601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004
T 202.778.3200
F 202.331.7487
ahip.org

February 27, 2024

The Honorable Joseline A. Pena-Melnyk
Chair, House Health and Government Operations Committee
241 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Re: AHIP Opposes House Bill 726 in relation to ERISA

Dear Chair Pena-Melnyk:

I write today on behalf of AHIP to respectfully oppose HB 726, legislation regulating pharmacy benefits managers (PBM). Our concern focuses on the bill's extension to ERISA policies. This legislation will jeopardize the single, cost-saving standard your state's self-insured employers rely upon to provide uniform and affordable health insurance coverage to Marylanders.

Health insurance should be simple, effective, and affordable. Patients and employers should not have to navigate complex regulations to get the care they need at a cost they can afford. AHIP supports a single, cost-saving national standard of regulation for self-funded employer-provided coverage, ensuring more affordable coverage for all, that is easier to understand. A 50-state patchwork of complicated and inconsistent mandates for employer-provided coverage will cause more confusion and make coverage more expensive for Maryland's employers and employees.

HB 726 will increase health care costs by subjecting Maryland's self-insured employers to new state requirements. Self-funded employer-provided health plans are currently regulated by the Employee Retirement Income Security Act (ERISA), which sets standards and creates uniformity for employers managing benefits across multiple state lines under its preemption provision. HB 726 changes the term "purchaser", which under current law acts to exclude self-funded ERISA plans from being subjected to state laws. This definitional change will subject Maryland self-insured employers to new state pharmacy coverage requirements.

ERISA's preemption provision was recently upheld in the Supreme Court case *Rutledge v. PCMA* and in the Tenth Circuit case *PCMA v. Mulready*. These cases affirmed the long-standing precedent that state laws are preempted by ERISA when they impact a core function of health plan administration or directly relate to the health plan. The *Rutledge* Court clarified a very narrow set of activities that states could regulate; it did not create a new category of permissive state regulation, which HB 726 attempts to accomplish.

- We have attached **an analysis from ERISA experts at The Groom Law Group that outlines which HB 726 (as introduced) provisions exceed the scope of the *Rutledge v. PCMA* and *PCMA v. Mulready* decisions** and thus should be preempted.

Thank you for your consideration of AHIP's concern and opposition to HB 726. We stand ready to partner together in making health care more affordable and accessible for the citizens of Maryland.

Sincerely,

Keith Lake
Regional Director, State Affairs
klake@ahip.org / 220-212-8008

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

ERISA Preemption of MD HB 726/SB 626

ERISA expressly preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g.*, *Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). In *Egelhoff*, the Supreme Court reiterates the longstanding rule that a state law "relates to" an ERISA plan if it has a connection with or reference to such a plan. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (internal quotations and citations omitted).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id*. at 320.

In *Rutledge*, the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law that regulates the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that the state law was not preempted by ERISA because it merely regulated costs rather than dictate ERISA-plan choices. *See id.* at 81. Instead, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille* at 320.

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *PMCA. v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central

matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1]

With respect to Maryland HB 726/SB 626, the legislation seeks to impose certain of the state's insurance laws governing PBMs on pharmacy benefit management services provided to ERISA-covered, self-insured group health plans. HB 726 and SB 626 accomplish this by eliminating current law limitations on the applicability of state PBM requirements to "carriers". Despite the contentions of the legislators, if this statutory change is adopted a number of these provisions should be preempted by ERISA based on existing Supreme Court jurisprudence, including *Rutledge*. In the following chart, we identify the specific bill provision, provide a description of the provision, and include the basis for federal law preemption.

Provision	***Description***	***Reason for Federal Law Preemption***
Md. Code Ann., Ins. § 15-1611.1	Prohibits PBMs from requiring the use of pharmacies affiliated with the PBM.	This provision limits the ability of ERISA-covered plans to determine the scope of their pharmacy networks, which is inherent in the plan's benefit design. Thus, the provision should be preempted because it requires a specific benefit design choice by the plan sponsor consistent with the holding in *Mulready*.
Md. Code Ann., Ins. § 15-1612(b)	Prohibits a PBM from reimbursing a non-affiliated pharmacy less than the PBM reimburses affiliated pharmacies.	This provision limits the ability of ERISA-covered plans to contract for high-value pharmacy networks, which is inherent in the plan's benefit design. Thus, the provision should be preempted because it requires a specific benefit design choice by the plan sponsor consistent with the holding in *Mulready*.
Md. Code Ann., Ins. § 15-1613	Imposes requirements on P&T Committees operated by PBMs with respect to all business.	This provision imposes restrictions on the composition of P&T Committees with respect to, among other things, ERISA-covered, self-insured group health plans. P&T Committees

[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id*. at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id*. at 1195

		determine formulary design which is a core component of plan design and thus should be preempted under the same analysis adopted by the court in *Mulready*.
Md. Code Ann., Ins. § 15-1629	Proscribes the manner in which PBMs may audit pharmacies and recover overpayments.	This provision could impose acute *and* direct economic burden on plans because it limits recovery of plan assets. Moreover, it could directly conflict with ERISA's fiduciary duty to act solely in the interest of the plan. As a result, the provision should be preempted.