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VIA ELECTRONIC TRANSMISSION

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The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20510

RE: Request for Information: ERISA's 50th Anniversary: Reforms to Increase Affordability and Quality in Employer-Sponsored Health Coverage

Dear Chairwoman Foxx:

On behalf of CareFirst BlueCross BlueShield (CareFirst), we appreciate the opportunity to comment on the Request for Information (RFI) on matters related to the Employee Retirement Income Security Act of 1974 (ERISA). CareFirst is the largest not-for-profit insurer in the Mid-Atlantic region, serving approximately 3.5 million members. In Maryland, Washington, DC, and Northern Virginia, over 70% of small businesses offering health insurance choose CareFirst, and nearly 2.5 million of our 3.5 million members receive our coverage through their or their relative's workplace. On the national level, since 2019, roughly 60% of all non-elderly insured individuals were enrolled in employer-sponsored insurance (ESI)[1] and 50% of children receive health coverage through a parent's or guardian's job.[2] As the largest source of health coverage for non-elderly people, ESI provides coverage to over 180 million Americans and is the foundation of the country's health insurance system.[3]

ERISA plays an essential role in enabling employers to provide affordable health insurance coverage to employees as it defines and regulates ESI as we know it today; and the data illustrates how well it is working. An AHIP survey found over 60% of consumers are satisfied with their current employer-provided coverage, and the vast majority (68%) prefer to get their coverage through their employer rather than through the Federal or state government.[4]

[1] KFF. What are the Recent Trends in Employer-based Health Coverage?
[2] AHIP. The Value of Employer-Provided Coverage.
[3] Ibid.
[4] Ibid.

CareFirst commends the Committee on Education and the Workforce (the Committee) for seeking feedback on ways to build upon and strengthen ERISA. It is crucial for Congress to determine how to optimally position ERISA for the next 50 years, to enable it to continue fulfilling its original purpose of ensuring employers can offer plans tailored to meet the needs of their employees. Specifically, CareFirst recommends Congress clarify state laws that regulate healthcare costs, impose mandates on contracting entities or plan administrators, or regulate extraterritorial group health plan activities are preempted by ERISA. CareFirst believes this clarification is essential for ESI to remain a viable mechanism for the nation's workforce to access affordable insurance coverage. We offer the reasoning for our preemption recommendation and our perspective on other issues raised in the RFI below.

Preemption

As noted in the RFI, ERISA preemption was established to create uniform regulatory standards for employee benefit plans, irrespective of where employees work or reside, and remove the challenge of navigating numerous (and potentially conflicting) state regulations that make it onerous for employers to offer tailored insurance coverage to employees. The preemption provision in ERISA, however, is neither clearly defined nor absolute. This has left ERISA preemption vulnerable to legal challenges, requiring courts across various jurisdictions to interpret the scope of ERISA preemption. The vague phrase "relate to any employee benefit plan" has caused confusion regarding when state laws should be preempted, resulting in several U.S. Supreme Court cases in which the Court has been unable to establish a clear, consistent test for when a state law sufficiently "relates to" an employee benefit plan. Most notably, the 2020 Supreme Court decision in *Rutledge v. Pharmaceutical Care Management Association* has enabled states to pass laws regulating contracted service providers such as pharmacy benefit managers (PBMs), gradually weakening ERISA preemption and necessitating clarification from Congress on the "relate to" language in statute. Since the *Rutledge* decision, legislation has been introduced in multiple states, with several instances of enactment, that regulates healthcare costs through PBMs in order to avoid direct regulation of self-funded health plans. Examples include, but are not limited to, the following: Arkansas (Act 302/SB 94, Act 501/HB1274), Indiana (PL 190/SB 400), Louisiana (Act 254/SB 110, Act 333/SB 188), Florida (HB 1509/SB 1550), Oklahoma (HB 737, HB 2632), Tennessee (HB 2661), West Virginia (HB 2263, HB 4112), New Jersey (A.536), South Dakota (HB 1135), and Kentucky (SB 188).

States should not be able to bypass ERISA preemption by enacting laws that indirectly regulate self-funded health plans through mandates on contracted service providers, such as third-party administrators or PBMs. The legislation and laws listed above would be overridden by ERISA preemption if they applied directly to self-funded group health plans. The proliferation of these laws has started to create a patchwork of requirements for employers that contradicts the original intent of ERISA and will lead to increasing administrative costs to maintain compliance across multiple state regulatory frameworks. Congress should clarify the intent behind ERISA preemption and prevent states from doing indirectly what they cannot do directly.

Self-funded group health plans utilize PBMs to design and implement medical management programs to reduce avoidable medication errors, monitor for drug-to-drug interactions, and encourage medication adherence. PBMs also provide member education and promote the use of clinically appropriate medications and therapies to ensure optimal health outcomes—functions that fall under management of a plan's prescription-drug benefits. Therefore, regulating PBMs, or their contractual terms, equates to regulating the administration of a self-funded group health plan. As such, states should not be permitted to undermine this vital aspect of self-funded group plan administration by imposing their own regulations on PBMs.

ERISA's preemption clause plays an important role in our nation's healthcare system by promoting efficiency and cost-effectiveness in ESI plans. Clarifying the scope of ERISA's preemption clause through Congressional action is necessary to prevent burdensome regulations that threaten the ability of employers to offer affordable, innovative coverage options and, more importantly, to support the continued success of ERISA.

Fiduciary Requirements
CareFirst believes the current definition of fiduciary in ERISA is adequate and does not require clarification by Congress. Any attempts to clarify the definition of fiduciary would add unnecessary complexity for stakeholders.

Cybersecurity
The Health Insurance Portability and Accountability Act (HIPAA) has become the cornerstone of privacy and data security in the healthcare industry. While the healthcare system has changed significantly since 1996, the regulatory framework established under HIPAA continues to provide essential consumer privacy protections by holding health insurers and healthcare providers accountable. HIPAA provides strong consumer protections for data controlled by Covered Entities and their Business Associates. With sensitive health information being increasingly collected, used, and stored by entities not subject to HIPAA, CareFirst recommends Congress expand HIPAA or apply similar requirements to these entities.

Both Federal and state policymakers continue to enact mandates imposing new cybersecurity requirements on the private sector. CareFirst recommends policymakers continue to work toward aligning security requirements to support compliance. Aligning new cybersecurity requirements with existing standards, such as the National Institute of Standards and Technology's (NIST) Cybersecurity 2.0 Framework and other established statutory and regulatory requirements like HIPAA, is fundamental to the success of other policy priorities like interoperability.

Similarly, incident and breach notification requirements can be important for sharing information with regulators to counteract the actions of bad actors, but the current patchwork of Federal, state, and sector-specific rules makes such reporting overly complex and costly. Policymakers should explore ways to reduce the complexity and costs associated with compliance while continuing to differentiate between reporting requirements for information sharing and reporting requirements to regulators that are subject to enforcement actions.

Specialty Drug Coverage
CareFirst regularly develops innovative products and programs to enhance access to high-value care for the communities we serve. We believe it is critical to utilize evidence-based practices to pioneer new ways to better meet the needs of our members and communities in a culturally competent manner. Last year, we helped launch Synergie Medication Collective (Synergie), a new medication contracting organization aimed at improving affordability of drugs under the medical benefit. CareFirst's President and CEO, Brian Pieninck, is a member of Synergie's Board of Directors. We are constantly looking for new ways to better support our members in accessing necessary prescription drugs recognizing the increasing cost are placing undue strain on our nation's families. As the Committee explores innovative ways to reduce barriers for employers to cover high-cost specialty drugs for their employees, we encourage the Committee to develop holistic policies that recognize and leverage current private market solutions but are not limited to them.

For example, CareFirst has a reinsurance solution with BCS Financial and Synergie to help reduce our financial exposure for cell and gene therapies (CGTs). As currently structured, Synergie includes a few products to help promote access and affordability. The Gene + Risk Protection program is meant to reduce financial liability for CGTs. There is also the Cell & Gene + Patient Navigation product which helps patients navigate to the most clinically appropriate care at the lowest cost. Lastly, the Gene+ Outcomes product provides recourse for insurers to recoup money for CGTs that are not successful. There are triggering events identified for each drug or therapy whereby this payout would go into effect. Under our existing reinsurance product, CareFirst provides access to CGTs for members who fall within medical necessity criteria based on evidence-based clinical guidelines. CareFirst believes there is a robust market to manage our financial risk today; however, these market solutions were not designed to account for "blockbuster" scenarios like CGTs that could potentially apply to a large population and result in utilization levels that are much higher than those currently expected for the therapies approved for Sickle Cell Disease. Though current market solutions may be suitable for certain therapies and others with low expected use, CareFirst believes depending entirely on reinsurance and stop-loss products for potential future therapies with uncertain utilization and costs would be short-sighted.

Thank you again for considering our views. We appreciate the Committee taking time to solicit and review recommendations on how Congress can enhance ERISA moving forward to ensure the law remains intact to preserve the availability of affordable ESI for future generations of the American workforce.

Sincerely,

David Schwartz