THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

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Director, State Advocacy

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The Honorable Ken Paxton
Attorney General of Texas
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Submitted Electronically

Re: Whether HB 1763 and HB 1919, enacted by the 87th Legislature and codified in chapter 1369 of the Insurance Code, are enforceable against a health benefit plan issuer and a pharmacy benefit manager administering the pharmacy benefits of the health benefit plan in certain circumstances (RQ-0539-KP) – Public Comments from The ERISA Industry Committee

Dear Attorney General Paxton:

The ERISA Industry Committee ("ERIC") appreciates the opportunity to submit comments on the recent request for opinion filed by Senator Charles Schwertner regarding applicability and enforceability of Texas state law to self-funded ERISA plans ("Request"). While ERIC recognizes the growing interest among state lawmakers in regulating the practices of pharmacy benefit managers ("PBMs"), we are deeply concerned by state policies, such as those adopted by HB 1763 and HB 1919, that could lead to an overstep of state authority by directly impacting the design and administration of self-funded health benefit plans governed by the federal Employee Retirement Income Security Act of 1974 ("ERISA").

While the Texas laws at the heart of the Request do not appear to feature language covering self-funded ERISA plans, any state attempt to enforce the laws' provisions on these plans would: 1) likely be preempted by federal ERISA law, 2) likely spark costly litigation challenging enforcement, 3) threaten to erode ERISA's national uniformity, 4) undermine the valuable benefits that self-funded employer plans are able to provide to Texas residents, and 5) diminish Texas's attractiveness as a state in which to do business.

ERIC therefore strongly urges the Office of the Attorney General to, in its response to Senator Schwertner's Request, recognize the regulatory limitations pursuant to ERISA and prevent any future enforcement of HB 1763 and HB 1919 on self-funded ERISA plans within Texas.

ERIC is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the

voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state and city across the country.

Large employers like ERIC member companies have long been at the forefront of innovating health care benefit design and administration trends. Their ability to do so depends in large part on ERISA preemption. ERISA allows for a single set of standards for multistate employers to design and administer uniform health care and retirement benefits to their nationwide employees, regardless of where they live or work. Since ERISA's enactment, multistate employers have done just that, securing truly effective and efficient health care coverage enjoyed today by millions of Americans.

Unfortunately, a series of state laws and regulations proposed and adopted in recent years threatens to erode ERISA preemption, endangering valuable benefits that self-funded, large-employer plans have long provided. Many are preempted by ERISA because they overstep the limited authority that court interpretations have granted to states in this space. Furthermore, many of these well-intentioned state laws have the ultimate effect of increasing rather than decreasing health care costs for employers and their workers.

Within this context, the Request submitted by Senator Schwertner focuses on the question of whether existing Texas state laws, enacted by HB 1763 and HB 1919, are enforceable against an ERISA health benefit plan issuer or a PBM administering the pharmacy benefits of such an ERISA health benefit plan – our answer to this question is no, they are not. ERIC's following comments address this question by underscoring: 1) the non-applicability of HB 1763 and HB 1919 to self-funded ERISA plans, 2) the impact HB 1763 and HB 1919 would have on self-funded ERISA plans if enforced, and 3) the direct conflict with federal law that would be created by enforcement of HB 1763 and HB 1919 on self-funded ERISA plans.

HB 1763 and HB 1919 feature unambiguous language regarding non-application to self-funded ERISA plans

The first issue is whether the text of HB 1763 and HB 1919 as enacted provides for the possibility of enforcement against self-funded ERISA plans. As the Request correctly summarizes, both state laws feature extensive definitions of "issuers" and "PBMs" that broadly include health benefit plans providing benefits for medical expenses as a result of a health condition, accident or sickness. Critically, plan issuers do not often administer self-funded ERISA plans.

While both laws do include a list of explicit exceptions to these broad definitions – including issuers and PBMs administering a worker's compensation insurance policy or other form of medical benefits under state law – neither law features a comparable carve-out or exemption for self-funded ERISA plans.

In summary, the state laws at issue do not expressly include plan issuers or PBMs involved in the design and administration of self-funded ERISA plans from the laws' range of requirements. While this ambiguity would appear to leave the question of self-funded ERISA plan enforceability up to regulatory interpretation, the long-established principles of ERISA preemption – as our following comments explain – ultimately prevent HB 1763 and HB 1919 from being applied to self-funded ERISA plans, regardless of the textual uncertainty.

ERISA prohibits states from controlling the design and administration of self-funded plans established under ERISA

ERISA was implicitly constructed by Congress with the objective of establishing nationally uniform rules for the design and administration of employee benefit programs. To uphold this national uniformity, Congress built into Section 514 of ERISA an extremely strong preemption clause stating 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". Over the 50 years since ERISA's enactment, the U.S. Supreme Court has interpreted this preemption clause very broadly to supersede state laws that either: 1) refer explicitly to ERISA plans, or 2) have a substantial financial or administrative impact on them, including regulating the provider networks that plans may use.

As outlined above, the language used by both HB 1763 and HB 1919 does not clearly apply the laws' provisions to self-funded ERISA plans and does not explicitly reference them. However, they would nonetheless create a conflict with federal law to the extent that they would limit the design and administrative options available to plan issuers should they be applied to ERISA plans. To state plainly, ERISA prohibits states from controlling self-funded ERISA plans, even if that control is exerted indirectly via regulation of the third-party administrators or PBMs that administer those ERISA plans.

While the U.S. Supreme Court has established precedent in the case of *Rutledge v. PCMA*, 141 S.Ct. 474 (2020) allowing states to regulate the narrow issue of PBM payment calculations to pharmacies, that authority is narrowly limited to a "state law that merely increases costs." Unlike the state law at issue in *Rutledge*, both HB 1763 and HB 1919 have a broader impact on and relation to core elements of plan design and administration.

Most recently, the United States Court of Appeals for the Tenth Circuit applied the logic of *Rutledge* to the case of *PCMA v. Mulready*, No. 22-6074 (10th Cir. 2023), holding that several aspects of an expansive Oklahoma law that sought to regulate a broad range of PBM network practices were preempted by ERISA. The Court found that these aspects of the state's PBM regulation overstepped state authority and impermissibly controlled the design and administration of self-funded ERISA plans.

As the Court stated, "Our role is to answer whether the Act's four challenged provisions veer into the regulatory lanes that Congress has reserved for itself … we conclude that they do.

Though the Act avoids mentioning ERISA plans … by name, it encompasses these plans by striking at the heart of network and benefit design." Importantly, several of the challenged Oklahoma provisions bear a striking resemblance to the provisions and requirements adopted by HB 1763 and HB 1919.

HB 1763 and HB 1919 include policy provisions that overstep state authority to regulate self-funded ERISA plans

Though HB 1763 and HB 1919 do not appear to have been enforced against self-funded ERISA plans in the years since their enactment, ERIC believes that attempting to apply their requirements to these plans now or in the future would cause direct and immediate ERISA preemption conflicts.

While large portions of HB 1763 are aimed at protecting claim payment amounts and pharmacy reimbursement, other provisions dictate the network standards and practices that both plan issuers and their administering PBMs are forced to adopt. Namely, the law features an extremely broad "any willing pharmacy" provision that prohibits plan issuers and PBMs from forming contracts that apply pharmacy accreditation standards "inconsistent with, more stringent than, or in addition to federal and state requirements," while making it nearly impossible for a plan issuer or PBM to terminate or refuse to renew a pharmacy contract without an implication of retaliation. If applied to self-funded ERISA plans, these provisions would effectively strip plans of their ability to design or operate any kind of distinct provider network. As legal precedent surrounding ERISA has made clear, such a blanket usurpation of network design and administration choices by the state would be preempted if applied to or enforced against self-funded ERISA plans, either directly or indirectly through plan vendors.

Additionally, HB 1919 prohibits the use or transfer of identifiable prescription information and patient records to affiliate pharmacies for "commercial use". While this may be intended to prevent PBMs from steering patients to their own pharmacies, it is overly broad and would greatly restrict the ability of plan issuers and their PBMs to freely communicate pertinent information that could lead to improved quality or reduced cost of treatment. This ability is a core aspect of plan administration. To the extent HB 1919 would strip this ability from plan issuers if enforced against self-funded ERISA plans, it would be preempted by federal law.

Conclusion

ERIC appreciates the opportunity to provide comments on the applicability and enforceability of HB 1763 and HB 1919 to self-funded ERISA plans. While we share the goal of reducing health care costs, policies that stand to erode ERISA preemption and national uniformity threaten to do more harm than good. To protect the ability of multistate employer plan sponsors to effectively offer health benefits plans to millions of Americans, **ERIC strongly urges the Office of the Attorney General to, in its response to Senator Schwertner's**

Request, recognize ERISA preemption and prevent any future enforcement of HB 1763 and HB 1919 on self-funded ERISA plans within Texas.

If you have any questions concerning our comments, please contact us at (202) 789-1400 or dclair@eric.org.

Sincerely,

Dillon Clair

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