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May 15, 2025

The Honorable Donna Bailey, Senate Chair
The Honorable Kristi Mathieson, House Chair
Of the Joint Standing Committee on Health Coverage, Insurance and Financial Services
c/o Legislative Information Office
100 State House Station
Augusta, ME 04333

**RE: AHIP Comments on LD 1906, An Act to Improve Accountability and Understanding of Data in Insurance Transactions – OPPOSE**

To Senate Chair Bailey and House Chair Mathieson, and Members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services,

AHIP appreciates the opportunity to comment on LD 1906, legislation which runs afoul of federal preemption because of its application to self-insured Employee Retirement Income Security Act of 1974 (ERISA) covered plans.

Today, more than half of Americans receive their health insurance through employer coverage that is governed by ERISA, which affords employers consistency and uniformity of health plan administration. This encourages health care coverage that improves the health and financial stability of employees and their families. In Maine, over 550,000 residents (64% of the state's covered population) are covered by employer insurance. Of those Maine employers that provide coverage to their employees, 59% of those employers offer self-insured ERISA plans.[1]

***AHIP strongly opposes any attempt to regulate ERISA self-funded plans beyond the limits allowed under federal preemption law and jurisprudence.*** We are concerned that LD 1906's contractual requirements for third-party administrators and pharmacy benefit managers pertaining to claims data ownership and full claims audit rights with self-insured plans are preempted by ERISA's transaction and fiduciary duty rules. Should the proposed policies be enacted, they may jeopardize the cost-saving, uniform standards your state's self-insured ERISA employers rely upon to provide affordable health insurance coverage to their employees.

***AHIP supports a single, cost-saving national standard of regulation for employer-provided health care coverage*** – one that gives employers the option to assume financial risk and allows employers to choose specifically tailored and uniform benefits for their employees regardless of where they live. This ensures more affordable coverage that is easier to administer and understand. The alternative, a 50-state patchwork of complicated and inconsistent mandates for employer provided coverage, would cause confusion, and make coverage more expensive for Maine employers and employees.

***We are providing a legal analysis supporting this position.*** Attached, the Groom Law Group as prepared a detailed legal analysis, including a discussion of the ERISA and jurisprudence landscape, a description of the specific provisions included in LD 1906 of concern, and the basis for the federal preemption.

***AHIP Recommendation:*** **To protect Maine's employers from increased health care costs, AHIP urges you to not to pass LD 1906.**

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[1] AHIP, Health Coverage: State-to-State – February 2023. https://www.ahip.org/documents/2023-AHIP_StateDataBook-ME.pdf.

Thank you for your consideration of this important request. AHIP and our member plans stand ready to work with you on this issue. Together, we can advance market-based innovative policy solutions that ensure consumers and employers have access to high-quality and affordable care choices that deliver financial protection and peace of mind – now and for the future.

Sincerely,

Sarah Lynn Geiger, MPA
Regional Director, State Affairs
America's Health Insurance Plans

Encl: AHIP - ME LD 1906 Groom Preemption Memo.pdf

*AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.*

**May 14, 2025**

***ERISA Preemption of Maine Legislative Document 1906***

ERISA preempts any state law that "relates to" an ERISA-covered employee benefit plan. ERISA § 514(a). As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan). A state law "relates to" a plan, and implicates preemption, when it has a "connection with or reference to" an ERISA plan. *Id.* at 147. The Supreme Court has made clear that a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans. *See, e.g., Egelhoff v. Egelhoff*, 432 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).

The Supreme Court clarified two main categories of state law that ERISA would preempt: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319-320 (2016) (internal quotations and citations omitted). Notably, the state law at issue in *Gobeille* applied to the third-party administrator ("TPA") acting on behalf of the ERISA-covered plan. In recognition of the statutory "deemer clause," which prevents states from "deeming" a self-insured, ERISA-covered plan to be an insurer for purposes of the insurance savings clause, the Court held that the Vermont law at issue was preempted, notwithstanding the fact that it applied to the insurer acting as a TPA for the plan. ERISA § 514(b)(2). A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers. *See id.* at 320. The Court in *Gobeille* found ERISA's preemptive effect extended to matters that are "fundamental components of ERISA's regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability." *Gobeille*, 577 U.S. at 323.

In *Rutledge*, the most recent Supreme Court case analyzing ERISA preemption, the Court affirmed both *Egelhoff* and *Gobeille* when reviewing a state law regulating the reimbursement amounts PBMs pay pharmacies for drugs covered by prescription drug plans. *Rutledge v. Pharm. Care Mgt. Assn.*, 592 U.S. 80, 86 (2020). In a narrowly tailored decision, the Court held that because the state law merely regulated costs rather than dictate ERISA-plan choices, it was not preempted by ERISA. *See id.* at 81. In arriving at that decision, the Court focused squarely on the facts of the Arkansas cost-regulation while applying earlier Court precedent addressing the extent to which state-level cost regulation is preempted. Importantly, the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and found that the state law did not govern a "central matter of plan administration" by increasing costs for ERISA plans without forcing plans to adopt certain rules for coverage. *Id* at 80; *Gobeille*, 577 U.S. at 320. Moreover, the Court in *Rutledge* also reaffirmed the long-held view of the Court

that a state law "which requires employers to pay employees specific benefits, clearly 'relate to' benefit plans," and are thus subject to preemption.

More recently, the Tenth Circuit properly read *Rutledge* as being limited to indirect cost regulation. In *Mulready* the court examined an Oklahoma state law that imposed regulations on PBMs and pharmacy networks in an effort to establish minimum and uniform guidelines regarding a patient's right to choose a pharmacy provider. *PCMA v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023). The state law included four key provisions that subjected PBMs to certain rules including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network pharmacies. *See id.* at 1190-1191. The court held that all four provisions were preempted by ERISA because they had an impermissible connection with ERISA plans by mandating certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit). *Id.* at 1199-1200. The court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration." *Id.* at 1200.[1]

**Maine Legislative Document 1906**

Maine Legislative Document 1906 ("LD 1906") imposes additional requirements on TPAs and PBMs with respect to their contracts with self-insured, ERISA-covered plans. Specifically, the bill mandates that these contracts assign ownership of claims data to the plan, instead of the TPA or PBM. The bill also requires that the contracts include an annual right to a full claims audit by the plan of the claims administered by the TPA or PBM.

Much like the Vermont all-payer claims data requirement at issue in *Gobeille*, the provisions of LD 1906 do not necessarily interfere with the application of ERISA's rules governing group health plans. But, ERISA does impose detailed requirements, both through its prohibited transaction requirements and its fiduciary duty obligations, on the manner in which group health plans select, contract with, and monitor their service providers. For example, ERISA prohibits plan fiduciaries from entering into a contract for plan-related services with a party in interest, which includes plan service provider. ERISA § 406(a)(1)(C). ERISA then goes on to exempt from that category of prohibited transactions contractual agreements where the plan has agreed to pay no more than reasonable compensation for the services rendered to the plan. ERISA § 408(b)(2)(A).

Similarly, under ERISA's fiduciary duty of prudence, "a plan sponsor can incur liability when it fails to carefully select or monitor the service provider, and that service provider then

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[1] Notably, the Tenth Circuit also squarely rejected the State's argument that the state law in question was not preempted by ERISA because the law regulates PBMs rather than the actual health plan. *Id.* at 1194. Many courts have recognized that state laws regulating PBMs function as the regulation of an ERISA plan because most plans cannot operate without a PBM. *Id.* at 1195.

breaches a delegated duty. *See* 29 U.S.C. §§ 1104, 1105(c)(2)." *Moitoso v. FMR LLC*, 451 F. Supp. 3d 189, 207 (D. Mass. 2020). Finally, ERISA defines the plan fiduciary on a functional basis with respect to whether or not an individual exercises discretion over, among other things, the assets of the plan. ERISA § 3(21)(A)(i). Taken together these requirements ultimately dictate that when an ERISA-covered group health plan contracts with TPAs and PBMs those contracts must be negotiated in a manner consistent with both ERISA's prohibited transaction rules and the more general fiduciary obligations imposed on the plan fiduciaries negotiating those contracts on behalf of the plan.

Both primary components of LD 1906 seek to regulate areas already governed by ERISA's prohibited transaction and fiduciary duty rules. With respect to the data as a plan asset provision, LD 1906 would effectively dictate the parties that are deemed to be fiduciaries under ERISA. By specifying what property is a plan asset, this provision intrudes upon one of the core regulatory structures imposed under ERISA, and thus both regulates a central matter of plan administration and upsets nationally uniform plan administration, both of which result in the "connection with" test articulated by the Court in *Gobeille*.

Furthermore, because plans have an ongoing need to monitor plan service providers, ERISA already regulates the plan fiduciaries need to access and audit plan-level claims data. While ERISA does not specify the availability of periodic claims audits, those audits are often conducted as a means of ensuring that the plan's fiduciary have exercised sufficient oversight of plan service providers, thus fulfilling their fiduciary duty of prudence. The audit provision of LD 1906 would not necessarily conflict with that requirement, but under the formulation of preemption specified in *Gobeille*, no conflict is necessary. Rather, a state law has an impermissible "connection with" an ERISA-covered plan if it regulates "fundamental components of ERISA's regulation of plan administration." *Gobeille*, 577 U.S. at 323. Because the parallel state regulation imposed under LD 1906 is the kind of regulation that "could create wasteful administrative costs and threaten to subject plans to wide-ranging liability," it too has an impermissible "connection with" ERISA plans and also falls in the face of ERISA's preemption provision.