GNDC
Greater North Dakota Chamber

GREATER NORTH DAKOTA CHAMBER
HB 1584
Senate Industry & Business
Chair Jeff Barta
April 1, 2025

Mr. Chairman and members of the Committee, my name is Arik Spencer, President and CEO of the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** to House Bill 1584.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, **the number one answer was to make healthcare more affordable**. I'm before you today because our members indicate that HB 1584, in both its introduced form and the engrossed form, will increase their health insurance costs instead of making it more affordable.

The federal Employee Retirement and Income Security Act (ERISA) of 1974 was enacted to provide employers with the ability to provide a uniform set of benefits to employees in multiple states. It was also enacted to provide employers with all their employees in one state the ability to self-fund health benefits for employees in a way that allows the employer flexibility in determining the benefits that make the most sense for their employees. And employers who self-fund health benefits for their employees assume all the risk; therefore, such benefits or health plans should not be considered insurance nor subject to the state regulation of insurance.

In North Dakota, close to 430,000 people rely on employer-provided health insurance, which consists of close to 60% of North Dakota's workforce being covered under ERISA-regulated self-funded health plans. These plans are the backbone of our state's health care coverage. ERISA's uniformity is essential to enabling businesses to offer competitive benefits and maintain operational efficiency without the complexities of varying state mandates. For small and medium-sized businesses in particular, ERISA's protections are crucial for providing affordable and consistent benefits across their workforce.

Federal ERISA law and over 50 years of federal case law generally preempt state laws from regulating health plans organized via ERISA. The language of HB 1584 may appear, by some parties, to apply only to pharmacy benefit managers (PBMs). However, enacting this language would result in an illegal attempt by the North Dakota Department of Insurance (DOI) to regulate ERISA plans via PBMs.

Federal ERISA preemption remains broad as described in more detail via the attachment to this testimony. Any attempt to extend current or future anti-PBM or anti-payor state law to ERISA plans violates federal law. The North Dakota business community is alarmed about the potential negative impacts. Because it's plan sponsors (rather than PBMs, who often pass along the regulatory costs) and their employees (working beneficiaries) who ultimately bear the cost of these increased regulatory and benefit costs.

GNDC strongly urges a **DO NOT PASS** recommendation, and I will be happy to stand for questions.

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Supplemental Information regarding HB 1584 – a bill relating to PBMs and ERISA health benefit plans

Federal ERISA preemption

Congress enacted ERISA to provide a "uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 248 (2004). "[B]y mandating certain oversight systems and other standard procedures" pursuant to uniform federal rules, ERISA "make[s] the benefits promised by an employer more secure" for employees while at the same time reducing the administrative burdens for multi-state employers. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016).

To achieve this objective, Congress included a "comprehensive" express preemption clause in ERISA, *id.*, which was "intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." *Shaw v. Delta Air Lines*, 463 U.S. 85, 99 (1983). As a corollary, "[s]tates are precluded from regulating in a field that Congress, acting within its proper authority has determined must be regulated by its exclusive governance." *Arizona v. United States*, 567 U.S. 387, 399 (2012). By protecting plans from competing state laws, ERISA's preemption clause "minimiz[es] the administrative and financial burdens on plan administrators – burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 149-50 (2001) (internal quotation omitted).

Consistent with this Congressional intent, it is well-established under current U.S. Supreme Court precedent that state laws may be preempted where they bear an impermissible "connection with" ERISA plans. This may occur where a state law "bind[s] plan administrators to [a] particular choice" concerning the substance of plan benefits. *Rutledge*, 141 S. Ct. at 480. Such provisions stand in contrast to mere "rate regulation[s]," which have "an indirect economic effect on choices made by . . . ERISA plans" but do not "bind plan administrators to any particular choice" concerning plan design. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 667 (1995). In addition, "state laws dealing with the subject matters covered by ERISA" also have a "connection with" ERISA plans and are preempted. *Shaw*, 463 U.S. at 98. Finally, state laws that "'govern[] a central matter of plan administration" have a connection with ERISA plans and are preempted. *Gobeille*, 136 S. Ct. at 943 (internal quotes omitted).

Recent Judicial Decisions in *Rutledge* and *Wehbi*

Rutledge did not alter the established legal framework for determining whether a law bears an impermissible "connection with" ERISA plans. Rather, it applied that framework to the targeted law in that case, Arkansas's Act 900 ("Act 900"), which regulated maximum allowable cost ("MAC") lists for generic drug reimbursements. The Court held that Act 900 was "merely a form of cost regulation" that "requires PBMs to reimburse pharmacies for prescription drugs at rates equal to or higher than the pharmacy's acquisition cost." 141 S. Ct at 481. Therefore, *Rutledge* categorized Act 900's MAC pricing requirement under its long-standing holding in *Travelers* that state cost regulations are not preempted by ERISA. Otherwise, the Court emphasized that benefit design, structure, coverage, and other central matters of plan administration would remain protected from conflicting state regulations.

Likewise, the Eighth Circuit's decision in *Wehbi* does not change fundamental ERISA preemption standards. Indeed, the court confirmed that state laws that "require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits or by binding plan

administrators to specific rules for determining beneficiary status,'" are preempted. *Id.* at 9 (quoting *Rutledge*, 141 S. Ct. at 480). The court ruled that there is no presumption against ERISA preemption and that, consistent with the D.C. Circuit's decision in *PCMA v. District of Columbia*, 613 F.3d 179, 188 (D.C. Cir. 2010), ERISA preemption applies to laws that regulate PBMs even if they do not regulate ERISA plans directly. *Wehbi* at 6-8.

In addition, the ERISA preemption analysis is fact-specific, and *Wehbi* is a narrow decision, limited to provisions in two unique North Dakota statutes, many of which were directed at pharmacies with only indirect impacts to PBMs and plans. By contrast, in both its introduced and current amended form, the language of HB 1584 would regulate PBMs and self-funded health plans in areas that affect central matters of plan administration, a core ERISA concern. Finally, *Wehbi* has limited persuasive impact, as it frequently relied on cursory reasoning that overlooked several important aspects of ERISA preemption analysis. For instance, the *Wehbi* court failed to recognize that state laws implicating self-funded ERISA plan provider networks strike at the heart of plan benefit design and are subject to preemption. *See Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003) (recognizing that state any-willing-provider law that restricts network design has a "connection with" ERISA plans).