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

DILLON CLAIR
Director, State Advocacy and Litigation

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Senator Jared Carpenter
Chair, Senate Standing Committee on Banking and Insurance
Kentucky General Assembly
702 Capital Ave
Annex Room 131
Frankfort, KY 40601
Submitted Electronically

RE: ERIC Written Testimony in Opposition to Kentucky Senate Bill 188 – State Regulation of Pharmacy Benefit Managers and Self-Insured Employer Plans

Dear Chair Carpenter and members of the Senate Standing Committee on Banking and Insurance:

The ERISA Industry Committee ("ERIC") appreciates the opportunity to comment on the proposed legislation contained in SB 188 being considered by the Kentucky Senate Standing Committee on Banking and Insurance ("Committee") during today's hearing. We have deep concerns with provisions of this legislation as currently drafted that would overstep state authority to control self-insured employer health care plans governed by the federal Employee Retirement Income Security Act of 1974 ("ERISA"), which pharmacy benefit managers ("PBMs") often administer.

If enacted, this legislation would raise health insurance and prescription drug costs across Kentucky and would stand in conflict with federal law governing the design and administration of employer-sponsored health plans nationwide. Provisions of the bill are preempted by ERISA and, therefore, ERIC may pursue or support litigation challenging it on behalf of our large employer member companies if enacted. **ERIC therefore urges Committee members to vote "no" and oppose SB 188, unless it is amended to entirely remove reference and application to self-insured employer plans established under federal ERISA law.**

ERIC is a national nonprofit 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 and lawfully operate benefit plans under ERISA. This important federal law provides protection from a patchwork of different and conflicting state and local laws under one unified federal standard designed to provide employer-sponsored plans with certainty as they structure their benefit offerings across multiple jurisdictions throughout the country.

Large employers have long been at the forefront of innovating health care benefit design and administration. By offering uniform benefit plans across their nationwide workforce, employers are able to negotiate from a position of strength and secure valuable health care coverage at reduced rates, all to the benefit of plan participants. Use of this cost-saving advantage was the precise intention behind ERISA's creation by Congress, which provides 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, 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 proposed and enacted in recent years have begun to erode ERISA preemption, endangering valuable benefits that self-insured, large-employer plans have long provided. Many of these state proposals clearly violate ERISA because they infringe on the national uniformity of self-insured plans and overreach to impact ERISA regulated health plans. As such, these laws are likely to be preempted and struck down under federal law. In fact, in the case of *PCMA v. Mulready*, No. 22-6074 (10th Cir. 2023), the Tenth Circuit has already held provisions of Oklahoma's PBM regulation law, which SB 188 follows in many ways, to be preempted by ERISA.

Many of the provisions contained in SB 188 threaten to directly undermine the ability of self-insured plans to continue to provide access to quality, affordable health care by explicitly including self-insured plans in statutory definitions, creating a range of costly administrative and reporting requirements, increasing statewide health care costs, and potentially leading to a mismatched patchwork of state rules rather than ERISA's uniform national framework. The impact of many of the bill's provisions will likely be weighed heavily by employers with operations, employees, and health care benefit plans throughout Kentucky, and could disadvantage the state's economic climate.

First and foremost, while SB 188 is focused generally on PBM networks and practice standards, it applies many of these same compliance requirements to insurers across the state as well. Because Section 1(4) of the bill defines "insurer" broadly to include both "self-insurers" and "self-insured employer-organized associations", it appears to subject self-insured employer plans established under federal ERISA law, as well as the PBMs administering those plans, to the legislation's requirements. Importantly, no language carving out or excluding self-insured ERISA plans is included in SB 188 as initially drafted or recently amended. This approach clearly exceeds the limited flexibility provided by the Supreme Court's decision in *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474 (2020), and intrudes upon employer plan design. SB 188 should be amended to remove all reference and application to self-insured employer plans, as they are established under and governed solely by ERISA.

Second, Sections 2(1) and 2(2) of SB 188 propose placing network adequacy requirements on PBMs and insurers, including the self-insured employer plans covered by the definition of "insurer" discussed previously. As mentioned above, ERISA preemption prevents

states from dictating the design and administration standards adopted by self-insured plans. Here, the bill would establish pharmacy network standards that PBMs and insurers must follow, such as how many pharmacies must be available, their proximity to count toward coverage adequacy requirements, and broad exclusion of mail-order services from this determination. Under the principle of ERISA preemption, states have long been prohibited from placing these kinds of adequacy standards on self-insured plans, as doing so would clearly control the administration of plans' nationwide benefits. To avoid conflict with federal law, SB 188 should be amended to prevent network adequacy standards from being applied to self-insured ERISA plans as well as the PBMs that manage them.

Additionally, SB 188 appears to place recordkeeping and reporting requirements not only on PBMs, but directly on the self-insured employer plans included under the broad definition of "insurer". Specifically, Section 2(3) of the bill requires PBMs and insurers to submit an annual report "*describing the networks of the insurer, pharmacy benefit manager, or other administrator that are utilized for the provision of pharmacy or pharmacist services under a health plan.*" As previously discussed, states do not have the authority to regulate the design or administration of a self-insured employer plan established under ERISA – this has been outlined in a number of Supreme Court cases, most recently in *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312 (2016). Not only would this requirement defy ERISA preemption, but it would also create counterproductive costs for administrators and lead to higher overall health care costs with no benefit to plan beneficiaries, since ERISA fiduciaries are already subject to a host of duties under ERISA and under the *Consolidated Appropriations Act of 2021*. SB 188 should therefore be amended to avoid placing any administrative or recordkeeping requirements directly on self-insured employer health plans.

Furthermore, current language in SB 188 seeks to broadly restrict PBM network and self-insured plans' use of mail-order pharmacies, regardless of their long-established track record of providing reliable prescription services to patients while reducing costs. Namely, Section 4(1)(A)(1) of the bill clearly states that PBMs and insurers shall not "*require or incentivize an insured to use a mail-order pharmaceutical distributor, including a mail-order pharmacy.*" This flat exclusion of using or even incentivizing mail-order pharmacies not only ignores the considerable cost-saving advantages they are able to provide to both plans and participants, but also has the effect of restricting the benefit design options available to self-insured employer health care plans established under ERISA and managed by PBMs. This conflict with the design and administration of ERISA plans raises further federal preemption concerns and would have dire consequences for prescription drug costs throughout the state. Because of the legal and policy impact posed, SB 188 should be amended to remove the restriction on mail order pharmacies within self-insured employer and PBM networks.

SB 188 also includes a broad "any-willing-pharmacy" requirement that would strip PBMs and insurers of their ability to establish minimum standards that pharmacies and pharmacists must follow in order to participate in their network. Specifically, Section (4)(1)(A)(3) of the bill prohibits PBMs and insurers from discriminating against any pharmacy or

pharmacist within a network's coverage area so long as they are "*willing to agree to, or accept, reasonable terms and conditions established for participation in the insurer's, pharmacy benefit manager's, other administrator's, or health plan's network*." While we understand that arbitrary discrimination by networks should not be encouraged, the language in SB 188 is extremely vague as to what a "reasonable" term or condition is or what latitude PBMs and insurers have to establish those network terms and conditions in the first place. Because terms and conditions to network participation are critical to prevent abuse and misconduct, SB 188 should be amended to provide further clarity and uphold the ability of PBMs and self-insured ERISA plans to establish critical network participation standards.

Finally, Section 3(2)(C)(2)(b) of the bill as amended proposes the establishment of a mandatory minimum dispensing fee of ten dollars and sixty-four cents ($10.64) for every prescription filled, representing more than a doubling of existing dispensing fees that have been negotiated and established in the commercial market. While policies such as minimum dispensing fees may be intended to foster pharmacy competition, their costs are ultimately absorbed by employer plans and plan participants, representing a counterproductive effect on statewide health care costs. SB 188 should therefore be amended to remove the minimum dispensing fee requirement and prevent the substantial economic impact it poses to have on Kentuckians.

If enacted, SB 188 would threaten to erode the ability of large-employer health benefit plans to effectively operate uniform benefits at scale, lead to litigation involving ERISA preemption concerns, raise statewide health care costs, and undermine the ability of many employers to do business in the state of Kentucky. On behalf of our large member companies, ERIC strongly opposes SB 188 as amended and respectfully urges the Senate Standing Committee on Banking and Insurance to amend this legislation to remove reference and application to self-insured employer plans governed by ERISA, as outlined above. If you have any questions concerning our comments or would like to discuss the legislation's posed impact on statewide health care benefits, please contact us at (202) 789-1400 or dclair@eric.org.

Sincerely,

Dillon Clair

Dillon Clair
Director, State Advocacy and Litigation