March 14, 2024

The Honorable Virginia Foxx
Chair
House Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, DC 20515

RE: American Benefits Council Response to ERISA Request for Information

Dear Chair Foxx:

The American Benefits Council ("the Council") is writing in response to your request for information (RFI) on ways to build upon and strengthen ERISA, commemorating the 50th anniversary of this landmark legislation. The Council commends you for recognizing ERISA as the foundation of employer-sponsored health care and, specifically, ERISA's federal preemption of state laws as enabling multi-state employers to offer uniform benefits to their employees, irrespective of their or their employees' location and tailored to meet the needs of employees and their families.

As you note in your RFI, employers view ERISA preemption as essential to the sponsorship of health and retirement benefits. The Council very much appreciates and welcomes the opportunity to provide feedback to the committee regarding the current state of ERISA and potential steps that could be taken to both reinforce and improve the ability of employers to offer high-quality, comprehensive, yet affordable health coverage to employees and their families.

The Council is dedicated to strengthening employer-sponsored benefit plans. The Council represents more major employers – over 220 of the world's largest corporations – than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or serve benefit plans covering virtually all Americans participating in employer-sponsored programs.

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We applaud your recognition that employer-sponsored health coverage ("ESI") is the core of America's health care system. Providing health coverage to more than 179 million Americans,[1] employers play a critical role in the health care system and drive innovations from which the entire health system benefits. More Americans rely on their employers for health coverage than any other source (such as the individual insurance markets or government programs). The Council's report, *American Benefits Legacy: The Unique Value of Employer Sponsorship,*[2] details the important contribution employer sponsored benefits make to the health and financial security of American workers, families and the economy. It represents a tremendous bargain for beneficiaries and the federal government and is a foundation upon which efforts to improve value and access should be built.

The tax expenditure for ESI affords significant business and societal benefits. According to the White House Office of Management and Budget, $225 billion in forgone revenue was attributable to the income tax exclusion for employer-provided health coverage in 2022.[3] Meanwhile, the Bureau of Economic Analysis (BEA) reports that employers spent $839 billion to provide health coverage the same year.[4] A back-of-the-envelope calculation of $839 billion divided by $225 billion reveals that each dollar of federal expenditure yielded approximately $3.73 in benefits for covered employees and their families.

This is a tremendous bargain for the government. It would cost taxpayers substantially more to provide the same level of financial protection for health expenses if it had to be provided through a direct government program, rather than incentivizing the ESI system.

America's employers recognize that helping employees thrive has a measurable impact on virtually every aspect of their business. According to a study by Avalere Health, employer-sponsored health insurance will have provided an estimated 47% return on investment to employers with 100 or more employees in 2022, rising to a 52% return in 2026. This includes $275.6 billion from improved productivity in 2022 and $346.6 billion in 2026.[5] When employers' commitment to their employees is coupled

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[1] U.S. Census Bureau, Health Insurance Coverage in the United States: 2022 (September 2023), Table 1.

[2] American Benefits Council, *American Benefits Legacy: the Unique Value of employer Sponsorship* (October 17, 2018)

[3] White House Office of Management and Budget, *Analytical Perspectives, Budget of the U.S. Government, Fiscal Year 2024*, Table 19-2 (March 2023)

[4] U.S. Bureau of Economic Analysis, Employer Contributions for Employee Pension and Insurance Funds by Industry and by Type, Table 611.d (accessed Wednesday, March 6, 2024)

[5] Avalere Health, *Return on Investment for Offering Employer-Sponsored Insurance* (June 28, 2022)

with a drive for innovation, employers are the key to lowering health care costs and increasing quality for individuals and the health care system as whole.

According to 2022 election night polling data, a plurality of voters (45%) trust employers the most (compared to either the federal (18%) or state (10%) governments or the individual market (18%)) to provide affordable, high-quality health coverage.[6] And, by a margin of more than two to one (62% to 29%), voters preferred an employer system where companies provide comprehensive health coverage options, rather than a stipend for employees to shop for their own health insurance in the individual market.[7]

According to a separate poll conducted in January 2023,[8] more than three-quarters (77%) of insured adults who receive ESI view it positively (28% view it as "excellent" and 49% view it as "good"). In the same poll, a bipartisan majority (69%) of insured adults prefer to strengthen the existing system so more people have ESI and fewer buy it themselves or get it from a government program.

Nationwide uniformity under ERISA is the cornerstone of employer-provided health coverage, enabling employers to provide affordable, high-value and equitable benefits to their workers, wherever they live or work. At the root of ERISA's success has been its commitment to ensuring that multi-state and national employers have the ability to offer comprehensive, uniform coverage to employees that best reflects the unique needs of workers and their families. Under ERISA, employers that self-fund their benefit plans can offer and administer coverage across the 50 states that is consistent and tailored to the specific needs of their workforce.

The importance of ERISA for employers has only grown over its 50-year history for two fundamental reasons. First, commerce is increasingly stretching across state lines and the workforce is becoming increasingly mobile and remote, resulting in larger and more multi-state and national employers. Second, as employers continue to seek new, innovative strategies to drive value and improved health outcomes, ERISA preemption is essential to these efforts.

As you highlight, employers have been at the forefront of creating innovative, market-driven approaches to providing high-value health benefits, while simultaneously driving down health care costs. Employers have pioneered initiatives to lower health costs and improve quality through various value-based strategies. This

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[6] American Benefits Council & Public Opinion Strategies, *2022 Post-Election Night Survey* (November 15, 2022)

[7] Alliance to Fight for Health Care & Public Opinion Strategies, 2022 Post-Election Night Survey (November 15, 2022)

[8] Alliance to Fight for Health Care & Morning Consult, *Coverage and Reforming the System* (February 21, 2023), pp. 4 and 11

was the message of *Leading the Way: Employer Innovations in Health Coverage,*[9] a report from the Council and Mercer showing how employer providers of health coverage are lowering costs and improving quality through innovation.

Employers, however, remain deeply concerned about rising health care costs that impede their ability to offer affordable, high-quality care. Employers are increasingly frustrated by fundamental failures in the health care marketplace that stifle competition, cloud line of sight to price and quality information, impede innovation – and, ultimately, increase costs. We have called upon Congress to take bold steps to address the root causes of rising health care costs, namely a lack of transparency and misaligned incentives that drive market consolidation and higher prices and we have offered our strong support[10] for the Lower Costs, More Transparency Act (H.R. 5378). These steps must be taken in concert with the uniformity that ERISA preemption affords.

Without ERISA uniformity, employers would have to comply with a patchwork of varying and ever-changing state laws, making plans extraordinarily difficult to administer. This would result in increased costs and administrative burdens for employer-sponsored plans and cause employees performing the same job for the same employer, albeit in different locations, to receive very different benefits. Furthermore, in the absence of ERISA preemption, employers would not be able to leverage economies of scale that nationwide plan design, administration and negotiation affords.

ERISA preemption enables employers to treat employees consistently regardless of where they live or work and, in so doing, supports the mobility of talent within an employer's workforce. Without ERISA preemption, employers could not provide a consistent employee experience, which in turn would create greater confusion, complexity, frustration and cost for both employees and employers. On its 50th anniversary, ERISA preemption is under assault on multiple fronts. Your request for information comes at a critical time to convey to the committee the seriousness of the threat to ERISA preemption and the imperative to protect it.

Set forth below are the Council's specific comments to the committee in response to the committee's RFI. Given the breadth and scope of the committee's RFI, our comment responds in detail to several of the specific areas of the committee's inquiry, including ERISA preemption, ERISA's fiduciary rules and ERISA's rules regarding prohibited transactions. We also provide comments on other questions we see as most relevant to employer initiatives to lower health care costs through increased transparency and competition and, more generally, employers' perspective with respect to specialty drugs. We hope to continue to provide feedback to the committee on other important

[9] American Benefits Council & Mercer, *Leading the Way: Employer Innovations in Health Coverage* (March 12, 2018)

[10] American Benefits Council Letter in Support of Lower Costs, More Transparency Act (H.R. 5378) (December 7, 2023)

topics raised in the RFI in additional communications. We stress that our comments are limited to health benefits. While the RFI is focused on employer-sponsored health coverage, we note that a number of these issues could have implications with respect to retirement plans as well. Therefore, we urge the committee to take into account any potential impact on retirement plans as well.

PREEMPTION

The committee seeks feedback on ways to strengthen and clarify ERISA preemption and to what extent do state laws prevent or purport to prevent multi-state employers from offering a uniform set of benefits across state lines.

As ERISA reaches its 50th anniversary, employers continue to view ERISA's preemption provision as an essential tool in ensuring that multi-state and national employers are able to continue to offer consistent, affordable and high-value health coverage that reflects the unique needs of their employee populations. The fundamental policies that underpinned ERISA's preemption provision 50 years ago remain just as important, indeed more so, today. Specifically, nationally uniform and central plan administration, flexibility in plan benefit design and the ability to treat employees consistently regardless of where they live or work are paramount for employers that offer benefits to their employees. The increasing remote and mobile nature of the workforce, particularly in the wake of the COVID-19 pandemic, has made ERISA preemption even more of an imperative as large and small employers alike find themselves "multi-state" employers. Moreover, ERISA preemption removes a barrier to mobility of employees within an employee's workforce, facilitating the transfer of talent to other company locations and opportunities nationwide.

ERISA established national standards for employers who decide to assume the financial risk of providing health coverage to employees and their family members. Employers choose to assume this risk and self-fund their employee health coverage because they have a vested interest in the health and productivity of their workforce and can tailor their coverage to best meet the needs of their workforce. Under ERISA's preemption provision, Congress protected such self-funded employers from a patchwork of state laws that would undermine their ability to offer uniform and affordable health coverage to the workforce nationwide.

Preemption is fundamental to ERISA working as intended. **Nearly 50 years ago, one of ERISA's authors, Representative John Dent (D-PA), identified the preemption provision to be the law's "crowning achievement" because without it, the legislation would not have enjoyed the support of both labor and management since it is so fundamental to the ability of multi-state employers to sponsor benefit plans to workers nationwide.**

Over the past five decades since ERISA's enactment, the preemption afforded to ERISA-covered group health plans has brought tremendous value to working families and the health care system as a whole through the employer innovation it has enabled. It is essential that Congress preserve ERISA preemption to ensure that employer innovation can continue.

Employers are uniquely situated to develop new and innovative plans and benefit designs aimed at improving outcomes and lowering costs. Employers are able to nimbly and rationally adopt these value-based insurance and other plan designs with an eye towards lowering costs and improving health outcomes for their employees and their families.

The employer community's response to the COVID-19 pandemic is but one recent example of how ERISA preemption is essential to allowing employers to react quickly to leverage new technologies to provide essential health care coverage to American families. During the COVID- 19 pandemic the Council reached out to hundreds of American employers to learn how their health plans managed the unprecedented trials of the pandemic. The Council's *Silver Linings Pandemic Playbook*[11] tells stories of expanding access to telehealth and mental health services and other actions to protect the physical and emotional health of their workers. These and other stories are a testament to employers' innovation and commitment to the health and well-being of their workers and families.

Employers, not saddled by state rate and form filings, were able to quickly amend plans to provide more robust benefits for COVID-19 screening and treatment. Additionally, employers quickly adopted policies that enhanced the availability of telemedicine and other remote services to ensure that non-COVID related treatments and therapies continued to be available as the country faced an unprecedented shut down. Employers were able to better adapt to changing realities on the ground due to the flexibility ERISA provides plan sponsors of employee welfare benefit plans in the design and administration of their plans. And in many respects, it was as a result of the actions taken by the employer community in first responding to the COVID-19 pandemic to develop and deliver new health care delivery models that showed other stakeholders a path forward and spurred broader change across the health coverage industry.

Fifty years after ERISA's enactment, its "crowning achievement" is under attack in the states, threatening employer innovation and employers' ability to promote affordable, high-value health coverage to employees on a uniform basis nationwide. It is now incumbent on Congress to protect and preserve the crowning achievement of this landmark legislation.

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[11] American Benefits Council, *Silver Linings Pandemic Playbook* (July 23, 2021)

Permitting states to impose their own requirements on self-funded group health plans – whether they be procedural rules, reporting and disclosure requirements, benefit mandates, rules regarding what providers may (or in some cases must) be utilized by the plan and/or restrictions regarding the type and nature of cost-sharing or coinsurance that may be applied to benefits – interferes with the fundamental policy goal of ERISA, which is to ensure that employers are able to offer uniform coverage to their employees, free from state regulation.

Envisioning a benefits landscape without ERISA preemption, employers would have to comply with an ever-changing patchwork of varying state laws, making the offering and administration of employer-sponsored health coverage significantly more costly, complex and burdensome. **Along with making their health plans extraordinarily difficult to administer, the absence of ERISA preemption would force employers to treat employees differently solely based on where they live or work.** This would increase costs, confusion, complexity and frustration for employees as well. Imagine an employee working in Illinois on the same team and doing the same job as a co-worker in New York who does not understand or appreciate why their co-worker with the same position receives different benefits. Imagine that the employee working in Illinois would like to transfer within the company to a job opening in a Texas facility but is unable to do so because differing state laws and benefits offerings create a barrier to interstate transfers.

ERISA preemption is essential to employer-sponsored health coverage. As you state in your letter, "Without preemption and uniformity, administrative complexity and increased costs would cause [employers] to stop offering health benefits or to charge significantly more for employees' health coverage." We urge Congress to reject any efforts that erode ERISA preemption.

The challenges to employers and employees from the growing patchwork of state paid leave laws serves as a cautionary tale of what the absence of ERISA preemption for group health plans would entail. Multi-state companies face the significant challenge of navigating a maze of increasingly complex and inconsistent state paid leave mandates that undermines their ability to offer valuable paid leave benefits to their employees on a consistent basis nationwide. The patchwork of state paid leave laws can stifle employer innovation and force employers to instead spend their time just trying to achieve compliance in each jurisdiction. The incentive to cease sponsoring the employer paid-leave plans grows as more states pass new and different requirements. Varying state paid leave laws is transforming the traditional role of employers as the single point of contact for employee benefit programs and can negatively impact the employee experience. The divergence of substantive and procedural requirements for approval by each state undermines the goal of protecting and leveraging private-sector paid leave benefits.

The same concerns surrounding paid leave laws also apply to health benefits. Increasing state efforts to regulate self-funded employer health benefits is incredibly troubling for employers. For example, state laws regulating pharmacy benefit managers hinder the ability of employers to utilize a uniform drug benefit across its employee population. Equally alarming is what this trend may portend for other areas of state regulation of group health plans, such as with respect to third party administrators (TPAs) more generally, other types of benefits provided by group health plans other than prescription drugs, provider networks, cost-sharing and value-based insurance designs generally.

At the root of some of this state activity is a deeply concerning misunderstanding of the U.S. Supreme Court's ruling in *PCMA v. Rutledge*. In that case, the Court ruled that an Arkansas statute was not preempted by ERISA. In its decision, the Court explained that ERISA does not preempt laws that result in indirect cost regulation *that do not otherwise affect a plan's benefit design or plan administration*. Unfortunately, some stakeholders have sought to use the Court's decision in *Rutledge* to mischaracterize ERISA's preemptive effect as part of their efforts to impose new rules on group health plan service providers.

Thankfully, the most recent appellate court decision addressing these efforts, *PCMA v. Mulready*, correctly limited the scope of *Rutledge* to indirect cost regulation. In particular, the court held that Oklahoma's any willing preferred provider, network access requirements and limitations on the use of certain affiliated pharmacies (such as mail-order pharmacies), impermissibly regulated the plan's benefit design and were thus preempted.

State legislative activity threatening ERISA preemption extends beyond PBMs, including with respect to all payer claims databases, prior authorization and specialty pharmacy "white bagging." *See, e.g.,* 2023 Ind. Legis. Serv. P.L. 190-2023 (S.E.A. 400) (imposing all-payer claims database reporting on self-funded group health plans and their TPAs); Fla. Stat. § 627.42393(5) (prohibiting the use of step therapy for certain drugs); Fla. Stat. § 626.8825(2)(e)(4)–(5) (prohibiting PBMs from administering "white-bagging" provisions).

In light of this state activity and the views expressed by the U.S. departments of Labor and Justice in their *amicus* brief to the Tenth Circuit Court of Appeals in *Mulready*, employers require greater certainty regarding the scope of ERISA preemption. In their amicus brief, the department staff incorrectly assert that ERISA's "deemer clause" only comes into play where a state law is seeking to directly regulate a self-insured group health plan, versus state laws that seek to regulate the self-funded group health plan's service provider, such as PBMs, other TPAs or the like.

If the departments' view of ERISA preemption were correct, this would effectively permit states to regulate self-insured plans so long as the regulation applied only to the

plan service provider and not also the plan. This view is plainly inconsistent with the statutory provisions of ERISA (see, in particular, the definition of "state law" included in Section 514 of ERISA) and the decades of case law holding that self-funded group health plans are generally immune from state regulation and is in direct tension with the underlying principles relied on in Congress adopting the broad ERISA preemption provision.

We firmly believe in the breadth of ERISA preemption under current law and that states currently lack the authority to regulate self-insured plans, even when the regulation applies indirectly to a plan through regulation of the plan's service provider. Accordingly, we strongly reject the departments' staffs' view of ERISA preemption. In light of the foregoing, the Council recommends that the committee and Congress articulate the breadth and reach of ERISA preemption whenever possible. While the statute and case law interpreting the statute remain clear on the breadth and scope of ERISA preemption, the committee should be aware of the ongoing threats state regulation pose to employer-sponsored health coverage and should be clear in any statements around preemption regarding the current reach of the statute.

Additionally, a growing number of state laws seek to mandate, via regulation of plan service providers, the specific cost-sharing designs that may be used by a self-funded group health plan or the benefit levels or reimbursement rates to providers that must be paid *directly* by the group health plan, such as minimum dispensing fees[12]. While these policies to date have largely focused on the PBM industry, it is likely, if not certain, that we will begin to see similar types of legislation being introduced regarding other non-drug benefits, which would only exacerbate the challenges already being faced by employer-sponsored plans in having to develop one-off solutions to respond to each state's unique legal developments.

ERISA FIDUCIARY STATUS

The committee also broadly seeks comment on whether ERISA's fiduciary protections require additional modification as they pertain to health benefits for the continued success of employer-sponsored group health plans and whether the statutory definition should be extended to health plan service providers who are not currently considered functional fiduciaries under ERISA.

[12] These types of state level mandates appear to be outside the scope of *Rutledge* because they mandate a specified amount that the plan must directly reimburse, whereas *Rutledge* dealt with amounts that the PBM was required to reimburse the retail pharmacy. Because of the unique nature of the drug supply chain, the amount that a plan pays a PBM for a given drug claim has a limited relationship to the amount that the PBM pays the pharmacy for the same claim.

ERISA is unique in that it imposes upon certain parties to a group health plan a fiduciary or "trustee-like" duty to act solely in the best interests of plan participants and beneficiaries. In support of this policy goal, ERISA sets forth a series of prohibited transaction rules and rules against self-dealing that are intended to ensure that plans are administered prudently and that plan assets are properly marshalled for the sole benefit of participants and beneficiaries. One such rule provides that a plan fiduciary may only expend plan assets on behalf of a plan and a plan service provider may only receive reasonable compensation for necessary services rendered by the service provider to the plan.

Generally, ERISA fiduciary status applies to any party that exercises discretion with respect to the administration of the plan or plan assets. As a result, in many instances, service providers may not be acting in a manner that results in ERISA fiduciary status – for example, where they lack decision making authority and are not otherwise exercising discretion over plan assets. And even where a party may be acting in a fiduciary capacity in one respect, that does not mean they are a fiduciary with respect to all of their actions with respect to the plan.

Historically, the roles of plan fiduciaries and non-fiduciary service providers have been fairly clear. Additionally, because plan service providers tended to focus on one specific component of the health care delivery chain, such as TPA services, it was fairly straightforward for plan fiduciaries to understand the role of the plan service provider and determine the extent of compensation that the plan service provider would receive in connection with providing services to the plan.

In recent years, however, with the vertical integration in the health care delivery chain and lack of transparency, it has become increasingly challenging for plan fiduciaries to understand the full amount they are paying for services (directly or indirectly) and in some respects *who* they are paying – for example, from what sources a plan service provider may be receiving indirect compensation and whether a downstream provider is in fact an affiliate of the service provider.

Employers also remain deeply concerned about prescription drug costs and the absence of appropriate price – and cost – transparency across the entire drug pricing system. The current rebate structure is complex and opaque for many employers, making it hard for them and plan participants and beneficiaries to understand the true prices and value of drugs. Employers continue to encounter barriers to PBM pricing transparency. Employers cannot effectively manage prescription drug costs unless they can see the full picture of rebates, fees and other remuneration generated from manufacturers and other parties, drug definition criteria and amounts charged to pharmacies. The Council strongly supports legislation to require greater transparency, oversight and accountability with respect to PBMs.

Transparency is an important first step in helping employers understand the true prices and value of prescription drugs. Increased transparency about rebates paid by manufacturers to PBMs and the passing through of such rebates to plan sponsors is essential and must be robust enough to capture PBM aggregate rebates, including those captured by Group Purchasing Organizations. It is also important to address misaligned incentives and pricing models in which PBMs charge employers more for a drug than the PBM paid the pharmacy for that drug. So-called "spread pricing" may lead to higher prescription drug costs for employers and employees without increased value as well as increased out-of-pocket costs for participants and beneficiaries. It is important to clearly specify the parameters of PBM responsibility to ensure that they act in the best interest of the health plan and participants.

In addition to the above, the Council is concerned that plan fiduciaries may find themselves subject to aggressive class action litigation similar to what has developed with respect to ERISA-covered 401(k) retirement plans, where law firms often bring meritless claims against employers for alleged fiduciary violations knowing that there may be a cash windfall at the end of the day because fiduciary liability insurers may prefer to settle these cases rather than fund the legal defense regardless of how prudently the fiduciaries may have acted. Defense costs alone are likely to total into the multi-millions.

While litigation is an important mechanism to ensure ERISA plans are protected and that fiduciaries are acting properly and in accordance with their ERISA-imposed duties, spurious litigation that relies on a costly game of financial "chicken" does nothing but increase the costs of providing coverage to employees, with that cost often being borne both by employers as well as employees in the form of higher premiums or plan costs.

For all of these reasons, **the Council believes the committee should consider expanding the scope of ERISA's fiduciary definition with respect to those entities that provide services to group health plans, but that any effort to do so should take account of the following:**

- First, in the group health plan context especially, cost alone does not provide a sufficient basis for plan fiduciaries to select service providers such as TPAs, PBMs and utilization management entities. Rather, a prudent fiduciary might consider, in addition to the cost of a specific item or service, the *overall* cost of the relevant service provider contract, the quality of the services rendered by the service provider and its downstream clinical providers and the extent to which the service provider offers services that align with the plan sponsor's goals of promoting value-based insurance design and a focus on high-quality, low cost care.

- Second, the committee should recognize that in expanding the parties that may be fiduciaries with respect to a group health plan may help employers in

exercising their own fiduciary responsibilities as this conceivably should result in the counterparty having to provide more robust disclosures regarding the compensation they are earning and also restrict the party's ability to engage in self-interested actions. Retirement plan fiduciaries under applicable disclosure rules already receive robust information from service providers and in turn provide detailed information to participants about the cost of the investments offered.

- Third, the committee should keep in mind that just because another party may become a fiduciary the employer is not relieved from fiduciary responsibility generally and, as a result, at a minimum, the employer would be said to have residual fiduciary liability regarding the selection and monitoring of the party. Thus, to the extent that the party is a fiduciary and acts improperly vis-à-vis the plan, under ERISA's current statutory scheme, the employer may well have co-fiduciary liability for any resulting plan losses.

- Fourth, for the reasons noted above, one should expect that class-based litigation against employer fiduciaries would increase to the extent that plan service providers are made fiduciaries to the plan. Accordingly, the Council urges the committee to consider as part of any initiative to expand fiduciary status to service providers, ways to protect employer fiduciaries against having to bear the costs associated with a service provider's alleged fiduciary breach, such as through the establishment of certain pleading standards for ERISA-based class action litigation (such as that the plaintiff show that there is no exemption that could apply to the alleged fiduciary conduct at issue) or statutory safe harbors for when an employer fiduciary is deemed to have met its responsibilities in the selection and monitoring of plan service providers.

- Fifth, the committee should evaluate the benefits of an expanded fiduciary definition within the goal of plans achieving overall cost-savings. For example, if the committee were to craft legislation that statutorily deems PBMs as fiduciaries regardless of the specific functions they perform with respect to the plan, the impact on overall cost-savings should be considered. Currently many PBMs take the position that when they negotiate for drug manufacturer rebates, they negotiate on a "book of business" basis, rather than for a specific plan. This allows them to effectively aggregate all of the covered lives (and the related drug claims) across their book of business to pursue the best drug manufacturer rebates. Where the PBM utilizes a pass-through PBM model, this results in the maximum rebate amount finding its way to each plan. Where the PBM utilizes a traditional model, this may allow the PBM to charge a lower administrative fee to the plan since the PBM is receiving and retaining a maximum amount of rebates from the drug manufacturers, but a lack of transparency clouds line of sight into overall plan savings. Expanded disclosure of drug manufacturer

rebates and spread pricing to employer fiduciaries will allow plans to better negotiate regarding the total remuneration paid by the plan (directly or otherwise) to the PBM and how much cost-savings is actually generated. Conferring PBMs with fiduciary status could serve to lower costs by removing misaligned incentives that drive up costs. There could be some instances, however, when this approach may actually increase overall plan costs, if PBMs' leverage to negotiate rebates based on a book of business is curtailed. The goal of employers is to lower prescription drug costs and ensure they and their employees are paying for value.

In light of the foregoing, as the committee considers expanding when service providers of health plans will be deemed ERISA fiduciaries, the Council urges the committee to carefully consider the potential consequences and to take necessary steps to protect against a loss of flexibility as well as increased plan costs.

REPORTING REQUIREMENTS

The committee broadly seeks feedback on ways to streamline reporting and disclosure requirements and how Congress can better support electronic disclosure when electronic disclosures are beneficial to the plan participant. The Council is strongly supportive of expanded use of electronic disclosures when beneficial to plan participants and where it can help reduce administrative burdens. Electronic disclosures of plan documents provides secure and timely access by plan participants to important information about their benefits and can lead to better engagement.

PROHIBITED TRANSACTIONS

The committee broadly seeks feedback on the extent to which vertical integration in the health care sector implicates ERISA's prohibited transactions rules and related exemptions. Additionally, the committee requests comments on how recently enhanced transparency around plan benefit payments impacts existing fiduciary duties.

As noted above, with the infusion of investment dollars into the health care arena as well as increased vertical integration with respect to the health care delivery chain, it has become increasingly challenging for plan fiduciaries to understand the full amount they are paying for services (directly or indirectly) and in some respects *who* they are paying – for example, from what sources a plan service provider may be receiving indirect compensation or other remuneration and whether a downstream provider is in fact an affiliate of the service provider. Accordingly, the Council believes that existing prohibited transactions may require additional detail to ensure that the vertical integration of group health plan service providers and clinical entities/providers does

not provide an opportunity for masking the compensation paid to service providers by plans.

To be clear, such vertical integration is not necessarily to the detriment of plans and participants. In fact, vertical integration has the potential to result in increased efficiencies, lower costs and improved outcomes. However, these types of corporate transactions can result in increased challenges for plan fiduciaries, as well as increased costs, where the relevant parties fail to disclose affiliate status and/or where a plan service provider uses its role vis-à-vis the plan to encourage or cause a plan (or its participants) to utilize a downstream provider and is setting a price for those services. This is especially problematical where such price is at an amount that is higher than fair market value or where the plan can be said to be paying twice for the same service (such as fees for administering access to in-network providers).

In light of this, the Council recommends to the committee that additional detail be added to ERISA's prohibited transaction rules *as they pertain to health plans* – such as ERISA Section 408(b)(2) – to require plan service providers , at a minimum, to disclose to the plan and the plan fiduciary in advance of services being provided (in the case of a downstream provider, both the affiliate status of the party/provider and the cost that will be charged with respect to any services being provided by the affiliate. We note that this recommendation is limited to health plans only and does not extend to retirement plans as there is already sufficient disclosure with respect to retirement plans.

As for exemption standards, it is crucial, as innovation continues in the market place, that plans have the flexibility, without adhering to onerous exemption standards, to enter into contracts that prevent inappropriate use of plan assets, reasonably compensate plan service providers and facilitate the ability of employers to offer their employees high-quality, low-cost coverage. For example, as many employers seek to provide direct access to care through onsite clinics or via direct contracts with medical facilities, overly burdensome exemptions requirements, which are generally foreign to clinical providers (as opposed to service providers to ERISA-covered plans), could limit the ability of plans to enter into reasonably structured arrangements that provide affordable, high-quality care to employees.

DATA SHARING

The committee broadly seeks feedback on ways to improve data sharing between employer-sponsored health plans and contracted entities and, more specifically, the committee seeks feedback on the Consolidated Appropriations Act, 2021 (CAA) prohibition on provisions in health plan service agreements that prevent plan fiduciaries from accessing quality and cost information, known as "gag clauses."

A competitive and value-driven health care market is predicated on transparency. Increased access to pricing and quality data will enable market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes. Many employers that have had success decreasing the rate of health care spending have done so by analyzing their plan data to better understand how much is being spent on specific services and then using plan design features to encourage lower utilization overall or engagement of higher-value, relatively lower-cost providers. Programs focused on leveraging value-based benefit designs and value-based payment reforms can potentially transform our system by realigning incentives to keep participants healthier while at the same time lowering costs. These changes are not feasible without meaningful transparency, specifically where plan sponsors have access to pricing and quality data and the ability to share and use the data to drive lower cost and higher quality health care.

Our plan sponsor members are doing their part to support increased health care transparency. They recognize that access to pricing and quality data is critical to unleashing the power of employers to drive lower cost and higher value health care. We want to ensure the optimal utility of the price *and quality* data to support these employer efforts. Accordingly, we strongly support policies that remove barriers to employers accessing, sharing and using price information to promote higher value health care – notably, one of the principal goals of the "gag clause" provision in the CAA. With respect to the "gag clause" provision, we encourage the agencies to implement the provision with this broader policy goal in mind. We also note that some plan fiduciaries report that they are still struggling to receive this information from TPAs.

We recognize that price is just one side of the value equation – quality is the other. However, the efforts by employers to pursue innovative strategies that improve the value of health care are hampered by inconsistent and incomplete quality metrics. Federal programs can spur these efforts by adopting uniform measures across federal programs. Congress can promote consensus sets of quality measures to incentivize value-based payments. Congress and federal regulators should facilitate cost-effective access to quality data to allow employers, other innovators and academics to define and evolve the quality metrics.

CYBERSECURITY

The committee is seeking feedback on policies to strengthen and build upon privacy protections for employer-sponsored health plans and their business associates. We hope to have further discussion with the committee on this important topic. We stress that HIPAA already contains comprehensive federal protection for the privacy and security of protected health information. We strongly caution against the federal agencies creating additional or inconsistent requirements outside of HIPAA.

DIRECT AND INDIRECT COMPENSATION

The committee seeks feedback on the implementation of the CAA requirement that, when entering into a contract or arrangement with a group health plan, entities engaging brokerage or consulting services disclose to a plan fiduciary a description of the direct and indirect compensation they expect to receive in connection with the services they provide to the plan. We reiterate our strong support for lowering health care costs through increased transparency. The Council supports the goal of clarifying the application of fee disclosure reporting requirements to covered service providers and strengthening requirements for PBMs and TPAs to disclose compensation to plan fiduciaries.

ERISA ADVISORY COUNCIL

The committee seeks feedback on whether Congress should consider expanding the role of the ERISA Advisory Council with respect to health plans to provide recommendations to Congress on issues effecting employer-sponsored health benefits, similar to the Medicare Payment Advisory Committee (MedPAC).

The Council strongly cautions the committee against expanding the role of the ERISA Advisory Council to make recommendations to Congress on issues affecting employer-sponsored health benefits similar to MedPAC. We note that MedPAC has an entirely different mission and Medicare is an entirely different program from the employer-sponsored health plan marketplace. Moreover, MedPAC commissioners have vastly different professional expertise than the ERISA Advisory Council. As a result, we believe that any expansion of the ERISA Advisory Council's role in this regard could provide limited practical benefit while creating headwinds for the kinds of innovation that are the hallmark of the employer-sponsored health care system.

SPECIALTY DRUG COVERAGE

The committee seeks feedback on innovative ways to reduce barriers for employers to cover high-cost specialty drugs for their employees and to share in the savings associated with such coverage.

As the committee notes, new, innovative specialty drugs have the potential to improve the long-term health and lives of patients. Employers recognize the potential value of new therapies to help their employees and family members live longer, healthier lives. Employers have a vested interest in ensuring that employees have access to these life-saving new therapies as science and technology continue to evolve, which may, over time, improve health outcomes, increase productivity and reduce health care utilization – and reduce costs. However, the up-front costs of these therapies can be

astounding. Employers are increasingly concerned about the cost of existing and future high-cost specialty drugs.

We appreciate that the committee recognizes the challenge employers face in paying for these high-cost treatments. We applaud the committee for seeking feedback on innovative ways to reduce barriers for employers to cover high-cost specialty drugs for their employees and to share in the savings associated with such coverage. Tackling this challenge faced by employers while harnessing the value of innovative new therapies calls upon stakeholders to come together and explore market-based solutions, public-private partnerships and government action.

You seek feedback on a number of options for addressing this challenge that are promising and that we seek to work with the committee and other stakeholders to explore further, including:

- Examining the role of reinsurance models
- Identifying - and removing - barriers in ERISA or elsewhere that hinder employers' ability to leverage reinsurance models to mitigate the risk
- Expanding risk pools to lower the collective costs of high-cost specialty drugs
- Facilitating employers, drug manufacturers and other entities in managing the risks and sharing the costs and savings
- Identifying - and removing - any barriers in ERISA that prevent employers from entering into value-based arrangements with drug manufacturers

Employers are already at the forefront of innovative value-based payment models. As Employers and policymakers turn to specialty drug coverage, employers can help lead the way in pioneering innovative payment models. Government policy should facilitate, not hinder, these efforts. Employers face key regulatory hurdles as they seek to address these issues. Notably, rigid application of federal and state rules regarding what constitutes insurance precludes some employers from effectively managing the cost of offering these types of therapies. The Council urges the committee to consider legislation that provides some tailored relief in order to ensure that the most innovative, but expensive therapies available are accessible to as many employees as possible.

The Council also stresses how important it is to employers to promote value-driven prescription drug spending that aligns price with outcomes. In the context of new gene and cell therapies, aligning price with outcomes may be more challenging, but even more imperative.

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For the past 50 years, ERISA has enabled employers to offer robust health benefits to generations of working families across the nation. Today, this foundation of employer-sponsored health coverage is under attack. As we look to the future, ERISA preemption must withstand these attacks and remain the "crowning achievement" of this landmark legislation of 1974. The Council stands ready to assist you in any way possible. Please do not hesitate to reach out with any questions.

Sincerely,

Ilyse Schuman
Senior Vice President, Health Policy