EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
AT CHATTANOOGA

MCKEE FOODS CORPORATION, **Plaintiff,** **v.** **BFP INC. d/b/a THRIFTY MED PLUS PHARMACY and CARTER LAWRENCE in his Official Capacity as COMMISSIONER OF THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE,** **Defendants.**	**Case No.: 1:21-CV-00279** **JUDGE ATCHLEY** **MAGISTRATE JUDGE LEE**

BRIEF *AMICUS CURIAE* OF THE ERISA INDUSTRY COMMITTEE IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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INTEREST OF THE *AMICUS CURIAE*[1]

The ERISA Industry Committee ("ERIC") is a national nonprofit organization exclusively representing approximately 100 large employers throughout the United States in their capacity as sponsors and administrators of employee benefit plans for tens of millions of their nationwide employees and their families. With member companies that are leaders in every sector of the economy, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to offer benefit plans and to see to their sound administration.

INTRODUCTION

Congress enacted ERISA to provide "a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To encourage employers to offer benefits plans voluntarily while preserving their discretion over plan design, ERISA broadly preempts state laws that "relate to" ERISA-covered plans. 29 U.S.C. § 1144(a).[2] The alternative, "[r]equiring ERISA administrators to master the relevant laws of 50 States[,] . . . 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 Mutual Insurance Co.*, 577 U.S. 312, 321 (2016) (quotation omitted).

The manner in which ERISA plans are structured is within the sole discretion of the plan sponsor. *See Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 833 (2003) (plan sponsors "have large leeway to design ... plans as they see fit"). In the context of prescription-drug plans,

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[1] *See* accompanying Unopposed Motion for Leave to File *Amicus Curiae* Brief in Support of Plaintiff's Motion for Summary Judgment for further explanation of ERIC's interest in this matter. Pursuant to FRAP Rule 29(a)(4)(E), no party's counsel authored this brief in part or in whole, and no party or party's counsel or individual other than ERIC contributed financially to the preparation or submission of this brief.

[2] ERISA preemption embodies Congress's goal that "employee benefit plan regulation would be 'exclusively a federal concern.'" *Davila*, 542 U.S. at 208 (citation omitted).

two critical components of plan design are the pharmacy network and the benefit cost-sharing structure. Plan sponsors and administrators such as Plaintiff McKee Foods Corporation ("McKee") structure, design and operate pharmacy networks that are appropriate for their plan participant population in terms of service and cost. Plans utilize a variety of financial incentives, such as lower participant co-pays for using network pharmacies, to provide cost-effective benefits.

In this case, McKee challenges Tennessee Tenn. Code Ann. §§ 56-7-3120, 56-7-3121, and 56-7-2359, as amended (collectively, "the Tennessee Law"),[3] on grounds that it is preempted by ERISA as applied to self-insured plans. ERIC agrees and urges the Court to grant McKee's motion for summary judgment on that basis. The Tennessee Law is preempted by ERISA because it directly interferes with prescription-drug benefit plan design and administration by (1) restricting plan sponsors' ability to design pharmacy networks for their plans, requiring them to admit "any willing pharmacy" into their networks; (2) limiting their ability to implement effective cost-savings measures for their plans; and (3) requiring them to adopt Tennessee-specific plan provisions, thereby interfering with nationally uniform plan administration. *See Rutledge v. PCMA,* 592 U.S. 80, 86-87 (2020); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987); *Shaw v. Delta Air Lines, Inc*., 463 U.S. 85, 96-97 (1983).

In addition to statutory preemption, the Tennessee Law is preempted by ERISA under principles of conflict or obstacle preemption. Conflict preemption applies "where compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (internal quotation marks and ellipses omitted). The

[3] ERIC generally relies on and refers the Court to McKee's summary judgment brief (Dkt. 119) for a comprehensive discussion of the relevant provisions and history of the Tennessee Law.

Tennessee Law restricts sponsor's plan design choices and imposes significant administrative burdens on them, thereby interfering with Congress's intent to preserve employers' freedom to design plans to best fit their participant populations without the burden of conflicting state-by-state requirements. The Tennessee Law also conflicts with ERISA's fiduciary provisions, which require administering a plan prudently and in the best interests of participants. *See* 29 U.S.C. § 1104(a)(1)(A), (B). If a plan sponsor determines that a pharmacy has engaged in fraud, deception, unfair billing practices, or otherwise acted in a way that harms plan participants, ERISA's fiduciary rules may require the plan to take appropriate remedial steps, potentially including the removal of that pharmacy from the network. But the Tennessee Law places ERISA plan fiduciaries between the proverbial rock and hard place if they identify fraudulent or unscrupulous pharmacies: either remove them and face liability under the Tennessee Law or allow them to remain and face potential fiduciary-breach claims from plan participants. For plans that address prescription-drug cost-sharing in the governing plan documents, the anti-steering and cost incentive provisions of the Tennessee Law may also contradict plan terms, which conflicts with ERISA's fiduciary duty to administer the plan in accordance with its written terms. *See* 29 U.S.C. § 1104(a)(1)(D).

The ERISA preemption concerns raised in this case extend far beyond the underlying dispute between McKee and Defendant BFP Inc. d/b/a Thrifty Med Plus Pharmacy ("Thrifty Med"). The Tennessee Law interferes with the ability of *all* self-insured ERISA plans with participants in Tennessee to design and administer their plans in a nationally uniform manner and as they deem appropriate for their participants. It impacts participants directly by altering their plan benefits. These are exactly the concerns that ERISA preemption was designed to prevent.

BACKGROUND

I. The Provider Network And Participant Contributions Are Critical Components of An Employer-Sponsored Health Plan's Benefit Design.

The majority of Americans get their healthcare benefits, including prescription-drug benefits, through an employer-sponsored plan. As of 2021, approximately 153 million non-elderly Americans obtain their health insurance through their employer.[4] Approximately 75% of those offered health coverage through their employer accept it. *Id.* Around 65% of employer-sponsored healthcare plans are self-insured, meaning the employers fund the benefits and services covered by their plans rather than purchasing third-party insurance to do so.[5]

There are three primary components of plan design in the context of prescription-drug plans: (1) which prescriptions and related services are covered; (2) the pharmacies from whom covered prescriptions can be obtained, generally referred to as the pharmacy network; and (3) the cost-sharing arrangement between the plan sponsor and participants, including employee contributions, deductibles, and co-payments.

A pharmacy network is a designated group of pharmacies that have contracted to provide prescription medications to the plan's participants at pre-negotiated rates. Participants who use in-network pharmacies typically do so at lower costs compared to going out-of-network to a non-contracted pharmacy. By using pharmacy networks, plans are able to obtain certain benefits and cost reductions, which are, in turn, passed on to plan participants. Pharmacies within a plan network are willing to agree to discounted rates in exchange for an increased volume. The plan

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[4] *See* https://www.kff.org/report-section/ehbs-2023-section-3-employee-coverage-eligibility-and-participation/#fn11; *see also* https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf (63.5% of adults aged 19-64 have employment based health insurance coverage).

[5] *See Kaiser Family Foundation*, 2023 Employer Health Benefits Survey (Oct. 18, 2023), https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.

and plan participants, in turn, benefit from the discounted rates. Having a pharmacy network also creates greater cost certainty and predictability: plans generally negotiate and thus know the cost of prescription drugs offered by in-network pharmacies. This allows plans to more accurately project prescription drug costs. On the other hand, if plans cannot maintain a pharmacy network, the resulting decrease in cost certainty will cause plans to be more conservative with the services designated as covered or to require higher cost-sharing from plan participants, leading to less overall benefits to such participants.

Pharmacy networks also increase administrative efficiency because pharmacies in a network generally agree to subject themselves to plan rules for claims processing, whereas without such an agreement the plan must be prepared to negotiate claims processing individually with each pharmacy. Finally, pharmacy networks allow plans to achieve quality control. By screening, monitoring, and selecting which pharmacies are in-network, plans can ensure that only quality pharmacies are covered, and can exclude pharmacies that do not meet the plan's quality standards. The vast majority of prescription-drug plans use pharmacy networks, which have been found to reduce costs to plan participants without negatively impacting the quality of services.[6]

ERISA affords plan sponsors wide latitude to structure pharmacy benefits, networks and participant cost-sharing to fit the needs of their participants. *See, e.g., Lockheed Corp. v. Spink,* 517 U.S. 882, 887 (1996) (discussing freedom of plan sponsors to design their employee benefit plans). A plan sponsored by a manufacturing company with a significant long-term/older employee population may have different considerations than a plan sponsored by a retail company with a younger and more transient workforce. An employer with geographically dispersed

[6] *See* 2020 Provider Networks and Health Plan Premium Variation study by Health Services Research (https://pmc.ncbi.nlm.nih.gov/articles/PMC7839649/) (finding that a broader provider network correlated with more expensive premiums).

employees may design a wider pharmacy network, while an employer whose workforce is concentrated primarily in a single region may choose to design a more geographically limited network. Some plans use broad pharmacy networks. Other plans use narrower pharmacy networks through which they can obtain greater discounts, resulting in even more savings for employees and their families, with greater quality control. Many plans use pharmacy benefit managers or "PBMs" to assist in managing prescription drug coverage. *See PCMA v. Mulready*, 78 F.4th 1183, 1188–89 (10th Cir. 2023) (discussing PBMs), *pet. for cert. filed,* No. 23-1213 (May 10, 2024).

ARGUMENT

I. ERISA Preemption Encourages Employers To Offer Benefits to Employees.

ERISA was intended to "encourag[e] the formation of employee benefit plans." *Davila*, 542 U.S. at 208. An employer that chooses to provide a benefits plan "undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax,* 482 U.S. at 9. In enacting ERISA, Congress recognized that "[r]equiring ERISA administrators to master the relevant laws of 50 States" would undermine Congress's purpose of "'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-150 (2001).

Accordingly, ERISA includes an express preemption provision mandating that ERISA preempts all state laws that "relate to" ERISA plans. 29 U.S.C. § 1144(a). Through ERISA's preemption provision, Congress "ensure[d] that plans and plan sponsors would be subject to a uniform body of benefits law, thereby minimizing the administrative and financial burden of complying with conflicting directives and ensuring that plans do not have to tailor substantive

benefits to the particularities of multiple jurisdictions." *Rutledge,* 592 U.S. at 86 (cleaned up). The Tennessee Law is exactly the type of directive ERISA preempts.

II. The Tennessee Law Is Preempted By ERISA.

A state law "relates to" a covered benefit plan (and thus is preempted by ERISA) if it has a "reference to" or "connection with" such a plan. *See*, *e.g.*, *Shaw*, 463 U.S. at 96-97; *Rutledge*, 592 U.S. at 86-87. The Tennessee Law has both.

A. The Tennessee Law Expressly Applies To ERISA Plans.

As discussed in more detail in McKee's summary judgment brief (Dkt. 119 at 4-13), the Tennessee Law expressly regulates ERISA-covered prescription-drug plans by requiring that "any willing pharmacy" be included in the plans' provider networks and by restricting copayments, other fees, and financial inducements that may be charged to plan participants. *See* Tenn. Code Ann. §§ 56-7-3120, 56-7-3121, 56-7-2359. The Tennessee Law expressly references and targets ERISA plans for substantive state regulation. Accordingly, as to self-insured plans (addressed by McKee at Dkt. 119 at 17), the Tennessee Law is preempted by ERISA on its face. *See, e.g., Alessi v. Raybestos-Manhattan, Inc*., 451 U.S. 504, 524 (1981) (holding state law was preempted because it "eliminates one method for calculating pension benefits … that is permitted by federal law").

B. The Tennessee Law Has An Impermissible "Connection With" ERISA Plans Because It Interferes With Plan Design And Administration And Inhibits Uniform Plan Administration.

A state law has an impermissible "connection with" ERISA plans and is therefore preempted if it "bind[s] plan administrators to [a] particular choice" concerning the substance of plan benefits, "governs a central matter of plan administration[,] or interferes with nationally uniform plan administration[.]" *Rutledge*, 592 U.S. at 86-87 (citations omitted). The Tennessee Law directly interferes with ERISA plan design and uniform administration.

First, the Tennessee Law requires that "any willing pharmacy" be included in a prescription-drug plan's provider network. The Sixth Circuit has previously ruled that a similar statute had a "connection with" ERISA for preemption purposes because it "not only affect[ed] the benefits available by increasing the potential providers, [it] directly affect[ed] the administration of the plan[]." *See Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 363 (6th Cir. 2000) (ruling Kentucky's "any willing provider" law regulating healthcare plans "related to" ERISA plans for preemption purposes), *aff'd sub nom. Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).[7] *See also Mulready*, 78 F.4th at 1198 (ruling ERISA preempted similar provisions in Oklahoma's PBM law); *CIGNA Healthplan of Louisiana v. Louisiana ex rel. Ieyoub*, 82 F.3d 642, 647-48 (5th Cir. 1996) (ruling Louisiana's any-willing-provider statute was preempted because it "den[ied] insurers, employers, and HMOs the right to structure their benefits in a particular manner … effectively requiring ERISA plans to purchase benefits of a particular structure"); *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt*., 995 F.2d 500, 501-02 (4th Cir. 1993) (ruling Virginia's any-willing-provider law was preempted by ERISA because it regulated "the structure" of health-plan provider networks).

Plans cannot realize the same cost-savings if a pharmacy network must be open to *all* pharmacies because the pharmacies in the network will not anticipate higher patient volume to offset lower reimbursements. In today's market, it is critical for prescription-drug plan sponsors to incentivize pharmacies to offer lower costs and/or better services by promising higher volume through an "in network" designation. The Tennessee Law precludes plans from offering that in-

[7] While the Supreme Court ultimately determined that the Kentucky law could avoid preemption because it regulated insurance and thus fell under ERISA's savings clause, *Miller*, 538 U.S. at 342, the Sixth Circuit's holding that the Kentucky law "relates to" ERISA plans remains undisturbed and in full effect. The Commissioner is wrong to suggest (Dkt. 123 at 21) that *Rutledge* abrogated *Nichols*, since *Rutledge* did not address an any-willing-provider law.

network incentive, which in turn, means that pharmacies have little or no incentive to compete for that volume. *See Mulready*, 78 F.4th at 1189 ("preferred pharmacies have agreed to accept lower reimbursements from plans in exchange for higher customer volumes [and] achieve this higher volume by lowering the required copayments owed by customers filling their prescriptions").[8]

Second, Tenn. Code Ann. §§ 56-7-3120 significantly limits cost-containment mechanisms in prescription-drug plans, which directly impacts plan participants by altering their plan benefits. This provision restricts plans from offering lower co-pays to participants as incentives to use in-network pharmacies and prohibits plans from offering financial or other incentives for participants to use pharmacies owned by the plan. Through these statutory mandates, self-insured plans are hampered in their ability to control costs, "thereby hindering those plans from structuring their benefits as they choose." *Mulready*, 78 F.4th at 1199 (citing *Black & Decker*, 538 U.S. at 833, and holding similar provisions in Oklahoma law were preempted by ERISA).[9] This hindrance is

[8] *See also* 2014 Selective Contracting in Prescription Drugs: The Benefits of Pharmacy Networks (https://scholarlycommons.law.emory.edu/cgi/viewcontent.cgi?article=1171&context=faculty-articles) (study concluding that "[w]hen drug plans have the ability to exclude pharmacies from their network and steer patients elsewhere, pharmacies compete aggressively for selective contracts by offering price discounts for filling prescriptions," and that "clients that choose more exclusive network options pay less for the prescription drug costs of their covered individuals.").

[9] The Commissioner's motion for summary judgment (Dkt. 123 at 17-19) ignores these economic realities and argues that the Tennessee Law is similar to the Arkansas PBM law that survived ERISA preemption in *Rutledge*. The Commissioner is wrong. Arkansas' law required PBMs to "tether reimbursement rates to pharmacies' acquisition costs," compelled PBMs to create procedures for pharmacies to appeal their reimbursement rates, and enabled pharmacies to decline to dispense drugs when their acquisition costs exceeded the PBMs' reimbursement rates. The Supreme Court ruled the law was not preempted because it was "merely a form of cost regulation" that did not have an effect "so acute that it will effectively dictate plan choices." *Rutledge*, 592 U.S. at 88. Here, in contrast, the Tennessee Law does far more than simply regulate cost. "[A] pharmacy network's scope (which pharmacies are included) and differentiation (under what cost-sharing arrangements those pharmacies participate in the network), are key benefit designs for an ERISA plan." *Mulready*, F.4th at 1198 (analyzing Oklahoma's PBM law in light of and consistent with *Rutledge*). Furthermore, the Tennessee Law's employer-participant cost-sharing and co-pay provisions not only interfere with the plan's right to establish the benefit structure, they also impact

not imagined; McKee has already faced a complaint by a non-network pharmacy (Preferred Cherokee Pharmacy of Cleveland, Tennessee) based on these provisions, challenging McKee's ability to offer lower-cost prescriptions to employees who use an onsite pharmacy at a McKee facility. (Dkt. 119 at p.8). The non-network pharmacy has asked the State of Tennessee to mandate that McKee charge its *Tennessee* employees higher co-pays at the onsite pharmacy or increase plan benefits by providing lower copays to *Tennessee* employees who use other pharmacies—in either case, contrary to the terms of McKee's plan. *Id.*

This is just one example, but it illustrates the problems created by the Tennessee Law. McKee has chosen to make it cost-effective and convenient for its employees to fulfill their prescriptions onsite. Other plan sponsors and administrators may choose other ways to design and operate their plans based on their own participant populations and demographics. ERISA affords them the freedom to do so. *See Moore v. Reynolds Metals Co. Retirement Program,* 740 F.2d 454, 456 (6th Cir. 1984) ("Neither Congress nor the courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide").[10]

Third, applying the challenged provisions of the Tennessee Law to plans with participants in multiple states increases the administrative burdens—and costs—on those plans by requiring

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participants by altering their plan benefits. From a participant perspective, the amount they pay or don't pay for a covered prescription *is* the benefit.

[10] The Commissioner urges the Court to ignore the substantial body of case law finding any-willing-provider laws to be preempted by ERISA, arguing "ERISA nowhere expressly preserved the option of excluding willing providers[.]" (Dkt. 123 at 23; *see also id.* at 21-22). The Commissioner is wrong again. When Congress enacted ERISA, it left *all* health plan design decisions to the discretion of the employers offering them. *See Shaw,* 463 U.S. at 96-97; *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.") (citations omitted). In any event, it is disingenuous for the Commissioner to minimize the role of provider networks in the design of benefit plans.

plan sponsors to design their prescription-drug plans in Tennessee-specific ways, which is "exactly the burden ERISA seeks to eliminate." *Egelhoff*, 532 U.S. at 151. The Tennessee Law not only increases the costs and burdens on plan sponsors and administrators, it also directly impacts plan participants by creating Tennessee-specific requirements that may *disadvantage* some participants.

C. The Tennessee Law Conflicts With ERISA's Objectives Of Safeguarding Plan Design Decisions From State Regulation And Establishing National Uniformity In Plan Administration.

A state law is also preempted if it "conflicts with the provisions of ERISA or operates to frustrate its objects." *Boggs,* 520 U.S. at 841. ERISA safeguards employer freedom to define the terms of ERISA plans and customize benefit plan design, including designing provider networks and participant cost incentives, without state intervention. *See Shaw,* 463 U.S. at 96-97; *Moore*, 740 F.2d at 456. The Tennessee Law contradicts this fundamental ERISA principle by interfering with the choices available to self-insured plans. Applying the Tennessee Law to self-insured ERISA plans also runs contrary to ERISA's policy of minimizing the administrative burden on employers—multi-state employers in particular—who sponsor prescription-drug plans by requiring them to carve out a set of Tennessee-specific plan rules. *See Rutledge*, 592 U.S. at 86-87. Thus, the Tennessee Law "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" in enacting ERISA. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (citations and quotation marks omitted).

D. The Tennessee Law Conflicts With ERISA's Fiduciary Obligations.

The Tennessee Law also conflicts with ERISA's fiduciary provisions. *See Boggs*, 520 U.S. at 841; *Sherfel v. Newson*, 768 F.3d 561, 568 (6th Cir. 2014) (ruling state law was preempted because it "imposes conflicting obligations upon the plan administrator—if the administrator complies with one obligation, it violates the other"). ERISA plan fiduciaries must operate their plans prudently and in the best interests of plan participants. *See* 29 U.S.C. § 1104(a)(1)(A), (B).

The any-willing-provider provisions of the Tennessee Law require plans to expand their networks to include any pharmacy even if it inhibits employers from fulfilling their fiduciary duties. As illustrated in this case, if a plan fiduciary determines that a service provider is overcharging for prescriptions or engaging in other improper practices, the fiduciary has the right (and obligation) to address those improprieties in the best interest of the plan, which may include removing that provider from the network. Failing to do so could expose the fiduciary to potential claims by participants alleging breach of fiduciary duty. *See, e.g., Chao v. Merino*, 452 F.3d 174, 183 (2d Cir. 2006) (affirming fiduciary-breach finding based on plan fiduciary's failure "to take precautionary steps" against a service provider known to have previously embezzled from the fund: "[i]f a fiduciary was aware of a risk to the fund, he may be held liable for failing to investigate fully the means of protecting the fund from that risk.").[11] ERISA plan fiduciaries in recent years have seen a significant increase in lawsuits claiming breach of fiduciary duties for retaining plan service providers that allegedly engaged in misconduct, charged excessive fees, or otherwise harmed participants, including in the context of prescription-drug plans. *See, e.g.,* Complaint, *Lewandowski v. Johnson & Johnson*, No. 1:24-cv-00671, ECF No. 1, (D.N.J, February 5, 2024) (alleging multiple ERISA fiduciary violations based on prescription-drug plan's arrangements with PBM and alleged overcharging of prescriptions to participants).

Because plans are required to address participant cost-sharing in the plan documents, the anti-steering and cost-incentive provisions of the Tennessee Law may also contradict plan terms. But ERISA requires administering the plan in accordance with its terms, 29 U.S.C. § 1104(a)(1)(D). In *Sherfel*, the Sixth Circuit ruled that ERISA preempted a Wisconsin law that

[11] *See also Bartnett v. Abbott Lab'ys*, 492 F. Supp. 3d 787, 797 (N.D. Ill. 2020) (acknowledging that a fiduciary's failure to protect against a known risk would constitute a fiduciary breach).

would have required a plan to pay benefits contrary to the plan terms. 768 F.3d at 568. The Tennessee Law forces plan fiduciaries into a similar "Hobson's choice": they either "obey the state law, and risk violating [ERISA], or disobey the state law" and hope that an ERISA preemption defense is successful. *See Denny's, Inc. v. Cake*, 364 F.3d 521, 527 (4th Cir. 2004).[12]

CONCLUSION

The Court should grant McKee's motion for summary judgment and deny the Commissioner's motion for summary judgment.

Dated: January 7, 2025

Respectfully submitted,

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[12] *See also NGS Am., Inc. v. Jefferson*, 218 F.3d 519, 529 (6th Cir. 2000) ("Challenging [state] regulations by violating them and then raising ERISA preemption as a defense in a state enforcement action would have risked breaking the law.").

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States District Court for the Eastern District of Tennessee by using the court's CM/ECF system on January 7, 2025.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the court's CM/ECF system.

Dated: January 7, 2025

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