Comments for the Record

House Committee on Education and Workforce RFI Response: ERISA Preemption

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Dear members of the Committee on Education and Workforce,

I am writing in response to your request for information (RFI) entitled "ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage." I appreciate the Committee's desire to address a wide variety of challenges surrounding the Employee Retirement Income Security Act (ERISA) of 1974, a foundational law in our nation's private insurance system. Below, I will focus on the Committee's interest in ERISA preemption, including background on preemption, court decisions surrounding preemption, and ways to strengthen this key feature of ERISA.

Introduction

ERISA's preemption clause exempts applicable insurance plans from state insurance laws and specifies that those applicable plans include all self-insured private-sector employer and union plans, with some exceptions. Self-insured health insurance plans are defined as those in which the sponsoring organization takes on the full risk of medical costs for beneficiaries. Plan sponsors may contract with a third-party administrator (TPA), such as a pharmacy benefit manager (PBM) or a provider network manager (PNM), but the sponsor must retain all the risk. The point of the preemption clause is to incentivize employers to provide health insurance plans to employees by reducing the financial and regulatory burden involved in offering health insurance. This is particularly important for companies that have employees in more than one state, where multiple regulatory regimes would dramatically increase the cost to provide insurance.

A primary concern surrounding the strength of ERISA preemption is found in the wording of the clause itself: State laws are preempted by ERISA "insofar as they may now or hereafter relate to any [self-funded] plan."[1] It is the phrase "relate to" that has caused a great deal of confusion as to the extent of ERISA preemption, resulting in over four decades of Supreme Court cases on the matter and little clarity on the meaning of "relate to," culminating in the *Rutledge v. Pharmaceutical Care Management Association (2020)* ruling that threatens a deluge of state regulation over the TPAs on which plans rely to provide benefits to members.

The Importance of *Rutledge*

The *Rutledge* case, which ruled that an Arkansas law (Act 900) that required PBMs to pay pharmacies at or above acquisition cost for medicines was not preempted by ERISA, is important because of the distinction it made between TPAs and self-funded plans. In ruling that Act 900 didn't "refer to" ERISA, the Court pointed out that the law did not even affect the plans directly, merely the PBMs.[2] This implies that PBMs, and any other TPA, are not a fundamental part of providing "nationally uniform plan administration" (see *Egelhoff v. Egelhoff, 2001*) or benefit design (see *Shaw v. Delta Air Lines, Inc., 1983*), and thus laws targeting those TPAs are not preempted by ERISA.[3],[4]

The problem with this reasoning is that self-funded plans rely on TPAs to function. The average company is simply not capable of negotiating its drug prices and provider networks, ensuring payments are made and rebates are collected, or completing a wide variety of other tasks that come with administering a health plan. As such, TPAs are essential to a plan's operation, and the regulation of a TPA seems to functionally regulate plan design. It is, after all, the TPA that handles the benefit design and plan administration, while the employer takes the financial risk. This does not mean the Court was wrong in its interpretation of ERISA preemption – TPAs were not commonly used by health plans and employers until over a decade after ERISA was originally written – but rather points to a gap in the law itself that does not account for the way modern plans are designed and administered.

Rutledge also reaffirmed previous decisions in ruling that "not every state law that affects an ERISA plan…has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs."[5] Citing the 1992 *Travelers* ruling, the Court noted that "cost uniformity was almost certainly not an object of preemption."[6] Act 900 did not directly dictate a new cost, however. Instead, it functionally forced PBMs to change the way they calculate payments to pharmacies to a method that would likely increase costs for PBMs (and thus plans and beneficiaries). Payment calculations are part and parcel of plan design and administration – but the Court has now ruled that laws dictating how those calculations must be done are functionally cost impositions and not relevant to plan governance or a nationally uniform plan design and administration.

The distinction between the TPA and the plan, and the separation of payment calculation methods by those TPAs from plan design and administration, has created a perception of weakness in the ERISA preemption statute by implicitly suggesting that TPAs' benefit design and administration processes are not inherent to the plan itself. Proof of this perception can be seen in the wide variety of new legislation states have introduced and passed over the last several years impacting ERISA preemptions through regulations on TPAs.

Solutions

Congress should take up legislation that clarifies what it means for a state law to "relate to" a self-funded plan and, more specifically, ensure that TPAs are functionally considered part of the plan itself for purposes of plan design and administration. This can be done by clarifying in 29 USC 1003(a) that ERISA preemption applies to any self-funded plan *and* any TPAs that plan uses for plan design and administration. This change would ensure that the original intent of the law – to reduce costly regulatory burdens in order to encourage employers to offer health insurance – can be fulfilled in the modern health care landscape, where TPAs are vital to the existence of self-funded plans.

This change is important for multiple reasons. First, such a change could help businesses with employees in more than one state avoid an onslaught of increased costs. Employers that have to comply with numerous different regulatory schemes – and the added expense that comes along with those regulations – are going to cut benefits or increase employee contributions and deductibles to make up the difference. This is bad for the employees but could also be bad for employer-sponsored insurance in general. If benefits are cut enough – or

employee contributions and deductibles rise enough – employees may decide to leave for the individual market. The more individuals covered by federal programs, the more political pressure on the government to increase subsidization and benefits for these programs.

Second, this change will help employers that are only in one state provide more benefits for their employees as well. When it comes to increasing employer-sponsored coverage, it's small businesses that have the most room to grow. While small firms (fewer than 50 employees) account for 61.7 million workers (or 46.4 percent of all U.S. employees), less than a third of small businesses offer coverage. In contrast, 91 percent of firms with 50–199 workers offer benefits, and 99 percent of firms larger than that offer benefits. Again, this means fewer individuals relying on government-subsidized insurance through the Affordable Care Act or Medicaid.

Conclusion

ERISA preemption is an important brick in our private health system's foundation, but there is now a greater perception of weakness as to the extent and applicability of preemption. Congress should amend ERISA to clearly state that preemption applies not just to self-funded plans, but also to the TPAs that aid self-funded plans in plan design and administration. This will modernize ERISA to ensure its original intent can be applied to the modern health care system, while strengthening the private insurance market and enabling more businesses to offer better health benefits to more employees.

[1] 29 USC 1144(a)

[2] Rutledge v. Pharmaceutical Care Management Association, 592 U.S. ___ (2020), https://supreme.justia.com/cases/federal/us/592/18-540/

[3] Egelhoff v. Egelhoff, 532 U.S. 141 (2001), https://supreme.justia.com/cases/federal/us/532/141/

[4] Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983), https://supreme.justia.com/cases/federal/us/463/85/

[5] Rutledge v. Pharmaceutical Care Management Association, 592 U.S. ___ (2020), https://supreme.justia.com/cases/federal/us/592/18-540/

[6] Ibid.