U.S. Chamber of Commerce

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The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

The Honorable Bobby Scott
Ranking Member
Committee on Education and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Foxx and Ranking Member Scott:

Thank you for the opportunity to respond to the Committee's Request for Information seeking feedback on ways to build upon and strengthen the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Chamber strongly supports employer-sponsored insurance coverage as the backbone of America's healthcare system, through which more than 150 million Americans obtain health coverage. American workers and their families value these benefits that employers want to continue to offer.

The Chamber advocates for policies that allow more individuals to access health care coverage through employer-sponsored plans. Below are several issues highlighted in your January request we believe are important.

ERISA Preemption: The Business Perspective

Preemption – intended to establish uniform standards for employer-sponsored benefit plans, including health and retirement plans – is crucial to enable a consistent, equitable, and efficient regulatory environment for employer-sponsored benefit plans, and it plays a vital role in safeguarding the interests of employers and employees alike. The Chamber strongly opposes any attempts to directly or indirectly curtail, restrict, or otherwise diminish ERISA's pre-emption provisions.

Preemption generally enables employers to offer competitive and comprehensive benefit packages to their employees regardless of the states where they reside and work. By preventing the imposition of varying state laws on benefit plans, ERISA preemption reduces administrative complexities and compliance costs for employers. This efficiency allows employers to focus resources on providing robust and competitive benefit packages to their employees. Furthermore, ERISA preemption provides legal certainty for employers, plan sponsors, and participants, creating a stable environment in which to design and administer benefit plans.

The History of ERISA Preemption of State-based Employee Benefit Laws

ERISA preemption was a deliberate policy decision made by Congress and explicitly overrides state laws that are related to employee benefit plans. According to ERISA § 514(a), the act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The crafters of ERISA specifically referred to preemption as "the crowning achievement of [ERISA], the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation" (120 Cong. Rec. 29,197, 1974).

ERISA's drafters intentionally crafted the act's expansive preemption provisions to incentivize employers to provide benefits. Specifically, they designed broad federal preemption authorities to alleviate the administrative cost burdens that would have been imposed upon employers if they needed to navigate a patchwork of multiple state laws. However, Congress explicitly exempted state laws regulating insurance, banking, or securities from preemption. The result is that Congress enabled states to retain their authority to regulate insurance companies themselves, but states are unable to regulate the actual fully-insured employer-sponsored health plans.

Additionally, with the intention of preventing states from treating employee benefit plans as if they were insurance arrangements, Congress explicitly specified employee benefit plans cannot be considered as an "insurance company" or engaged in the "business of insurance, banking, or securities." The inclusion of the "deemer clause" prevents states from bypassing preemption by categorizing an employer-sponsored plan as an insurance company. This clause is critically important for self-funded group health plans; without it access to employer-provided health insurance that many Americans enjoy today would be jeopardized. If ERISA preemption were to be upended, it would increase cost and complexity by forcing employers to comply with 50 separate state laws making it impossible to administer health benefits to their employees.

ERISA preemption has been the subject of numerous Supreme Court and lower court cases in the past 50 years. The U.S. Supreme Court has frequently acknowledged ERISA preemption aims to maintain employers' capacity to uniformly administer benefits without concerns about conflicting state laws. In *FMC v. Holliday*, 498 U.S. 52 (1990) the U.S. Supreme Court characterized the preemption clause as notably extensive in its scope. In 2016, the court held in *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. 312 (2016) that ERISA preempted a state law that would have mandated distinct health plan reporting to the state. In doing so, the Court emphasized how ERISA's reporting, disclosure, and recordkeeping schemes are critically important to the uniform administration system of employee benefit plans.

Narrowing of Preemption — the Impact of *Rutledge*

Recently, some state legislatures have sought to regulate employee benefits plans more heavily, which directly undermines an employer's ability to uniformly design and administer benefit plans. The primary driver of the current state encroachment into employee benefit plan regulation is the Supreme Court's recent decision in *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, 141 S. Ct. 474 (2020).

In *Rutledge*, the Supreme Court ruled that an Arkansas statute mandating minimum payment amounts that a pharmacy benefit manager (PBM) pays retail pharmacies for drugs was not preempted by ERISA because it did not regulate employee benefit plans directly and it did not impact uniform plan administration.

After the *Rutledge* decision, many states passed laws regulating PBMs in a manner that goes well beyond the Arkansas statute. For example, both Oklahoma and Florida have passed laws that directly impact group health plans relating to cost sharing, mail order drugs, and any willing provider laws. The Florida law goes further than the Oklahoma statute in that it mandates specific pricing terms for existing contracts between employers and the PBM. Litigation is likely with respect to the Florida law, and as discussed below, the Oklahoma law was struck down by a federal court of appeals.

In *PCMA v. Mulready*, 78 F.4th 1183 (10th Cir. 2023), Oklahoma's law regulated PBM networks by requiring minimum distance standards for network retail pharmacies, prohibiting cost-sharing discounts for mail-order pharmacies, and requiring PBMs to contract with "any willing provider" was challenged as being preempted by ERISA. The challenge was based on the law directly affecting a plan's ability to design its benefits because of the law's network standards and cost-sharing standards. The Oklahoma law was upheld at the district court level, but the Tenth Circuit reversed that decision, concluding that that law was preempted by ERISA because it effectively mandated employee benefit structures and their administration. *Mulready*, 78 F.4th at 1197. As the Court said "[h]owever sliced, the network restrictions 'require providers to structure benefit plans in particular ways,' *Rutledge*, 141 S. Ct. at 480, and 'prohibit employers from structuring their employee benefit plans in a [certain] manner[.]" *Mulready*, 78 F.4th at 1198.

While the Chamber welcomed the Tenth Circuit's decision regarding preemption, uncertainty in the wake after *Rutledge* remain in a variety of areas.

- States are testing the breadth of *Rutledge.* The *Mulready* decision is just one case, but there will no doubt be a series of lawsuits and significant operational challenges employee benefit plans will need to confront while courts sort out various state laws;
- The Department of Labor (through the U.S. Department of Justice) filed an amicus brief in *Mulready,* which appeared to abandon fifty years of ERISA preemption interpretation by arguing the Oklahoma law should be preempted from applying directly to ERISA plans, *but not preempted with respect to regulating PBMs*. In effect, DOL's position would allow states to indirectly regulate ERISA plans by targeting the law at a plan's service provider, such as a PBM or a third-party administrator (TPA) for medical benefits. Movements in this direction would significantly weaken ERISA preemption because they contradict established case law regarding the "deemer clause." [1]
- The *Rutledge* decision contains no limiting principle that would suggest ERISA's preemption doctrine can be limited only with regard to PBMs or prescription drug coverage. *Rutledge* opened the door to limitations to ERISA's preemption doctrine beyond regulation of health benefits. Chamber members are worried that the precedent set in *Rutledge* could lead to state laws that would:
    - Require behavioral health counselors, pediatricians, chiropractors, or nurse practitioners or any other health care provider to be paid more than the TPAs network or out of network reimbursement for their services.
    - Regulate the levels of cost sharing imposed for network and out of network benefits administered by the TPA, undercutting common benefit tiers that encourage consumers to utilize lower cost and higher quality providers.

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[1] *See America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1333 n. 18 (11th Cir. 2014) (state prompt pay law preempted when applied to TPAs of self-funded plans: "[w]hether direct or indirect, state regulation of self-insured ERISA [plans] is not allowed by operation of the deemer Clause.")

- Require or prohibit TPAs to administer plans to either cover or not cover services such as abortion, contraception, gender affirming care.
- Regulate common medical management programs offered by the TPA and establish network adequacy or other standards that apply to the TPA's networks, or prohibit TPAs from administering "Centers of Excellence" programs.
- Regulate service providers for other employee benefit plans, such as only allowing service providers to provide service to retirement plans that have certain vesting schedules.

Congress should recognize that Rutledge's narrowing of ERISA preemption will limit employers' ability to offer and administer employee benefit plan and could potential discourage plan them. For this reason, we encourage the Committee to advance policies that maintain ERISA preemption.

Preserving ERISA's Fiduciary Definition

ERISA imposes fiduciary duties and liability on individuals who are plan fiduciaries. There are two types of fiduciaries under ERISA: named fiduciaries and functional fiduciaries. Named fiduciaries are those individuals or entities that are actually named as the plan fiduciary in the plan document. Functional fiduciaries are those who, under ERISA's fiduciary definition, perform one of the following functions: (i) exercises any discretionary authority or discretionary control respecting management or disposition of its assets, (ii) renders investment advice for a fee or other compensation, or (iii) has any discretionary authority or discretionary responsibility in the administration of such plan. ERISA fiduciaries must act prudently, solely in the interest of the plan, follow plan documents, and avoid "prohibited transactions." With respect to the views held by employers the Chamber represents, this functional definition of an ERISA fiduciary has worked well for 50 years.

Under the current fiduciary definition, the courts have routinely found that a person may be a fiduciary for one purpose, but not for others. For example, TPAs to health plans are fiduciaries for appeals if they have taken on that responsibility and are the ultimate decision maker. However, TPAs are not fiduciaries in other cases, such as negotiating provider network agreements, creating plan designs or determining what services they will offer to their customers.

Your Committee requested information on whether a "statutory fiduciary" definition for PBMs and TPAs should be considered for purposes under ERISA. The functional definition of ERISA has worked well for 50 years, and the Chamber views any changes as unprecedented and a highly unadvisable course of action for Congress to take. Imposing a statutory fiduciary definition under ERISA runs the risk of service providers, such as PBMs and TPAs, being found to be a fiduciary in running their ordinary business and in creating and offering services, which ultimately could increase costs and discourage innovation.

Electronic Disclosure

On May 27, 2020, DOL finalized regulations that would make it easier for retirement plans to provide required disclosures electronically, while also allowing those who wish to receive paper disclosures to do so. In our comments on the proposed regulation, we encouraged DOL to include group health plans in the final regulation. However, the final regulations did not. The result is that

different standards apply to different types of plans. We support encouraging DOL to allow group health plans to utilize the 2020 regulation.

Conclusion

We urge Congress to continue supporting ERISA preemption and to resist any efforts that may undermine the uniformity and efficiency that it brings to employer-sponsored benefit plans. Maintaining a clear and consistent federal framework ensures the continued success of employer-sponsored benefit plans and supports the broader goals of economic growth and workforce stability.

Thank you for your attention to this matter. We look forward to ongoing collaboration to create a regulatory environment that encourages employers to provide these highly valued benefits.

Sincerely,

Anna Vredenburgh
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U.S. Chamber of Commerce