No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE STATES OF NEW YORK, MARYLAND, MASSACHUSETTS, NEW HAMPSHIRE, OREGON, AND UTAH AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Many States require health-care payers to report certain basic data about paid medical claims to state databases, which are used to improve health-care policy. These state laws apply equally to all public and private plans, including traditional plans, self-funded plans, government programs such as Medicare, and third-party administrators.

The question presented is:

> Whether ERISA preempts a state health-care data collection law as applied to a self-funded ERISA benefit plan, even though the law does not regulate, much less conflict with, the financial disclosures that are required by ERISA in order to assure the financial soundness of a plan.

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INTEREST OF THE *AMICI*[1]

This case presents an important question of preemption under the Employee Retirement Income Security Act of 1974 (ERISA). At stake is whether States can audit the cost and effectiveness of the health care provided within their borders and to their residents by requiring all in-state health-care payers—including self-funded insurance plans[2]—to report medical claims data that such payers collect in the ordinary course of business. At least sixteen States have enacted legislation creating health-care data collection programs of this type.[3]

In the decision below, a divided panel of the Second Circuit held that ERISA preempts these state laws as they apply to self-funded insurance plans. That decision misapprehends the purpose of the laws at issue and rests on an overbroad view of ERISA preemption that this Court long ago abandoned. If

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[1] *Amici* States submit this brief pursuant to Supreme Court Rule 37.4. Counsel of record for all parties received timely notice of *amici* States' intent to file this brief.

[2] A self-funded insurance plan is one in which the employer itself bears the cost and risk of paying for employee health care, instead of contracting that risk to an outside insurance company.

[3] Colo. Rev. Stat. § 25.5-1-204; Conn. Gen. Stat. § 38a-1091; Kan. Stat. Ann. § 65-6804; Me. Rev. Stat. Ann. tit. 22, §§ 8703, 8704; Md. Code Ann., Health-Gen. § 19-133; Mass. Gen. Laws Ann. ch. 12C, § 12; Minn. Stat. Ann. § 62U.04; N.H. Rev. Stat. Ann. § 420-G:11-a; N.Y. Pub. Health Law § 2816; Or. Rev. Stat. § 442.466; R.I. Gen. Laws § 23-17.17-10; Tenn. Code Ann. § 56-2-125; Utah Code Ann. § 26-33a-106.1; Vt. Stat. Ann. tit. 18, § 9410; Va. Code Ann. § 32.1-276.7:1; W. Va. Code § 33-4A-2.

left uncorrected, the decision below will diminish the ability of States to improve the quality and affordability of the health-care services available to their residents.

Amici are the States of New York, Maryland, Massachusetts, New Hampshire, Oregon, and Utah. Each *amicus* State either has created or is developing an all-payer claims database (APCD) to store and analyze medical claims information from all health-care payers within the State. That data describes the health-care services provided within the State and to state residents, and it includes information about the patient's diagnosis, the service provided, the cost of the service, the identity of the provider, and the patient's demographic characteristics (*e.g.,* age and sex). Health-care payers, including the respondent in this case, typically collect this information in the ordinary course of their business. State APCD laws require them to transmit the information they collect to the State, for use in a manner consistent with the privacy protections of the federal Health Insurance Portability and Accountability Act (HIPAA).

In the eleven States with fully functional APCDs, these databases have been a valuable tool for improving the quality and efficiency of health-care services. State authorities have used them to study the frequency and costs of particular types of health-care claims across insurers, regions, or providers, and to develop responsive policies.

New York and Connecticut, which are directly affected by the decision below, are among the five States currently developing and implementing APCDs. New York enacted authorizing legislation in 2011, *see* Ch. 59, pt. H, § 38, 2011 McKinney's N.Y.

Laws 263, 367-68 (*codified as amended at* N.Y. Pub. Health Law § 2816), and after several years of pilot studies and other preparatory work, the State is now about a year away from launching an operational database. To date, New York has allocated $10 million for its APCD project. Likewise, Connecticut has been developing its APCD for several years, *see* Conn. Gen. Stat. § 38a-1091, and has received a $6.5 million federal grant to implement its database, which it expects will be operational by the end of 2014, *see* Conn. Health Ins. Exchange, *Policies and Procedures: All-Payer Claims Database,* 1-3 (Dec. 5, 2013); *see also* The Kaiser Family Found., *State Marketplace Profiles: Connecticut* (Sept 27, 2013).

The decision below threatens to disrupt these important health-care policy initiatives. The usefulness of an all-payer claims database comes principally from its comprehensiveness. If a large and distinctive category of payers need not report medical claims data to a state APCD, the database will not accurately reflect the availability and cost of local health-care services, and state authorities cannot rely on it to help them develop health-care policies with a robust evidentiary basis.

Moreover, in the few short months since the Second Circuit's decision, the Sixth Circuit has already rejected its reasoning. The Sixth Circuit criticized the Court below for failing to adhere to the test that this Court has applied in the last two decades—namely, whether the state law actually interferes with the administration of ERISA plans. This circuit split on the fundamental character of ERISA preemption affords an additional reason to grant certiorari.

ARGUMENT

I. The Decision Below Diminishes the Ability of States to Secure Efficient and Effective Health Care for Their Residents.

A. State APCD Laws Promote Efficient and Effective Health Care by Allowing Evidence-Based Policymaking.

Sixteen states, including all of the *amici* states, have enacted APCD laws similar to the Vermont law struck down as preempted in this case. The purpose of these laws is unambiguous: it is to provide the States with data they need to improve the quality of health care while controlling costs. For example, Vermont enacted the law at issue here "to ensure that all residents have access to quality health services . . . and, until health care systems are successful in controlling their costs and resources, to oversee cost containment." Vt. Stat. Ann. tit. 18 § 9401(a) (Pet. App. 91). Connecticut likewise enacted its APCD law to foster "economically sound and medically appropriate health care decisions." Conn. Gen. Stat. § 38a-1091(b)(4)(A). And in New York, APCD legislation was proposed and passed on the understanding that it would "go a long way to improving the quality of care and controlling costs." *See* State Budget Includes Major Health Reforms: Statement by N.Y. State Assembly Health Committee Chair Richard N. Gottfried, March 31, 2011.

Thus, state APCD laws are centrally concerned with "the safe and effective provision of health care services," contrary to the Court below (*see* Pet. App. 18 n.8), and for that reason operate in an area where the presumption against preemption is at is

strongest. The close relationship of state APCD laws to the provision of health-care services is confirmed by their express language calling for the use of APCD data in health-care policymaking. Vermont's law instructs state authorities to use its APCD data for, *inter alia*, "determining the capacity and distribution of existing resources," "identifying health care needs and informing health care policy," "comparing costs between various treatment settings and approaches," and "providing information to consumers and purchasers of health care." Vt. Stat. Ann. tit. 18 § 9410(a) (Pet. App. 92). Similarly, Connecticut's law directs officials to use the State's APCD data "to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors." Conn. Gen. Stat. § 38a-1091(c)(2). And New York's statute entrusts oversight of its APCD to the Commissioner of Health, who is authorized to use the data to "[e]valuate reform efforts," make "strategic assessments of health care disparities," and "[i]dentify high-performing communities that provide cost-effective care" in ways that could be applied elsewhere. *See* N.Y. State Dep't of Health, *All Payer Database*.

The experiences of the eleven States with fully functional APCDs even more strikingly show how APCDs help to promote efficient and effective health care. New Hampshire has used its APCD to set priorities for improving local access to medical services, by studying the circumstances in which its residents travel to other States to obtain health care. Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health-Care Transparency* 5 (The Commonwealth Fund Issue Brief, Sept. 2010). In Colorado, health-care consumers can use the

State's APCD to compare the prices that different medical providers charge for the same procedure; the cost of a magnetic resonance imaging examination of the knee, for example, ranges from $297 to $1,261 across the twenty largest providers in that State. *See* Ctr. for Improving Value in Health Care, *Imaging Services: Range of Average Imaging Payments to Facilities—2011*. And Utah, in an innovative program, analyzes APCD data about the preventive care its healthiest citizens receive in order to improve the efficacy of preventive care to other citizens. *See* Utah Dep't of Health, *Making* Cents *of Utah's Healthy Population*, Utah Atlas of Health Care, Oct. 2010.

Although New York is still in the process of implementing its APCD, a regional pilot study has already alerted its health authorities that one out of every six hysterectomies performed in the State may be medically unnecessary. *See* N.Y. State Dep't of Health, *New York State All Payer Database Use Cases* 8-9 (Oct. 12, 2011). Based on other states' experiences, New York's health authorities anticipate that its APCD will eventually allow policymakers and health care plans to identify and study, *inter alia*, anomalies in care suggesting a failure to keep pace with evolving medical science, underuse of services resulting in poor health or death, overuse of services resulting in unnecessary and even harmful procedures, misuse of services and treatment errors, and disparities in quality of services across demographic groups. *Id.*

In sum, there can be no dispute that state health-care data collection laws advance the States' regulation of "matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*,

520 U.S. 806, 814 (1997) (citing *Hillsborough County v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985)). That conclusion finds clear support in the legislative purpose and content of these laws, and in the evidence of how States have put them to use.

B. The Decision Below Undercuts State APCD Initiatives By Excising Key Demographics From State Databases.

In the decision below, the court of appeals held that ERISA preempts the application of state APCD laws to self-funded insurance plans. The direct effect of that ruling will be to create significant and serious gaps in the medical claims data available to state authorities. The vast majority of large companies with more than one-thousand employees insure their workers via self-funded plans (more than eighty-five percent, nationwide), and most private-sector workers with health coverage are insured through such plans (nearly sixty percent, nationwide). *See* Employee Benefit Research Inst., *Self-Insured Health Plans: State Variation and Recent Trends By Firm Size*, Notes, Nov. 2012, at 1. In particular, companies with young, healthy employees are especially likely to opt for self-funding, while traditional commercial insurers are increasingly likely to cover a disproportionately older workforce. *See* Robert Pear, *Employers With Healthy Workers Could Opt Out of Insurance Market, Raising Others' Costs*, N.Y. Times, Feb. 18, 2013, at A9.

If the medical claims data of a large and distinctive subpopulation is omitted from a State's APCD, the APCD will not be able to accurately capture the availability and cost of the health-care services provided within the State and to state

residents. Consequently, state authorities will not be able to rely on the APCD to help them develop health-care policies underpinned by a robust evidentiary basis. The decision below thus threatens to undercut the integrity of state APCDs, and significantly diminish the ability of States with APCD laws to regulate health care through the evidence-based approaches they have elected.

II. The Decision Below Invokes an Overly Broad View of ERISA Preemption That Is in Tension with Recent Precedents of This Court and the Sixth Circuit.

The decision below also threatens harm to state interests through its sweeping approach to ERISA preemption, which is inconsistent with this Court's recent decisions. The Second Circuit essentially held that Vermont's APCD law is preempted by ERISA because both laws contain reporting requirements. The Second Circuit reasoned that ERISA must bar the application of state APCD laws to self-funded plans because APCD laws require reporting of medical claims data and "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." Pet. App. 23; *see also Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) ("subject matters covered by ERISA" include "reporting, disclosure, fiduciary responsibility, and the like").

But as the dissenting judge observed, that approach "misses the nuance of what 'reporting' means in the context of ERISA, and ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted." Pet. App. 32-33 (Straub, J., dissenting in part and concurring in part)). The

state APCD laws at issue here—and the similar APCD laws of the *amici* States—do not conflict with any of ERISA's reporting requirements. ERISA's reporting requirements largely concern disclosure of plan details and finances. *See* 29 U.S.C. §§ 1021-1030. Their purpose is to ensure that plan administrators provide beneficiaries and the United States Department of Labor with information to assess whether the plans are fiscally secure and free from mismanagement or misappropriation of funds. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 15 (1987). In contrast, APCD laws require reporting of medical claims data with the aim of helping States to promote better delivery of health care. There are no points of overlap between State APCD reporting requirements and ERISA's reporting requirements. It thus "make[s] no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate." *Id.* at 16.

ERISA preempts state laws "*insofar* as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). As this Court has emphasized, that limiting phrase preserves a role for state regulations that do not overlap with or burden compliance with ERISA's requirements, and accordingly do not interfere with ERISA's core purposes. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (overlap); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (burden).

The decision below is in grave tension with that principle by holding that even when a state requirement "differs in kind from the 'reporting' that

is required by ERISA," the preemption analysis is unchanged. Pet. App. 24 n.11 (quotation marks omitted). The Second Circuit reasoned that "[a] hodge-podge of state reporting laws, each *more* onerous than ERISA's uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption." Pet. App. 24 n.11 (emphasis in original). But that view misconceives the purposes of ERISA and ERISA preemption. Congress enacted ERISA to "prevent abuses of the special responsibilities borne by those dealing with plans." *Fort Halifax*, 482 U.S. at 15 (quotation marks omitted). ERISA's preemption clause serves that aim by shielding the statute's requirements from potentially inconsistent state regulations that would burden ERISA's objectives by interfering with the obligations it imposes.

The Second Circuit's expansion of ERISA preemption has already precipitated a circuit split. The Sixth Circuit has expressly rejected the decision below, criticizing the Second Circuit for resting its preemption holding on the grounds that both ERISA and Vermont's statute involve "reporting" in a literal sense. *Self-Insurance Inst. of Am., Inc. v. Snyder*, No. 12-2264, --- F.3d ---, 2014 WL 3804355, at *7 (6th Cir. Aug. 4, 2014). The Sixth Circuit, in upholding the law at issue in its case—a one-percent tax on all health-care claims paid for services to Michigan residents that also required plans to submit quarterly tax returns to the state treasury and maintain records for audit purposes, *id.* at *1—took it as a given that States may require employee-benefit plans to submit many kinds of reports, so long as the States do not intrude on ERISA's exclusive regulation of "reports related to the plans' financial stability." *Id*. at *5-*6.

More broadly, the Sixth Circuit recognized that ERISA preemption does not "preclude states from enacting administrative burdens—of any kind—upon plan administrators and sponsors unrelated to the administration of the plans." *Id.* at *5 (citing *Travelers*, 514 U.S. at 655). Rather, the court held, "Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans."[4] *Id.* (emphasis added).

The Sixth Circuit's view is the correct one. Where there are no inconsistent state regulations and no burden on ERISA's objectives, ERISA should not be permitted to "bar state action in fields of traditional state regulation." *Travelers*, 514 U.S. at 655. The Second Circuit's reasoning, by disregarding that principle, would allow ERISA to become a special shield for the very entities it is intended to regulate. Indeed, the "burden" that the Second Circuit found dispositive here was simply the basic financial cost to the self-funded plan of complying with a new rule. Pet. App. 25-27; *see also* Pet. App. 39 (Straub, J., dissenting in part and concurring in part).

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[4] The Sixth Circuit, after rejecting the Second Circuit's ERISA analysis, also distinguished the case before it on the additional grounds that Michigan's law involved the core state function of tax reporting, whereas the data collection law at issue in the Second Circuit's decision appeared not to implicate a core state function. *Self-Insurance Inst. of Am., Inc.*, 2014 WL 3804355, at *7. However, the issue of data collection for APCD purposes was not before the Sixth Circuit, and neither party to its case had occasion to explain why claims-data reporting is in fact inextricably linked to the core state function of improving health care.

As this Court has made clear, however, a state law of "general application" may impose reasonable financial burdens on ERISA plans without being preempted. *De Buono*, 520 U.S. at 815; *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir. 1989) ("If ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." (quotation marks omitted)). In any event, there is considerable irony to the Second Circuit's finding that mandatory participation in a state APCD burdens self-funded plans, because APCD laws are wholly aimed at improving health-care delivery. As New York and other *amici* States have found, health plans can use APCDs to improve their reimbursement models, tailor their contracts to the needs of particular geographic areas, and compare costs across hospitals and providers. See *supra* at 4-7. Any cost associated with reporting APCD data is likely to be counterbalanced by the utility of the data itself.

That the benefits of mandatory participation in a state APCD program will likely exceed any costs is especially clear because APCDs do not require plans to collect any new information. Plans receive claims data from providers and physicians in the ordinary course of their business. To comply with state APCD reporting requirements, the plan need only forward that information to the agency responsible for maintaining the database. As the dissent below noted, respondent's third-party administrator has been providing data to Vermont's APCD for all of its other clients, because the data consists only of "after-the-fact information" that the administrator already

possesses. Pet. App. 39 (Straub, J., dissenting in part and concurring in part). A self-funded plan's preference not to submit its data to a state APCD should not be permitted to undermine the important state interests served by that APCD.

The Second Circuit failed to adhere to this Court's instruction that claims of federal preemption "in fields of traditional state regulation," such as health care, must be addressed "with the starting presumption that Congress does not intend to supplant state law," *Travelers* 514 U.S. at 654-55. Pet. App. 18. To justify its departure from that guiding principle, the Court below advanced a severely narrow view of the presumption's scope.

But this Court's cases do not permit the conclusion that a state health-care law must *directly* dictate "the safe and effective provision of health care services," Pet. App. 18 n.8, in order to merit a presumption against federal preemption. Indeed, the Second Circuit's approach cannot be squared with the far broader understanding of the presumption that this Court adopted in *De Buono*, where it recognized that a gross-receipts tax on all in-patient hospital services, although "a revenue raising measure, rather than a regulation, . . . clearly operates in a field that has been traditionally occupied by the States"—namely, "the regulation of matters of health and safety." 520 U.S. at 814 (internal quotation marks omitted). As *De Buono* makes clear, a presumption against federal preemption applies to any state law enacted to improve health care, whether it advances that goal by directly regulating providers, or by indirectly strengthening the health-care system. *See De Buono*, 520 U.S. at 814.

The effect of the Second Circuit's approach to ERISA preemption in this case is to curtail States' authority to regulate not only here but also in many areas of traditional state interest, including health and safety, taxation, and licensing. See Pet. 32-33. Congress did not contemplate that outcome when enacting ERISA.

CONCLUSION

The petition for a writ of certiorari should be granted.

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