptions to employees who use an onsite pharmacy at a McKee facility. Brief in Support of Plaintiff's Motion for Summary Judgment, R. 119, PageID# 1626-27. The non-network pharmacy asked the State of Tennessee to mandate that McKee charge its Tennessee employees higher copays at the onsite pharmacy or increase plan benefits

by providing lower copays to Tennessee employees who use other pharmacies—in either case, contrary to the terms of McKee's plan. *Id.*

This is just one example involving one plan sponsor, but it illustrates the Tennessee Law's broader problems. McKee, as plan sponsor, has chosen to make it cost-effective and convenient for its employees to fulfill their prescriptions onsite. Other plan sponsors may choose other ways to design their prescription-drug benefits and cost structures based on their own participant populations and demographics. ERISA affords them the freedom to do so. *See Moore v. Reynolds Metals Co. Ret. Program,* 740 F.2d 454, 456 (6th Cir. 1984) ("Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide"). The Tennessee Law would restrict the freedom established by federal law, which is exactly the sort of result that Congress sought to prevent through ERISA's preemption provision.

At times, the State seems to suggest that the Tennessee Law is simply a form of cost regulation comparable to the Arkansas PBM law that avoided preemption in *Rutledge*. Any such comparison is meritless. Arkansas' law required PBMs to "tether [pharmacy] reimbursement rates to pharmacies' acquisition costs," compelled PBMs to create procedures for pharmacies to appeal their reimbursement rates to the PBMs, and enabled pharmacies to decline to dispense drugs when their acquisition costs exceeded the PBMs' reimbursement rates. *Rutledge*, 592 U.S. at

84-85. The Supreme Court ruled that the law was not preempted because it was "merely a form of cost regulation" that did not have an effect "so acute that it will effectively dictate plan choices." *Rutledge*, 592 U.S. at 88. The Tennessee Law, in contrast, does far more than simply regulate the prices that PBMs must pay to all pharmacies: it severely restricts plans' ability to encourage participants to use a network of preferred pharmacies. "[A] pharmacy network's scope (which pharmacies are included) and differentiation (under what cost-sharing arrangements those pharmacies participate in the network), are key benefit designs for an ERISA plan." *Mulready*, 78 F.4th at 1198 (analyzing Oklahoma's PBM law under *Rutledge*). Allowing states like Tennessee to regulate these aspects of plan design would impermissibly authorize states to directly regulate the terms of benefits that participants receive. Employer-participant cost-sharing and copay terms are central to the prescription-drug benefits offered by self-funded plans. From participants' perspective, the amount they pay or don't pay for a covered prescription *is* the benefit.

3. Finally, applying the challenged provisions of the Tennessee Law to plans with participants in multiple states increases the administrative burdens—and costs—on those plans by requiring plan sponsors to design their prescription-drug benefits in Tennessee-specific ways, which is "exactly the burden ERISA seeks to eliminate." *Egelhoff*, 532 U.S. at 151; *see also Gobeille*, 577 U.S. at 323 (state law

that "intrudes upon a 'central matter of plan administration' and 'interferes with nationally uniform plan administration'" is preempted (citation omitted)). As illustrated by the complaint discussed above, the Tennessee Law not only increases the costs and burdens on plan sponsors and administrators, it also directly affects participants and their benefits by creating Tennessee-specific requirements that may *disadvantage* some participants, such as participants who prefer having the option to pay lower copays at an onsite pharmacy.

III. The Tennessee Law also fails an implied-preemption analysis.

As the district court recognized, the Tennessee Law's impermissible connection with ERISA plans obviates any need to analyze implied preemption. But even if ERISA's express preemption provision were somehow inapplicable, the Tennessee Law would still be impliedly preempted under ordinary implied-preemption principles. *See, e.g.*, *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 352 (2001) ("[N]either an express pre-emption provision nor a saving clause 'bar[s] the ordinary working of conflict pre-emption principles.'" (citation omitted)). A state law is impliedly preempted when it "conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs*, 520 U.S. at 841. In at least two ways, the Tennessee Law fails this test.

A. The Tennessee Law interferes with sponsors' freedom to design plans as they wish and thwarts uniformity of administration.

The first implied-preemption problem is apparent from the discussion above. ERISA establishes and safeguards employer freedom to define the terms of ERISA plans and customize benefit plan design, including designing provider networks and participant cost incentives, without state intervention. *See Shaw,* 463 U.S. at 96-97; *Moore*, 740 F.2d at 456. As detailed already, the Tennessee Law contravenes this fundamental ERISA principle by interfering with the choices available to self-insured plans. *See supra* Section II.B.

Applying the Tennessee Law to self-insured ERISA plans also runs contrary to ERISA's policy of minimizing the administrative burden on employers who sponsor such plans—multi-state employers in particular—by requiring them to carve out a set of Tennessee-specific plan rules. *See Rutledge*, 592 U.S. at 86-87 (ERISA is "primarily concerned with preempting laws that require providers to structure benefit plans in particular ways," thus "ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions"); *Sherfel v. Newson*, 768 F.3d 561, 568 (6th Cir. 2014) (state laws that "interfere[] with nationally uniform plan administration upset[] the careful balance struck by ERISA's comprehensive and exclusive civil-enforcement remedy, and arrogates to [the state] the power to regulate ERISA benefit plans, which Congress intended to be exclusively a federal concern.") (quotations omitted and cleaned up); *see supra*

Section II.B. For this reason too, the Tennessee Law "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" in enacting ERISA. *See John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) (citations and quotation marks omitted).

B. The Tennessee Law interferes with ERISA's fiduciary obligations.

The second implied-preemption problem is no less significant. The Tennessee Law conflicts with ERISA's fiduciary provisions and is preempted for this reason as well. *See Boggs*, 520 U.S. at 841; *Sherfel*, 768 F.3d at 568 (ruling state law was preempted because it "imposes conflicting obligations upon the plan administrator—if the administrator complies with one obligation, it violates the other").

First, ERISA plan fiduciaries have a duty to operate their plans prudently and solely in the interest of plan participants. *See* 29 U.S.C. § 1104(a)(1). The any-willing-provider provisions of the Tennessee Law require plans to expand their networks to include any pharmacy even if doing so inhibits employers from fulfilling their fiduciary duties to plan participants. As illustrated in this case, if a plan fiduciary determines that a plan service provider is overcharging participants for prescriptions or engaging in other improper practices, the fiduciary has the right (and obligation) to address those improprieties in the manner they see fit for their plan, which may include removing that provider from the network. Failing to do so could expose the fiduciary to potential claims by participants alleging breach of fiduciary

duty. *See, e.g.*, *Chao v. Merino*, 452 F.3d 174, 183 (2d Cir. 2006) (affirming fiduciary-breach finding based on plan fiduciary's failure "to take precautionary steps" against a service provider known to have previously embezzled from the fund: "[i]f a fiduciary was aware of a risk to the fund, he may be held liable for failing to investigate fully the means of protecting the fund from that risk."); *Bartnett v. Abbott Lab'ys*, 492 F. Supp. 3d 787, 797 (N.D. Ill. 2020) (acknowledging that a fiduciary's failure to protect against a known risk would constitute a fiduciary breach). Allowing states to constrain ERISA fiduciaries' oversight of plan service providers could undermine the obligations that Congress decided to impose at the federal level.

What's more, ERISA's fiduciary provisions require plan fiduciaries to administer the plan in accordance with its written terms. 29 U.S.C. § 1104(a)(1)(D). For plans that address participant cost-sharing and copays in the governing plan documents (as most plans with prescription benefits do), the anti-steering and cost-incentive provisions of the Tennessee Law may contradict plan terms and thus interfere with this fiduciary duty as well, further adding to the law's preemption problems. In *Sherfel*, for example, this Court ruled that ERISA preempted a Wisconsin law that would have required a plan to pay benefits contrary to the plan terms. 768 F.3d at 568.

In these ways, the Tennessee Law forces plan fiduciaries into a "Hobson's choice": they either "obey the state law, and risk violating [ERISA], or disobey the

state law" and hope that an ERISA preemption defense succeeds sometime in the future. *See Denny's, Inc. v. Cake*, 364 F.3d 521, 527 (4th Cir. 2004); *see also NGS Am., Inc. v. Jefferson*, 218 F.3d 519, 529 (6th Cir. 2000) ("Challenging [state] regulations by violating them and then raising ERISA preemption as a defense in a state enforcement action would have risked breaking the law."). The Court should eliminate this conflict now by reaffirming the supremacy of federal law. Doing so will bring needed reassurance to plan fiduciaries with participants in Tennessee, who will know that they can and should continue to fulfill their ERISA obligations.

* * *

Whether based on express preemption, implied preemption, or both, the Court should affirm the district court's decision that ERISA preempts the Tennessee Law as applied to self-insured plans. Such a holding will protect employers' ability to design their ERISA plans as they deem appropriate for their participants and will ensure the uniformity of benefits for employers that operate in multiple states. It will also preserve the ability of plan fiduciaries to manage their plans consistent with their statutory obligations.

CONCLUSION

For all these reasons and those in McKee's brief, this Court should affirm the judgment of the district court.

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Respectfully submitted,

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This brief complies with the type-volume limitation of Rules 29(a)(5) and 32(a)(7)(B) of the Federal Rules of Appellate Procedure because it contains 5,919 words, excluding the parts of the brief exempted by Rule 32(f) and 6th Cir. R. 32(b)(1).

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