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The Honorable Ken Paxton
Attorney General of Texas
P.O. Box 12548
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Re: Request No. 0539-KP

Dear General Paxton, Mr. Kinghorn, and Members of the Opinions Committee:

On behalf of the members of the Texas Civil Justice League (TCJL), thank you for the opportunity to provide comments on Request No. 0539-KP.

Background and Interest

TCJL is a § 501(c)(6) organization established in 1986 for the purpose of representing Texas employers from all sectors of the economy, health care providers, and trade, industry, and professional associations in efforts to reform the civil justice system and make the Texas business climate the best in the nation. Largely by virtue of enlightened public policy-making by the Texas Legislature, the leadership of our statewide elected officeholders, and the wisdom of the Texas Supreme Court, the Texas economy has been set on a path of spectacular growth and opporunity that has drawn businesses and their employees from all over the world. We appreciate the critical role the Office of the Attorney General has played in helping to protect economic liberty, eliminate unnecessary regulation, and allow Texas businesses to *do business* without undue government interference.

That is why we have serious concerns about this opinion request and its potentially adverse implications for Texas businesses. The request queries whether the provisions of Chapter 1369, Texas Insurance Code, are enforceable against self-funded, employer-sponsored employee benefit plans governed by the Employer Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.). As you may recall, during the 88th Regular Session the Legislature considered proposals (HB 2021/SB 1137) that purportedly would have subjected ERISA plans to Chapter 1369. In the face of united opposition from the Texas business community, neither of these proposals advanced from committee, indicating in our view a legislative determination, at least for the time being, that Chapter 1369 violates ERISA pre-emption in important respects (which we will examine in detail below).

In this regard, it is important to be clear that piercing ERISA pre-emption, as these bills sought to do, harms *Texas employers*, not pharmacy benefit managers or third-party ERISA plan administrators. Employer-sponsored health insurance covers nearly 50% of US workers (approximately 80 million) and their dependents, and self-funded plans provide nearly two-thirds of that coverage (approximately 53 million). Elizabeth McCuskey, "State Cost-Control Reforms and ERISA Preemption," Commonwealth Fund, May 16, 2022, [https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption; last accessed December 14, 2022]. TCJL members, which include hundreds of businesses that operate nationally, rely on ERISA pre-emption to offer cost-effective, uniform coverage to hundreds of thousands of their employees and dependents. It is not an exaggeration to state that in the absence of ERISA pre-emption, many Texas employers would be forced to curtail employee health care coverage because of the prohibitive costs of state-specific mandates and compliance costs. This is exactly what ERISA pre-emption was designed to avoid, and we are grateful to the Legislature for preserving it last session.

A Review of HB 2021 and SB 1137

As discussed above, legislation introduced last session would have required a pharmacy benefit manager (PBM) contracted to administer a self-funded, employer-sponsored employee benefit plan governed by ERISA to comply with certain state statutes and regulations. The legislation, as similar legislation in other states has done, set up a potential clash over whether it crossed the line into federal preemption territory.

HB 2021/SB 1137 added a new section to Subchapter D, Chapter 4151, Insurance Code, which requires pharmacy benefit managers to issue identification cards to enrollees and prohibits them from selling a list of patients that contains information through which the identity of an individual patient is disclosed. That subchapter further requires a PBM to maintain the confidentiality of patient information unless disclosure is authorized by law or by the patient. The proposed new subsection, § 4151.155, stated that a PBM "must comply with the provisions of Chapter 1369 with respect to each plan administered by the [PBM], *regardless of whether a provision of that chapter is specifically made applicable to the plan*" (italics added). The italicized language referred to ERISA plans that contract with PBMs for third-party administration of prescription drug benefits. The bill went on to exempt a PBM from complying with a provision of Chapter 1369 "(1) with respect to a plan expressly excluded from the applicability of the provision; or (2) to the extent that the commissioner [of insurance] determines that the nature of third-party administrators renders the provision inapplicable to [PBMs]."

Chapter 1369, Insurance Code, broadly regulates a health benefit plan's coverage of prescription drugs, devices, and related services. It applies to a health benefit plan that "provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness," which includes individual and group policies. § 1369.002. The following section lists the types of health benefit plans *not* subject to Chapter 1369, but this list does not specifically exempt ERISA plans. We presumed that, unless ERISA plans are exempted elsewhere in Chapter 1369, HB 2021,SB 1137 purported to bring those plans under the general regulatory umbrella that

applies to other employee health benefit plans provided by insurance carriers and other licensed issuers.

Recent Federal Court Rulings Pertinent to Chapter 1369 and Pre-emption

Had HB 2021/SB 1137 been enacted and signed into law, the question became which provisions of Chapter 1369, if applied to an ERISA plan, raise a preemption concern. The only part of Chapter 1369 that explicitly *excludes* "a self-funded health benefit plan as defined by [ERISA]" is Subchapter F, which regulates the manner in which a PBM may audit a pharmacy or pharmacist. As noted above, the rest of the chapter would presumably have applied to an ERISA plan by virtue of HB 2021/SB 1137 unless pre-empted. The proposed Texas legislation occurred in the context of recent federal court decisions that address ERISA preemption of state regulations of PBMs. HB 2021 undoubtedly stemmed from these decisions at least in part, so it is important that we look closely at them in attempt to distinguish which provisions of Chapter 1369 might pass muster and which won't.

The leading case is *Rutledge v. Pharmaceutical Care Management Association*, 141 S.Ct. 474 (2020), which arose from a 2015 Arkansas statute that required pharmacy benefit managers (PBMs) to reimburse pharmacies at or above the pharmacies' cost to obtain a covered drug from a wholesaler. This law required PBMs to update their lists specifying the maximum allowable cost (MAC) for each drug each time the wholesale price changed, established an appeals process for pharmacies challenging the amount of reimbursement, and increased the reimbursement rate if a pharmacy could not obtain the drug at a lower price than the MAC list specified from its customary wholesaler. If a pharmacy could not get reimbursement from a PBM at the price of acquisition or above, the pharmacy could decline to sell the drug to a beneficiary of the plan. SCOTUS upheld the Arkansas statute over an ERISA pre-emption challenge brought by the Pharmaceutical Care Management Association (PCMA) on the basis that the statute merely established a floor for the *cost* of benefits that a plan may choose to provide, which may indirectly increase the cost of pharmacy benefits but does nothing to interfere with plan design or administration. The Court thus drew a clear line between legislation that deals with contracts between PBMs and in-network pharmacies and legislation that crosses the line into direct regulation of plan benefits or how the employer chooses to structure those benefits.

In the most recent federal decision following *Rutledge*, which came down on August 15, 2023, the U.S. 10th Circuit Court of Appeals, considering similar legislation enacted by the Oklahoma Legislature in 2019, found that Oklahoma statute violated ERISA pre-emption
In *Pharmaceutical Care Management Association v. Glen Mulready, in his official capacity as Insurance Commissioner of Oklahoma; Oklahoma Insurance Department* (No. 22-6074; filed August 15, 2023), the 10th Circuit reviewed an Oklahoma federal district court decision holding that certain requirements of the "Oklahoma's Patient's Right to Pharmacy Choice Act," Okla. Stat. tit. 36, § 6958 *et seq.*, escaped ERISA pre-emption. Among other things, the statute regulated the relationship between a PBM and its network pharmacists, prohibited a PBM from restricting an individual's choice of an in-network pharmacy, barred a PBM from requiring an individual to use an affiliated pharmacy, and required a PBM to meet certain access standards. The district court held that none of these changes had a "connection with" an ERISA plan because they did not "interfere with plan design or administration." Rather, the provisions "may

alter the incentives and limit some of the options that an ERISA plan can use, [but] none of the provisions force[d] ERISA plans to make any specific choices." PCMA appealed the court's decision to the 10th Circuit Court of Appeals. Several states, including Texas, joined in an *amicus curiae* brief defending the Oklahoma statute. The United States filed an *amicus* brief taking the position that ERISA pre-emption applied.

In an opinion by Judge Gregory A. Phillips, joined by Senior Judge Michael R. Murphy and Judge Veronica S. Rossman, the court reversed the district court. Under 29 U.S.C. § 1144(a), ERISA pre-empts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." A state law "relates" to an ERISA plan if it has "(1) a 'connection with' or (2) a 'reference to' an ERISA plan" (citing *Rutledge*). As SCOTUS likewise reminded everyone in *Rutledge*, "two categories of state laws [] have this impermissible connection with ERISA plans: 'laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan administrators to specific rules for determining beneficiary status,' and laws whose 'acute, albeit indirect, economic effects . . . force an ERISA plan to adopt a certain scheme of substantive coverage." 141 S. Ct. at 480. In other words, the question is whether the state law "govern[s] a central matter of administration or interfere[s] with a nationally uniform plan administration"?

Noting that PCMA made only the "connection with" argument (the Oklahoma law, like HB 2021, assiduously avoided a direct "reference" to ERISA plans), the court first turned to Oklahoma's argument that ERISA did not pre-empt the statute "because it regulates PBMs, not health plans." In other words, the state asserted, since "PBMs are not plans, nor fiduciaries to plans" and such "plans need not contract with PBMs," ERISA did not apply. This argument did not persuade the court. First, nothing in ERISA jurisprudence says that a state law has to expressly attack ERISA plans in order to invoke pre-emption. Rather, the inquiry goes to "the nature of the effect of the state law on ERISA plans" (citing *Cal. Div. of Lab. Standards Enf't v. Dillngham Constr., N.A.*, 519 U.S. 316, 325 (1997)), whether it "nominally" regulates them or not. Second, SCOTUS has explicitly held that "state laws can relate to ERISA plans even if they regulate only third parties." In illustration, the 10th Circuit summarized two SCOTUS decisions, *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a state law requiring insurers to provide mental health benefits was subject to ERISA) and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding that a state law regulating HMOs was subject to ERISA). Third, the court had no trouble finding that the logic of these decisions squarely applies to PBMs. Observing that PBMs administer pharmacy benefits for about 270 million Americans and that, at the admission of Oklahoma's pharmacist expert, pharmacies commonly rely on PBMs for up to 95% of their business, the court concluded that "[b]ecause a plan's choice between self-administering its benefits and using a PBM 'is in reality no choice at all,' regulating PBMs 'function[s] as a regulation of an ERISA plan itself'" (citations omitted).

The question then became whether the Oklahoma statute "preclude[d] the ability of plan administrators to administer their plans in a uniform fashion." Specifically, the court examined the law's "network restrictions," which include access standards, discount prohibition, and any willing provider provisions, and its "integrity and quality restriction," that is a probation provision. Briefly, the access standards required a PBM to construct its pharmacy network so that most enrollees reside within a certain number of miles of a preferred pharmacy, based on

whether they live in urban, suburban, or rural areas. They also barred a PBM from using mail-order pharmacies to meet the standards. The discount prohibition blocked a PBM from offering cost-sharing discounts, such as reduced copayments, to incent enrollees to use in-network pharmacies. The any willing provider provision required a PBM to accept any pharmacy into its preferred provider network if it agreed to network terms. Finally, the probation provision blocked a PBM from denying, limiting, or terminating a pharmacy's contract because one of its pharmacists is on probation with the State Board of Pharmacy.

The court determined that ERISA pre-empted each of these provisions because each goes directly to benefit design, a "central matter of plan administration." Regarding the network restrictions, the court looked to decisions from the 5th and 6th Circuits that rejected any willing provider laws on the basis that "ERISA plans that choose to offer coverage by PPOs are limited by the statute to using PPOs of a certain structure—i.e., a structure that includes every willing provider" (citing *CIGNA Healthplan of La., Inc. v. Louisiana ex rel. Ieyoub*, 82 F.3d 642 (5th Circ. 1996). In other words, the court observed, "the law *prohibited* ERISA plans from choosing a PPO that did not include all willing providers." In response to Louisiana's argument that its law did not mandate PBMs to use PPOs, the 5th Circuit replied that "Louisiana's law ensured that ERISA plans that chose to use a PPO had to 'purchase benefits of a particular structure,' so it was pre-empted." Oklahoma's network restrictions similarly foreclosed an employer's option to "choose a PPO that did not include all willing providers." As the 10th Circuit opinion puts it, "the network restrictions mandate benefit structures; they at least 'eliminate[] the choice of one method of structuring benefits."

Specifically, the court ruled, the Oklahoma law's access standards, any willing provider provisions, and discount prohibitions work together to "either direct[] or forbid[] an element of the plan structure or benefit design," i.e., the scope of the pharmacy network and differential cost-sharing for the benefit of enrollees (even the State of Oklahoma was forced to admit this). The court looked at the implications of the case from a broader perspective as well. "Consider how the network provisions change the landscape for PBM networks in Oklahoma," the court posed. "Before the Act, PBMs could use mail-order pharmacies to serve rural Oklahomans and reduce plan costs. Now, to comply with the Access Standards, PBMs working for Oklahoma plans with rural-dwelling employees must include many more brick-and-mortar pharmacies. Because adding pharmacies costs plans money, this is a choice that plans might not otherwise make." The court made a similar point regarding the any willing provider provisions, which it observed would functionally collapse a two-tiered system designed to save employers and enrollees money to a one-tiered system that would cost everybody more money. In the words of the court, "[e]ach network restriction winnows the PBM-network design options for ERISA plans, thereby hindering those plans from structuring their benefits as they choose." The court likewise determined that the probation provision was pre-empted because it requires a plan to accept *all* pharmacists into its network, even those subject to state discipline. When coupled with the any willing provider provision, the probation provision dictated which pharmacies must be included in the network, just like the network restrictions.

The court easily distinguished the *Rutledge* decision. "Unlike Arkansas's reimbursement-rate regulations," the court wrote, "Oklahoma's network restrictions do more than increase costs. They home in on PBM pharmacy networks—the structures through which plan beneficiaries

access their drug benefits. And they impede PBMs from offering plans some of the most fundamental network designs, such as preferred pharmacies, mail-order pharmacies, and specialty pharmacies." The court dismissed out-of-hand various arguments advanced by the State of Oklahoma, to wit: the network restrictions are "narrower than they seem"; the restrictions also apply to non-ERISA plans; since ERISA doesn't contain network restrictions, the state can impose them; the restrictions do not require plans to provide any particular benefits (it just took away those benefits).

Does ERISA Pre-empt §§ 1369.551-555 and 1369.601-610?

With this broader context in mind, we may turn to the specific provisions of Chapter 1369 that are the subject of the opinion request.

- Subchapter L blocks a plan issuer or PBM from transferring to or receiving from the issuer's or PBM's affiliated provider a record containing patient- or prescriber-identifiable information for a commercial purpose (§ 1369.553) or steering or directing a patient to use an affiliated provider through online messaging regarding the provider or other advertising, marketing, or promotion of the provider (§ 1369.554). Finally, an issuer or PBM may not require a patient to use an affiliated provider to receive the maximum benefit or reduced cost-sharing, nor to solicit a patient or prescriber to transfer a patient's prescription to an affiliated provider (§ 1369.555).

- Subchapter M (§§ 1369.601-610): prohibits an issuer or PBM reducing the amount of a claim payment to a pharmacist or pharmacy after adjudication of the claim through the use of an aggregated effective rate, quality assurance program, or other direct or indirect remuneration fee except in accordance with an audit pursuant to Subchapter F (§ 1369.603). It further bars a PBM from paying an affiliated pharmacist or pharmacy a reimbursement amount that is more than the amount the PBM pays a nonaffiliated pharmacist or pharmacy for the same service (§ 1369.604); prohibits an issuer or PBM from, as a condition of a contract, barring a pharmacy or pharmacist from sending an enrollee's drugs by mail under certain circumstances (§ 1369.607), prohibits an issuer or PBM from requiring a pharmacy or pharmacist to meet accreditation or recertification standards more stringent than or inconsistent with federal and state requirements or blocking the dispensing of drugs that may be dispensed under the pharmacy's or pharmacist's license (§ 1369.608), and prohibits retaliation against a pharmacy or pharmacist (§ 1369.609).

Subchapter L, §§ 1369.554 and 1369.555, and Subchapter M raise many of the same issues that derailed the Oklahoma statute and are almost certainly pre-empted. By eliminating cost-sharing discounts and other incentives to use affiliated providers (or even communicating with enrollees about it, as §§ 1369.554 and 1369.555 prohibit), restricting the use of mail-order pharmacies, effectively establishing a single-tier network, and requiring plans to accept pharmacists even if they are subject to state discipline, Subchapter M would force employers into (more expensive) plan choices that they would otherwise have made. (There is a further problem in § 1369.603, which blocks a PBM or issuer from reducing the amount of reimbursement after adjudication of a claim unless the reduction is made pursuant to an audit under Subchapter F. Subchapter F,

however, exempts ERISA plans because the statutory audit process clearly infringes directly on plan administration, and the Legislature knew it when it enacted that statute. The opinion request thus asks about enforcement of a statute against ERISA plans that explicitly exempts ERISA plans.)

We are certainly aware and appreciative of the fact that until a federal court of last resort tells us that a statute violates ERISA pre-emption, we can never be sure and can only make an informed analysis based on applicable federal precedent. In any event, if the Texas Department of Insurance changes its policy and begins to enforce Chapter 1369 against ERISA plan, litigation will ensue, as it has in all other states that have gone down that road. A better course, perhaps, would be to wait out the Tenth Circuit decision in *Mulready*. If it holds up, the network restrictions in Subchapters L and M must fall. If it doesn't, we have another conversation that will in all likelihood require legislative intervention. In either case, preserving the *status quo* for the moment would seem the best option.

Employer choice is the quintessence of ERISA, which, after all, is designed to permit employers the most cost-effective benefit packages for their employees. Restricting those choices and running up the cost of ERISA plans undermines the whole purpose of ERISA. In any discussion of the policy choices facing lawmakers over the various industry issues involving health care providers and health insurers, the fundamental question must be asked: how does a specific regulatory requirement affect employer choice? How it may affect the provider or insurer is a secondary concern, if ERISA is to accomplish its purpose of allowing employers to offer uniform health plans to their employees, not just in Texas, but all over the country.

Respectfully submitted,

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