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June 17, 2024

The Honorable Ken Paxton, Attorney General
Office of the Attorney General
Attention: Opinion Committee
P.O. Box 12548
Austin, Texas 78711-2548
Via email: opinion.committee@oag.texas.gov

Re: OAG Request RQ-0539-KP

Dear Attorney General Paxton:

The Texas Association of Business ("TAB") respectfully submits this letter brief to assist your office in responding to Texas Senate President Pro Tempore Charles Schwertner's request for a legal opinion regarding the enforceability of two statutes against certain health benefit plans. Specifically, Senator Schwertner has asked your office to opine on whether House Bill ("HB") 1763 and HB 1919 (the "Laws") can be enforced against (1) an ERISA health benefit plan (and/or a pharmacy benefit manager ("PBM") administering the pharmacy benefits of an ERISA health benefit plan); and (2) an out-of-state health benefit plan that provides coverage to Texas residents and uses a PBM to contract directly with Texas-based providers.

Respectfully, the answer to both of Senator Schwertner's questions is "no." Objective analysis of the statutory language and legislative history reflects that the Laws cannot be fairly read to apply to out-of-state plans or plans organized under the Employee Retirement Income Security Act of 1974 ("ERISA"). Furthermore, any direct or indirect application (via PBMs or other third-party administrators ("TPAs")) to ERISA plans would violate the federal statute's preemption provision, which prohibits state laws that have a "connection with" employee benefit plans, including laws that require plans to "structure benefit plans in particular ways." *PCMA v. Rutledge*, 141 S. Ct. 474, 481 (2020). In addition, Texas laws cannot apply to an out-of-state insurance company that issues a group policy to a non-Texas employer where the contract is entered into in another state, *Butler v. Mutual Life Assurance Co.*, 600 F. 2d 532, 534 (5th Cir. 1979), and the Commissioner of Insurance previously recognized this limitation on the scope of Texas laws vis-à-vis out-of-state insurance plans. *BlueCross BlueShield of Tenn.*, SOAH Docket No. 454-07-1184.H, No. 09-0569 (Comm'r of Ins. of Tex. Jul 16, 2009) (official order).

Therefore, TAB respectfully requests that any legal opinion state that the scope of HB 1763 and HB 1919 cannot be extended to allow agency enforcement against ERISA plans or to out-of-state plans. Not only would such an extension be illegal, but it would gravely damage the interests of employers who furnish coverage for Texas residents. Businesses and other health plan sponsors would see increased costs and burdens and reduced flexibility and many of the

attendant costs would be passed-through to worker beneficiaries. Such a result would undermine Texas' reputation as the preeminent jurisdiction for business and harm the state's ability to foster economic growth and development.

HB 1763 and HB 1919

HB 1763 and HB 1919 (the "Laws") regulate health benefit plans and the PBMs that administer pharmacy benefits for those plans. The Laws, which were passed in the 2021 legislative session and became effective on September 1, 2021, impose significant restrictions on the ability of plans to design and administer benefits in accordance with their fiduciary duties. Each amends the Texas Insurance Code, Chapter 1369, titled "Benefits Related to Prescription Drugs and Devices and Related Services," by adding a new Subchapter L.[1]

HB1763 imposes numerous restrictions on health benefit plans and PBMs serving those plans, including Section 1369.608, which prohibits plans and PBMs from requiring accreditation from specialty pharmacies, and intrudes upon health benefit plan-pharmacy contracts.

HB 1919 imposes three restrictions on health benefit plans and PBMs relative to "affiliated providers," which are defined as "pharmac[ies] or durable medical equipment provider[s] that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a health benefit plan issuer or pharmacy benefit manager."

First, Section 1369.553 prohibits PBMs and health benefit plan issuers from transferring to or receiving from an affiliated provider any record containing patient- or prescriber-identifiable prescription information "for a commercial purpose." A "commercial purpose" is defined only by exclusion – it "does not include pharmacy reimbursement, formulary compliance, pharmaceutical care, utilization review by a health care provider, or a public health activity authorized by law."

Second, Section 1369.554 prohibits PBMs and health benefit plan issuers from steering or directing a patient to use an affiliated provider through any oral or written communication. This prohibition includes online messaging and patient (or prospective patient) marketing for the affiliated provider. The provision does not prohibit the plan or PBM from including the affiliated provider in communications if (1) the communication regards information about the cost or service provided by network providers; and (2) the communication includes "accurate comparable information" regarding non-affiliated providers in the network.

[1] Confusingly, both laws add different titles for Subchapter L. HB1919 is titled "Affiliated Providers" and HB1763 is titled "Contracts with Pharmacists and Pharmacies." Portions of HB1763 were redesignated as Subchapter M, also titled "Contracts with Pharmacists and Pharmacies." Additionally, HB 1919 makes no reference to self-funded ERISA plans. Whereas HB 1763 refers to a "self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code." In this context, neither the facts nor law allow a "professional employer organization" to encompass a self-funded ERISA plan within its definition.

Third, Section 1369.555(a) prohibits PBMs and health benefit plans from requiring patients to use affiliated providers "in order for the patient to receive the maximum benefit for the service under the patient's health benefit plan." Section 1369.555(b) provides that PBMs and health benefit plans may not provide reduced cost-sharing to patients using affiliated providers. Sections 13669.555(c) and (d) provide that PBMs and health benefit plans may not solicit a patient or prescriber to transfer a patient prescription to an affiliated provider and may not require an unaffiliated provider to transfer a prescription to an affiliated provider without the prior written consent of the patient.

The Statutes Cannot be Fairly Read to Apply to ERISA or Out-of-State Health Benefit Plans

The plain language and legislative history of both statutes demonstrate that they apply neither to self-funded ERISA plans nor to plans domiciled out of state.

As an initial matter, and as set forth in more detail below, *no* part of the Texas Insurance Code applies to out-of-state plans. Rather, the entirety of the Code applies only to "the business of insurance in this state." Tex. Ins. Code. Ann. S. 31.002. Therefore, there is no basis to apply either statute to health benefit plans domiciled outside of Texas.

The statutes are also not facially applicable to self-funded ERISA plans. Each statute includes provisions applicable to a "health benefit plan," "health benefit plan issuer," and "pharmacy benefit manager." "Health benefit plan" is defined by reference to Section 1369.251, "pharmacy benefit manager" is defined by reference to Section 4151.151, and "health benefit plan issuer" is not defined. Neither the definition of "health benefit plan" nor the definition of "pharmacy benefit manager" make any reference whatsoever to self-funded ERISA plans. The definition of health benefit plan is "a plan that provides benefits for medical, surgical, or other treatment expenses incurred as a result of a health condition, mental health condition, an accident, sickness or substance abuse." Although that language seems broad, the nine enumerated examples include nearly every sort of plan sponsor or issuer *except* employers self-funding their benefits. Section 1369.251 (3). From there, the state expressly excluded numerous types of plans, including those offered by the state Medicaid program. Section 1369.552. Given the statute's extensive identification of those plans that fall within its definition, and the fact that self-funded plans are mentioned nowhere, it is evident that the statute was not intended to apply to self-funded ERISA plans.

This conclusion is bolstered by Senator Schwertner's recent unsuccessful attempts at enacting legislation to extend application of HB1919 and HB1763 to self-funded ERISA plans or plans based outside of Texas. In 2023, Senator Schwertner introduced a bill, Senate Bill ("SB") 1137, that sought to expand the scope of the entirety of Chapter 1369. He testified regarding SB1137 before the Senate Committee on Health & Human Services on April 26, 2023. In his brief opening remarks, Senator Schwertner acknowledged that neither Chapter 1369 as a whole nor the 2021 statutes applied to self-funded employer plans, explaining to the Committee that "self-funded health plans and their PBMs as defined by ERISA have been historically exempt

from state regulation.[2]" He advocated for a bill to reverse that historical precedent with respect to the two laws that he sponsored which, according to Senator Schwertner, are only "currently applicable to commercial plans." *Id.* He also noted that SB1137 would expand applicability to out-of-state plans, confirming that the existing law did not apply to those plans. *Id.*

Neither SB1137 nor HB2021 (its companion bill) came out of committee – in large part due to the significant negative financial consequences of expansion. Indeed, when the legislature considered the application of the 2021 bills to only one state-sponsored employee benefit plan, the Teacher Retirement System ("TRS"), a fiscal note indicated that the financial consequences would be dire.[3] In 2023, the TRS indicated that "the bill would restrict the agency's ability to make changes that are intended to mitigate rapid cost inflation," and that "additional costs may result in the need for additional contributions from the State, employers, or members to the TRS-CARE and TRS-ActiveCare programs." \[4] The Senate Committee for Health & Human Services also proposed a substitute, CS2021, that would limit the expanded applicability only to the provisions of HB1919 and HB1763. That, too, did not pass out of committee.

Given the clearly defined scope of the Texas Insurance Code, the plain language of Chapter 1369, and Senator Schwertner's own characterization of the law's applicability, it is evident that HB1763 and HB1919, as engrossed in Chapter 1369, do not apply to health benefit plans that are domiciled outside of Texas, or to self-funded ERISA plans. This office should reject Senator Schwertner's efforts to accomplish through legal opinion what he failed to do legislatively. As described below, extension of the statutes to the ERISA market and out-of-state plans, would not only be illegal, but would catastrophically impact Texas businesses, and their employees, and mar the state's business-friendly reputation. If the Texas legislature intended to affect such a momentous outcome then it would have spoken clearly through its laws—in the meantime, such dramatic impacts should not be casually inferred or imposed through extra-legislative agency enforcement.

The Devastating Consequences of Applying the Statutes to Employer-Sponsored Benefits and Out-of-State Health Benefit Plans

Senator Schwertner's request represents the latest effort to selectively boost the narrow interests of a small group of independent pharmacy owners to the detriment of thousands of Texas businesses and millions of Texan workers. The negative impacts that would flow from extra-legislative enforcement of the Laws against ERISA and out-of-state health plans cannot be understated.[5] Such a measure would be an affront to the employer health plan sponsors who

[2] Testimony available at http://tlcsenate.granicus.com/MediaPlayer.php?view_id=53&clip_id=17778.
[3] Legislative Budget Board, Fiscal Note, 87th Legislative Regular Session – HB 1919 (May 18, 2021) [available at: http://capitol.texas.gov/tlodocs/87R/fiscalnotes/pdf/HB01919E.pdf].
[4] Legislative Budget Board, Fiscal Note, 88th Legislative Regular Session – Revision 1 – HB 2021 (March 21, 2023) [available at: http://capitol.texas.gov/tlodocs/88R/fiscalnotes/pdf/HB02021I.pdf.
[5] As the Texans for Lawsuit Reform (TLR) recently noted regarding a separate attempt to expand enforcement of Texas' Prompt Payment of Claims At (PPCA) to ERISA plans, such extension would

provide coverage for Texas residents who purposefully self-insured under ERISA to avoid discordant state regulation. Indeed, it would fundamentally threaten Texas' competitive position and well-deserved reputation as a state uniquely receptive to business interests.

Employer- and union sponsored coverage accounts for around 57 percent of health coverage in Texas, which includes approximately 14 million people. Job-based coverage is known to be generous, as many plans cover far more than "essential health benefits," and the vast majority of covered employees (80%) rank their plan as "excellent" or "good." The wide prevalence and scope of employer sponsorship is testament to its nature as a recruitment tool, as three out of four employees cite health benefits as their reason for accepting a job.[6]

This well-established system of employer-sponsored healthcare in Texas would be undermined by any extension of the Texas Insurance Code to self-insured ERISA plans, whether directly or indirectly through restrictions on their PBMs and other TPAs. Proponents of anti-payor laws in Texas and other states contend their laws only affect PBMs without negative impacts to other stakeholders. This is clearly not true for these Laws, which regulate health plans directly as well as PBMs.[7] Moreover, this position overlooks how regulations of PBMs substantially affect health plans. It is important to realize that PBMs are ***agents*** acting on behalf of plan sponsors to administer pharmacy benefits—through development of provider networks, processing claims, etc. As a result, any state-imposed restrictions or costs incurred by PBMs inevitably impact employer plan sponsors who structure and pay for benefits.

Data demonstrates the enormous cost-impacts associated with state anti-payor laws. For instance, an analysis of HB2021 (the companion bill to SB1137) found that its restrictions on preferred pharmacy networks, specialty pharmacies, and mail-order pharmacies would generate $464 million in excess drug spending in the first year alone, and over $5.4 billion over a decade.[8] State government plans would encounter similar cost impacts from anti-payor laws. A fiscal note on HB1919 determined that its restrictions would lead to the following cost increases in fiscal year 2023 alone: $24.9 million (University of Texas System); $6.9 million (Texas A&M System); $28.4 million (School Employees Uniform Group Insurance Program Trust Fund); and $7 million (Retired School Employee Group Insurance).[9]

"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 insurance and retirement plans." Lee Parsley, The Case for Preserving ERISA, Texans for Lawsuit Reform (Jan. 2023).

[6] TAHP, Oppose HB 2021 & SB 1137: New ERISA Mandates.

[7] The Laws impact each and every health plan in Texas, either indirectly though regulations imposed on PBMs that contract with health plans, or directly to any health plans that administer their own pharmacy benefit.

[8] PCMA, Texas HB 2021 Committee Sub Will Cost Self-Insured Plans over $5.4 Billion in Increased Prescription Drug Costs, available at: http://tahp.org/wp-content/uploads/2024/03/Texas-HB-2021-ERISA-Cost-Analysis.pdf.

[9] Legislative Budget Board, Fiscal Note, 87th Legislative Regular Session (May 18, 2021), available at http://capitol.texas.gov/tlodocs/87R/fiscalnotes/pdf/HB01919E.pdf#navpanes=0.

State lawmakers and officials should not assume that businesses can easily absorb the negative impacts spawned by applying anti-payor laws to ERISA plans. Health care is already one of the top line-item expenses for employers and applying these laws to employer-sponsored benefits would dramatically increase the costs of those benefits, inviting dire consequences. This is a major issue not simply for the large employers, but also for the small business owners in Texas, who have ranked the cost of health insurance as the single biggest problem every year since 1986. Likewise, a recent national survey found that the vast majority of employers (93%) feel an increased sense of urgency to preserve and enhance ERISA preemption.[10]

Unfortunately, many of the cost-inflating impacts to businesses would inevitably be passed along to Texas workers. Higher employer costs can translate into higher premiums, increased out-of-pocket obligations, and reduced benefits, negatively impacting insured patients. For example, 70% of businesses said a premium increase of 4% would force them to consider increasing costs for workers. These laws can also hamper employers' ability to increase wages, which can be especially detrimental during today's inflationary environment. With increasing costs and government restrictions in healthcare, many businesses may be pressured to end their benefit offerings. Many Texans would then be left with no choice but to seek coverage through the ACA exchanges or individual markets, creating enormous disruption. The damage to employer sponsorship would also invite government expansion into healthcare and tax increases, causing a domino effect that trends toward government-managed healthcare.

Finally, extension of the state's anti-payor laws to self-insured ERISA plans would threaten Texas' economic development and prosperity. In recent years, there has been a growing trend of internal migration as American businesses and workers are attracted to states offering lower taxes and reduced regulations. Texas has been a huge beneficiary of these changes, while higher tax and regulatory environments, like California, New York, and Illinois have suffered. Accordingly, state competition for businesses and workers has increased, and states must address economic and regulatory factors to remain competitive. Because health benefits remain one of the most expensive line-items paid for by employers, regulations affecting health benefits should remain a primary concern.

The Texas government should be mindful of this trend when considering legislative attempts or lobbying efforts designed to target ERISA plans. Should the state allow unprecedented intrusions on self-insured ERISA benefit designs, it would demonstrate hostility to the state's business community—particularly after notice of the costly impacts. Companies currently doing business in Texas or considering investment in the state could be discouraged by these new and unnecessary costs. Texas therefore faces a choice between advancing the interests of a small, special interest group or protecting its well-earned legacy of attracting and fostering business growth and economic development.

Extension of the Statutes to ERISA Plans Is Forbidden by ERISA Preemption

[10] Business Group on Health, 2024 Large Employer Health Care Strategy Survey (Aug. 2023), *available at*: 2024 Large Employer Health Care Strategy Survey.

Not only would application of the Laws to employer benefits harm Texas employees, employers, unions, and the business community writ large, but it would also be unlawful. Under well-established and consistent judicial precedent from the U.S. Supreme Court and multiple circuit courts of appeal, states may not interfere with the design and administration of employer benefits.

ERISA was enacted in 1974 "'to make the benefits promised by an employer more secure'" for employees. *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 480 (2020) (quoting *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. 312, 320-21 (2016)). To that end, ERISA includes a robust preemption provision that "supersede[s] any and all State laws insofar as they may now or hereafter relate to any" ERISA plan. 29 U.S.C. § 1144(a). This provision, which has been described as "what may be the most expansive pre-emption provision in any federal statute," *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. 312, 327 (2016) (Thomas, J., concurring), was designed to ensure a uniform regulatory regime over employee benefit plans by making employee benefit plan regulation "exclusively a federal concern." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quotation omitted).

The U.S. Supreme Court's interpretation of ERISA preemption provision has remained remarkably stable throughout more than forty years of jurisprudence. The Court has remarked that sponsors have "large leeway" under ERISA to "design . . . [benefit] plans as they see fit" and that state governments may not dictate benefit design. *Black & Decker v. Nord*, 538 U.S. 822, 833 (2003). The corollary is that a state law that requires an employer to design a benefit in a particular way is "clearly" preempted. *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983). Included within the scope of preemption are state laws that (1) "dictate plan choices" or "forc[e] plans to adopt any particular scheme of substantive coverage," *Rutledge*, 141 S. Ct. at 480- 81; (2) "govern[] a central matter of plan administration," *Gobeille*, 577 U.S. at 320; (3) "deal[] with the subject matters covered by ERISA," *Shaw*, 463 U.S. at 98; or (4) otherwise "interfer[e] with nationally uniform" regulation of benefit plans. *Gobeille*, 577 U.S. at 320. In sum, to further its objective to "provide a uniform regulatory regime over employee benefit plans," *Davila*, 542 U.S. at 208, Congress fashioned ERISA's preemptive standard to preempt, not simply those laws that may overlap with matters specifically referenced in ERISA, but moreover to "preempt the field [of employee benefits] for Federal regulations. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,933 (Aug. 22, 1974)).

While ERISA broadly preempts state laws, the Court has held that its scope does not apply to certain "cost" or "rate regulations" imposed in relation to third party service providers. *Rutledge*, 141 S. Ct. at 481. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995). For instance, in *Travelers* (which addressed a state law assessing a fee on all hospital payors), and in *Rutledge* (which addressed a state law that set minimum reimbursement rates for drugs), the Court held that such laws did not dictate plan choices about benefits structures, but instead regulated the rates that plans had to pay, incidentally making covered benefits more costly. To the extent these holdings are viewed as an exception to ERISA preemption, it is undeniably narrow in scope, and leaves undisturbed ERISA's broad proscription against laws that relate to substantive ERISA plan designs.

The most recent appellate decision on ERISA preemption of state legislation relating to health benefits comes from the Tenth Circuit, which held that provisions of an Oklahoma law directed at PBMs and health plans were preempted by ERISA. *Pharm. Care Mgmt. Ass'n v. Mulready,* 78 F.4th 1183 (10th Cir. 2023). *Mulready* is consistent with the Supreme Court cases described above, including *Rutledge*. The Tenth Circuit held that provisions of an Oklahoma law with striking similarities to certain provisions of HB 1919 and HB 1763 were preempted by ERISA. The court considered Oklahoma's attempt to restrict and/or dictate how plans design their pharmacy provider networks, including provisions aimed at eliminating steering to preferred pharmacies and a provision that precluded plans from setting their own quality standards for pharmacists participating in the network. The court held that each of these network restrictions was preempted because it "either directs or forbids an element of plan structure or benefit design." *Id.* at 1198. The Court recognized that "ERISA preempts these provisions because a pharmacy network's scope (which pharmacies are included) and differentiation (under what cost-sharing arrangements those pharmacies participate in the network) are key benefit designs for an ERISA plan." *Id.*

The same is true with respect to the provisions of HB 1919 and HB 1763. HB 1919 affects provider networks, thereby imposing on network design in at least two respects. First, Sections 1369.554 and 1369.555 dictate the pharmacy network's scope by forbidding popular designs that offer inexpensive prescription drug coverage at a narrow, restricted preferred network consisting of affiliated pharmacies. Second, the same provisions forbid differentiation of the pharmacy network by prohibiting particular cost-sharing arrangements. Sections 1369.554 and 1369.555 act together to effectively prohibit plans from offering network tiers limited to affiliated providers, by limiting marketing and price incentives unless the same incentives are applied to all unaffiliated providers. This would likely impact PBMs and health benefit plans that offered limited networks. Similarly, the provisions prevent plans from offering benefit designs that require mail-order pharmacies for certain drugs. In this way, the law impermissibly affects benefit structure by binding plan administrators to particular choices and dictates the terms under which plans must make payments. No longer may a plan choose to offer cost-incentives at select pharmacies, nor may a plan design its benefits to require the use of a mail-order pharmacy for certain drugs.

In addition, Sections 1369.554 and 1369.555 intrude on ERISA's regulation of conflicts of interest and related party transactions. 29 U.S.C. §1108(b). ERISA permits plans to contract with a "party in interest" for a contract, provided "no more than reasonable compensation is paid therefore." *Id.* The U.S. Department of Labor also has required some third-party providers to make disclosures to prevent conflicts of interest. 29 C.F.R. §2550.408b-2(c) (service providers to ERISA-covered pension plans), and considered, but declined to require, PBMs to disclose their own compensation and fees. U.S. Dep't of Labor, PBM Compensation and Fee Disclosure, perma.cc/CDM8-HZW6. These statutory and regulatory provisions make clear that ERISA covers the matter of whether a plan may permit an interested or related-party transaction, and shows that Congress intended that such transactions would be permitted, provided the compensation is reasonable. Sections 1369.554 and 1369.555 place further limits on these transactions by imposing restrictions not only on the amount paid for the transactions, but also on

the plan's choice to enter into such transactions at all. This provides an independent ground for preemption.

In addition, Section 1369.553 places restrictions on PBMs' and plans' ability to disclose patient or prescriber information for unspecified, undefined "commercial purposes." This provision is preempted because it regulates an area where federal requirements in ERISA already occupy the field. ERISA includes extensive reporting, recordkeeping, and disclosure requirements. *See e.g*. 29 U.S.C. §§ 1021, 1022, 1023, 1024; *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 944 (2016) ("ERISA's reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive"). The Supreme Court has previously stated that reporting, recordkeeping, and disclosure are integral aspects of ERISA and among the areas that express preemption provision was intended to protect from state regulation. *Gobeille*, 136 S. Ct. at 945. State laws imposing reporting, recordkeeping, and disclosure requirements are preempted even where those state laws apply to third-party administrators. *Id.*

Provisions of HB 1763 do no better. In particular, Section 1369.608 prohibits health plans from establishing qualitative requirements for those providers seeking to participate in the plan's provider network. This is very similar to the Oklahoma provision that the Tenth Circuit struck down, which prohibited exclusion from the pharmacy network based on disciplinary action. *Mulready*, 78 F.4th at 1204. Like that provision, Section 1369.608 interferes with the ability of a health benefit plan to ensure that its members are receiving quality care. By preventing plans and their PBMs from imposing particular accreditation or other quality-specific requirements, Section 1369.608 makes it impossible for plans to offer benefit designs that include specific specialty pharmacy networks for the dispensing of complicated and costly specialty drugs. This eliminates a common benefit design that plans deploy to ensure high quality, cost-efficient care.[11]

Therefore, under the consistent preemption framework established by the Supreme Court over five decades, these provisions of HB 1919 and HB 1763 would be invalid as preempted by ERISA should the state seek to apply them to ERISA-sponsored plans.

[11] Other aspects of HB1763's amendments to the insurance code raise legal concerns. Notably, Texas Insurance Code § 1369.554, which restricts PBMs and plans from communicating about preferred pharmacies with plan members, is facially unconstitutional under the First Amendment. The Supreme Court has held that "bans against truthful, nonmisleading commercial speech," such as Section 1369.554, are evaluated with "special care" and "rarely survive constitutional review*." 44 Liquormart v. Rhode Island*, 517 U.S. 484, 504 (1996) (plurality). That is because "bans that target truthful, nonmisleading commercial messages rarely protect consumers from" commercial harm and instead "often serve only to obscure an underlying governmental policy." *Id*. at 502-503 (cleaned up). That is the case here: Section 1369.554 censors truthful, non-misleading communications with plan beneficiaries that would encourage them to seek high-quality, low-cost medicines from efficiently managed pharmacies. By prohibiting such speech, Section 1369.554 furthers an ill-conceived policy to favor certain market participants, and it will do nothing but raise drug prices. It does not further any substantial governmental interest, and it would not survive judicial scrutiny.

ERISA Plan Benefit Designs Cannot be Directly or Indirectly Regulated in an Intrusive Manner

HB 1919 and HB 1763 amended the Texas insurance code to include provisions that apply equally to health plans as well as PBMs, meaning that health plans are either directly or indirectly impacted by the law. For example, the pharmacy network restrictions set forth in Sections 1369.554 and 1369.555 directly apply to the minority of health plans who administer their own networks as well as the majority of health plans who depend upon PBMs to administer their networks. Accordingly, if the statutes were impermissibly extended into the ERISA space, they would illegally restrict ERISA plans both directly and indirectly.

Federal courts have consistently held that indirect regulation of an ERISA plan—such as through regulation of plan TPAs, PBMs, and other agents—triggers the same sort of ERISA preemption scrutiny as direct regulation. *See Gobeille*, 577 U.S. at 326. Within the context of drug benefits, courts have noted that because plans routinely depend on their PBM administrators, state laws targeting PBMs that restrict plan choice over benefit design are viewed "as a regulation of an ERISA plan itself." *PCMA v. D.C.*, 613 F.3d at 188; *see also Mulready*, at 1200 (rejecting argument that state law escapes preemption because provisions "burden PBMs, not plans," and noting that the Supreme Court did not recognize any such distinction); *PCMA v. Wehbi*, 18 F.4th 956, 966 (8th Cir. 2021) (same). For these reasons, in *Rutledge* the Court rejected any distinction between plans and PBMs as a ground to determine preemption, but instead focused its analysis on the challenged state law's actual operation. *Rutledge*, 141 S. Ct. at 480. Any opinion on HB 1919 and HB 1763 should do the same.

The Laws Cannot be Legally Extended to Regulate Out-of-State Health Plans

In addition to being preempted, HB 1919 and HB 1763 cannot be enforced against health benefit plans that are domiciled outside of Texas. Each of these laws amend Chapter 1369 of the Texas Insurance Code. The Texas Insurance Code is a comprehensive set of laws that regulate "the business of insurance in this state." Tex. Ins. Code. Ann. S. 31.002.

It is well-established that "when an out-of-state insurance company issues a group policy to a non-Texas employer and the contract is entered into in another state, the law of the other state applies unless at the time it was issued the insurance company was otherwise doing [insurance] business in Texas." *Butler v. Mutual Life Assurance Co.*, 600 F. 2d. 532, 534 (5th Cir. 1979); *see also BlueCross BlueShield of Tenn.*, SOAH Docket No. 454-07-1184.H, No. 09-0569 (Comm'r of Ins. of Tex. Jul 16, 2009) (official order) (determining that commissioner could not enforce Texas Insurance Code against insurers that served employer groups headquartered in either Alabama or Tennessee).

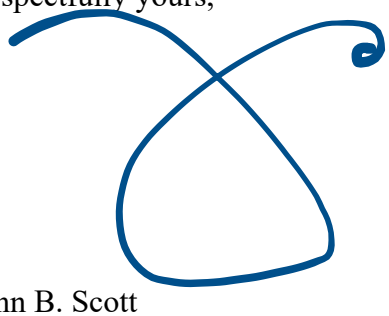
Senator Schwertner's question specifically references an out-of-state plan's use of "a pharmacy benefit manager that directly contracts with a network of providers including Texas pharmacy providers," suggesting that this could provide a basis for application of Texas insurance laws to out-of-state plans. It does not. In fact, the *BlueCross BlueShield* order involved a Texas-based provider network, which was made available to the out-of-state plans at

issue by virtue of a third-party contract, not unlike the contract between a health plan and a PBM. Regardless, in that case, the Commissioner of Insurance determined that two out-of-state health benefit companies did not do insurance business in Texas, because the plans' conduct did not constitute "entering into a contract within this state or doing business within this state for purposes of Tex. Ins. Code Ann. Art. 21.42." Indeed, the decision made clear that the contract in question is the insurance policy itself. *Id.* In Senator Schwertner's hypothetical, it is clear that the policy documents are issued by an out-of-state entity and are not entered into in Texas; therefore, Texas law does not apply.

Even if the Texas Department of Insurance could enforce the Insurance Code against out-of-state plans, it undoubtedly should not. Challenging out-of-state insurance policies and practices, subject to the laws of other states, would be a poor use of Texas resources. Moreover, as described above, application of Texas's laws to insurance companies and employers based out of state would dramatically reduce the state's attractiveness to national (and global) employers, which would have significant negative impacts on this state's vibrant and unique economy and its residents.

To conclude, as a matter of law and policy, the applicability of HB 1919 and HB 1763 should not be expanded to include ERISA-sponsored health benefit plans and plans issued by out-of-state employers and companies.

Respectfully yours,



John B. Scott