No. 23-1213

In the Supreme Court of the United States

GLEN MULREADY, *in his official capacity as Insurance Commissioner of Oklahoma*; OKLAHOMA INSURANCE DEPARTMENT,

Petitioners,

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF IN OPPOSITION

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CORPORATE DISCLOSURE STATEMENT

Pharmaceutical Care Management Association states that it has no parent corporation and that no publicly held company owns 10% or more of its stock.

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INTRODUCTION

Further review is unwarranted. The Tenth Circuit faithfully applied settled precedents from this Court, including *Rutledge*. Every other circuit would decide this case in the same way if it were presented with a law like Oklahoma's, which regulates the design of provider networks in a state-specific way. And this case is a poor vehicle in light of Oklahoma's waiver and the Tenth Circuit's alternative holding.

The relevant principles are straightforward. A prescription-drug benefit plan comprises three substantive elements: (1) the drugs that are covered, (2) the network of pharmacies from which participants can get covered drugs, and (3) the amounts that participants must pay as copays, coinsurance, and premiums. Pet. App. 55.

Variation in the second element, network design, is a principal means by which plans compete. Some offer more extensive networks in exchange for higher premiums. Others use narrower networks through which they obtain better reimbursement rates and thus offer lower premiums. Still other plans use tiered networks, which typically include "preferred" providers from whom participants can obtain lower copays or coinsurance. In all events, a plan sponsor's decisions concerning the design of its provider network are, without a doubt, decisions concerning the design of the benefit itself.

The Oklahoma law at issue in this case—the Patient's Right to Pharmacy Choice Act of 2019 (the Act)—limits the ways in which sponsors of health plans may design the networks of pharmacies within their prescription-drug benefit plans. Among other things, it requires plan sponsors to allow any willing pharmacy to participate in a preferred provider network. At the same time, the Act effectively forbids plans from using preferred networks by barring them from offering participants discounts or

preferential cost-sharing terms at preferred pharmacies. And maybe worst of all, it forbids plans from excluding a pharmacy from a network on the ground that the pharmacy employs pharmacists who are on regulatory probation. In addition, the Act's restrictions apply to all plans—either directly, by applying to plans that administer their own pharmacy benefits; or indirectly, by applying to the pharmacy benefits managers (PBMs) that plans retain.

The Tenth Circuit correctly held that these elements of the Oklahoma statute are preempted as applied to plans covered by the Employee Retirement Income Security Act (ERISA) and that the any-willing-provider provision is preempted as applied to plans offered under Medicare Advantage or Medicare Part D. This Court has said time and again that any state law that "prohibits employers from structuring their employee benefit plans in a [particular] manner" is "clearly" preempted. *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). As the Court confirmed more recently in *Rutledge* v. *PCMA*, 592 U.S. 80 (2020), ERISA was intended to "ensur[e] that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." *Id.* at 86. Similarly, lower courts have broadly construed preemption under the Medicare Advantage and Part D programs. See, *e.g.*, *Medicaid & Medicare Advantage Products Association of Puerto Rico* v. *Emanuelli Hernandez*, 58 F.4th 5, 12 (1st Cir. 2023) (*MMAPA*).

For its part, Oklahoma does not disagree that ERISA and Medicare both preempt state laws that directly limit the choices that plan sponsors are permitted to make in designing their provider networks. Nor does it take issue with the Tenth Circuit's own framing of the baseline rules for preemption. It instead takes issue with the Tenth Circuit's characterization of the challenged state law, contending that state laws that regulate PBMs are ex-

empted from ERISA preemption, and that, in any event, the Act's impact on ERISA plans cannot be said to substantially affect benefit design.

Oklahoma made these arguments below, and the Tenth Circuit rightly rejected them. Consistent with this Court's cases, it concluded that even where a state law affects ERISA plan design indirectly through a third-party, such as a PBM, it can have an impermissible connection with ERISA plans. Here, the court assessed the "Act's substantial, indirect effects on ERISA plans" and determined that each challenged provision is pre-empted because it "either directs or forbids an element of plan structure or benefit design." Pet. App. 25-26.

Oklahoma's bid for further review is grounded on a distorted reading of *Rutledge*, with which it says the Tenth Circuit's decision "conflicts." But the Tenth Circuit carefully reconciled its holding below (concerning state regulation of network design) with *Rutledge*'s non-novel reasoning (concerning state regulation of reimbursement rates). Lacking refuge in *Rutledge* itself, Oklahoma grounds the asserted conflict on the Tenth Circuit's description of the Act and how it works. But case-specific squabbles over the workings of state statutes is unworthy of this Court's attention.

That alone is enough to doom the petition. But there is more: This case is also glaringly unsuitable as a vehicle for resolving either of the questions presented.

As for the first question, this case does not present a contentious legal issue. There is no dispute among the federal courts on whether states can directly or indirectly regulate ERISA-covered provider networks, and this Court's recent decision in *Rutledge* did not alter the analysis. But even if it did, review in this case would be premature; additional time is needed to give the other circuits opportunities to further illuminate the issues presented. That is especially so because the Tenth Circuit

expressly declined to reach ERISA's preemption saving clause, holding that Oklahoma waived the issue. See Pet. App. 39-40. This case thus does not involve the full range of issues that the Court would need to address to fully resolve the first question presented.

As for the second question, the Tenth Circuit expressly agreed (Pet. App. 47) with the First and Eighth Circuits that the Medicare statute's express "preemption clause mandates field preemption." Although it identified possible tension in how the courts of appeals have applied that uniform rule of law, the Tenth Circuit explained (Pet. App. 49) that "the result would be the same even under" Oklahoma's preferred approach. Thus, even supposing the second question presented warranted review in the abstract—it assuredly does not—this case would provide no opportunity to resolve it.

* * *

Two final points bear emphasis at the outset.

First, Oklahoma's petition (and the briefs of its amici) rely substantially on anti-PBM invective and one-sided mischaracterizations of the relevant markets and stakeholder conduct. Not only are these arguments out of place in a legal brief, but they tell only half the story. In fact, the Act is a plainly protectionist measure that favors the economic interests of a discrete special interest group to the detriment of Oklahoma employers and Medicare plan sponsors and hundreds of thousands of their beneficiaries, who face higher costs and reduced benefits as a result. The Act hurts Oklahoma consumers by leading to higher copays and coinsurance, higher premiums, and reduced benefit offerings—while at the same time forbidding plan sponsors from offering beneficiaries discounts for using preferred pharmacies. That is why major national employer and labor groups supported PCMA before the Tenth Circuit.

And Oklahoma is wrong that the preemption ruling below limits states' authority to regulate PBMs. PBMs must meet extensive requirements for state licensure and comply with all state laws of general application, including contract laws, consumer protection laws, unfair trade practices statutes, antitrust laws, privacy laws, and so forth. And the states are free to regulate PBMs and health insurance plans in private and Medicaid markets, outside the ERISA and Medicare contexts.

But that is all beside the point since the Act does not police "misconduct" by PBMs in any event; rather, it prevents health plans from administering common provider network tools designed to lower costs and ensure quality, safety, and convenience. And precisely because the Act dictates design decisions for provider networks, it is preempted as applied to ERISA and Medicare plans in accordance with decades of this Court's cases. Setting aside Oklahoma's policy rhetoric, this case does not involve any pressing questions of law.

Second, in prior cases like this, the Court has sometimes called for the views of the Solicitor General. But that is unwarranted here. At the Tenth Circuit's invitation, the Office of the Solicitor General filed a brief in proceedings below. It generally agreed with PCMA on preemption but took the position that final resolution of the enforceability of the Oklahoma statute required consideration of ERISA's saving clause. On that front, it should not take a second brief from the Solicitor General to point out the obvious: The Tenth Circuit declined to reach that issue because Oklahoma waived it. The Court thus should deny the petition straight away, without a CVSG order.

STATEMENT

A. Statutory background

This case concerns the express preemption clauses of the Employee Retirement Income Security Act (ERISA) and the Medicare statute.

1.a. In enacting ERISA, Congress recognized that "[a] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation," leading to "reduce[d] benefits" overall. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987). Avoiding inefficient patchworks of regulation "is impossible, however, if plans are subject to different legal obligations in different states." *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001).

ERISA thus contains an express preemption clause that specifies that ERISA and its implementing regulations "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a). With this language, Congress "intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Shaw*, 463 U.S. at 99. In doing so, it ensured that "the regulation of employee welfare benefit plans" would be "exclusively a federal concern." *New York State Conference of BCBS Plans* v. *Travelers Insurance*, 514 U.S. 645, 656 (1995).

Under ERISA's preemption clause, state laws are preempted as applied to ERISA-covered plans if, among other things, they "bind ERISA plan administrators to a particular choice" concerning benefit design. *Egelhoff*, 532 U.S. at 147. Such regulations "prohibit[] employers from structuring their employee benefit plans in a [particular] manner" and thus "clearly 'relate to' benefit plans." *Shaw*, 463 U.S. at 97. As the Court confirmed

more recently in *Rutledge*, it was a primary objective with ERISA to "ensur[e] that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions." 592 U.S. at 86.

b. There are two categories of ERISA-covered healthcare benefit plans: (1) "fully insured" plans and (2) "self-funded" or "self-insured" plans. Sponsors of fully insured plans purchase third-party group health insurance policies to cover their employees, whereas sponsors of self-funded plans pool risk and collect premiums themselves. Self-funded plans engage third-party administrators (TPAs)—including PBMs for prescription drug benefits—as agents to assist with the details of plan design and administration.

In fashioning ERISA's preemption regime, Congress was concerned that health insurance companies selling commercial policies to fully insured ERISA-covered benefit plans might assert that state regulation of their insurance businesses is preempted. See H.R. Rep. No. 94-1785, at 48 (1977). Because independent third-party insurance policies "are not established or maintained by" ERISA-covered plans themselves, and because state-law regulation of the business of insurance is a matter of local importance (29 U.S.C. § 1002), Congress added a preemption saving clause specifying that ERISA's preemption clause "shall [not] be construed to exempt or relieve any person from any law of any State which regulates insurance[.]" 29 U.S.C. § 1144(b)(2)(A).

At the same time, Congress was concerned that states might "deem" self-funded ERISA plans to be commercial insurers not subject to preemption, which would gut ERISA's preemption clause of its meaning. Accordingly, Congress added a so-called deemer clause, which provides in relevant part that no self-funded ERISA-covered benefit plan "shall be deemed to be an insurance company or other insurer" for purposes of the saving clause. 29

U.S.C. § 1144(b)(2)(B). In other words, the deemer clause exempts "self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause." *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990).

2. The Medicare program is the federal health insurance program for people aged 65 or older or with certain disabilities. It comprises four parts: A, B, C, and D. See Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588, 4589 (Jan. 28, 2005). Medicare Part A is the hospital insurance program, and Part B is the medical insurance program. *Ibid.* The federal government provides coverage to beneficiaries enrolled in Parts A and B, which together are known as traditional Medicare. *Ibid.*

Part C, also known as the Medicare Advantage or MA program, invites private companies to contract with CMS to provide beneficiaries with Part A and Part B benefits together with additional benefits subsidized by the federal government. See CMS, *How Do Medicare Advantage Plans Work?*, perma.cc/9YP3-X56F.

Part D is Medicare's optional outpatient prescription drug coverage. It operates like Part C. Private companies contract with CMS to sponsor plans providing outpatient prescription drug coverage to Medicare-eligible beneficiaries, either as a freestanding plan (typically for those with traditional Medicare) or as part of an MA plan. The federal government pays sponsors of MA and Part D plans a monthly per-member amount for the coverage they provide, equivalent to the risk-adjusted sum that CMS determines it would pay if the member were enrolled in traditional Medicare instead.

To ensure that Medicare remains purely "a federal program operated under Federal rules," as to which "[s]tate laws, do not, and should not apply" (H.R. Rep. No. 108-391, at 557 (2003) (Conf. Rep.)), Congress provided that "[t]he standards established under this part

shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." 42 U.S.C. § 1395w-26(b)(3). Section 1395w-26(b)(3) applies to Medicare Part C, and Congress incorporated this same provision into the Part D program (*id.* § 1395w-112(g)).

The lower courts have construed preemption under the MA and Part D programs similarly to ERISA's preemption clause. See, *e.g.*, *MMAPA*, 58 F.4th at 12. A capacious reading of Medicare's express preemption clause makes sense in light of the federal funding of Medicare, and of federal regulators' expertise in overseeing the program. Among other things, it ensures that federal standards established by Congress and developed by the Centers for Medicare and Medicaid Services (CMS) are not subverted by the states attempting to impose their own standards in service of varying local interests.

B. Factual background

1. Prescription-drug benefit plans

The questions presented here concern state regulation of prescription-drug benefit plans, which typically require participants to obtain covered drugs from a network of pharmacies. Pet. App. 4-5.

The work of designing and implementing a prescription-drug benefit plan is complex and multifaceted. The plan sponsor, often working with a PBM, must identify which drugs to cover, determine how costs will be shared, identify and negotiate discounts and rebates from manufacturers, and settle the terms of reimbursement with thousands of pharmacies. Insurers and employers typically offer and consumers have come to expect a range of options that balance the scope of the benefit with overall cost in varying ways.

Whereas some plans use extensive networks, offering greater convenience in exchange for higher premiums, others use narrow networks through which they obtain better reimbursement rates and thus charge lower premiums. C.A. App. 472-474. Still other plans use tiered networks, which designate "preferred" in-network pharmacies at which beneficiaries can obtain drugs on more favorable cost-sharing terms. C.A. App. 476-477. Preferred pharmacies are willing to accept lower reimbursements in exchange for increased store traffic and sales-volume. C.A. App. 477. Preferred pharmacies also often must meet more stringent quality standards. By using tiered networks, plans are thus able to encourage beneficiaries to use higher-quality, more cost-effective pharmacies, generating cost-savings to both the plan and the beneficiary. *Ibid.*

Plan sponsors often include mail-service pharmacies within their provider networks. C.A. App. 505-506, 547. Like preferred pharmacies in a tiered brick-and-mortar network, mail-service pharmacies generally accept lower reimbursement rates because they have greater purchasing power and lower acquisition costs. Plans, in turn, are able to adjust beneficiary cost-sharing terms to share the savings. In addition to being less expensive, mail-service also improves patient adherence. C.A. App. 477.

Plans also ordinarily include "specialty" pharmacy networks. Specialty pharmacies dispense and manage drug regimens for rare or complex diseases involving especially expensive and sensitive drugs. They have particular expertise in handling specialty drugs, considering such factors as refrigeration, light exposure, or kinetic sensitivity. C.A. App. 470. It is industry standard for plans to require beneficiaries to use selected specialty pharmacies to obtain certain covered specialty drugs. C.A. App. 417-418, 547-548, 600.

When designing the provider network and other substantive elements of a prescription-drug benefit, plan sponsors must carefully balance access and quality against the cost to the plan and the beneficiaries. C.A. App. 22, 477-478, 509, 517-519, 545-549. For large employers or MAOs, these choices concerning network design are made on a multistate basis, so that participants enjoy a uniform benefit no matter the state in which they live or to which they travel.

2. The Patient's Right to Pharmacy Choice Act

The Oklahoma Legislature passed the Prescription Access and Affordability Act at the urging of local brick-and-mortar pharmacies. Pet. App. 7. The governor initially vetoed the bill because of concerns over ERISA and Medicare preemption. *Ibid.* (quoting Okla. S.J., 57th Leg., 1st Reg. Sess. 1272 (2019), perma.cc/SW6s-2ULG). But the legislature passed a revised version of the Act, which the governor signed. *Id.* at 7-8.

As enacted, the Act aims to "establish minimum and uniform access * * * standards and prohibitions on restrictions of a patient's right to choose a pharmacy provider." Okla. Stat. tit. 36 § 6959 (2019). The Act accomplishes its goal of overriding pharmacy-network design in four ways:

The law's **access standards** require pharmacy networks to satisfy certain geographic requirements. In particular, they require that a set percentage of beneficiaries must live within a certain distance to network pharmacies depending on the area's density. Pet. App. 8-10; Okla. Stat. tit. 36 § 6961(A)-(B). For urban areas, 90% of beneficiaries must live within two miles of a network pharmacy and five miles of a preferred pharmacy; for suburban areas, 90% of beneficiaries must live within five miles of a network pharmacy and seven miles of a preferred pharmacy; and for rural areas, at least 70% of beneficiaries must live within 15 miles of a network pharmacy and 18

miles of a preferred pharmacy. *Ibid.* PBMs are permitted to satisfy these standards only with brick-and-mortar pharmacies, not mail-service pharmacies. *Id.* at 10.

The **discount prohibition** forbids the use of cost-sharing discounts or copay reductions to encourage beneficiaries to use particular network pharmacies. Pet. App. 10; Okla. Stat. tit. 36 § 6963(E). This prohibition effectively forbids the use of traditional tiered networks, under which plans attempt to direct participants to lower cost, higher quality pharmacies.

The **any willing provider provision** requires plans to admit any pharmacy into a preferred network if that pharmacy is "willing to accept the terms and conditions that the PBM has established" for preferred-network providers. Pet. App. 10; Okla. Stat. tit. 36 § 6962(B)(4).

Finally, the **probation-based limitation prohibition** forbids plans from excluding pharmacies that employ pharmacists who are on probation with the State Board of Pharmacy from pharmacy networks. Pet. App. 10-11; Okla. Stat. tit. 36 § 6962(B)(5).

Individually and collectively, these provisions substantially constrain plans' choices with respect to the shape and design of the pharmacy networks they offer. For instance, the access standards combined with the any-willing-provider provision effectively eliminate exclusive mail order and specialty preferred networks. The discount prohibition works with the access standards to limit plans' ability to use variable cost-sharing to encourage the use of mail-order pharmacies. And the probation prohibition bars terms and conditions of network participation designed to ensure quality, safety, and responsibility.

Notably, these provisions all apply not only to PBMs that help design and administer benefit plans on sponsors' behalves, but also to plans that manage their own pharmacy benefits. See Okla. Stat. tit. 36 § 6960 (defining

PBM as any "person that performs pharmacy benefits management").

C. Procedural background

1. Shortly before the Act's effective date, the Pharmaceutical Care Management Association (PCMA) sued to enjoin the Act's enforcement. Pet. App. 11. The parties cross-moved for summary judgment.

The district court rejected PCMA's ERISA preemption claims, holding that none of the Act's provisions, including the four pharmacy-network provisions, were preempted by ERISA. Pet. App. 57-58. It further held that the any-willing-provider provision was not preempted by Medicare Part D. *Id.* at 61-62, 63.[1]

2.a. The court of appeals reversed (Pet. App. 1-51), remanding with instructions to enter judgment for PCMA on the appealed provisions.

The court held first that ERISA preempts each of the appealed provisions. Pet. App. 15-40. As a starting point on that front, the court rejected Oklahoma's contention that Act escapes preemption because it "regulates PBMs, not health plans." Pet. App. 17-21. State laws dictating benefit design "relate to" ERISA plans even where the obligations fall as a practical matter on a TPA implementing the plan at the sponsor's direction. *Id.* at 18-19 (discussing *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 359 (2002)).

To adopt Oklahoma's contrary view that states may freely regulate ERISA plan benefit design by imposing obligations on a plan's TPA, the court reasoned, would

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[1] Oklahoma conceded that the Medicare statute preempts the law's discount prohibition for preferred networks. Pet. App. 13 n.4. It did not cross-appeal the district court's conclusion that the Medicare statute preempts the Oklahoma's network access standards. *Ibid.*

force plans to forego the benefits of ERISA preemption. That is because a supposed choice between "self-administering its benefits and using a PBM 'is in reality no choice at all.'" Pet. App. 19 (quoting *PCMA* v. *District of Columbia*, 613 F.3d 179, 188 (D.C. Cir. 2010) (panel including then-Judge Kavanaugh)).

That issue aside, the court held that each of the four challenged provisions—the network access standards, tiered network discount prohibition, any-willing-provider provision, and probation provision—impermissibly regulates plan design.

The court began by observing that "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." Pet. App. 26. By operation of the any-willing-provider provision, access standards, and discount provision, ERISA plans in Oklahoma would be permitted to use only "a single-tiered network with uniform copayments, unrestricted specialty-drug access, and complete patient freedom to choose a brick-and-mortar pharmacy." *Id.* at 28. These "are quintessential state laws that mandate benefit structures," which "ERISA forbids." *Ibid.*

As to the probation provision, the court explained that it also "forc[es] plans to adopt [a] particular scheme of substantive coverage." Pet. App. 37 (quoting *Rutledge*, 141 S. Ct. at 480). It forces the use of "*all* pharmacies, even those employing pharmacists on probation" and thereby "acts just like the network restrictions—dictating which pharmacies must be included in a plan's PBM network." *Ibid.* The court rejected the "novel rule" urged by the government in an amicus brief that a state law with a "*de minimis* effect" on benefit design is not preempted. *Id.* at 34-36. As the court explained, state laws that regulate benefit design "relate to" ERISA plans

regardless the effect size. More, the effect on network design is more than *de minimis* in any event. *Id.* at 37-38 (discussing record evidence).

Wrapping up on ERISA preemption, the court held that Oklahoma had waived any reliance on ERISA's saving clause or deemer clause. Pet. App. 38-40. Because the argument had been raised only by the United States in an amicus brief (and before then only in two passing footnotes by Oklahoma), the Court declined to reach the question whether either clause applies here.

b. The court of appeals held that the Medicare statute also preempts the any-willing-provider provision as applied to Medicare Part D plans. Pet. App. 41-50. The court explained that the "preemption clause's plain wording" "precludes States from regulating Part D plans except for licensing and plan solvency" in a manner "akin to field preemption." *Id.* at 41-43. That conclusion, the court noted, was consistent with decisions of the First and Eighth Circuits. *Id.* at 43.

The court had no trouble concluding that the any-willing-provider provision—under which PBMs "must allow all Oklahoma pharmacies that are willing to accept the PBMs' preferred-network terms into their preferred networks"—intrudes into an area of regulation in which Congress intended only CMS to set standards. Pet. App. 48-49. The court held in the alternative that, under the narrower "overlapping standards" approach to Medicare preemption advocated by Oklahoma, the any-willing-provider provision still is preempted because it "encroaches on an existing Medicare standard" that "requires Part D plans to allow any willing pharmacy to participate in the plans' *standard* network" but does not require allowing any willing pharmacy into a *preferred* network. *Id.* at 49-50. That CMS could have adopted but did not adopt the more specific rule enacted by the Oklahoma legislature is clear evidence that Part D

preempts Oklahoma's contrary rule under any formulation of the preemption test. *Ibid.*

3. Oklahoma petitioned for rehearing en banc, which was denied. Pet. App. 52-53.

ARGUMENT

Certiorari should be denied. *First*, the decision below adhered closely to this Court's precedent, *Rutledge* included. *Rutledge* did not create any PBM-specific preemption rules; after that case, as before, states may not regulate the design of benefits offered by ERISA plans, including provider networks, whether directly or indirectly. The Tenth Circuit rightly held that the challenged provisions do just that. Oklahoma's dispute with the court's construction of the Act and its operation is unconvincing and unworthy of review.

Second, there is no disagreement among the lower courts. Before *Rutledge*, federal courts, including the Fifth and Sixth Circuits, agreed the regulations of provider network design are preempted; and after *Rutledge*, no other circuit has considered regulations of the sort that Oklahoma enacted here. The Eighth Circuit's decision in *PCMA* v. *Wehbi*, 18 F.4th 956 (8th Cir. 2021), involved a different statute, different record evidence, and almost no legal analysis. There is no basis to believe it would have decided the preemption claims in this case any differently than did the Tenth Circuit.

Third, this is a poor vehicle. To begin, *Rutledge* was decided only a few terms ago. That case casts no doubt on the correctness of the decision below, but even if it did, further percolation would be needed, especially given the thinness of the Eighth Circuit's reasoning in *Wehbi*. More, Oklahoma waived any argument from ERISA's preemption saving clause, which the United States (and now Oklahoma) believe relevant to answering the question presented.

Finally, there is nothing about the inclusion of the second question presented that makes the petition any more worthy of certiorari. There is no division on that question, and the decision below is plainly correct. Medicare is a federally-funded, federally-administered program to which state law does not apply.

A. The decision below faithfully followed this Court's precedents, including *Rutledge*

The petition asserts that further review is needed foremost because the lower court's ERISA preemption decision "conflicts" with *Rutledge*. But because parties "are likely to regard any case they have lost in a lower court as necessarily in conflict with some Supreme Court precedent," this Court's Rule 10(c) requires an asserted "conflict" with its own cases to be "direct" and "readily apparent," such as when the court of appeals utterly "fails to apply prior Supreme Court decisions" by some "oversight." Stephen Shapiro et al., *Supreme Court Practice* 251 (10th ed. 2013). That does not describe the course of proceedings here.

The Tenth Circuit's decision turns on a straightforward application of this Court's settled precedents. The lower court held simply that the Act's provider network regulations are preempted because they restrict ERISA plan benefit design. In so ruling, the court expressly acknowledged *Rutledge* and thoughtfully applied its reasoning to the facts presented. See Pet. App. 16-17, 26, 28-30. To be sure, *Rutledge* rejected a preemption challenge, whereas the Tenth Circuit here upheld one. But that is because the laws at issue in the two cases are wholly different. It should come as no surprise that different facts produce different results.

In arguing otherwise, Oklahoma ignores the broader context of this Court's precedents and asks for case-specific error correction. It thus describes (Pet. 2) *Rutledge* as holding that ERISA preempts only "state laws

that actually regulate ERISA plans" and not laws that "regulate entities like PBMs that contract with ERISA plans." And it argues that the Act regulates only PBMs.

We explain below why that is wrong. But it bears emphasis first that if *Rutledge* had said what Oklahoma asserts, it would mark a startling break from decades of this Court's precedents. For example, in *Gobeille* v. *Liberty Mutual Insurance Co.*, 577 U.S. 312 (2016), the Court held preempted a Vermont reporting law, despite openly acknowledging that the law operated upon plans' TPAs rather than plans themselves. See *id.* at 326. According to Oklahoma's logic, that case was wrongly decided. So was *Kentucky Association of Health Plans* v. *Miller*, 538 U.S. 329 (2003), where the Court took as given the Sixth Circuit's earlier holding that a state any-willing-provider law (which likewise operates on TPAs) falls within the scope of ERISA's broad preemption clause. The Court should look with great skepticism on Oklahoma's view that *Rutledge* wiped those cases away.

1. *Rutledge* concerned Arkansas's Act 900, which regulates the maximum allowable cost (MAC) lists that prescription-drug benefit plans use for reimbursements of generic drug purchases. Act 900 requires plans to update their MAC lists when the MAC is less than the average acquisition cost for a drug (Ark. Code Ann. § 17-92-507(c)(2)) and to disclose any list updates to network pharmacies within a certain number of days (*id.* § 17-92-507(c)(3)). If the MAC is below the pharmacy's acquisition cost, the plan or its PBM must allow the pharmacy to reverse and rebill the original claim. *Id.* § 17-92-507(c)(4)(C). Alternatively, a pharmacy may simply decline to provide the prescribed drug to a patient on the plan's terms if the MAC-based reimbursement is less than the pharmacy's invoice price. *Id.* §17-92-507(e).

Rutledge held that ERISA does not preempt MAC laws like Act 900, relying principally on *New York State*

Conference of Blue Cross & Blue Shield Plans v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). In *Travelers*, the Court held that a New York law requiring hospitals to add a surcharge to the bill for patients covered by commercial insurers was a "basic rate regulation" not preempted under ERISA. *Id.* at 667 n.6, 668. Although the Court acknowledged that the law "ha[d] an indirect economic effect on choices made by insurance buyers, including ERISA plans," it held that indirect economic effects on insurance choices do not trigger ERISA preemption. Varying charges affect "a plan's shopping decisions" but do not "bind plan administrators to any particular choice" and thus did not "function as a regulation of an ERISA plan itself." *Id.* at 659-660.

In *Rutledge*, the Court described Act 900 as "a form of cost regulation" as to which "[t]he logic of *Travelers*" controls. 592 U.S. at 88. The Court concluded that Act 900 merely requires plans or their PBMs "to reimburse pharmacies for prescription drugs at a rate equal to or higher than the pharmacy's acquisition cost." *Ibid.* Although this kind of regulation may have "an indirect economic influence" on health benefit plans by raising prescription drug reimbursement rates, Act 900 "d[oes] not create an impermissible connection" with ERISA plans because it "d[oes] not bind plan administrators to any particular choice" concerning the substance of the benefit offered. *Id.* at 87.

In reaching that conclusion, the Court stressed that "[r]equiring PBMs to reimburse pharmacies at or above their acquisition costs does not require plans to provide any particular benefit to any particular beneficiary in any particular way." *Rutledge*, 592 U.S. at 90. If, in contrast, a state law "forc[es] plans to adopt [a] particular scheme of substantive coverage," it would be "pre-empted by ERISA." *Id.* at 80-81. That is also what *Travelers* held: Any state law that in practical effect "function[s] as a

regulation of an ERISA plan itself" is preempted. 514 U.S. at 659-660.

2. The Tenth Circuit comprehended well these basic points. It held that the Oklahoma provisions at issue in this case are preempted by ERISA because they, unlike Arkansas Act 900, force plans to design or refrain from designing their provider networks in particular ways.

According to the Tenth Circuit, "Oklahoma's network restrictions do more than increase costs." Pet. App. 30. In contrast with Act 900, they directly regulate "pharmacy networks—the structures through which plan beneficiaries access their drug benefits." *Ibid.* And by forcing plans to adopt certain substantive features for their networks, and by forbidding them from adopting other features, "[e]ach provision either directs or forbids an element of *plan structure* or *benefit design*." Pet. App. 25-26 (emphasis added).

3. In light of this reasoning, it is hard to take seriously Oklahoma's contention (at 29) that "[t]he decision below flouts *Rutledge*." A court of appeals does not "flout" a decision of this Court by acknowledging the decision's holding and reconciling it with the outcome in the case. To be sure, Oklahoma disagrees with the Tenth Circuit's analysis, but that is a merits issue, not a ground under Rule 10 for further review.

And if anyone has flouted *Rutledge*, it is Oklahoma. Its petition ignores the *Travelers*-based reasoning at the heart of the Court's holding in that case. The petition does not once even cite the phrase "cost regulation" or "rate regulation," which drove the reasoning in *Rutledge*. Instead, Oklahoma mischaracterizes the case as introducing a new categorical rule that ERISA preemption does not apply when states purport to regulate PBMs rather than plans. Pet. 25-28.

That is not what *Rutledge* held. See Pet. App. 30 n.12 ("*Rutledge* did not draw a bright line between PBMs and

ERISA plans" and instead "treated the Arkansas law like any other by analyzing the law's effects on ERISA plans"). Indeed, *Rutledge* could not have announced any such rule without overturning other of this Court's own precedents, including *Gobeille* and *Miller*.

To be sure, the United States advanced an argument in *Rutledge* that Act 900 was not preempted because it "imposes obligations on PBMS, not plans." Gov't Br. 27-33, *Rutledge*, 592 U.S. 80 (2020) (No. 18-540). But the Court did not buy that argument. On the contrary, the Court recognized that regulations of PBMs may indeed be preempted if, either directly or indirectly, they "forc[e] plans to adopt [a] particular scheme of substantive coverage." *Rutledge*, 592 U.S. at 88. That has been the holding of every other court of appeals to address the issue, both before and after *Rutledge*: "Because PBMs manage benefits on behalf of plans, a regulation of PBMs" that in practical effect dictates the design of the benefits they administer "'function[s] as a regulation of an ERISA plan itself.'" *Wehbi*, 18 F.4th at 966 (quoting *District of Columbia*, 613 F.3d at 188).

Perhaps for this reason, the government has since disavowed its view that state laws that impose obligations on PBMs and other TPAs are never preempted. It thus described as "incorrect" Oklahoma's "argu[ment] that the Act does not implicate ERISA because it directly regulates only PBMs, not ERISA plans." Gov't C.A. Br. 15-16. That is so not only because state regulations of PBMs (and other TPAs) may dictate plan design, but also because the Act applies directly to plan sponsors that administer their own ERISA-covered benefits. *Id.* at 16 (citing Okla. Stat. tit. 36 § 6960(3)). If Oklahoma were correct that the Act regulates only PBMs and not plans, then plans that choose to forego the assistance of PBMs would not have to comply with the Act. That isn't the case. Oklahoma is thus simply wrong to say (as it does at

25) that "Oklahoma's Act does not regulate plans at all; it regulates only PBMs."

In sum, the decision below does not conflict with *Rutledge*. Quite the contrary, the Tenth Circuit diligently applied *Rutledge*, reaching a result that conformed appropriately to the reasoning of that case and the long line of holdings that precede it. The principal basis on which Oklahoma seeks review (a "conflict" with *Rutledge*) is little more than a reframing of its unpersuasive merits arguments. It is no basis for granting the petition.

B. There is no conflict of authority on the first question presented

1. The petition asserts a shallow 1-1 conflict with *Wehbi*, but only with respect to the probation-based pharmacy limitation provision. That is an admission that federal cases addressing state regulations of ERISA-covered plan provider networks is uniform in all other respects. As the Tenth Circuit explained (Pet. App. 23), the decision below is consistent not only with *Rutledge*, but also "with the reasoning in cases from the Fifth and Sixth Circuits." In *CIGNA Healthplan of Louisiana* v. *Ieyoub*, 82 F.3d 642 (5th Cir. 1996), and *Kentucky Association of Health Plans* v. *Nichols*, 227 F.3d 352 (6th Cir. 2000), those two courts of appeals both held that state any-willing-provider laws fall within the scope of ERISA's preemption clause because such laws regulate network design. See Pet. App. 23-25. Oklahoma attempts (Pet. 27) to distinguish those cases on the ground that their underlying laws directly regulated plans. But again, federal courts (including this Court) have long held that state laws indirectly impacting ERISA plan design may be subject to preemption. Moreover, the Act, like the statutes in the other cases, *does* apply directly to plans that self-administer their benefits.

2. Even with respect to the probation-based limitation provision, there is no conflict. The state statute

at issue in *Wehbi* was materially different from the provision here, and the Eighth Circuit's fact-based analysis was limited to the record presented.

The North Dakota statute in *Wehbi* forbade PBMs from "requir[ing] pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state." N.D. Cent. Code §§ 19-02.1-16.1(11), -16.2(4). In upholding that provision against an ERISA preemption challenge, the Eighth Circuit reasoned that it "regulat[ed] a non-central 'matter of plan administration' with *de minimis* economic effects" (18 F.4th at 968)—a ruling that did not turn on *Rutledge*, as Oklahoma suggests (Pet. 2).

Citing the substantial factual record in this case, the Tenth Circuit held as a matter of fact that "the Probation Prohibition cannot so easily be dismissed as *de minimis*." Pet. App. 37. As the evidence here shows, plans rely on PBMs to ensure that plan members have safe access to prescription drugs. C.A. App. 510, 514. One way in which PBMs do so is by setting network participation terms that allow a plan to remove pharmacies based on pharmacists' probation status under state law. *Ibid.* The state's own expert witness confirmed that the Board may put on probation "pharmacists [that] engage in drug diversion, make mistakes that harm patients, or dispense controlled substances without a prescription." Pet. App. 37 n.16; see also C.A. App. 586-587.

The probation-based limitation provision would force plans to keep pharmacists prone to negligence or fraud in their provider networks. As the Tenth Circuit correctly concluded, that would be no *de minimis* impact. Pet. App. 37. That conclusion has special traction in this case, when considered alongside the any-willing-provider provision, which forces plans to allow pharmacists on probation into

their *preferred* networks. *Id.* at 37-38. There was no such provision present in *Wehbi*.

As the Tenth Circuit explained, moreover, *Wehbi* did not assess the North Dakota law's "effects on the structure of the provider network and connected effect on plan design." Pet. App. 36 ("the court did not explain why dictating network composition would not count as governing a central matter of plan administration"). The record here showed, in contrast, that the probation provision "dictat[es] which pharmacies must be included in a plan's PBM network" and thereby "affect[s] the benefits available by increasing the potential providers" and "eliminates the choice of one method of structuring benefits." *Id.* at 37-38.

Oklahoma disagrees with the Tenth Circuit on this point, insisting (Pet. 23) that "the provision simply preserves the State's traditional authority to license pharmacists within the State and determine how best to sanction and rehabilitate individuals in that field who have transgressed." That makes no sense. Private sanctions are a common collateral consequence for professional discipline. Disciplined physicians often lose hospital privileges, for example, and disciplined attorneys often lose their jobs. But more to the point, by forcing plans to contract with pharmacists on probation, Oklahoma is not regulating licensing—it's compelling benefit plans to do business with pharmacists simply because they *are* licensed. That has nothing to do with the state's licensure authority and has everything to do with how plan sponsors may structure their provider networks.

Wehbi's analysis—conclusory and incomplete, concerning a different factual record and a different statutory scheme—does not conflict with that holding. And even if there were tension between the reasoning in *Wehbi* and the reasoning below, the disagreement would be very shallow and capable of resolving itself. That is especially

so because *Wehbi*'s reasoning is so unhelpfully thin and flimsy that it is unlikely to guide future cases.

C. This is neither the right time nor the right vehicle to address the first question presented

1. The first question presented—regarding whether states can directly or indirectly restrict the structure of ERISA-plan provider networks—does not involve a discrete legal issue over which any square conflict has developed. *Rutledge*, which turned on *Travelers*'s cost-regulation analysis, did not address (let alone alter) this Court's and the lower courts' longstanding precedents concerning regulation of plan design. And the only other post-*Rutledge* ERISA preemption case even remotely like this one, *Wehbi*, was factually dissimilar and extremely light on reasoning.

At the same time, additional litigation may arise in coming years concerning ERISA preemption in the broader context of state laws impacting health benefit design, including prescription drug benefits. As Minnesota and the other states explain in their amicus brief (at 5), many states recently have been considering or enacting laws that regulate PBMs—and through them, benefit plans—in varying ways. The other courts of appeals should have an opportunity to determine whether and why these varying regulations are preempted as applied to plans covered by ERISA, including in light of the states' position on *Rutledge*. And the Eighth Circuit should have an opportunity to consider the precedential weight of *Wehbi*'s very thin preemption analysis.

As matters now stand, it would be premature to rush forward with review before the nuances of preemption in this context are fully identified and explored by the lower courts. This is especially so here given the lack of any conflict and the high likelihood that other circuits will align with the Fifth, Sixth, and now Tenth Circuits on the question of whether states may regulate ERISA provider-

network design. See Estreicher & Sexton, *A Managerial Theory of the Supreme Court's Responsibilities*, 59 NYU L. Rev. 681, 699 (1984) ("By leaving courts of appeals free to decide independently issues already decided by other courts of appeals, the system encourages the 'percolation' of legal issues," which better informs this Court's decisionmaking).

2. Even if the ERISA question did warrant review at this time (it surely does not), this would not be a suitable vehicle for addressing it. Oklahoma declined in proceedings below to address the relevance of ERISA's saving clause, relegating the issue to passing footnotes in two opposition briefs before the lower courts. Pet. App. 39. When the Tenth Circuit invited the United States to file an amicus brief, the Solicitor General's Office took the position that the saving clause is essential to resolution of the ERISA preemption question. See U.S. C.A. Br. 21-22 & n.4. Oklahoma now takes the same position before this Court. See Pet. 28. But the Tenth Circuit held that "Oklahoma did not preserve a saving-clause argument" in the district court or "pursue the saving clause as an alternative reason to affirm" in the court of appeals. Pet. App. 39. The Tenth Circuit thus "decline[d] to address the saving clause." *Ibid.*

As this Court reminded practitioners just this month, it is "a court of review, not of first view." *Moody* v. *NetChoice*, 144 S. Ct. 2383, 2399 (2024). Because an answer to the first question presented in the petition admittedly would require resolving an unpreserved issue, this case is not a suitable vehicle for certiorari.

D. The second question presented is unworthy of review

Oklahoma also appears to seek review of the Tenth Circuit's holding that the Medicare statute preempts the "any willing provider" requirement as applied to MA and Part D plans. The Tenth Circuit's holding on that score is

manifestly correct, implicates no division of authority, and does not warrant review.

1. There is no conflict on the second question presented, assuming it is presented at all

a. As a starting point, this case does not pose the second question as framed in the petition. The second question, according to Oklahoma, is "[w]hether Medicare Part D preempts state laws that limit the conditions PBMs may place on pharmacies' participation in their preferred networks." Pet. ii. But the only provision at issue with respect to Medicare preemption is the any-willing-provider provision (Okla. Stat. tit. 36 § 6962(B)(4)). That provision does not dictate the conditions that a plan may place on network participation—it instead requires that plans allow into their network any and every provider who is willing to meet the conditions for participation, *such as those conditions are*. It is thus unclear whether this case even presents the second question as framed.

b. Oklahoma asserts (Pet. 31-33) that the Tenth Circuit's Medicare preemption analysis conflicts with the approach taken by the Eighth Circuit. That is wrong; all circuits to address the issue agree that the standard for preemption under Medicare's express preemption clause is co-extensive with field preemption.

In *Wehbi*, the Eighth Circuit recognized that a prior version of the Medicare statute called for a conflict preemption analysis. But, the court reasoned, "the effect of [a] 2003 amendment" to the Medicare statute "was to expand the scope of express Medicare preemption from conflict preemption to field preemption." 18 F.4th at 971. By this understanding, a state law is preempted when it "adds" in any way "to a federal regulatory scheme that was designed to be comprehensive." *Id*. at 970.

The First Circuit adopted the same approach in *MMAPA*, concerning Medicare Part C, which incorpor-

ates the same preemption clause as Part D. Citing *Wehbi*, the First Circuit agreed that federal regulations under the MA program "'preempt[] the field,'" displacing all direct state regulation of MA plans other than "licensing and solvency laws." *MMAPA*, 58 F.4th at 12.

In this case, the Tenth Circuit aligned with the First and Eighth Circuits, holding that "the sweeping Part D preemption clause is 'akin to field preemption' and precludes States from regulating Part D plans except for licensing and plan solvency." Pet. App. 43. Accord *id.* at 47 ("we share *Wehbi*'s view that Part D's preemption clause mandates field preemption"). All of the courts of appeals that have addressed the question are thus in agreement that the legal standard for Medicare's express preemption clause is field preemption.

c. Oklahoma contends (Pet. 31) that the courts of appeals have disagreed on how best to apply the field preemption analysis in this circumstance. In its view (*ibid.*), the Tenth Circuit rejected the Eighth Circuit's "fastidious" field preemption analysis as "slicing the baloney too thin." In fact, the most Oklahoma has demonstrated is a difference in how the two courts of appeals have applied a common legal standard to substantively different state statutes.

As Oklahoma explains (Pet. 30), the state laws at issue in *Wehbi* regulated PBMs' communications with plan participants and with pharmacies, as well as asserted conflicts of interests involving PBM-owned pharmacies. No such laws were at issue in this case, and the Tenth Circuit thus had no occasion to consider whether such laws are preempted as applied to MA and Part D plans. And Oklahoma ultimately acknowledges (Pet. 33) the lack of a conflict here, as it must. The Tenth Circuit held expressly that even if it were to narrowly apply the field preemption standard, as did the Eighth Circuit in *Wehbi*, "the result would be the same." Pet. App. 49.

In short, any difference there may be between the Eighth Circuit's and Tenth Circuit's description of the applicable legal standard is semantic only, with no impact on the outcome here.

2. The any willing provider provision is preempted by the Medicare statute

a. Further review of the second question presented is also unwarranted because the decision below is plainly correct. Medicare Advantage is an "exclusively federal program." *NFIB* v. *Sebelius*, 567 U.S. 519, 630 (2012) (Ginsburg, J., concurring). To preserve Medicare's exclusive federal nature, Congress enacted an extraordinarily broad express preemption clause specifying that the Medicare statute and its implementing regulations "shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [prescription drug] plans which are offered by [plan sponsors] under this part." 42 U.S.C. §§ 1395w-26(b)(3), -112(g).

Medicare's preemption clause could hardly be more capacious. The word "any" modifying "law or regulation" is a broadening term that "is most naturally read to mean [law or regulation] of whatever kind." *Ali* v. *Federal Bureau of Prisons*, 552 U.S. 214, 220 (2008). The preclusion of state regulation "with respect to" Medicare Part D prescription drug plans is likewise expansive, referring to any state regulation within a field of federal regulation of Part D plans. Thus, state regulations of Medicare benefits are "presumed to be preempted unless they relate to licensure or solvency." *MMAPA*, 58 F.4th at 13 (quoting Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4319 (Jan. 28, 2005)). In other words, this provision "precludes States from regulating Part D plans except for licensing and plan solvency." Pet. App. 42-43; see also *MMAPA*, 58 F.4th at 12-13. It is for federal authorities to decide whether and

how to regulate a Medicare plan's operations, not the states.

The broad scope of Medicare's preemption provision makes sense in light of the federal government's funding of the program. It also makes sense considering CMS's expertise in overseeing such a tremendously complex federal benefit. It ensures that state laws driven by parochial interests do not subvert federal standards developed by CMS. And it protects the "[s]trong and distinctly federal interests [that] are involved in uniform administration of [a federally-funded health benefit] program, free from state interference, particularly in regard to coverage, benefits, and payments." *Coventry Health Care of Missouri* v. *Nevils*, 581 U.S. 87, 96 (2017) (citation omitted) (construing preemption under the Federal Employees Health Benefit program). As the First Circuit has put it, "Congress's purpose in enacting § 1395w-26(b)(3) was to protect the purely federal nature of Medicare Advantage plans operating under Medicare." *First Medical Health Plan* v. *Vega-Ramos*, 479 F.3d 46, 52 (1st Cir. 2007).

As applied to Medicare Advantage and Part D plans, a state any-willing-provider law is very plainly a law that operates "with respect to" such plans. As we have shown, decisions concerning what pharmacies are allowed to participate in a plan's provider network is central to the design of the benefit itself. With MA and Part D, Congress expressly authorized plans to establish unique provider networks by "select[ing] the providers from whom the benefits under the plan are provided" and entering contracts with them. 42 U.S.C. § 1395w-22(d)(1). Plans are thereby required to create a "network of providers that are under contract * * * to deliver the benefit package approved by CMS" (42 C.F.R. § 422.4(a)(1)), subject to minimum guardrails established by CMS. See *Morrison* v. *Health Plan of Nevada*, 328 P.3d 1165, 1169 (Nev. 2014)

("[F]ederal law provides standards that MA organizations must adhere to in conducting the relationship with their contracted providers."). Any effort by state regulators to dictate who may, may not, or must be admitted to an MA plan's network is clearly preempted.

b. Before the Tenth Circuit, Oklahoma argued in favor of a different standard for Medicare preemption, asserting that preemption does not occur unless there is an "overlapping or on-point federal standard" that regulates in the precisely same way as the state law. Okla. C.A. Br. 43-44. That is the same standard it says the Eighth Circuit adopted. See Pet. 31-32.

But that is not what the statute says. The Medicare statute does not preempt state laws that regulate with respect to *overlapping federal standards*; rather, it preempts state laws that regulate "with respect to [Part D] plans which are offered by [Part D sponsors] under this part." 42 U.S.C. § 1395w-26(b)(3), -112(g). Oklahoma's rewriting of the statute would restore the old conflict preemption standard that prevailed before Congress amended the Medicare statute in 2003. But as even the Eighth Circuit recognized, "the effect of the 2003 amendment was to expand the scope of express Medicare pre-emption from conflict preemption to field preemption." *Wehbi*, 18 F.4th at 971.

In any event, "the result would be the same even under Oklahoma's narrower approach." Pet. App. 49. Congress has already included a federal any-willing-provider provision that requires Part D plans to allow any willing pharmacy to participate in the plan's standard network. 42 U.S.C. § 1395w-104(b)(1)(A). And CMS has implemented that requirement by regulation. See 42 C.F.R. § 423.120(a)(8)(i). Medicare's preemption clause would mean nothing if Oklahoma were free to stick its nose in federal business like this by enacting its own,

state-specific any-willing-provider requirements for MA and Part D plans.

Because no court would or could have decided the Medicare preemption issue differently, the second question presented is unworthy of review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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