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

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

**BRIEF FOR THE UNITED STATES AS AMICUS CURIAE**


M. PATRICIA SMITH
*Solicitor of Labor*
G. WILLIAM SCOTT
*Associate Solicitor*
NATHANIEL I. SPILLER
*Counsel*
MELISSA MOORE
*Attorney*
*Department of Labor*
*Washington, D.C. 20210*

DONALD B. VERRILLI, JR.
*Solicitor General*
*Counsel of Record*
EDWIN S. KNEEDLER
*Deputy Solicitor General*
JOHN F. BASH
*Assistant to the Solicitor General*
*Department of Justice*
*Washington, D.C. 20530-0001*
*SupremeCtBriefs@usdoj.gov*
*(202) 514-2217*

## QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts, as applied to self-insured health benefit plans or their third-party administrators, a Vermont statute that requires healthcare payers to report claims and healthcare-services data to a state agency.

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## INTEREST OF THE UNITED STATES

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

## STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is designed to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C.

1001(b). The statute requires every plan to be established and maintained pursuant to a written instrument and to have named fiduciaries who have authority to control and manage the administration of the plan and its assets. 29 U.S.C. 1102(a)(1), 1103(a). With specific exceptions, ERISA preempts "any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. 29 U.S.C. 1144(a).

Various provisions of ERISA impose reporting requirements on plans. Plan administrators generally must file detailed financial and actuarial information with the Secretary of Labor (Secretary). See 29 U.S.C. 1021(b), 1023, 1024(a). In addition, plan administrators must file reports with the Secretary when certain events occur, such as when a pension plan winds up its affairs, 29 U.S.C. 1021(c), or when the employer fails to make a payment required under ERISA's minimum funding standard, 29 U.S.C. 1021(d). Under 29 U.S.C. 1024(a)(3), however, the Secretary has exempted welfare plans from most reporting requirements. See 29 C.F.R. 2520.103-1, 2520.104-20, 2520.104-44. Only when a welfare plan's assets are held in trust must it provide the Secretary with financial information. 29 C.F.R. 2520.103-1.

In addition, the Secretary has broad authority to investigate health plans for enforcement purposes. See 29 U.S.C. 1132(a)(5) (authority to enforce statutory provisions or enjoin violations); 29 U.S.C. 1134 (authority to investigate). Such investigations typically entail the inspection of plan documents, administrative contracts, and claims records to determine whether breaches of fiduciary duty or violations of the claims-processing rules have occurred or whether a

plan is out of compliance with other legal requirements. ERISA also authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." 29 U.S.C. 1143(a)(1).[1]

2. a. A Vermont statute requires the Green Mountain Care Board (Board), a state agency, to maintain a healthcare-information database. Vt. Stat. Ann. tit. 18, § 9402(17) (2012), *id.* § 9410(a) (Supp. 2014) (Database Statute). The database is designed to help the state government achieve a variety of health-policy objectives, including "identifying health care needs," "comparing costs between various treatment settings and approaches," "determining the capacity and distribution of existing resources," and "providing information to consumers and purchasers of health care." *Id.* § 9410(a)(1) (Supp. 2014).

The Database Statute requires "[h]ealth insurers" and other entities to submit to the Board "reports, data, schedules, statistics, or other information" that the Board finds necessary. § 9410(c)-(d) (Supp. 2014). In particular, it authorizes the Board to require health insurers to file "health insurance claims and enrollment information" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* § 9410(c)(1) and (3) (Supp. 2014). The Board is authorized to enforce the Database Statute

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[1] The Secretary has informed this Office that, in aid of his authority to ensure compliance with ERISA's fiduciary standards and claims-processing rules, the Secretary is currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, utilization of medical services, and plan administration.

through the imposition of financial penalties, *id.* § 9410(g) (Supp. 2014), and through its general subpoena power, Vt. Stat. Ann. tit. 18, § 9374(i) (Supp. 2014); *id.* § 9412(a) (2012).

In 2008, the Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Commissioner), who had authority to enforce the Database Statute until June 7, 2013, promulgated a regulation to implement the statute. See Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) (Database Regulation); see also 2013 Vt. Acts & Resolves 724-727 (transferring authority to administer statute to the Board). The Database Regulation provides that "[h]ealth insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information." § 4(D). It includes requirements for how the data must be formatted and when it must be submitted, as well as confidentiality protections. *Id.* §§ 5-8. The Database Regulation defines "[h]ealth insurer" to include any "third party administrator" and "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *Id.* § 3(X). It exempts health insurers with fewer than 200 enrolled or covered members from the reporting requirements (although they may voluntarily comply). *Id.* § 3(Ab) and (As).

b. Respondent is the named fiduciary and administrator of an ERISA self-insured health plan covering 80,000 individuals, 137 of whom are Vermont residents. Pet. App. 7, 50. A self-insured plan is one in which the plan sponsor pays claims out of its own assets, rather than contracting with an insurance

company to pay claims under an insurance policy. *Id.* at 7. Self-insured plans may be administered by a third party, however, and respondent has contracted with Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross) to serve as the plan's third-party administrator in Vermont. In that capacity, Blue Cross handles administrative functions such as claims processing, bill review, and claims payments. *Id.* at 8, 50-51.

In August 2011, the Commissioner issued a subpoena to Blue Cross, seeking eligibility information and medical- and pharmacy-claims files for Vermont residents covered by respondent's plan. Pet. App. 8-9. Respondent, believing that the request was preempted by ERISA, instructed Blue Cross not to comply with the subpoena. *Id.* at 9.

3. Respondent filed suit in the United States District Court for the District of Vermont against the Commissioner.[2] Pet. App. 48. Respondent sought a declaratory judgment that the Database Statute and Database Regulation "are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to [respondent's health benefit] [p]lan or its participants and beneficiaries." Cert. Reply Br. App. 16. Respondent also sought to enjoin the Commissioner "from attempting to obtain, from [Blue Cross] or any other source, any medical records or data relating to the [p]lan or its participants and beneficiaries." *Id.* at 17.

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[2] Vermont's Department of Banking, Insurance, Securities, and Health Care Administration was renamed the Department of Financial Regulation in 2012. 2012 Vt. Acts & Resolves 57; see Pet. App. 49 n.1.

The Commissioner moved to dismiss the complaint for lack of standing and, alternatively, on the merits. D. Ct. Doc. 15, at 1 (Sept. 15, 2011). Respondent moved for summary judgment. D. Ct. Doc. 35 (June 25, 2012). Respondent argued generally that, due to their asserted complexity, the Vermont reporting requirements impose burdens on the administration of its ERISA plan, but respondent did not submit any affidavits describing or quantifying the alleged burdens. See D. Ct. Docs. 35-37 (June 25, 2012).

The district court concluded that respondent had sufficiently alleged standing but granted the Commissioner's motion to dismiss on the merits and denied respondent's motion for summary judgment. Pet. App. 48-80. The court held that although "[c]ompliance with the reporting requirements * * * may have some indirect effect on health benefit plans," the possible "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." *Id.* at 78. The court emphasized that respondent had "not submitted any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.* at 73 n.5.

4. Respondent appealed. The Acting Secretary of Labor filed an amicus brief in favor of the Commissioner in the court of appeals, arguing that ERISA does not preempt the Database Statute or Database Regulation. In a divided decision, the court of appeals reversed, holding that the Vermont reporting requirements are preempted. Pet. App. 1-47.[3]

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[3] Every member of the panel agreed that respondent has standing. See Pet. App. 9-10; *id.* at 30 (Straub, J., dissenting in part and concurring in part).

a. The court of appeals began by explaining that under this Court's construction of ERISA's preemption provision, 29 U.S.C. 1144(a), "a state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (brackets in original) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court of appeals further explained, however, that this Court has made clear that the preemption provision's "relate to" requirement cannot be read literally, because "if the phrase 'were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.'" *Id.* at 19 (quoting *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (*Travelers*)). The court of appeals understood this Court's decisions to teach that "'state statutes that mandate[] employee benefit structures *or their administration*' have a 'connection with' ERISA plans and are therefore preempted." *Id.* at 20 (brackets in original) (quoting *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 328 (1997) (*Dillingham*)).

Applying those principles, the court of appeals held that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" and are therefore preempted. Pet. App. 23 (footnote omitted). Although the court cautioned that "[n]ot every state law imposing a reporting requirement is preempted," *id.* at 24, it determined that "the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky," *id.* at 25. The court noted that Vermont could change the requirements at any

time, *id.* at 27, and it postulated that if respondent were subject to "one of several or a score of uncoordinated state reporting regimes," the burden would be "obviously intolerable," *id.* at 25.[4]

b. Judge Straub dissented in relevant part. Pet. App. 30-47 (dissenting in part and concurring in part). Adopting the view of the Acting Secretary's amicus brief, he concluded that the Vermont reporting requirements do not have a sufficient "connection with" ERISA plans to fall under the preemption provision. *Id.* at 47. Judge Straub explained that in analyzing the preemption issue, "[t]he distinction between general administration and administration of plans, claims, and benefits is important." *Id.* at 42. "Many state laws," he continued, "may have an impact on the administration of an ERISA plan—for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Ibid.* Although "[s]uch laws may impose additional costs," he concluded, "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Ibid.* (citing *Dillingham*, 519 U.S. at 319). Judge Straub also found that "on the record before [the court,]" no basis existed to conclude that the Vermont reporting requirements would "hinder the national administration of employment benefit plans in any way," because

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[4] The court of appeals had no occasion to address whether its holding applies to insurance companies that insure ERISA plans. ERISA generally exempts from its preemption provision "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A); see *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329, 341-342 (2003).

"[n]o new records need be kept" to comply with the reporting obligation. *Id.* at 44; see *id.* at 41-42.

5. Approximately one month before the court of appeals issued its decision, a Vermont statute transferred the responsibilities for administering the reporting requirements from the Commissioner to the Chair of the Board. See p. 4, *supra*. The Commissioner did not file a motion for substitution of parties in the court of appeals, see Fed. R. App. P. 43(c)(2), and she subsequently filed a petition for rehearing, which was denied, Pet. App. 81-82. The Chair of the Board, however, filed the petition for a writ of certiorari in this Court. The petition states that the Chair was automatically substituted for the Commissioner under Rule 35.3 of the Rules of this Court. See Pet. ii.

**DISCUSSION**

The court of appeals erred in holding that the Vermont reporting requirements that respondent challenges are preempted by ERISA. Moreover, with the encouragement of the federal government, other States are establishing similar healthcare databases to help improve health outcomes for their citizens, and thus the question presented has national importance. But the decision of the court of appeals does not conflict with any decision of this Court or another court of appeals, and this Court's consideration of the question would likely be aided by further percolation in the courts of appeals. Accordingly, the petition for a writ of certiorari should be denied.

1. As a threshold matter, petitioner, the Chair of the Board, is an appropriate party to seek certiorari review in this case. The Chair assumed the relevant responsibilities for administering the Database Statute on June 7, 2013. See 2013 Vt. Acts & Resolves

724-727 (transferring authority to administer statute to Board). Respondent seeks prospective relief in the form of a declaratory judgment that enforcement of the reporting requirements against petitioner is preempted by ERISA and an injunction barring any attempt to "obtain, from [Blue Cross] or any other source, any medical records or data relating to the Plan or its participants and beneficiaries." Cert. Reply Br. App. 16-17.[5] Because the Chair of the Board now administers the reporting requirements and is the state official who seeks to enforce respondent's compliance with those requirements with respect to the subpoena in this case and would enforce its requirements in the future, prospective relief would properly run against the Chair, not the Commissioner.

Respondent appears to argue (Br. in Opp. 10-13) that because the subpoena that prompted this case was issued under the Commissioner's general subpoena power (at a time when the Commissioner administered the Database Statute), the Board's power to enforce the Database Statute is not at issue. But the Chair of the Board also has a general subpoena power, see Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Supp. 2014); *id.* § 9412(a) (2012), and there is no question that, going forward, the Board would invoke its own subpoena power to enforce the Database Statute and Database Regulation. See Cert. Reply Br. 11-13. The gravamen of the challenge here concerns the obligations imposed

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[5] The court of appeals characterized the injunctive relief sought by respondent as relating only to the subpoena issued to Blue Cross. See Pet. App. 9. The complaint, however, seeks an injunction against any enforcement of the reporting requirements for records or data relating to respondent's plan. See Cert. Reply Br. App. 17.

by the Database Statute and Database Regulation, not the particular source of subpoena authority. Accordingly, petitioner is correct that the Chair of the Board is the proper party to defend Vermont's reporting requirements at this point in the proceedings.[6]

2. ERISA does not preempt the Database Statute or Database Regulation.

a. ERISA's preemption provision, 29 U.S.C. 1144(a), provides that the statute "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. *Ibid.* This Court has long held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (footnote omitted); see, *e.g.*, *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

A law has a "reference to" ERISA plans if the law "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 325-326 (1997). Barring such a reference, the Court "look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that

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[6] Supreme Court Rule 35.3 does not by its terms provide for automatic substitution in the situation in which statutory authority has been transferred from one government official to another. For that reason, it may have been the wiser course for petitioner to file a motion for substitution of parties in the court of appeals or in this Court. If this Court concludes that a motion is necessary, it could treat the petition for a writ of certiorari as encompassing such a motion.

Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans," to "determine whether [the] state law has the forbidden connection" with ERISA plans. *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). Where a state law unrelated to the basic purposes of ERISA operates in an area of traditional state regulation, such as "matters of health and safety," the fact that the law will have "some effect on the administration of ERISA plans" is insufficient for preemption, *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814, 816 (1997), particularly if the state law merely "alters the incentives, but does not dictate the choices, facing ERISA plans," *Dillingham*, 519 U.S. at 334.

b. Under the foregoing standards, the Vermont reporting requirements are not preempted. Respondent does not contest the court of appeals' holding that the requirements lack any "reference to" ERISA plans. Pet. App. 23 & n.9. The requirements apply to "all health care payers," not only to ERISA plans. *Id.* at 23 n.9. And the requirements could readily operate independently of the existence of ERISA plans (although excluding ERISA plans would render Vermont's database less comprehensive). See *Dillingham*, 519 U.S. at 326.

Accordingly, as the court of appeals correctly held, the key question in this case is whether the Vermont reporting requirements have the requisite "connection with" ERISA plans. In the view of the United States, Judge Straub was correct that, at least on the record before the court of appeals, the panel majority erred in holding that such a connection exists. That conclu-

sion follows both from the significant difference between the purpose of the Database Statute and ERISA's reporting requirements and from the lack of any record evidence that the Vermont statute will have more than an incidental effect on respondent's administration of its plan or its ability to comply with ERISA's requirements.

As discussed above, ERISA imposes a number of reporting requirements on plans, such as the submission of financial and actuarial information to the Secretary. See pp. 2-3, *supra*. Those requirements serve the basic purposes of ERISA: to prevent the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-327 (quoting *Massachusetts* v. *Morash*, 490 U.S. 107, 115 (1989)). Any state-law reporting requirements serving the same functions would raise a substantial preemption question. Cf. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 12-13 & n.7 (1987) (discussing *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), summarily aff'd, 454 U.S. 801 (1981)). That is because such requirements would effectively alter the balance that Congress struck between, on the one hand, accountability and disclosure, and, on the other hand, administrative costs and complexity. See *Boggs* v. *Boggs*, 520 U.S. 833, 844 (1997) ("States are not free to change ERISA's structure and balance.").

The Vermont reporting requirements, however, have an entirely different focus. As the court of appeals explained, the information submitted to the Board enables it to populate a database that is designed as a tool to assess and improve healthcare

outcomes for Vermont residents. See Pet. App. 4-5 (citing Vt. Stat. Ann. tit. 18, § 9410(a)(1) (Supp. 2014)). The reporting requirements have nothing to do with ERISA's principal concerns with the soundness of plans and the actions of plan fiduciaries in administering plans and paying promised benefits. They are therefore "quite remote from the areas with which ERISA is expressly concerned." *Dillingham*, 519 U.S. at 330. For that reason, absent more, they do not fall within ERISA's preemptive scope. As this Court has explained, "in the field of health care, * * * there is no ERISA preemption without [a] clear manifestation of congressional purpose." *Pegram* v. *Herdich*, 530 U.S. 211, 237 (2000) (citing *Travelers*, 514 U.S. at 654-655).

The court of appeals nevertheless believed that the Database Statute and Database Regulation have the forbidden "connection with" ERISA plans because they require "reporting of health claims, pharmacy claims, *etc.*, information about the essential functioning of employee health plans." Pet. App. 29 n.13. But the mere fact that a state-law reporting obligation encompasses information about the operation of an ERISA plan does not suffice for preemption. In *De Buono*, for example, this Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, see 520 U.S. at 809-810, 816, even though the administration of the tax required the hospital to file quarterly reports about its taxable gross receipts, see U.S. Amicus Br. at 2-3, *De Buono*, *supra* (No. 95-1594). The principal inquiry under the "connection with" prong of the ERISA preemption test is whether a state law "implicates an area of core ERISA concern." *Egel-*

*hoff*, 532 U.S. at 147. The fact that some information relevant to the operation of an ERISA plan is also relevant to non-ERISA areas of state legislative concern does not broaden the scope of ERISA preemption to include reporting requirements that have nothing to do with the financial soundness of ERISA plans or with their federal-law obligation to pay promised benefits.

That is not to say that *any* reporting obligation unrelated to the basic objectives of ERISA falls outside the scope of ERISA's preemption provision. As petitioner correctly acknowledges (Pet. 21), a state-law reporting obligation could in theory have effects on the administration of an ERISA plan that are "so acute," *De Buono*, 520 U.S. at 816 n.16, that preemption is warranted. See *Travelers*, 514 U.S. at 668; see also Br. in Opp. 19-20 & n.9. Moreover, in considering the effects of a state-law requirement, a court must consider the effects of a potential patchwork of state laws imposing different requirements, as the court of appeals held. See Pet. App. 29; see also *Egelhoff*, 532 U.S. at 149-150.

But in the posture of this case, no sound basis exists to conclude that the Vermont reporting requirements affect the administration of ERISA plans in a qualitatively different or more substantial way than "myriad state laws in areas traditionally subject to local regulation," such as health and safety, "which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. As Judge Straub explained, "[o]n the record before [the court of appeals], there is no basis to find that the Vermont statute would cause [respondent] to increase its costs more than a *de* [*minimis*] amount to cover the cost of

sending information to the state, much less that it would cause a fiduciary to change a plan in any way." Pet. App. 40-41 (dissenting in part and concurring in part).

Respondent contends (Br. in Opp. 20) that the court of appeals' view of the burdens created by the reporting requirements "reflects a common sense assessment of the administrative realities of ERISA plans," because reporting requirements like the ones at issue here "require ERISA plans to provide states with specific information in a prescribed format and at prescribed intervals on every claim processed by the plans" and thus "directly affect those activities." But that supposition is not obvious without any factual support. If the plan has the necessary information readily at hand, for example, it is unlikely that merely reporting it to a state agency will significantly interfere with plan administration. Similarly, if Blue Cross already has procedures in place to submit the reports on behalf of other plans that Blue Cross insures or administers, it may entail little additional cost or administrative burden in submitting reports for respondent's plan. See Pet. App. 73 n.5 (noting that Blue Cross apparently provides the data on behalf of other plans).

In any event, as respondent acknowledges (Br. in Opp. 26), a state law that merely adds administrative costs to an ERISA plan is not preempted. After all, ordinary tax and employment laws can entail substantial administrative costs. To be preempted, the law must interfere with the way in which the plan is administered—for example, by requiring plan administrators to "familiarize themselves with state statutes" in order to determine to whom to pay benefits,

*Egelhoff*, 532 U.S. at 148-149. Without any showing that the requirements here have such an effect, the court of appeals was wrong to conclude that they are preempted.

c. Respondent briefly argues (Br. in Opp. 22-23) that the Database Statute and Database Regulation conflict with ERISA's requirement that fiduciaries follow plan documents, 29 U.S.C. 1104(a)(1)(D), because the plan documents in this case required respondent and Blue Cross to maintain the confidentiality of the medical records of participants and beneficiaries. See *Boggs*, 520 U.S. at 841 (holding that a state law is preempted by ERISA if it "conflicts with the provisions of ERISA or operates to frustrate its objects" regardless of Section 1144(a)'s applicability). But this Court has never suggested that the mere fact that a state law could conflict with a plan term is sufficient for preemption, and such a rule would effectively allow plan sponsors to evade any state law merely by adding a contrary plan term. See, *e.g.*, *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54, 56-65 (1990) (analyzing whether ERISA preempted state law barring plan provision under the normal ERISA preemption framework rather than holding it preempted by Section 1104(a)(1)(D)). Respondent cites *Egelhoff*, 532 U.S. at 151 n.4, but the Court's only point in the cited discussion was that a state law that directly regulates the administration of a plan (there, the payment of benefits) is not saved from preemption if it permits a plan sponsor to expressly opt out of the law by amending plan language. That principle has no application here.[7]

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[7] In any event, the Vermont statute mandates that confidential information be "filed in a manner that does not disclose the identi-

3. Although the court of appeals erred in holding that the Vermont reporting requirements are preempted by ERISA, this Court's review of the question presented is not warranted at this time. The decision below does not squarely conflict with a decision of another court of appeals, and further percolation in the courts of appeals would likely aid this Court's ultimate review of the preemption issue.

a. Petitioner generally argues throughout the petition that the decision below conflicts with this Court's ERISA preemption decisions. Although the United States agrees that the court of appeals misapplied those general principles to the particular context of the recordkeeping requirements at issue here (see pp. 11-17, *supra*), that misapplication does not rise to the level of a direct conflict with this Court's precedent that would warrant review. This Court, in fact, has not considered a state law similar to the Vermont scheme.

Similarly, petitioner's contention (Pet. 14, 25, 31) that "[t]he Second Circuit embraced an expansive view of ERISA preemption" overstates the error of the court of appeals. The court made clear that it did

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ty of the protected person"; prohibits public disclosure of "direct personal identifiers," including names, addresses, and Social Security numbers; and requires submitters to comply with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. Database Statute § 9410(e) and (h)(3) (Supp. 2014). The federal Centers for Medicare and Medicaid Services provide Medicare claims data to Vermont for its database on the condition that Vermont protect the privacy of the information. See Pet. 22 n.3.

not believe that all reporting requirements would be preempted, see Pet. App. 24, and the court emphasized what it saw as the particularly burdensome nature of the requirements here, see *id.* at 25-29. Although the United States agrees with petitioner that the court of appeals lacked factual support for that conclusion, the decision below does not purport to rest on a significant expansion of ERISA preemption principles.

b. Petitioner also briefly contends (Pet. 32-33; Cert. Reply Br. 7-8) that the decision below conflicts with the Sixth Circuit's decision in *Self-Insurance Institute of America, Inc.* v. *Snyder*, 761 F.3d 631 (2014), petition for cert. pending, No. 14-741 (filed Dec. 18, 2014) (*Self-Insurance Institute*). In *Self-Insurance Institute*, the Sixth Circuit held that the application to ERISA plans of a Michigan tax on claims paid by, among others, ERISA plans to healthcare providers for services rendered was not preempted. See *id.* at 633, 641. The tax required the plans to submit quarterly returns to the state tax authority and to keep certain records. *Id.* at 633. The Sixth Circuit held that the tax law did not have the requisite "connection with" ERISA plans because the law did "not require a plan administrator to change how it administers the plan at all" but rather merely "create[d] work independent of the core functions of ERISA—as do permissible state property and employment laws." *Id.* at 635-636.

With respect to the Michigan law's recordkeeping requirements in particular, the Sixth Circuit held that although "Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans," that "basic conclu-

sion * * * does not mean that Congress intended federal law to bar states from imposing additional administrative burdens unrelated to the plans' core functions." 761 F.3d at 637-638. The Sixth Circuit pointed to *Travelers* and *De Buono* as decisions of this Court that upheld state laws that included record-keeping requirements. See *id.* at 638; see also p. 14, *supra*. And it noted that the contrary view would mean that "ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records." 761 F.3d at 638.

The Sixth Circuit rejected the plaintiff's reliance on the Second Circuit's decision in this case, characterizing the Second Circuit's analysis as a "literal approach" that swept too broadly. 761 F.3d at 639. But the Sixth Circuit also "distinguished" the decision below "on two other grounds." *Ibid.* First, the court said, the Michigan law's "reporting requirements are intimately related to a state tax—a traditional area of state concern that [courts] presume Congress left untouched"—whereas "the Vermont statute mandates reporting to build a healthcare database, a purpose," the court believed, that is "not entitled to the presumption." *Ibid.* Second, in the Sixth Circuit's view, the Vermont scheme "actually affects the administration of [ERISA] plans" because it requires an ERISA plan to choose between directing a third-party administrator to turn over records in violation of a plan document or to indemnify the administrator for violating state law. *Ibid.*

Although some tension exists between the analysis of the decision below and that of *Self-Insurance Institute*, that tension does not amount to a square conflict

warranting this Court's immediate review. The Sixth Circuit took pains to distinguish the decision below, and thus if a state law similar to Vermont's came before the Sixth Circuit, the State could not rely on *Self-Insurance Institute* as significant support for non-preemption. Indeed, the Sixth Circuit's opinion, if anything, seems to suggest that the result of the decision below was correct because "[t]he Vermont scheme actually affects the administration of the plans." 761 F.3d at 639. Although the United States disagrees with that dicta, it demonstrates that no square conflict exists over the question presented at this time.

c. The question presented is important, but in our view it does not require this Court's review at the present time, before any other court of appeals has had the opportunity to address a similar reporting scheme.

As petitioner explains (Pet. 26-31), the development of state healthcare claims databases has great potential to improve healthcare outcomes nationally.[8] For example, the federal Center for Medicare and Medicaid Innovation, which supports the development and testing of new healthcare payment and service-delivery models, funds a variety of state-conducted models, including models for "all payers," that rely on state data-collection efforts for evaluation purposes.

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[8] See, *e.g.*, Ctrs. For Medicare & Medicaid Servs., *Rate Review Cycle III Funding Opportunity: Frequently Asked Questions*, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-6-6-2013.html (last visited May 19, 2015); Ctrs. For Disease Control & Prevention, *CDC's Assessment Initiative Cooperative Agreement: New Hampshire*, http://www.cdc.gov/ai/states/nh.html (last visited May 19, 2015).

See 42 U.S.C. 1315a(a)(1) and (b)(2)(B). In evaluating a model, the Secretary of Health and Human Services (HHS) must analyze "the quality of care furnished under the model, * * * [and] the changes in spending under [Medicare, Medicaid and the Children's Health Insurance Program (CHIP)] by reason of the model." 42 U.S.C. 1315a(b)(4). In part because models may sometimes shift costs among different payers or have health effects that are not reflected in the Medicare, Medicaid, and CHIP databases, it is essential to the accuracy of some evaluations to be able to analyze state-level databases that include all payer claims. According to HHS, using incomplete data sets often impedes the government's ability to assess whether initiatives have achieved cost savings or improved quality. Relatedly, Congress, recognizing the importance of access to comprehensive claims data for healthcare evaluation purposes, has made Medicare data available to States that use claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. 1395kk.

Although federally created health claims databases exist for Medicare and federal employees, no federal agency has created an all-payer database that encompasses ERISA-covered plans along with other payers. For that reason, States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data. If States are unable to acquire such data from self-insured ERISA healthcare plans, their databases will be significantly less comprehensive and thus not as useful in developing health policy at both the state and national

levels. See Pet. 29-30; Sec'y of Labor C.A. Amicus Br. 10; see also States Cert. Amicus Br. 3.

Although the question presented thus has substantial importance to the Nation's healthcare system, further percolation of the question presented among the courts of appeals is likely to prove helpful to the Court. In addition to furnishing the perspective of other courts of appeals on the legal issue, additional appellate decisions in this area may furnish this Court with more information to assess the impact of similar reporting requirements on the administration of ERISA plans generally. And because States in the First, Fourth, Sixth, Eighth, Ninth, and Tenth Circuits "have enacted legislation creating health-care data collection programs" similar to Vermont's scheme (States Cert. Amicus Br. 1 & n.3), it is reasonably likely that other circuits will have the opportunity to consider the question presented.

## CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

DONALD B. VERRILLI, JR.
*Solicitor General*
EDWIN S. KNEEDLER
*Deputy Solicitor General*
JOHN F. BASH
*Assistant to the Solicitor General*

M. PATRICIA SMITH
*Solicitor of Labor*
G. WILLIAM SCOTT
*Associate Solicitor*
NATHANIEL I. SPILLER
*Counsel*
MELISSA MOORE
*Attorney*

MAY 2015