CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

March 15, 2024

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
United States House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515

RE: Comments on the Request for Information (RFI) on building upon and strengthening the Employee Retirement Income and Security Act of 1974 (ERISA)

Dear Chairwoman Foxx:

On behalf of the Brown University Center for Advancing Health Policy through Research (CAHPR), thank you for the opportunity to provide feedback on potential options to increase affordability of coverage and increase quality and access to care through improvements to ERISA.

The responses to the RFI represent the views of faculty members affiliated with CAHPR at the Brown School of Public Health. CAHPR is a research center that seeks to make fundamental contributions towards understanding and developing policies that reduce costs, enhance patient well-being, and bring about transformations in how health care is provided in the United States. The mission of CAHPR is to bridge the gap between research and policy change by transforming the knowledge gained through research into practical and actionable policies. As a team of health economists, health services researchers, and lawyers, we hope our comments are useful as you consider ways to build up and strengthen ERISA.

ERISA Preemption

Congress passed ERISA in 1974 to provide national standards for employee benefit plans, including reporting, disclosures, fiduciary responsibilities, claims and appeals, and remedies for noncompliance. Congress included broad preemption of state laws that could interfere with the uniform administration of ERISA plans. ERISA preempts "any and all state laws as they may now or hereafter relate to any employee benefit plan."[1]

Clarifying the Scope of ERISA Preemption: The scope of ERISA preemption does not require broadening. The unanimous *Rutledge* opinion properly clarified that Arkansas's law regulating pharmacy benefit manager (PBM) reimbursement rates to pharmacies was a form of health care cost regulation that is not preempted under ERISA.[2] We have not seen evidence that these state laws have prevented

[1] 29 U.S.C. § 1144.
[2] Rutledge v. Pharm. Care Mgmt. Ass'n, 592 U.S. 80, 83, 141 S. Ct. 474, 478, 208 L. Ed. 2d 327 (2020).

multistate employers from offering a uniform set of benefits across state lines. The *Rutledge* opinion clarified that ERISA continues to preempt state laws that laws that (1) require plans to cover specific benefits; (2) bind plan administrators to specific rules for determining beneficiary status; and (3) create acute, indirect, economic effects that force a plan to adopt a certain scheme of coverage.[3] In so doing, *Rutledge* strikes a balanced approach to ERISA preemption that permits state health care cost regulation–a traditional matter of state authority–and preempts state regulation of matters central to plan administration, where uniformity is more desirable.

Nevertheless, Congressional clarification of the scope of ERISA preemption would be helpful both for employer-based benefit plans and for state health policymakers to reduce the resources and time spent litigating whether ERISA preempts salutary efforts to reign in health care costs and improve quality and access. Such clarification could help resolve the unpredictability and confusion[4] around ERISA jurisprudence, at very least by adding a federal waiver mechanism,[5] which has bipartisan support.[6]

Fiduciary Requirements

Approximately 150 million Americans receive health insurance coverage from an employer or union. The most common form of insurance among this population is "self-funded insurance" plans, in which the employer or union sponsors a plan.[7,8] Of the 48.7% of the population with employer-based coverage, 65% are in self-funded plans, or more than 31% of the U.S. population. Most self-funded plans and purchasers rely on third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to administer these benefits. Most plans also rely heavily on brokers and consultants.

Sponsors of self-funded health plans finance health expenses primarily from worker wages.[9,10] As a result, they have an obligation to be responsible purchasers of health benefits. Current plan fiduciary regulations state that, "The primary responsibility of fiduciaries is to run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses."[11]

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[3] *Rutledge*, 592 U.S. at 87-88 (citing New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995)).
[4] Fuse Brown EC, McCuskey EY. The Implications Of Rutledge v. PCMA For State Health Care Cost Regulation. *Health Affairs Forefront*. Published online December 17, 2020. https://www.healthaffairs.org/content/forefront/implications-i-rutledge-v-pcma-i-state-health-care-cost-regulation
[5] McCuskey EY. ERISA Reform as Health Reform. *Journal of Law, Medicine & Ethics*. 2020;48(3):450-461. doi:https://doi.org/10.1177/1073110520958868
[6] NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL). *Resolution in Support of Amending ERISA to Enable State Policymakers to Enact More Meaningful State Health Care Reforms*. NCOIL); 2019. https://ncoil.org/wp-content/uploads/2019/03/ERISA-Resolution-FINAL.pdf
[7] Kaiser Family Foundation (KFF). Health insurance coverage of the total population. KFF. 2022. Accessed March 15, 2024. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0.
[8] Kaiser Family Foundation (KFF). 2023 Employer Health Benefits Survey. KFF. October 18, 2023. Accessed March 15, 2024. https://www.kff.org/report-section/ehbs-2023-section-10-plan-funding/.
[9] Arnold D, Whaley CM. *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*. RAND Corporation; 2020. https://www.rand.org/pubs/working_papers/WRA621-2.html
[10] Baicker K, Chandra A. The Consequences of the Growth of Health Insurance Premiums. *American Economic Review*. 2005;95(2):214-218. doi:https://doi.org/10.1257/000282805774670121
[11] U.S. Department of Labor. Fiduciary Responsibilities. U.S. Department of Labor. Fiduciary Responsibilities | U.S. Department of Labor

Increased guidance on fiduciary requirements: While necessary, these regulations lack guidance on the responsibilities of plan sponsors. In particular, our research has found prices paid by self-funded purchasers are high and variable.[12,13] These prices impact plan participants through higher premiums, lower worker wages, and higher patient out-of-pocket responsibilities, which have been shown to delay access to critical care. The 2021 Consolidated Appropriations Act (CAA) provides guidance on documentation required by plan sponsors from these entities to ensure they disclose potential conflicts of interest. However, neither the Department of Labor fiduciary rules nor the CAA regulations provide guidance on plan responsibilities on appropriate administrative fees.

In addition, Section 201 of Title II of CAA[14] prohibits gag clauses between plans and providers, TPAs, or other service providers that would prevent the disclosure of provider-specific cost or quality information to the plan sponsors, enrollees, or beneficiaries.[15] Group health plans or their TPAs must annually submit an attestation of compliance with the gag clause prohibition starting December 31, 2023.[16] Such information allows plan sponsors to fulfill their fiduciary obligations to provide plan benefits solely in the interest of plan participants only at a reasonable expense.[17] Yet, organizations representing plan sponsors have reported that their TPAs, PBMs, and other service providers continue to refuse to provide plan sponsors with access to the health care data necessary for plan sponsors to fulfill their fiduciary duties.[18] As a result, there is considerable uncertainty about whether service providers share fiduciary responsibilities with plan sponsors and what recourse plans have to ensure their service providers comply with CAA Section 201 to provide the information needed for plan sponsors to satisfy their own fiduciary obligations.

The lack of guidance is particularly relevant given recent legal actions. For example, the Johnson & Johnson (J&J)[19] self-funded plan has recently faced a class-action lawsuit alleging that prices paid by the PBM used by the J&J plan agreed to "excessively high" prices that violate J&J's fiduciary obligations.

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[12] RAND Corporation. Hospital Price Transparency Study Round 4. RAND Corporation. Published 2022. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing/round4.html
[13] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics*. 2019;134(1):51-107. doi:https://doi.org/10.1093/qje/qjy020
[14] Codified at Internal Revenue Code (IRC) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9.
[15] U.S. Department of the Treasury, U.S. Department of Labor, U.S. Department of Health & Human Services. *Gag Clause Prohibition Compliance Attestation*. Centers for Medicare & Medicaid Services (CMS); 2023. Gag Clause Prohibition Compliance Attestation Annual Submission Webform Instructions | US Department of Labor
[16] Gag Clause Prohibition Compliance Attestation | CMS. www.cms.gov. https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/gag-clause-prohibition-compliance-attestation
[17] U.S. Department of Labor, Employee Benefits Security Administration (EBSA).Understanding Your Fiduciary Responsibilities *under a Group Health Plan*. U.S. Department of Labor; 2023. Understanding Your Fiduciary Responsibilities Under A Group Health Plan
[18] The Purchaser Business Group on Health (BPGH). RE: Attestation Requirement Related to Section 201 of the 2021 Consolidated Appropriations Act (CAA), Prohibiting Gag Clauses. Published October 31, 2023. https://www.pbgh.org/wp-content/uploads/2023/10/PBGH-Letter-to-Tri-Agencies-Re-CAA-Section-201-Gag-Clause-Attestations-10.31.2023.pdf
[19] Hansard S. Johnson & Johnson Case Signals Employee Drug Price Suits to Come. *Bloomberg Law*. https://news.bloomberglaw.com/daily-labor-report/johnson-johnson-case-signals-employee-drug-price-suits-to-come. Published February 9, 2024.

Other litigation filed by ERISA group health plans against their TPAs alleged that the TPA bore fiduciary liability for failing to disclose participant claims data in compliance with Section 201 of the CAA.[20] Previous ERISA class action litigation alleged high administrative fees for retirement benefits.[21] As a result of these lawsuits, administrative fees for ERISA-regulated retirement funds have decreased dramatically. Our research shows that in many markets, prices vary by orders of magnitude, with little relationship between price and quality.[22,23,24] Without guidance on the appropriateness of prices or administrative fees, nearly all self-funded plan sponsors potentially face the same liabilities as J&J.

DOL should clarify the terms of health plan sponsors' fiduciary obligations and the circumstances that extend those fiduciary obligations to the plan sponsor's TPAs, PBMs, and other service providers. In particular, it's recommended that if a TPA or PBM withholds plan data, they should share fiduciary responsibility with the plan sponsor. The only way service providers could avoid fiduciary obligations is to fully share the plan sponsor's data for audit and oversight purposes. At the same time, secondary fiduciary status should not interfere with obligations to share plan data with the primary fiduciary, the self-funded plan.

Develop regulations around self-funded plan fiduciaries that ensure ready-to-access plan data: Under existing Department of Labor guidelines, employers who provide health insurance in a self-funded role have a fiduciary responsibility to use plan resources solely for the purpose of providing benefits to plan participants and members. This fiduciary responsibility is essential for employers who offer self-funded insurance because health plan dollars are financed directly from worker wages and other benefits. Increased health care expenses lead to reductions in worker wages.

To ensure they are using health plan resources responsibly, self-funded employers need data to have timely and reliable access to health plan claims data that account for services rendered and incurred costs, as well as payments made to providers on behalf of the plan. Many self-funded plans rely on consultants and external parties to analyze plan data on behalf of the plan. Access to plan data for external data users should also be ensured. Both claims and payment data that cover services incurred by plan members and paid for by the plan should be considered plan assets. Plan sponsors should not be restricted by trade

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[20] Emerson J. Employers are increasingly suing their health plan for claims data . *Becker's Payer Issues*. https://www.beckerspayer.com/payer/employers-are-increasingly-suing-their-health-plan-for-claims-data.html. Published July 20, 2023.
[21] Good Jobs First. Retirement-plan class action payouts by large corporations top $6 billion. Good Jobs First. April 3, 2019. Accessed March 15, 2024. https://goodjobsfirst.org/erisa_prrel/.
[22] RAND Corporation. Hospital Price Transparency Study Round 4. RAND Corporation. Published 2022. https://www.rand.org/health-care/projects/price-transparency/hospital-pricing/round4.html
[23] Chartock BL, Simon K, Whaley CM. Transparency in Coverage Data and Variation in Prices for Common Health Care Services. *JAMA Health Forum.* 2023;4(10):e233663. doi:10.1001/jamahealthforum.2023.3663
[24] Crespin DJ, Whaley C. The effect of hospital discharge price increases on publicly reported measures of quality. *Health Services Research*. 2022;58(1):91-100. doi:https://doi.org/10.1111/1475-6773.14040

secrets or other provisions in using these assets to monitor and audit the performance of the plan, as well as entities contracted by the plan, such as TPAs and PBMs.

Without these data, self-funded plans cannot audit prices and network designs made on their behalf. The inability to monitor plan data and payments makes fulfilling fiduciary obligations challenging. Employers, unions, and other self-funded purchasers cannot be responsible fiduciaries without access to underlying plan claims and payment data. Any regulations around self-funded plan fiduciaries should ensure ready access to plan data.

Data Sharing

Many self-funded plan sponsors face barriers to accessing underlying plan claims and payment data. Third-party administrators routinely place obstacles to data access necessary for plan auditing purposes. These data are essential for plans to be responsible purchasers of health benefits on behalf of plan members.

Reduce barriers for self-funded plan sponsors in accessing plan claims and payment data*:* It should be clarified that plan sponsors own their participants' health care claims data and that third-party service providers' withholding of such data would (a) violate the CAA 2021's prohibition on gag clauses and (b) impose upon the service provider the fiduciary obligations held by the plan sponsor.

If a plan sponsor cannot obtain plan claims and payment data from its service providers, there is no other source to access this information. In the 23 states with all-payer claims databases (APCDs), fully insured group health plans can access their claims data from the APCD. However, self-funded plans cannot. The 2016 Supreme Court decision of *Gobeille v. Liberty Mutual Ins. Co.* held that ERISA preempts state requirements for self-funded plans and their third-party administrators to submit data to the state all-payer claims database (APCD).[25] Since *Gobeille*, a large data gap has emerged with state APCDs missing nearly all claims data from self-funded plans, despite efforts to harmonize state APCD reporting requirements to a common data layout to ease concerns about data uniformity.[26] Even when plan sponsors have attempted to voluntarily opt-in to state APCDs, their TPAs have created barriers to submission through contractual prohibitions and additional fees.[27]

One potential option is statutory clarification about plan sponsors' rights with respect to their claims data, including the right to receive their claims data and/or direct the TPA to submit the data to a relevant

[25] Gobeille v. Liberty Mutual Ins. Co., 577 U.S. 312, 136 S.Ct. 936 (2016).
[26] All-Payer Claims Database (APCD) Council. Common Data Layout. APCD Council. Common Data Layout | APCD Council
[27] McAvey K. *Realizing the Promise of All Payer Claims Databases a Federal and State Action Plan*. Manatt Health Strategies and Robert Wood Johnson Foundation; 2022. Realizing the Promise of All Payer Claims Databases

APCD. In addition, a federal fix for the self-funded plan data gap would provide plan sponsors with the data transparency needed to obtain lower-cost, higher-quality care.

We appreciate the opportunity to provide feedback as you consider next steps. Should you have any questions about our comments, please feel free to contact me at christopher_whaley@brown.edu or Jared Perkins, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.

Sincerely,

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