No. 18-40863

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

DIALYSIS NEWCO, INCORPORATED,
doing business as DSI Laredo Dialysis,

Plaintiff-Appellee,

v.

COMMUNITY HEALTH SYSTEMS GROUP HEALTH PLAN;
CHS/COMMUNITY HEALTH SYSTEMS, INCORPORATED;
MEDPARTNERS ADMINISTRATIVE SERVICES, L.L.C.,

Defendants-Appellants.

Appeal from the United States District Court
for the Southern District of Texas, Laredo Division
No. 5:15-CV-272, Judge Marina Garcia Marmolejo

BRIEF FOR AMERICAN BENEFITS COUNCIL AND THE ERISA INDUSTRY COMMITTEE AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS AND REVERSAL

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SUPPLEMENTAL STATEMENT OF INTERESTED PARTIES

Pursuant to Fifth Circuit Rule 29.2, the undersigned counsel certifies that the following listed persons and entities, in addition to those already listed in the Appellants' opening briefs, have an interest in the outcome of this case.

Amici Curiae:
American Benefits Council
The ERISA Industry Committee

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STATEMENT OF THE *AMICI CURIAE*

American Benefits Council ("the Council") is a national nonprofit organization dedicated to protecting and fostering privately-sponsored employee benefit plans. The Council's approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs. One of the Council's key goals is the protection and advancement of national uniformity in the laws governing employee benefits.

The ERISA Industry Committee ("ERIC") is a national trade association and represents the interests of large employers with 10,000 or more employees that sponsor health, retirement, and compensation benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*. ERIC's member companies voluntarily provide benefits through these plans to millions of workers and their families across the U.S. ERIC's member companies operate multistate and in every major sector of the U.S. economy. ERIC's mission includes lobbying and litigation advocacy for nationally-uniform laws regarding employee benefits under ERISA, so that ERIC's member

companies need not operate under a patchwork of different and conflicting state and local laws in addition to federal law.

In this case, among its chief holdings, the district court found ERISA not to preempt the operation of a Tennessee law "requir[ing] that insurance contracts providing for healthcare allow the beneficiary to assign the benefits to 'healthcare provider[s] and [that] such rights must be stated clearly in the policy.'" ROA.1239 (quoting Tenn. Code § 56-7-120(a)(1)). Finding the Tennessee statute applicable in the context of a self-funded ERISA plan (*i.e.*, one in which the employer carries the insurance risk, *see infra* p. 21), and resting on this Court's holding against ERISA preemption in *Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System*, 461 F.3d 529 (5th Cir. 2006) ("*Rapides*"), the district court determined that an anti-assignment provision in the plan was null and unenforceable. As organizations that promote nationally-uniform employee-benefit-plan regulation and whose members have multistate operations and provide benefits to their employees throughout the U.S., the Council and ERIC have strong interests in reversal of the district court's ruling that ERISA does not preempt a state law – here, Tennessee's – directing both to whom ERISA-plan benefits must be paid and the content of ERISA plans regarding the effect of assignments.

Counsel for the *amici* has contacted counsel for each of the Appellants and for the Appellee, and they indicated that the Appellants and the Appellee consent to the filing of this brief.

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

The *amici* state that: (1) a party's counsel did not author the brief in whole or in part; (2) a party or party's counsel did not contribute money that was intended to fund preparing or submitting the brief; and (3) no person – other than the *amici*, their members, or their counsel – contributed money that was intended to fund preparing or submitting the brief.

SUMMARY OF ARGUMENT

I. The *amici* focus on the district court's holding that ERISA does not preempt the pertinent Tennessee statute, and they therefore summarize at the outset the overarching legal framework for ERISA preemption. ERISA is a detailed, comprehensive statute governing the offering of various types of employee benefits, including health benefits, by private employers to their employees. A vital facet of ERISA – termed by Congress to be the statute's "crowning achievement" (*see infra* p. 8) – is ERISA's express preemption provision, which provides that ERISA preempts any state laws that "relate to" ERISA plans. 29 U.S.C. § 1144(a). Congress's aim with the preemption provision was to ensure national uniformity in the administration of employee benefit plans, and the

Supreme Court has consistently given the provision an expansive reading, including in its most recent ERISA preemption decision, *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016).

II. In concluding that ERISA did not preempt the Tennessee law, the district court found the dispute to be controlled by *Rapides*; however, even assuming *Rapides* did control (and the *amici* believe it does not), *Rapides* has been undermined by intervening Supreme Court precedent – most notably *Gobeille* – and therefore should no longer be followed. *Rapides* upheld, against an ERISA preemption challenge, a Louisiana law requiring that insurers honor participant authorizations of direct payments to providers. It did so, first, by emphasizing that there is a strong presumption against ERISA preemption and, second, by utilizing a standard whereby a state law is invalid under ERISA's preemption clause only if the state law, in its particulars, would be burdensome for an ERISA plan to obey.

Neither of these underpinnings of the *Rapides* decision survives *Gobeille*. In *Gobeille*, and then in a subsequent decision (*see Puerto Rico v. Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016)), the Supreme Court directed the lower courts no longer to apply a presumption against preemption in express-preemption cases, including ERISA cases. Moreover, also in *Gobeille*, the Court held squarely that preemption can ensue even if the given state's law, on its own, is not burdensome; instead, if the law touches an area central to ERISA-plan

administration, *the prospect* of differing laws among the states is sufficient for preemption. Had *Rapides* applied these standards, as now govern, the Fifth Circuit necessarily would have reached an opposite result – namely, a holding in favor of ERISA preemption.

III. In any event, even if *Rapides* remains good law, the situation in this case is distinguishable, so that preemption here is required even if not in *Rapides*. The Tennessee statute, unlike the Louisiana law in *Rapides*, requires that insurers include *in their insurance policies* terms authorizing participants to assign their benefits, and the district court determined that Tennessee's law – though aimed at insurers and insurance policies – likewise applied to self-funded ERISA plans. A directive by a state with respect to ERISA-plan terms, absent in *Rapides*, straightforwardly undermines the uniformity that ERISA's preemption provision seeks to ensure, since a uniform national plan cannot exist when each state requires its own terms. And though the Tennessee law is directed at insurers and insurance policies, it is not saved under ERISA's savings clause for insurance regulations, because what is known as ERISA's "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), removes self-funded ERISA plans (such as the one at issue here) from the savings clause's scope.

IV. Preemption in this instance promotes participant and ERISA-plan interests. A provider's desire to obtain payment for his or her services directly

from a plan can prompt the provider to join a plan's "network" of providers and, in so doing, agree to discounted payments and prohibitions on balance billing to participants. Such discounts and balance-billing prohibitions are advantageous to participants and plans alike. State laws that require plans to authorize assignments of benefits to providers reduce a provider's incentive to join the network and even encourage plans to exclude, in the plan's terms, coverage for any services from out-of-network providers.

ARGUMENT

I. ERISA PREEMPTION IS ROBUST AND COMPREHENSIVE

The *amici*'s presentation centers on the issue of whether ERISA preempts Tennessee's statute requiring insurers to allow assignments of benefits and to include terms to that effect in their policies. Because ERISA preemption is their focus, the *amici* begin with a review of ERISA's general framework and the extensive preemption principles applicable in the ERISA context.

The Supreme Court has "observed repeatedly that ERISA is a '"comprehensive and reticulated statute," the product of a decade of congressional study of the Nation's private employee benefit system.'" *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993), quoting *Nachman Corp. v. PBGC*, 446 U.S. 359, 361 (1980)). ERISA's compass extends to any employee benefit plan –

whether pension, health, or disability – established or maintained by a private employer or employee organization. *See* 29 U.S.C. §§ 1002(1), 1003(a)-(b).

Despite ERISA's comprehensive coverage, "[n]othing in ERISA requires employers to establish employee benefit plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Rather, "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)).

Uniformity in the regulation and administration of ERISA plans was paramount to Congress: "'Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of "minimiz[ing] the administrative and financial burden[s]" on plan administrators – burdens ultimately borne by the beneficiaries.'" *Gobeille v. Liberty Mut. Ins. Co.,* 136 S. Ct. 936, 944 (2016) (quoting *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001), quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)). To accomplish that goal, Congress included in ERISA an express preemption provision, 29 U.S.C. § 1144(a). Section 1144(a) states that "the

provisions of [ERISA] . . . shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in [29 U.S.C.] section 1003(a) and not exempt under section 1003(b)." *Id.* (emphasis added).

Following from the preemption terms Congress chose, the Supreme Court has characterized § 1144(a)'s text as "clearly expansive," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324 (1997) ("*Dillingham*") (internal quotation marks and citations omitted) (cataloging statements in prior precedents). Near the time of ERISA's enactment, the Supreme Court termed the preemption provision as revolutionary for its era (*see Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983) (describing § 1144(a) as a "virtually unique pre-emption provision")) and the "'crowning achievement'" of the statute. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)). In its most recent ERISA preemption decision – namely, *Gobeille* – the Court described the preemption provision as having a "broad scope" and "comprehensive," with Congress having intended to make the regulation of employee benefit plans "'exclusively a federal concern.'" 136 S. Ct. at 944 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

To be sure, there was a time in the mid-1990s when the Supreme Court hit the "pause" button on ERISA preemption, to reassess its jurisprudence in the area. *See, e.g.*, *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655-56 (1995) ("*Travelers*"); *see also, e.g.*, *Dillingham*, 519 U.S. at 324; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 (1997). As a result of the reexamination, the Court instructed the lower courts not to apply woodenly or "literal[ly]" the preemption provision's text and to ensure that preemption in the particular situation furthers "the objectives of the . . . statute," which serve "as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. At the time, the Supreme Court also invited in ERISA cases a "presumption against pre-emption" (*Travelers*, 514 U.S. at 655), though that instruction, as the *amici* later explain (*see infra* pp. 14-17), has since waned. Ultimately, the reexamination resulted in the overruling of no prior precedents. *See De Buono*, 520 U.S. at 813.

Furthermore, both before and after the *Travelers* period, a constant has been the Supreme Court's division into "two categories" the types of "state laws that ERISA pre-empts." *Gobeille*, 136 S. Ct. at 943; *accord Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). First, a state law will "relate to" ERISA plans so as to require preemption under § 1144(a) whenever it makes a "reference to" ERISA plans, such as "'[w]here 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.'" *Gobeille*, 136 S. Ct. at 943 (quoting *Dillingham*, 519 U.S. at 325). Second, "ERISA pre-empts a state law that has an impermissible 'connection with' ERISA plans, meaning a state law that 'governs . . . a central matter of plan administration' or 'interferes with nationally uniform plan administration.'" *Id.* (quoting *Egelhoff*, 532 U.S. at 148).

Still another feature of the ERISA preemption framework is that § 1144(a) is immediately followed by a savings clause allowing otherwise-preempted state insurance regulations to survive. The savings clause states that "nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). In turn, the savings clause is followed by what is known as a "deemer" clause, which ensures that ERISA plans self-insured by employers – *i.e.*, self-funded plans – shall not be subject to state insurance laws. *See id.* § 1144(b)(2)(B) ("Neither an employee benefit plan [governed by ERISA] . . . , nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment

companies."); *see FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990) (noting difference between ERISA self-funded and insured plans).

II. *RAPIDES* IS INHARMONIOUS WITH CURRENT PREEMPTION LAW AND THEREFORE SHOULD NOT BE FOLLOWED IN THE EVENT THE COURT OTHERWISE FINDS *RAPIDES* TO RESEMBLE THIS CASE

A. *Rapides* Depended on a Strong Presumption Against Preemption and a Narrow View of the Burdens Sufficient to Prompt ERISA Preemption

In holding that ERISA does not preempt the Tennessee statute, the district court thought *Rapides* was controlling. In *Rapides*, the Fifth Circuit considered whether ERISA preempted a Louisiana law that "require[d] insurance companies to honor all assignments of benefit claims made by patients to hospitals." 461 F.3d at 530. Specifically, Louisiana's law stated:

> No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any . . . [such] entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits.

La. Rev. Stat. Ann. § 40:2010 (2004).

Concluding that the Louisiana measure did *not* "relate to" ERISA plans (under the "connection with" prong of preemption analysis) and therefore was not

preempted under § 1144(a), the Fifth Circuit repeatedly stated that there is a strong presumption against preemption, in light of the *Travelers* decision. The Fifth Circuit said: "we start with the assumption that 'the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress.'" 461 F.3d at 537 (quoting *Travelers*, 514 U.S. at 655). In particular, the Fifth Circuit rested heavily on the presumption in rejecting the decisions of two sister Circuits that had already determined state laws facilitating assignments to be preempted by ERISA. *See Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460 (10th Cir. 1995). As the Fifth Circuit put it, "[n]either the Eighth nor Tenth Circuits operated with the starting assumption that Congress did not intend[] to preempt state law in an area of traditional state regulation." 461 F.3d at 540.

With the presumption as the backdrop, the Fifth Circuit then proceeded to determine that the Louisiana law would not "interfere with nationally uniform plan administration" and therefore not frustrate the policy undergirding ERISA's express preemption provision. *Id.* at 539. Looking solely at "the particular burden the [Louisiana] statute imposes on plan administration," the Fifth Circuit deemed the burden to be "minimal" because assignments in Louisiana were reported on a "uniform claim form" and "most hospitals file claims with insurance companies

electronically," thereby not "creat[ing] any additional paperwork for Blue Cross" by requiring the honoring of direct-payment authorizations. *Id.*[1]

As the *amici* show below, these foundations for the *Rapides* decision do not survive subsequent case-law developments on ERISA preemption. As the law now stands, a state's statute mandating benefits payments to assignees *is* preempted under ERISA's express preemption clause. Accordingly, assuming *Rapides* would govern this matter (as the district court determined it would, but the *amici* dispute, *see infra* pp. 20-24), this Court should no longer follow *Rapides*, and the district court's reliance on it to invalidate the relevant ERISA plan's anti-assignment language is reversible error. *See generally Todd v. S.S. Mut. Underwriting Ass'n (Berm.) Ltd.*, 601 F.3d 329, 332, 333 (5th Cir. 2010) (panel overruling earlier Fifth

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[1] The Court of Appeals in *Rapides* also buttressed its non-preemption holding by reasoning that the operation of the Louisiana law furthered ERISA's definition of "beneficiary" (461 F.3d at 539), which in full describes a beneficiary as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8). But the Court's determination, if it was a holding, that the assignment constituted a participant designation of the provider to be a beneficiary was contrary to prior Fifth Circuit precedent. *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 576 (5th Cir. 1992), *overruled on other grounds by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012) ("[w]e perceive a distinction between the rights of a beneficiary, as referred to in ERISA, to receive covered medical services or reimbursement therefor, and one entitled to receive payment as an assignee of such a beneficiary"; "[n]either [the participant's] act of authorizing the Plan to make payments directly to Hermann, nor [the beneficiary's] assignment of the right to recover payments for benefits provided, elevated Hermann to the status of beneficiary under the Plan"). The statement in *Hermann* is the law in this Circuit, as a decision pre-dating *Rapides*'s contrary (and thus ineffective) conclusion. *See United States v. Connor*, 907 F.3d 316, 317, 321 (5th Cir. 2018).

Circuit precedent because, in the meantime, the Supreme Court "effectively" had "rejected the reasoning in [the earlier decision]").

B. There Is No Longer a Presumption Against Preemption in Express-Preemption Cases, Including Those Involving ERISA's Express Preemption Provision

Doubtless, when the Supreme Court decided *Travelers* and the other 1990s ERISA cases on which *Rapides* relies, the Supreme Court had adopted a presumption against preemption even when confronted with ERISA's preemption provision. *See Travelers*, 514 U.S. at 655; *Dillingham*, 519 U.S. at 325; *De Buono*, 520 U.S. at 813-14. Indeed, just prior to those ERISA cases, the Supreme Court in a non-ERISA case had ushered in the prospect of applying a "presumption against the pre-emption of state police power regulations" where a federal statute contains an express preemption clause. *Cipollone v. Liggett Group*, 505 U.S. 504, 518 (1992). The Supreme Court, however, has since retreated from that point of view, culminating with *Gobeille* and a post-*Gobeille* decision rejecting the presumption.

In concurring and dissenting opinions, five Justices of the Supreme Court had, by the mid-2010s, registered dissatisfaction with applying a presumption against preemption in express preemption cases. Writing for himself and three other Justices, Justice Scalia stated:

> I remain convinced that "[t]he proper rule of construction for express pre-emption provisions is . . . the one that is customary for statutory provisions in general: Their language should be given its ordinary meaning." *Cipollone v. Liggett Group, Inc.*, 505 U. S. 504, 548, 112 S.

> Ct. 2608, 120 L. Ed. 2d 407 (1992) (Scalia, J., concurring in judgment in part and dissenting in part). The contrary notion – that express pre-emption provisions must be construed narrowly – was "extraordinary and unprecedented" when this Court announced it two decades ago, *id.*, at 544, 112 S. Ct. 2608, 120 L. Ed. 2d 407, and since then our reliance on it has been sporadic at best, *see Altria Group, Inc. v. Good*, 555 U.S. 70, 99-103, 129 S. Ct. 538, 172 L. Ed. 2d 398 (2008) (Thomas, J., dissenting).

CTS Corp. v. Waldburger, 573 U.S. 1, 19-20 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.). Justice Kennedy added that the principle of a presumption against preemption, insofar as earlier case law supports it, is now better thought of "not as a presumption but as a cautionary principle to ensure that pre-emption does not go beyond the strict requirements of the statutory command." *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 570 U.S. 1, 21 (2013) (Kennedy, J., concurring).

Then, in *Gobeille*, the Court indicated the fading of the presumption in the ERISA context. In finding the state law in *Gobeille* to be preempted under § 1144(a), the Court summarized the basic preemption principles at the start of its decision, but there omitted any mention of a presumption against preemption. *See* 136 S. Ct. at 943. When it did mention a presumption against preemption, it was at the close of its opinion to question the existence of a presumption altogether and to reject its application in the circumstances of the case, thereby prompting a dissent from Justice Ginsburg. *Compare* 136 S. Ct. at 946 ("*Any* presumption against pre-emption, *whatever* its force in other instances, cannot validate a state law that

enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.") (emphasis added) *with id.* at 954 (Ginsburg, J., dissenting) (relying on "[t]he presumption against preemption"). Justice Thomas, in a concurrence, criticized *Travelers* and noted that "our interpretation of ERISA's express pre-emption provision has become increasingly difficult to reconcile with our pre-emption jurisprudence." *Id.* at 948 (Thomas, J., concurring).

Ultimately, in *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938 (2016), the Court came full circle and formally rejected application of a presumption in express-preemption cases, including ERISA. There, the Court considered whether Puerto Rico fit the definition of a "State" in the express preemption provision in the Bankruptcy Code, 11 U.S.C. § 903(1). *Puerto Rico*, 136 S. Ct. at 1942. Describing the governing preemption principles, the Court stated:

> The plain text of the Bankruptcy Code begins and ends our analysis. Resolving whether Puerto Rico is a "State" for purposes of the pre-emption provision begins "with the language of the statute itself," and that "is also where the inquiry should end," for "the statute's language is plain." *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241, 109 S. Ct. 1026, 103 L. Ed. 2d 290 (1989). And because the statute "contains an express pre-emption clause," we do not invoke any presumption against pre-emption but instead "focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent." *Chamber of Commerce of United States of America v. Whiting*, 563 U.S. 582, 594, 131 S. Ct. 1968, 179 L. Ed. 2d 1031 (2011) (internal quotation marks omitted); *see*

> *also Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. ---, ---, 136 S. Ct. 936, 194 L. Ed. 2d 20 (2016).

Puerto Rico, 136 S. Ct. at 1946. As a result of *Puerto Rico*, the lower courts are now directed *not* to use a presumption against preemption if the federal statute "contains an express pre-emption clause," which ERISA certainly does. *Id.* (internal quotation marks and citation omitted). If there were any doubt that the Court intended that directive particularly for ERISA cases, its citation in the above passage in *Puerto Rico* to *Gobeille* – now the Court's leading ERISA preemption precedent – for the proposition against a presumption clinches the point.

At this date, then, there is no presumption against preemption that may be applied in an ERISA or other express-preemption case. Yet, *Rapides* – being from a different era on this issue – relied on the presumption in its non-preemption holding concerning the Louisiana law. In fact, the Fifth Circuit emphasized the presumption no less than three times in its preemption analysis, including, again, when rejecting sister Circuits' holdings. *See* 461 F.3d at 539, 540 & n.59, 541. It said that the presumption, when weighed against ERISA being "a comprehensive statute with a 'clearly expansive' preemption provision," forced it to "walk a fine line between permissible and impermissible state regulation in this context." *Id.* at 541 (quoting *Dillingham*, 519 U.S. at 324). Without the presumption, there is no such "fine line," and state laws requiring benefits payments to assignees fall decisively on the side of being preempted.

C. *Gobeille* Negates *Rapides*' Narrow View of the Administrative Burdens Sufficient for Preemption

The other pillar of *Rapides*, which similarly now proves inadequate to support preemption, was that the Louisiana statute did not burden ERISA plans because it supposedly was a simple measure with which to comply. *See supra* pp. 12-13. The Fifth Circuit's reasoning on this front runs headlong into *Gobeille*. In addition to negating the presumption against preemption, *Gobeille* teaches that the burden created by any particular state law is not dispositive, when the state law affects a "central matter of plan administration." 136 S. Ct. at 945 (internal quotation marks and citation omitted). In that instance, preemption is "necessary" because "[d]iffering, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability." *Id.* The prospect of "novel, inconsistent, and burdensome" state regulations is alone sufficient, and a plan need not even "wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs." *Id.*

Like the state in *Gobeille*, the *Rapides* Court incorrectly focused exclusively on the "economic burdens caused by the state law," rather than on whether a state's law affects core administrative functions. *Id.* Had it focused its inquiry as *Gobeille* now instructs, the Court in *Rapides* would necessarily have found preemption. State laws requiring benefits payments to be made to assignees (as

with the Louisiana law in *Rapides*) "regulate[] a central aspect of plan administration," given that they dictate *to whom benefits shall be paid*, and "welfare benefit plans are in the business of providing benefits to plan participants." *Id.* at 945, 944. Furthermore, a fiduciary's foremost duty is "providing benefits to participants and their beneficiaries," 29 U.S.C. § 1104(a)(1)(A)(i), and the Department of Labor has promulgated a full set of federal standards on the claims procedures for paying benefits. *See* 29 C.F.R. § 2560.503-1. As the Supreme Court had earlier stated in *Egelhoff* in invalidating a Washington statute prohibiting pension payments to divorced spouses, "this statute governs the payment of benefits, a central matter of plan administration." 532 U.S. at 148.

Because paying benefits is "central to, and an essential part of, the uniform system of plan administration contemplated by ERISA," and a state law requiring payments to assignees "intrudes upon" that function, *Gobeille* directs – contrary to *Rapides* – the preemption of such a law. 136 S. Ct. at 945. That is so regardless of the burden any single state law might create, since "plans will face *the possibility* of a body of disuniform state [assignment] laws." *Id.* (emphasis added).

In sum, *Rapides* is an anachronism to be discarded, because it rested on now rejected standards concerning a presumption against preemption and the primacy of the burden posed by the state law at issue (rather than the core nature of the

administrative function implicated). As a result, the district court's non-preemption holding on Tennessee's law – based as it is on *Rapides* – falls with *Rapides*' outdated reasoning.

III. EVEN IF *RAPIDES* REMAINS GOOD LAW, IT DOES NOT GOVERN THIS CASE, GIVEN THAT THE CURRENT SITUATION IS DISTINGUISHABLE

Even assuming *Rapides* still survives, the district court erred in finding *Rapides* controlling. Preemption follows here, even if it did not in *Rapides*, because Tennessee's law differs in material ways from the Louisiana measure in *Rapides*. Appellants Community Health Systems Trust Health Plan and CHS/Community Health Systems, Inc. ("CHS Appellants") have noted that, unlike the Louisiana statute, the Tennessee law is broader because it addresses all assignments, not just "direct-payment authorizations," and the attendant additional friction with uniform plan administration distinguishes this case from *Rapides*. CHS Appellants' Br. 37. There is another difference too that moves this case further into the preemption category: the Tennessee law has a component whereby it requires the participants' entitlement to assign their benefits *must be stated in the ERISA plan itself*.

In pertinent part, the Tennessee statute provides:

> Notwithstanding any law to the contrary, if a policy of insurance issued in this state provides for coverage of health care rendered by a healthcare provider . . . , the insured or other persons entitled to benefits under the policy are entitled to assign their benefits to the healthcare

> provider and such rights *must be stated clearly in the policy*. Notice of the assignment must be in writing to the insurer in order to be effective unless otherwise stated in the policy.

Tenn. Code Ann. § 56-7-120(a)(1) (emphasis added). Thus, the Tennessee law initially gives insureds rights with respect to assignments, and then it directs that those rights be reflected in the terms of the "policy." The Louisiana law in *Rapides* had no counterpart requiring that the rights announced in the statute be added to the governing insurance agreement. *See* 461 F.3d at 530-31.

In this case, there is no insurance policy, at least as typically perceived – *i.e.*, a certificate of coverage issued by an insurance company. The dispute involves a self-funded ERISA plan. *See* ROA.1228-29. When a "[p]lan is self-funded[,] it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants." *FMC Corp.*, 498 U.S. at 405. The insurance arrangement, instead, is the self-funded plan itself: "self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan." *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 336 n.1 (2003).

Though the plan here at issue is self-funded, rather than a traditional insurance company or insurance policy, the district court found the Tennessee law operative. *See* ROA.1244; *see also* Tenn. Code § 56-7-101 (defining "contract of insurance" to be "an agreement by which one party, for a consideration, promises

to pay money or its equivalent, or to do some act of value to the assured, upon the destruction or injury, loss or damage of something in which the other party has an insurable interest"). The result, in these circumstances, is that the Tennessee law's mandate of assignment rights being memorialized in the policy operates as a requirement that the self-funded ERISA plan contain Tennessee's chosen terms.

Aside from any other preemption problems with the Tennessee law, the requirement in it that ERISA plans contain certain language means that the law "relate[s] to" ERISA plans under § 1144(a). A state law is preempted if it is "telling employers how to write their ERISA plans." *Operating Eng'rs Health & Welfare Tr. Fund v. JWJ Contracting Co.*, 135 F.3d 671, 679 (9th Cir. 1998) (internal quotation marks and citation omitted). That rule follows from ERISA's statutory provision that "a plan shall 'specify the basis on which payments are made.'" *Egelhoff*, 532 U.S. at 147 (quoting 29 U.S.C. § 1102(b)(4)). A state that orders a plan to draft payment terms to the state's liking necessarily "binds ERISA plans to a particular choice of rules" when the plan fulfils its obligation to specify the bases on which the plan's payments will be made. *Id.* at 147. "'The plan, in short, is at the center of ERISA,'" and a "focus on the written terms of the plan is the linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99,

108 (2013) (alteration in original) (quoting *US Airways, Inc.* v. *McCutchen*, 569 U.S. 88, 101 (2013), and *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996)).

The presence in the Tennessee law of a requirement as to the content of an ERISA plan's terms makes the law's disruption to nationally-uniform administration – § 1144(a) underlying purpose – especially acute. A multistate self-funded ERISA plan cannot have uniform nationwide plan language, unless it makes Tennessee's requirement the default rule for its plan nationally. And if another state currently or in the future has an assignment law differing from Tennessee's, or oppositely insists on *limiting* the effect of assignments, it will be impossible for the ERISA plan to comply with each state's law in the same plan, requiring different ERISA plans for different states. "Uniformity is impossible, . . . if plans are subject to different legal obligations in different States." *Egelhoff*, 532 U.S. at 148.

It might be thought that, notwithstanding the Tennessee law's mandate of specific plan terms bringing the statute readily within § 1144(a)'s ambit, the Tennessee law (which, after all, overtly is aimed at insurance policies) can survive preemption because it is saved as a state law "which regulates insurance." 29 U.S.C. § 1144(b)(2)(A); *see supra* p. 10. But the savings clause is of no consequence in this case because Tennessee's law is being used to regulate a self-funded ERISA plan, and a self-funded plan is protected by ERISA's deemer clause

from state insurance laws. *See supra* pp. 10-11. The Supreme Court has "read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the savings clause." *FMC Corp.*, 498 U.S. at 61.[2]

IV. PREEMPTION OF TENNESSEE'S LAW FURTHERS PARTICIPANT AND ERISA-PLAN INTERESTS

Not only does preemption obtain under § 1144(a), especially in light of the Tennessee law's requirement that assignment terms be stated in the "policy" itself, preemption furthers participant and ERISA-plan interests. Most notably, preemption helps ensure to participants access to a broader range of providers, while preserving cost-containment mechanisms beneficial to participants and ERISA plans.

Were ERISA plans required to permit assignments, and even include terms to that effect in the plans themselves, employers might choose to exclude altogether from coverage in their health plans services to what are known as non-

[2] In *Rapides*, Judge Owen in her concurrence asserted that the Louisiana law could be assumed to "relate to" ERISA plans and to be preempted under § 1144(a), because she believed it then would be saved from preemption as an insurance regulation. *See* 461 F.3d at 541. That view does not impact this case because another difference between *Rapides* and this one is that *Rapides* involved only insured ERISA plans. *See id.* at 543 ("Louisiana concedes that it has not attempted to enforce [the Louisiana law] with regard to self-funded ERISA plans"). In *Rapides*, therefore, it was "unnecessary to resolve whether the 'deemer clause . . . preclude[d] the application of the ERISA savings clause." *Id.* In *amici*'s view, it also is open to serious dispute whether state laws addressing assignments are saved state insurance regulations. *See Texas Life, Accident Health & Hosp. Serv. Ins. Guar. Ass'n v. Gaylord Entm't Co.*, 105 F.3d 210, 218 (5th Cir. 1997) (Texas statutory provision "that a policyholder assigns by operation of law all claims related to the policy . . . does not fall within the savings clause").

participating (or out-of-network) providers. Non-participating providers are those who are not part of an employer's, third-party administrator's, or insurer's network of contracted providers; being out of network, they have not agreed by contract to charge participants a discounted rate, to abide by the policies stated in the network contract, or to decline to balance bill patients for the difference between what the plan pays in benefits and the provider's billed charge. *See generally N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare,* 781 F.3d 182, 187 (5th Cir. 2015) (noting characteristics of provider participation in network); *Wash. Hosp. Ctr. Corp. v. Group Hospitalization & Med. Servs., Inc.*, 758 F. Supp. 750, 754 (D.D.C. 1991) (same).

The use of participating providers by participants has obvious advantages for containing medical costs, both for the participants and the plan (*see id.*), and nothing in ERISA requires (other than in emergency settings) that a plan offer coverage for services from any particular set of providers, and thus beyond services from participating providers. *See Heimeshoff*, 571 U.S. at 108 ("'[E]mployers have large leeway to design disability and other welfare plans as they see fit.'") (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003)). Consequently, it is gratuitous in the first place that an ERISA plan covers services by non-participating providers.

It is the prospect of "direct payment" from a plan that can entice a provider to become participating, as the possibility of immediate payment (without having to seek funds from the participant) serves as an incentive for the provider to agree to the discounted rates and other terms contained in a network contract. *Rapides*, 461 F.3d at 532. However, state laws that mandate the plan to authorize assignments of benefits, and thus to direct payment to whomever a participant assigns his or her rights, negate a provider's incentive to join the plan's network; in so doing, they concomitantly undermine the plan's effort to achieve cost containment for itself and the plan's participants. To compensate for the inability to use direct payment as an enticement to join the plan's network of providers – an incapacity caused by the application of state laws like Tennessee's – plans may find it necessary, in the plan's terms, to eliminate coverage for services from non-participating providers, an even more powerful bulwark toward achieving expanded provider networks and attaining the cost savings associated with in-network services.

CONCLUSION

The Court should reverse the district court's holding that ERISA does not preempt the Tennessee law at issue in the case.

Respectfully submitted,

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I hereby certify that on January 30, 2019, I electronically filed the foregoing with the Clerk of Court using the CM/ECF System, which will send notice of such filing to the following registered CM/ECF users:

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