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ERISA Preemption of Rhode Island Senate Bill 114/House Bill 5634

ERISA preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). A state law "relates to" a plan, and implicates preemption, when it has a "connection with or reference to" an ERISA plan. *Id*. at 147. The Supreme Court has made clear that a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "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" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). Notably, the state law at issue in *Gobeille* applied to the third-party administrator ("TPA") acting on behalf of the ERISA-covered plan. In recognition of the statutory "deemer clause," which prevents states from "deeming" a self-insured, ERISA-covered plan to be an insurer for purposes of the insurance savings clause, the Court held that the Vermont law at issue was preempted, notwithstanding the fact that it applied to the insurer acting as a TPA for the plan. ERISA § 514(b)(2). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id*. at 320.

In *Rutledge*, the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law regulating the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that because the state law merely regulated costs rather than dictate ERISA-plan choices, it was not preempted by ERISA . *See id.* at 81. In arriving at that decision, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille* at 320. Moreover, the Court in *Rutledge* also reaffirmed the long-held view of the Court that a state law "which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans," and are thus subject to preemption. *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 97 (1983); *Rutledge*, 592 U.S. at 86-87.

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on

PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *PCMA. v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1]

Rhode Island Senate Bill 114 and House Bill 5634

Rhode Island Senate Bill 114 and House Bill 5634 (collectively, the "Bills") add additional requirements to the state's regulation of pharmacy benefit managers ("PBMs"), particularly with respect to the treatment of 340B entities and their contract pharmacies. The Bills define "health insurer" to include, among others, "any entity defined as an 'insurer' under § 42-62-4, and any third-party administrator when interacting with health care providers and enrollees on behalf of the insurer." Prop. 5 R.I. Gen. Laws Ann. § 5-19-3.2(3). Section 42-62-4 defines "insurer" to include, among others, "all persons, firms, or corporations providing health benefits coverage for employees on a self-insurance basis without the intervention of other entities." 42 R.I. Gen. Laws Ann. § 42-62-4 (7). The Bills' sweeping definition of "health insurer" appears on its face, to encompass both self-insured, ERISA-covered plans and their TPAs. And so, the Bills' PBM reforms with respect to 340B pharmacies directly regulate those plans through a specific reference to the plan, and have direct impacts on self-insured, ERISA-covered plans.

Because of these impacts, a number of provisions are likely preempted by ERISA based on existing Supreme Court jurisprudence, including *Rutledge*. In the following chart, we identify the specific provision, provide a description of the provision, and include the basis for federal preemption.

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
5 R.I. Gen. Laws Ann. § 5-19-3.3(a)(1)	Requires that all reimbursements to 340B pharmacies be made on the same terms as non-340B pharmacies.	This provision imposes direct, and potentially acute, costs on plans. Because the provision applies directly to the plan sponsor and sets the rate paid by the plan, it should be preempted consistent with the holding in *Rutledge*.

[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id*. at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id*. at 1195

Proposed Statutory Provision	***Description***	***Reason for ERISA Preemption***
5 R.I. Gen. Laws Ann. §§ 5-19-3.3(a)(2), (3)	Prohibits a PBM seeking adjustments of payments made to 340B entities as a result of a PBM's discovery that the pharmacy is a 340B pharmacy.	This provision could impose acute *and* direct economic burden on plans because it could limit the ability of plans to enter into high-value contracts Moreover, it could directly conflict with ERISA's fiduciary duty to act solely in the interest of the plan. As a result, the provision addresses a central matter of plan administration and fiduciary obligation, and should be preempted per *Gobeille*.
5 R.I. Gen. Laws Ann. § 5-19-3.3(a)(4)	Prohibits a PBM from discriminating against a 340B entity in a manner that prevents or interferes with the patient's choice to receive drugs from the 340B entity.	This provision limits the ability of plans to develop and implement certain value-based network and plan designs. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
5 R.I. Gen. Laws Ann. § 5-19-3.3(a)(5)	Prohibits contract provisions between a health insurer, PBM, or third-party payor that prohibits the manner in which drugs are delivered, including the use of mail-order pharmacy benefits.	This provisions limits the ability of plans to adopt plan value-based plan designs, like mail-order only benefits. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.
5 R.I. Gen. Laws Ann. § 5-19-3.3(a)(5	Prohibits the exclusion of 340B entities from plan networks.	This provision limits the ability of plans to develop and implement certain network requirements. Because the provision requires a specific benefit design choice by the plan sponsor, it should be preempted because it consistent with the holding in *Shaw*.