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

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Director, State Advocacy

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Chair Buffy Wicks
California State Assembly
Appropriations Committee
1021 O St, Suite 8220
Sacramento, CA 95814
Submitted Electronically

Re: Public Comments from The ERISA Industry Committee – ERISA Preemption Concerns Raised by SB 966 – Broad Regulation of PBM Network Practices

Dear Chair Wicks and Members of the California State Assembly Appropriations Committee:

The ERISA Industry Committee ("ERIC") appreciates the opportunity to comment on the proposed legislation contained in SB 966 being considered by the California State Assembly Appropriations Committee ("Committee") during today's hearing. 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 included in SB 966, that could impact the design and administration of self-funded health benefit plans governed by the federal Employee Retirement Income Security Act of 1974 ("ERISA").

Because application of SB 966 to self-insured ERISA plans would cause a direct conflict with federal law, ERIC strongly urges the Committee to consider the ERISA preemption issues at hand and oppose SB 966 or amend it to explicitly exempt self-insured ERISA plans.

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 the protections offered by 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-insured, 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.

ERISA prohibits states from controlling the design and administration of self-insured plans

Congress enacted ERISA to establish nationally uniform rules for the design and administration of employee benefit programs. Specifically, under Section 514 of ERISA, Congress created 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.

Therefore, ERISA prohibits states from controlling self-insured plans, even if that control is not stated explicitly or if it is exerted indirectly through regulation of the third-party administrators or PBMs that administer those plans.

Under *Rutledge v. PCMA*, 141 S.Ct. 474 (2020), states may regulate PBM payment calculations to pharmacies, however, that authority is narrowly limited to a "state law that merely increases costs."[1] Unlike the state law at issue in *Rutledge*, the provisions featured in SB 966 have a broader impact on, and relation to, core elements of plan design and administration, which clearly trigger ERISA preemption if applied to ERISA plans.

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). In that case, the Tenth Circuit held an Oklahoma PBM law to be preempted in its application to self-insured ERISA plans due to the state's overreach in controlling the design and administration of those 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."[2] Importantly, SB 966 includes several policy provisions that are strikingly similar to those in the Oklahoma law at issue in *Mulready*.

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[1] *See Rutledge v. PCMA*, 141 S.Ct. 474 (2020)
[2] *See PCMA v. Mulready*, No. 22-6074, 53 (10th Cir. 2023)

SB 966 leaves the door open for application to self-insured ERISA plans, which could impact the design and administration of these plans

As currently drafted, SB 966 would create a range of compliance requirements for PBM services offered under health care service plans and health insurance policies. While the bill does not reference ERISA or self-insured employer plans, it likewise does not exempt or carve-out the application to these plans. Rather, the bill expressly states, under § 17004.5, that "Any activity conducted by a pharmacy benefit manager, as defined in this division, shall be construed as the business of insurance."[3]

This is concerning because it appears to greatly broaden the scope of SB 966 by deeming all PBM services as being insurance without providing further distinction or exception. State regulators could interpret this provision to include self-insured ERISA plans, jeopardizing the plans' control over the design and administration of plan benefits and potentially sparking legal challenges.

If SB 966 is interpreted as currently drafted to include self-insured ERISA plans, its range of compliance requirements would dictate the design and administrative options ultimately available to these plans. It would do so by hampering their ability to utilize flexible benefit designs to provide affordable access to care for their beneficiaries. By handcuffing their service providers, the PBMs, from providing the services they require for the plans, the bill would needlessly restrict benefit design by:

- Prohibiting PBMs from differentiating between affiliated and non-affiliated pharmacies – restricting utilization of plan design.[4]

- Prohibiting mandatory use of an affiliated pharmacy – restricting utilization of plan design.[5]

- Prohibiting financial incentives to transfer a prescription to an affiliated pharmacy– restricting utilization of plan design.[6]

- Requiring PBMs to accept any willing provider for preferred network status – restricting utilization of plan design.[7]

[3] California SB 966 § 17004.5 (2024)
[4] *Id* § 17030
[5] *Id* § 17035(a)
[6] *Id* § 17035(b)
[7] *Id* § 17035(f)

- Prohibiting PBM's from imposing credentialing requirements on specialty pharmacies above those permitted under state law – imposing a broad any-willing-pharmacy provision.[8]

- Requiring that PBMs be reimbursed on a flat, defined, dollar-amount basis – preventing fiduciary pursuit of contracts that provide greater benefit to participants.[9]

- Prohibiting PBM contract terms that create exclusivity for a manufacturers' drugs – directly regulating the plan's terms and benefit design by limiting the use formulary tiering.[10]

These provisions demonstrate the serious threat that SB 966 poses to preserving critical ERISA preemption protections – protections that allow large, multi-state employers to offer uniform, affordable health benefits to millions of workers and their families -- if unaddressed.

SB 966 must be amended to prevent any and all application to self-insured ERISA health benefit plans

As discussed above, federal law prohibits states from controlling the design and administration of ERISA plans under the express language of ERISA preemption. Because SB 966 features language that can be broadly read to include self-insured health care plans and does not feature an explicit carve-out for ERISA plans, its language certainly appears to imply application to the very employer health care plans that would trigger ERISA preemption of a state PBM policy proposal.

To prevent conflict with federal law and avoid costly legal challenges for state lawmakers in the future, the bill should be amended to: 1) clarify that ERISA plans are not deemed to be engaged in the business of insurance, and 2) include an exemption for self-insured ERISA plans. For example, to clarify the scope of the "business of insurance", a clause could be added to § 17004.5 to read:

> *"Notwithstanding any other provision of law, an employee benefit plan, as defined in section 3(3) of Employee Retirement Income Security Act of 1974 shall not be deemed to be an insurance company or engaged in the business of insurance for purposes of state law."*

Similarly, an explicit ERISA exemption section could be added to read:

[8] *Id* § 17045
[9] *Id* § 17050(a)
[10] *Id* § 17065

"This Act shall not apply to a self-insured health benefit plan subject to ERISA or exempted from ERISA under section 4(b) of ERISA."[11]

Alternatively, this explicit exemption section could be built out further to read:

"The following provisions of this Chapter shall not apply to a self-insured employer prescription drug plan offered pursuant to the federal "Employee Retirement Income Security Act of 1974," codified at 29 U.S.C. §1001 et. seq., or to a pharmacy benefit manager's provision of pharmacy benefit management services to such a self-insured employer plan. To the extent a pharmacy benefit manager is providing services for other health plans in addition to self-insured employer prescription drug plans governed by federal law, the provisions of this Chapter shall continue to apply to the pharmacy benefit manager in its performance of pharmacy benefit management services to those other health plans."[12]

If the scope of the "business of insurance" is clarified and self-insured ERISA plans are exempted in the bill, ERISA preemption concerns raised by SB 966 would be greatly alleviated and future litigation could very well be avoided.

Conclusion

ERIC appreciates the opportunity to share the ERISA preemption concerns raised by SB 966 with the Committee ahead of today's hearing. While ERIC recognizes continued interest in regulating PBM network practices, we are deeply concerned by proposals, such as SB 966, that open the door for enforcement against self-insured employer plans and threaten to erode ERISA preemption nationally. **ERIC therefore strongly urges the Committee to carefully consider the critical ERISA preemption issues at hand and vote to either oppose SB 966 or amend it to explicitly exempt ERISA plans.**

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

Sincerely,

Dillon Clair
Director, State Advocacy

[11] ERISA preemption language included in enacted Pennsylvania HB 1993 § 102(3) (2024) at ERIC's suggestion
[12] ERISA preemption language suggested by ERIC to New York Department of Financial Services in regulatory comments regarding "Proposed Consolidated Rulemaking to Amend Insurance Regulations 219, 222, 224, and 226-229"