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

March 15, 2024

Virginia Foxx
Chair
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair Foxx,

Thank you for this opportunity to provide input on behalf of members of The ERISA Industry Committee (ERIC) regarding your request for information (RFI) on ways to build upon and strengthen the Employee Retirement Income Security Act (ERISA), the foundation of employer-sponsored benefits. With the passage of ERISA in 1974, employers came together to form ERIC, the only national association advocating exclusively for large employer plan sponsors that provide health, retirement, paid leave, and other benefits to their nationwide workforces. With member companies that are leaders in every economic sector, ERIC advocates on the federal, state, and local levels for policies that promote quality, affordable health benefits. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

Americans engage with ERIC member companies many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

ERIC prides itself on exclusively serving large employers. Every day, we engage with our member companies to understand the challenges they face in providing world-class employee benefits while navigating the current laws in place. ERISA is fundamental to employee benefits -- large employers operating in multiple states need the consistency and certainty provided by ERISA to ensure that they can offer uniform, national benefits to their employees, families, and retirees. ERISA protects employers from conflicting state mandates by keeping regulation at the federal level so that benefit plans can be administered fairly and uniformly across the country. ERISA also provides employer plan sponsors with the flexibility and autonomy to create benefit plans that best serve their workforce.

ERIC strives to preserve and reinforce ERISA preemption and defend plan sponsors' ability to design benefits that drive value. We oppose any attempt to mandate state reporting or other administrative obligations on companies that offer ERISA-regulated plans. Below, we will discuss in further detail preemption as well as specific sections of the RFI ERIC members identified.

Preemption

An essential part of ERIC's core mission is to protect and uphold the principles of ERISA preemption. ERISA preemption allows multistate employers to design valuable health and retirement benefit plans tailored to their workforce, and to administer those plans uniformly – regardless of where employees live or work. It does so by preempting any state or local law that "relates to" an employee benefit plan subject to ERISA, with limited exception. Without ERISA preemption, employees working at the same company, in the same position, and in different states, would be offered different health benefits and compensation, creating significant inequities.

In enacting ERISA, Congress recognized that multistate employers cannot provide quality, affordable benefits to working families if they must comply with a patchwork of recordkeeping, reporting, or other state and local mandates on ERISA plans in addition to federal rules. ERISA's preemption rule expressly prohibits states and localities from forcing employers to create or amend an employee benefit plan or from enacting statutes or ordinances controlling the administration of an employee benefit plan established under ERISA, or creating state law rights or remedies that duplicate, supplement, or supplant ERISA's exclusive civil enforcement remedy.

When different states approach benefit policy issues individually, they unavoidably create inconsistent laws that, absent broad preemption by federal law, employers must follow. All too often, these laws feature directly conflicting provisions. In that case, an employer plan cannot "split the difference" and design a single benefit structure and administration platform that complies with both state laws at once. The result is fractured benefit administration that forces employers to design and administer satellite plans in jurisdictions that enact such laws, creating uneven and confusing benefits across a workforce. This balkanization of multistate employer benefit plans drives up administrative and compliance costs and ultimately reduces the resources that can be used to provide valuable employee benefits.

In addition, this results in employers with employees in multiple states providing different coverage for the same service or procedure to employees depending on where they live, thus creating inequities in their health benefits and compensation. This has become especially problematic today with the increasing prevalence of remote work situations in which two co-workers are in the same position, in the same business unit and reporting to the same manager who receive different benefits. It is difficult for an employer to justify this disparity. These impacts are exactly what Congress meant to prevent when it enacted ERISA.

Despite ERISA's statutory command, there is a growing wave of state and local laws that attempt to impose benefits design and coverage mandates, reporting, recordkeeping, or other requirements and burdens on employers and ERISA benefit plans. Below are a sampling of state actions that create administrative challenges for multistate employers:

- State Pharmacy Benefit Manager (PBM) laws. Many state legislators are not satisfied with the federal oversight of pharmacy benefit managers (PBMs) and are attempting to enact legislation intended to address complaints raised by independent and community pharmacies, and to lower drug costs. However, ERISA clearly preempts many of these state proposals. For instance, Florida recently enacted a sweeping state PBM law[1] mandating specific pricing terms for existing contracts between employers and their PBMs and mandating specific plan design elements. Other states, such as Oklahoma[2], Tennessee[3], New York[4], and New Jersey[5] have also passed legislation that directly impact group health plan provisions relating to cost sharing, mail order drugs, and "any willing provider" laws. ERIC understands the importance of competition between pharmacies and the desire to improve areas of health care coverage, but state legislation in this area impermissibly attempts to directly control the design and administration of self-funded ERISA plans, and further increases health care costs instead of reducing them.

- State telehealth laws. As critical shortages of health care providers continue across the country, there is a growing need among patients for improved access to a range of specialists, rehabilitation services, mental health experts, and primary care providers. State telehealth laws dictate practice standards, reimbursement rates, and patient access. ERISA-regulated plans that want to expand participant access to vital remote care services are forced to adapt to a state patchwork; nearly every state now has its own telemedicine practice law on the books, and each is slightly different. While work continues to improve and harmonize state telehealth practice standards[6], the Uniform Law Commission has developed model legislation[7] for states to adopt and consider so that there is access to vital telehealth services in a uniform way.

  But in the meantime, an ERISA plan offering telehealth benefits may be hampered by state mandates related to provider reimbursement, networks and access, overly restrictive provider licensing, unnecessary barriers such as banning store-and-forward communications, or specific technology requirements. ERIC member companies are interested in offering telehealth to certain sectors of their workforce who currently cannot be offered these services and urge Congress to pass the "*Telehealth Benefit Expansion for Workers Act of 2023*" (H.R. 824). This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled on the employer's full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and others, by removing barriers currently presented under current law.

[1] Florida Prescription Drug Reform Act, enacted as SB 1550
[2] Oklahoma Patient's Right to Pharmacy Choice Act, enacted by HB 2632
[3] Tennessee Public Chapter 569, enacted by HB 1398
[4] New York law governing PBM practices, enacted by SB 3762
[5] New Jersey PBM oversight law, enacted by AB 536/2841
[6] 2024 advocacy efforts continue to improve state telehealth practice standards, most recently Colorado SB 141 and Washington SB 5821.
[7] Uniform Law Commission – Telehealth Act model legislation for state consideration and adoption

To address state telehealth laws that impact ERISA governed self-insured health plans differently, Congress could create a new national standard for telehealth benefits offered under an ERISA governed self-insured health plan. Such a standard should consider the following tenets (which are the key areas in which state laws currently conflict and disadvantage telehealth patients):

- **Specifically allow telehealth to establish a patient-provider relationship:** In some states, provider lobbies have passed laws that ban telehealth visits if the individual does not have a pre-existing doctor-patient relationship with the particular doctor providing telehealth. This makes it impossible to use telehealth services like the ones large employers provide, making telehealth useless for connecting individuals in areas with doctor shortages to out-of-state providers (especially important in mental health), and reduces telehealth in the state to a slight convenience (Zoom with your doctor) instead of a game-changing improvement for mental health access.

- **Apply the same standard of care to in-person visits and telehealth visits:** One of the major arguments against telehealth is that individuals will receive different or a lesser standard of care. For instance, the patient-doctor interaction will be more rushed, patients will not be offered certain treatment options, or providers will not follow the same steps or protocols for a given indication or diagnosis. By explicitly requiring that the standard of care should not vary in person or via telehealth, this argument or risk is eliminated.

- **Do not require reimbursement for telehealth visits to be at the same rate as reimbursement for in-person visits:** In general, medical providers are opposed to the federal government "price setting" in the health care system. Instead, they want to negotiate directly with payers to determine network status, in-network reimbursement rates, and out-of-network payments. However, certain provider groups have lobbied on the state and federal level to mandate that telehealth service prices NOT be negotiated, and instead be mandated by law to be equal to the same reimbursement for a given product or service delivered via in-person care. This requirement is not only a vast government overreach, but also eliminates any and all savings that can be achieved via telehealth (due to efficiencies, lower infrastructure costs, ability of providers to accommodate more patients and services, etc.). It also undermines innovative providers who are focused on maximizing their practices by focusing on telehealth.

- **Encourage interstate practice among providers:** One of the biggest advantages of telehealth for patients is access to a wider pool of providers than those who are nearby. However, this access is significantly restricted due to state licensure of medical professionals. Even when states do participate in interstate licensure compacts, they tend to erect barriers that significantly reduce the effectiveness of those compacts (such as significant fees, continuing education requirements, in-person registration requirements, and more).

A national standard for telehealth could potentially include a limited interstate license for providers practicing telehealth under the auspices of an ERISA plan. This does not allow a provider to move into another state and set up an in-person location without approval by the state medical board, rather it allows patients and providers to connect over the telephone or internet and removes barriers restricting access to needed mental health care.

- **Coordinate between the patient's telemedicine provider and primary care provider is encouraged:** The best care is coordinated care that keeps a patient's entire care team in the loop and on the same page. Some telehealth critics worry that telehealth providers, especially those affiliated with telehealth specialty services or vendors, will be less likely to coordinate with a patient's medical home or existing care team. A national standard can alleviate this concern by requiring participating providers to coordinate with a patient's existing care team, preferably via the use of an interoperable, patient-owned, unified electronic medical record that allows for collaboration and information sharing among all of a patient's providers.

- **Simply define "telehealth" and "telemedicine" and apply the terms to broadly include all types of care that use technology to connect a provider in one location and a patient in a different location:** Telehealth comes in many forms – while the most popular at this time is two-way video, some telehealth takes place via telephone, email, or "store-and-forward" technology such as sending a photo or using a patient web portal. It is likely that telehealth platforms will continually evolve based on advancing science and technology, as well as patient preferences. However, some states attempt to define telehealth narrowly, often with the effect of outlawing certain technologies such as audio-only. This serves as a major barrier to care for patients (for example, patients who lack broadband internet are highly unlikely to be able to do video conferencing). A national standard should broadly define telehealth in order to be "future proof" as the technology advances, and to ensure that rural Americans or those without smart phones are not barred from care.

- **Do not require or encourage patients to travel to specific "originating sites" to access telehealth services:** There are still several states that continue the arcane practice of requiring individuals to travel to a "designated telehealth facility" before they can connect with a telehealth provider. Medicare traditionally has similar restrictions, although they were suspended during the Public Health Emergency. If these restrictions return, individuals lose the ability to conveniently access care, which is the overarching purpose of telehealth benefits, and will have to take time off work to access care. This type of restriction critically impacts individuals most in need of telehealth services, including those who care for small children at home or for an elderly parent or loved ones with special needs. These restrictions have not kept up with the advancement of medicine or technology, which now enables individuals anywhere to connect via wireless data.

A national standard should specify that these originating site restrictions do not apply, so that individuals can use telehealth to its fullest and most convenient potential.

- **Apply the same informed consent requirements to in-person visits and telehealth visits:** Privacy and consent are taken seriously in health care settings, and should be taken equally seriously when patients and providers connect via telehealth. However, some states have attempted to apply more restrictive or burdensome privacy and consent procedures to telehealth than to in-person care. This serves only to disincentivize both providers and patients from using telehealth. Instead, a national standard should specify that providers abide by the same privacy and consent rules that apply to in-patient visits.

- **Allow prescribing via telemedicine:** A small number of states have sought to discourage the use of telehealth by banning providers who see a patient via telehealth from prescribing medication to the patient. Access to medication is an integral part of health care, and many patients would eschew telehealth if any diagnosis would then require an additional (and costly, unnecessary) in-person follow-up visit before they could be prescribed a medication. A national standard should clarify that no special limitations are placed on providers utilizing telehealth. Since they are operating under the same standard of care, they should have the same discretion to develop a care plan, and if need be, to prescribe medication to the patient.

- State All-Payer Claims Database (APCD). The U.S. Supreme Court ruled in *Gobeille* v. *Liberty Mutual* [8] that a state may not require an ERISA plan to participate in a state APCD. Congress further confirmed this in December 2020, when it passed legislation that directed the U.S. Department of Labor (DOL) to build a standardized reporting format that enables *voluntary* participation in state APCDs by ERISA plans.
  A state law or rule that attempts to mandate or coerce an ERISA plan to participate in a state APCD is preempted by ERISA.

  To date, many states have enacted APCD laws that avoid this conflict[9]. However, some states, such as Indiana[10], have continued efforts to coerce claims data from self-insured plans despite the clear conflict with the decision in *Gobeille*. As such, ERIC advocates for states to access claims data through a federal clearinghouse, ensuring employers report only to the DOL and not to any state authority. Providing a single nationwide data submission versus individual submissions for each state would reduce employers' administrative burden and plan costs.

[8] *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312 (2016)
[9] APCD Council – Overview of APCD legislation by state
[10] Indiana APCD law requiring participation by employers, enacted by SB 400

- State Health Reform Efforts. As states work to reform health coverage offered within their borders, they often seek to mandate the level of health care coverage employers must provide — a clear violation of ERISA when applied to self-insured health plans. States are primarily doing this in two ways: levying assessments on payers and including new mandates in the Affordable Care Act (ACA) Section 1332 state innovation waivers.

    - Assessment on Payers. Some states have passed legislation to impose new taxes on the self-insured health plans sponsored by large employers, and use the funds collected to pay state-based insurance exchanges or other health-related activities. These "play-or-pay" laws, such as the Seattle Hotel Health Care Ordinance[11] and San Francisco Health Care Security Ordinance[12], require employers to make minimum health care expenditures for each employee. Other states have attempted to assess a "per covered life" tax on ERISA plans, redistribute funds from ERISA plans into a state "reinsurance" pool to subsidize ACA plans, or impose taxes on ERISA plans' health care claims (thus requiring disclosure of claims data to the state tax authority). While limited, these laws directly dictate the health care expenditures of employers and threaten to undermine ERISA preemption.

    - State Innovation Waivers. Under the ACA, states may pursue a Section 1332 waiver that permits increased flexibility in a state's health care laws and regulations.[13] While the scope of 1332 waivers is likely to vary greatly, in some instances a waiver can have a significant impact on employers that operate within a given state, including those offering self-insured health coverage for their employees.[14] Importantly, activity in this space continues as states continue to explore ways to improve health care administration and depart further from uniform national standards.[15]

These mandates violate ERISA's preemption provision, and ERIC has challenged state laws in federal court.

ERIC strives to preserve and reinforce ERISA preemption and defend plan sponsors' ability to design benefits that drive value. We urge you to consider the following to strengthen ERISA preemption:

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[11] Seattle Ordinance SMC 14.28 – Improving Access to Medical Care for Hotel Employees
[12] San Francisco L.E.C. Article 21 – Health Care Security Ordinance
[13] Centers for Medicare & Medicaid Services – Overview of 1332 state innovation waivers, history, and process
[14] KFF – Overview of past and existing 1332 state innovation waivers; to date, waivers have been accepted in Alaska, Colorado, Delaware, Georgia, Hawaii, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, and Wisconsin.
[15] 1332 state innovation waiver legislation continues to be introduced and considered, including 2024 proposals: California AB 2749, Connecticut SB 210, Illinois HB 5249, Louisiana HB 701, Michigan SB 637, Missouri HB 1901, New York AB 8807, Tennessee HB 2157, Virginia HB 30, and West Virginia HB 4001.

- Request the U.S. Government Accountability Office (GAO) study and report on the consequences of state requirements that circumvent ERISA preemption standards and their financial impacts on large, self-insured employers and their employees operating in multiple states.

ERIC is committed to defending ERISA preemption – critical to the ability of large, multistate employers to provide uniform packages of benefits to their nationwide workforces. Further erosion of ERISA preemption will adversely impact labor markets, disadvantage employees based on where they live or work, cause employers to cut back on benefit coverage, and raise the cost of health benefits – ultimately pricing some employees and their families out of coverage and undermining financial health and well-being.

Furthermore, if ERISA preemption is further eroded, large employers will end up with a growing patchwork of inconsistent state and local laws, similar to the current environment of state paid leave laws, that will make it impossible for employers to design and efficiently administer consistent, uniform, and equitable benefits for all employees regardless of work location. The likely result will be an increasing interest from employers in defined benefit options, where the employer provides a limited cash benefit to employees, and the employees are responsible for purchasing their own health insurance.

Fiduciary Responsibility

Plan sponsors are required as plan fiduciaries to ensure they are good stewards of the health care benefits employers provide for their employees. To that end, ERIC continues to support congressional efforts to designate that vendors involved in critical plan design and administration decisions, including an entity providing pharmacy benefit management services, are fiduciaries within the meaning of section 3(21) of ERISA with respect to a group health plan or group health insurance coverage. In doing so, we continue to urge Congress to make such entities subject to the responsibilities, obligations, and duties imposed on fiduciaries under the law and to make the required disclosure under section 408(b)(2)(B)(iii) of ERISA.

We recommend that Congress define "pharmacy benefit management services" as meaning those services related to negotiating prescription drugs on behalf of a plan or coverage, managing the prescription drug benefits provided by a plan or coverage, including but not limited to, designing and implementing a drug formulary, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, or the provision of services related thereto.

Reporting

Electronic delivery (e-delivery) of health plan communications

Each year, employers and health plans send more than a billion sheets of paper to America's families regarding their health care benefits. Despite a strong preference for electronic delivery (e-delivery) of health plan communications, federal law prohibits employers from defaulting to safe and secure electronic communications.[16] The 2020 E-Delivery Safe Harbor for Employee Pension Benefit Plans (RIN 1210-AB90) allowed for e-delivery in employee retirement plans. Currently, under ERISA (in accordance with guidance issued by the federal agencies), health and welfare plans are required by default to print and mail communications to members.

ERIC leads a diverse working group comprised of key advocates from employers, organized labor, environmental groups, and health plans — all of whom support expanding e-delivery flexibility in ERISA health plans. As we seek to modernize the law to keep pace with new standards of safety, security, and efficiency, defaulting to e-delivery is a commonsense endeavor.

Many consumers enrolled in ERISA plans prefer, benefit from, and are highly accustomed to e-delivery. Many ERISA plan members already benefit from e-delivery within their pension benefit plans and also use e-delivery for other important items such as utility and credit card bills. E-delivery enables plans to deliver disclosures through secure portals with password protection and multi-factor authentication, as well as a rapid, reliable, and consumer-friendly benefits experience. For example, consumers could search for key terms, quickly navigate to sections of documents, click links to secure web portals with additional information and actions, and even choose their preferred language. Importantly, e-delivery includes safeguards that enable members to easily opt-in to paper at any time. Applying e-delivery to health plan documents will allow flexibility and choice for consumers.

E-delivery would also save employers and unions hundreds of millions of dollars per year in administrative costs. Per internal estimates, the default paper requirement under ERISA costs $400 million per year for health plans alone. These costs are felt most acutely by smaller self-insured plans that may not have the resources or scale to print and mail millions of sheets of paper for their members. The hundreds of millions of dollars spent annually for printing and mailing would be better spent to enhance health benefits for their workforce. In the 2020 e-delivery rule for pension benefit plans, the DOL estimated the rule would save $317 million per year, and $3.2 billion over a decade.[17] The DOL also acknowledged there could be significant savings if the safe harbor were extended to health plans.[18]

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[16] https://www.eric.org/wp-content/uploads/2022/12/Morning-Consult-E-Delivery-Survey-Results.pdf
[17] EBSA. Default Electronic Disclosure by Employee Pension Benefit Plans Under ERISA. Rule. May 27, 2020. https://www.federalregister.gov/documents/2020/05/27/2020-10951/default-electronic-disclosure-by-employee-pension-benefit-plans-under-erisa.
[18] EBSA. Default Electronic Disclosure by Employee Pension Benefit Plans Under ERISA. Proposed Rule. October 23, 2019. https://www.federalregister.gov/documents/2019/10/23/2019-22901/default-electronic-disclosure-by-employee-pension-benefit-plans-under-erisa

The DOL even acknowledged in the Final Rule that ERISA disclosures may be appropriate or preferred as individuals' access to and use of electronic media has drastically increased since 2000 and will continue so into the future.[19]

Extending greater flexibility for e-delivery in health benefit plans is a regulatory action that would benefit the backbone of the economy — American workers, employers, and labor organizations — by reducing costs for employers while reducing the climate and environmental impacts of mandatory paper health care mailings. We urge the Chair and the Committee to engage with the DOL and the Departments of Health and Human Services (HHS) and the Treasury (the Tri-Departments) to prioritize rulemaking permitting ERISA health and welfare plans to use default e-delivery.

Compensation transparency and disclosure requirements

Transparency is needed regarding PBM compensation sources. Legislation being considered would require PBMs to disclose information on prescription drug spending by the plan and its beneficiaries, including rebates, discounts, and other remuneration received by the plan. It does not, however, require PBMs to disclose any of its own revenue sources except to the extent that it would bar a source of revenue (spread pricing for example) or require that it be passed through to the plan (rebates for example). This omission could undermine the objective of full transparency by allowing PBMs to restructure their compensation arrangements to avoid the bars and pass-through requirements that Congress advances.

Employers contract PBMs to help provide high-value prescription drug benefits to over 100 million workers and their families who receive health insurance through self-insured employers.[20] Under ERISA, employer group health plan fiduciaries are required to evaluate the "reasonableness" of the compensation PBMs (and other service providers) receive that is related – directly or indirectly – to the plan before agreeing to contract with that PBM (or other service provider). These requirements cannot be achieved without access to PBM compensation information as well as notification that the PBM is acting as a consultant. Requiring full disclosure of this information by explicitly requiring PBMs and their consulting subsidiary to be subject to the compensation disclosure requirements already codified in the *Consolidated Accountability Act of 2021* (CAA) would shine a light on PBM business practices and bring needed fair market competition to a critical link in the prescription drug supply chain.

Clarification of gag clause attestation requirements

The CAA also bans gag clauses in contracts between providers and health plans from disclosing certain price and quality information. The Tri-Departments issued Frequently Asked Questions (FAQs) in August 2021 stating that they would not issue regulations addressing the prohibition on gag clauses.

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[19] EBSA. Default Electronic Disclosure by Employee Pension Benefit Plans Under ERISA. Rule. May 27, 2020. https://www.federalregister.gov/documents/2020/05/27/2020-10951/default-electronic-disclosure-by-employee-pension-benefit-plans-under-erisa.

[20] 2022 Employer Health Benefits Survey, KFF (October 27, 2022) https://www.kff.org/mental-health/report/2022-employer-health-benefits-survey/

ERIC sent a letter in January 2022 requesting further agency guidance and clarification regarding requirements banning gag clauses in contracts between providers and health plans. The Tri-Departments subsequently issued FAQs Part 57 in late February 2023, but clarification is still needed that the following gag clause techniques are prohibited:

- **Section 201 extends to contracts between providers and group health plans.** Some TPAs and insurance carriers prevent plan sponsors from accessing de-identified claims data, stating that the information is proprietary. Congress should clarify that congressional intent was for Section 202, Division BB, of the CAA (P.L. 116-260) was that claims data is the property of plan sponsors, not a proprietary product owned by vendors such as TPAs and PBMs. Further, current law is abundantly clear that deidentified claims data can be shared under *Health Insurance Portability and Accountability Act* (HIPAA) business associate agreements with third parties for plan administration and quality improvement purposes, which absolves purported privacy concerns raised by TPAs as an excuse not to share data with plan sponsors.

- **Non-disclosure agreements (NDAs) between health plans and third parties**. ERIC believes that Section 201 applies to and prohibits these "downstream gag clause" agreements, and clarification is needed on what acceptable methods can be used to ensure that plan sponsors obtain and maintain access to their own claims data, regardless of claims by third parties such as hospitals and providers, point solution companies, manufacturers, distributers, and others who may be engaged in these gag clause agreements with our insurance carriers and third party administrators.

- **Liability of entities submitting gag clause attestations on behalf of plan sponsors**. Entities such as PBMs, managed behavioral health organizations, third-party administrators (TPAs), or other service providers can attest on behalf of a self-insured group health plan or health insurance issuer. The activity must be in a written agreement and the requirement to file annually by December 31 each year. However, the plan sponsor still retains liability for the timeliness, correctness, and completeness of the disclosure. The Tri-Departments should consider a TPA or other service provider that has been delegated the authority to submit the attestation liable as well – and likewise, if a plan sponsor relies on a third party to provide confirmation that all gag clauses have been removed, that third party should share liability based on the information they present to the attesting plan sponsors.

It would also be helpful if the agencies would clarify the effective date of gag clause bans, and whether and when existing contracts would be voided or modified. ERIC strongly encourages the Chair and the Committee to make the necessary clarification in statute or, at a minimum, to request further guidance from the Tri-Departments to ensure a more complete gag clause attestation process for employers and their TPAs.

Data Sharing

Healthcare transparency and PBM reform

Transparency is integral both to reducing health care costs and improving the quality of care. Specific changes in statute, and to the current regulatory regime, could significantly strengthen transparency in the health care system, thus giving rise to better care for patients, more competition, greater value, and improved quality and safety.

Experience has shown that competition and information are critical to a functioning marketplace for any product, and health care is no exception. Employers are major innovators in health care, and transparency will accelerate our member companies' ability to improve benefits and coverage, increase affordability for patients, and drive efficiency, quality, and value in the system.

ERIC appreciates the efforts which Congress, and both the previous and current administration, have undertaken to create more transparency across differing health care industries. This includes the Hospital Transparency Rule, the Transparency in Coverage (TiC) Rule, and numerous provisions under the CAA.

ERIC is generally supportive of the *Lower Costs, More Transparency Act* (LCMT) (H.R. 5378) as a positive step forward as it: 1) codifies the hospital and health plan transparency rules and creates PBM transparency requirements; 2) implements site-neutral payment policy and honest billing requirements; and 3) includes provisions intended to foster better data sharing and accountability for PBMs and other service providers when acting on behalf of plan sponsors (namely, section IV of the LCMT bill).

However, ERIC strongly supports enactment of the *Pharmacy Benefit Manager Reform Act* (S. 1339) and the inclusion of policy to address the linking of PBM revenue to fees paid by pharmaceutical manufacturers. Ideally, the strongest package of reforms impacting ERISA group health plans would include this, plus codification of the hospital and plan transparency requirements, full application of site-neutral payment policy and honest billing requirements, and section IV of the LCMT bill.

Improvements to the TiC Rule requirements

ERIC supports codification of the TiC Rule and urges the Chair and the Committee to adopt important modifications to the rule, such as:

- Requiring the use of application programming interface (API) technology;
- Increasing the frequency of the reports;

- Aligning requirements and consolidating the new consumer-facing tools and processes employers must create; and

- Evaluating whether other lower-value transparency provisions can be streamlined to reduce unnecessary costs and administrative burdens once the Advance Explanation of Benefits (AEOB) provisions are implemented.

Beneficiaries will have access to similar information, in a customized, personalized manner, via the tools required under the TiC Rule. However, the cost tools do not incorporate critical information obtained from providers through the good faith estimates required under Section 112 of the CAA as the AEOBs are required to contain. These estimates, once operationalized, hold the promise of providing consumers with close to exact pricing for scheduled services offering more predictability prior to services than when a member uses a cost tool to search for generalized cost estimates. As such, Congress should consider directing the agencies to streamline and combine all of the mandatory consumer-facing transparency tools and processes (including AEOB) into one single, unified tool for plan beneficiaries to use.

While we strongly support the transparency provisions of the CAA, certain aspects of the law and its implementing regulations add layers of red tape and unnecessary costs that will ultimately be paid by beneficiaries, in the form of higher health insurance premiums. For instance, the CAA takes steps in the wrong direction, requiring the provision of paper and snail mail communications, and the use of call centers, rather than newer electronic delivery technologies. We urge the Chair and the Committee to consider requesting the Tri-Departments issue data standardization requirements for the TiC Rule and the Hospital Transparency Rule so there is less administrative burden compiling, sharing, and understanding the data.

All Payers Claims Databases (APCDs)

The CAA also required the DOL to develop a common reporting framework for self-insured employers to voluntarily share data with state APCDs. While we applaud the effort the DOL has undertaken, self-insured employers are unlikely to go through the trouble and costs of reporting to the various state databases. Instead, we renew our call for creation of a federal APCD, which could then share self-insured employer plan data with state APCDs. This would increase price transparency, and greatly improve the ability of state authorities to promote value and control costs in state health care programs – and do so without damaging ERISA preemption or national uniformity.

Cybersecurity

Health data privacy is of utmost importance in today's digital age where wide access to information comes with heightened vulnerability to breaches, including of sensitive medical data. With the digitization of medical records and the proliferation of health tech devices, health data has become increasingly attractive to hackers. Health records and individuals' protected health information (PHI) are considered valuable assets in the underground economy.

They contain a wealth of information such as names, addresses, Social Security numbers, birth dates, demographics, financial information, and medical histories. This data can be used for identity theft, insurance fraud, or even to commit targeted attacks.

In the face of these risks, ERIC member companies favor efforts to protect health data privacy. Plan sponsors are eager to protect the data of participants from threats. As such, they think carefully about their current cybersecurity practices, contracts with service providers, and how best to improve their protocols.

There are multiple frameworks and standards that health plan sponsors and ERISA fiduciaries already comply with and use to protect sensitive plan and participant data. These include but are not limited to HIPAA, ERISA, the *Genetic Information Nondiscrimination Act of 2008* (GINA), and the *Health Information Technology for Economic and Clinical Health Act* (HITECH) *of 2009*.

The introduction of new or broadened requirements under ERISA would be redundant and would contribute to further complexity and administrative costs. Self-insured employers take an active role in contracting with major health plan carriers and are increasingly active in ensuring that their workers' health information is protected.

To that end, ERIC recommends that the Committee consider taking the following approach to bolster cybersecurity:

- Enable the health care industry to adopt cybersecurity best practices in real-time and to disseminate established best practices from existing methods and established research. ERIC recommends that any requirement applicable to the health care industry whether set by statute or the DOL, should make use of the existing cybersecurity guidelines and resources, such as those crafted by the National Institute of Standards and Technology (NIST) (or similar widely recognized standards) and the Department of Homeland Security (DHS). This approach is preferable to generating new, potentially inconsistent sources of requirements for plan sponsors and fiduciaries, which are likely to quickly become out of date.

- Foster cooperation among federal agencies such as the DOL, HHS, and DHS, to consolidate cybersecurity directives, obligations, and optimal strategies. Utilizing HHS as the suitable authority for monitoring the critical infrastructure system of health care will relieve redundant reporting mandates and certify that the health care industry can effectively recognize and alleviate system vulnerabilities impacting patient confidentiality and safety. In addition, the stringent security norms of HIPAA are rigorously enforced by the Office for Civil Rights (OCR). Any violation of data security due to a cyberattack requires notifying HHS, the affected parties, and media outlets.

Ultimately, ERIC recommends that Congress rely on the health care and technology industries to continue to evolve and update best practices in real-time, rather than setting an overly-prescriptive government standard.

Additionally, deference should be given to federal agencies of jurisdiction, for example, maintaining the existing regulatory authority by HHS for the health care sector. Government-recommended practices are not just a guide for employers and plans, but for hackers too. Having a set standard will give hackers the upper hand in knowing what strategy to take in getting their desired result. It is ERIC's understanding that while security standards and best practices are constantly evolving, so too are the tactics and strategies used by hackers – which necessitates a nimble approach that is neutral as to the exact tactics used, but instead focuses on having a robust process and keeping up with new developments.

Conclusion

Thank you for the opportunity to share our views. ERIC and our member companies are committed to working with you to improve employee benefits and make health care more affordable for workers, their families, and retirees. We look forward to working with you to further help in policy development.