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January 27, 2026

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Senate Committee on Financial Institutions and Insurance
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Vice Chairperson Michael Fagg
Senate Committee on Financial Institutions and Insurance
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AHIP Comments on Senate Bill (SB) 360: Point-of-Sale Rebate and ERISA Preemption

Dear members of the Committee on Financial Institutions and Insurance,

On behalf of AHIP, we oppose SB 360, which restricts health plans' ability to deliver savings to consumers through lower premiums and out-of-pocket costs and runs afoul of Employee Retirement Income Security Act of 1974 (ERISA) preemption because of its application to self-funded plans.

ERISA Preemption

More than half of Americans receive their health insurance through employer coverage that is governed by ERISA, which affords employers consistent and uniform plan administration and supports employees' health, affordability, and financial stability. In Kansas, more than 1.5 million residents (54% of the state's covered population) are covered by employer insurance. Of those Kansas employers that provide coverage to their employees, 62% 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. ERISA establishes a uniform national framework for self-insured employer health plans, ensuring consistent standards for funding, benefits, and fiduciary practices. The U.S. Department of Labor regulates these plans – not states – to prevent conflicting state-by-state requirements. In practice, employers that self-fund their coverage assume the financial risk for their employees' medical claims, often contracting with health plans to administer the benefits and develop provider networks.

AHIP supports a single, cost-saving national standard of regulation for employer-provided health care coverage, enabling employers to offer consistent, uniform benefits nationwide. This ensures more affordable coverage that is easier to administer and understand. A patchwork of 50-state mandates creates confusion, jeopardizes affordability, and raises costs for employers and employees in Kansas.

We are concerned with the amendment to include of self-funded health benefit plans in the definition of "covered entity" and the subsequent deletion of the existing exemption for self-funded plans from its definition in K.S.A. 40-3822(c) by SB 360. If these proposed amendments should be enacted, they will jeopardize the cost-saving, uniform standards your state's self-funded ERISA employers rely upon to provide affordable health insurance coverage to their employees.

[1] https://www.ahip.org/documents/202407-EPC_StateData-Kansas.pdf

Point-Of-Sale (POS) Rebates

SB 360 does nothing to control the soaring prices of prescription drugs but instead requires health plans to forfeit the savings achieved through manufacturer rebates used to benefit all beneficiaries and instead create a system in which POS rebates are provided to only a select group of health plan beneficiaries.

Everyone should be able to get the medications they need at an affordable cost. Pharmacy spending now accounts for more than 24 cents of every premium dollar – more than any other individual category.[2] Health plans are doing everything in their power to shield Americans from the high and rising cost of drugs by pursuing innovative approaches to make prescription drugs more affordable. But the underlying problem is the list price, which drug companies alone set and control without oversight.

Health plans and PBMs use market competition to negotiate rebates from drug manufacturers, lowering overall drug costs. Manufacturers typically offer rebates only when multiple therapeutically comparable drugs compete for formulary placement. Rebates are rarely paid for generics and other drugs without therapeutic equivalents – the majority of drugs dispensed.

POS rebates benefit a few patients but raise costs for everyone. Health plans currently pass on manufacturer rebates through lower premiums and/or cost sharing for all enrollees. SB 360 would instead require health plans to redirect those savings to the small subset of enrollees taking rebate-eligible drugs, limiting the broader impact rebates currently provide.

Because 90% of prescriptions filled are for generic[3] – products that typically do not receive rebates – this proposal would not help those patients, nor those using brand-name drugs without therapeutic competition. The California Health Benefits Review Program (CHBRP) found that a similar policy would only affect 3.48% of prescriptions.[4]

Evidence repeatedly shows that mandating POS rebates increases costs. When a comparable requirement was implemented in the Medicare Part D program, CMS's own actuaries estimated a 25% increase in premiums and federal spending by approximately $200 billion.[5] California reached similar conclusions, projecting a $200 million annual premium increase, which led its Senate Appropriations Committee to halt the proposal. Congress has likewise declined to allow the federal "rebate rule" to take effect.

POS rebates provide a "windfall" to drug manufacturers. Many patients who use brand-name drugs already have minimal or no cost sharing due to manufacturer coupons and similar programs. Under this bill, manufacturers would no longer need to offer patient assistance – allowing them to retain more revenue while driving up drug costs and insurance premiums. In addition to their findings of increased premiums, CMS's actuaries also estimated the proposed rebate rule would lead to a $137 billion windfall for drug manufacturers. Pharmaceutical manufacturers deliberately advocate for a focus on rebates rather than list prices to avoid legislation addressing the more serious issues surrounding the lack of competition, transparency, and accountability in their pricing of prescriptions drugs.

AHIP Recommendations

- AHIP urges you to (1) amend SB 360 to retain the self-funded ERISA exemption as it currently exists at K.S.A. 40-3822 and (2) remove the POS rebate provisions because they restrict health plans' ability to pass on savings to consumers through lower premiums and out-of-pocket costs.

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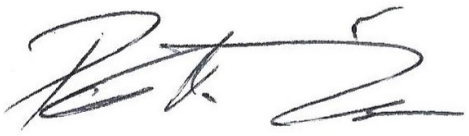
[2] Where Does Your Health Care Dollar Go? AHIP.

[3] *Generic Drugs*. FDA. Accessed January 13, 2025.

[4] Abbreviated Analysis of CA AB 933 Prescription Drug Cost Sharing. California Health Benefits Review Program. January 4, 2022.

[5] Memo On Proposed Safe Harbor Regulation. Center For Medicare & Medicaid Services Office Of The Actuary January 31, 2019.

Thank you for your consideration of this important request. AHIP and our member plans stand ready to work with you on these issues. 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.



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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.