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 IN OPPOSITION

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QUESTION PRESENTED

Vermont has enacted legislation and implementing regulations that require "health insurers" to regularly submit to the State "medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care" for use in Vermont's unified health care database. Health insurers—which Vermont defines as including, "to the extent permitted under federal law," the administrators of self-insured health care benefit plans—must submit annual registration forms and report claims data at specified intervals (monthly for some insurers) in a format prescribed by the State.

The question presented is:

Whether the Employee Retirement Income Security Act of 1974 preempts Vermont's reporting mandates insofar as they require self-insured plans governed by ERISA to submit data about claims paid under the terms of the plan.

PARTIES TO THE PROCEEDING

The petition in this matter has been filed by Alfred J. Gobeille, in his official capacity as Chair of the Green Mountain Care Board. Chair Gobeille was not a party to the proceedings below, however. The defendant in the district court and the original appellee was Commissioner Stephen W. Kimbell, in his official capacity as the Vermont Commissioner of Banking, Insurance, Securities, and Health Care Administration. Commissioner Susan L. Donegan was substituted for Commissioner Kimbell when she replaced him in office.

Chair Gobeille now claims that he has been substituted for Commissioner Donegan under Supreme Court R. 35.3 "because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013" (Pet. ii). As discussed below (at 10-13), Chair Gobeille has not been properly substituted for Commissioner Donegan because the relevant enforcement functions of her office—the issuance and enforcement of the subpoena giving rise to this litigation—have not been transferred to the Green Mountain Care Board. Accordingly, Chair Gobeille is not a party to this action entitled to petition for certiorari under 28 U.S.C. § 1254(1).

Respondent Liberty Mutual Insurance Company was the plaintiff in the district court and the appellant in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, respondent Liberty Mutual Insurance Company ("Liberty Mutual") states that it is a wholly owned subsidiary of Liberty Mutual Group Inc. No publicly held company owns 10% or more of the stock of Liberty Mutual Group.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-47) is reported at 746 F.3d at 497. The opinion of the district court (Pet. App. 48-80) is not reported but is available at 2012 WL 5471225.

JURISDICTION

The judgment of the court of appeals was entered on February 4, 2014. A petition for rehearing was denied on May 16, 2014. The petition for a writ of certiorari was filed on August 13, 2014. Although this Court's jurisdiction is invoked under 28 U.S.C. § 1254(1), as explained below (at 10-13), this Court lacks jurisdiction because no proper petitioner is before the Court.

STATUTES INVOLVED

In addition to the statutes and regulations reprinted in the appendix to the petition, this case involves 8 V.S.A. § 13, which is reprinted in an appendix to this brief. App. 1a.

STATEMENT

A. Vermont's Reporting Requirements

In 2008, the Vermont Department of Financial Regulation (the Department)[1] promulgated Regulation H-2008-01, which created the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Pet. App. 5. The Department promulgated Regulation H-2008-01 pursuant to a Vermont statute, 18 V.S.A. § 9410 (the Database Statute), that directed the Commissioner of the Department to "establish[] and maintain[] a unified health care database" (Pet. App. 99), as well as pursuant to its authority under 8 V.S.A. § 15(a) to "adopt rules and issue orders as shall be authorized by or necessary to the administration … of 18 V.S.A. chapter 221." Pet. App. 107 (Regulation H-2008-01 §2).

The Database Statute required "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to file those "reports, data, schedules, statistics, or other information" determined by the Commissioner of the Department to be necessary. Pet. App. 99, 101 (18 V.S.A. §§ 9410(a)(1), 9410(c) (pre-2013

[1] At that time, the Vermont Department of Financial Regulation was known as the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). For simplicity, this brief will refer to both BISHCA and the current Department of Financial Regulation as "the Department."

version)). The Database Statute also granted the Commissioner the power to "establish the types of information to be filed … and the time and place and the manner in which such information shall be filed." Pet. App. 102 (18 V.S.A. § 9410(d) (pre-2013 version)). Regulation-H-2008-01, which is still in force as a Department regulation, sets forth those reporting requirements. Pet. App. 107 (Regulation H-2008-01, § 1).

Under Regulation H-2008-01, "health insurers"—which the regulation defines to include, "to the extent permitted under federal law," the administrators of self-insured health care benefit plans (Pet. App. 112-113 (§ 3(X)))—must register annually with the Department and must "identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers." Pet. App. 116 (§ 4(A)). The regulation further provides that "[h]ealth insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information" in accordance with the regulation's data submission requirements. Pet. App. 117-118 (§ 4(D)).

The data submission requirements regulate, among other things, the content, coding, encryption, and file format of the data. Pet. App. 119-124 (§ 5(A)). The regulation also includes detailed file specifications that dictate such minutiae as the placement of decimal points and the justification of text fields. Pet. App. 124 (§ 5(B)). Data must be submitted on a prescribed schedule, which varies from monthly to quarterly to annually, depending on the number of members living or receiving services in Vermont. Pet. App. 127-128 (§ 6(I)). Insurers with fewer than 200 enrolled or covered members living or receiving services in Vermont

are considered voluntary reporters and may, but are not required to, submit data for use in the database. Pet. App. 113, 116, 118, 128 (§§ 3(Ab), 3(As), 4(E), 6(I)).

The Database Statute required the Commissioner to "adopt a confidentiality code to ensure" that the collected information "is handled in an ethical matter." Pet. App. 102 (18 V.S.A. § 9410(f) (pre-2013 version)). The statute also provided, however, that, "[t]o the extent allowed by" the federal Health Insurance Portability and Accountability Act (HIPAA) and without publicly disclosing data with direct personal identifiers, "the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies." Pet. App. 104 (18 V.S.A. § 9410(h)(3)(B), (D) (pre-2013 version)). Regulation H-2008-01 contains procedures for releasing claims data to the public and creates three categories—"unrestricted," "restricted," and "unavailable"—that determine the data's availability to the public. Pet. App. 130.

Vermont law empowers the Commissioner to "issue subpoenas, examine persons, administer oaths and require production of papers and records" to enforce 18 V.S.A. chapter 221, which includes the Database Statute. App. 1a (8 V.S.A. § 13(a)). The Commissioner may also impose financial penalties on, and suspend the authority to do business of, any person who fails to comply with a subpoena. App. 1a-2a (§ 13(b)). Regulation H-2008-01, § 10 authorizes the Commissioner to seek administrative penalties for violations of its provisions "in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies." Pet. App. 140.

B. Prior Proceedings

1. Liberty Mutual Insurance Company is the administrator and named fiduciary of a self-insured employee health plan that provides benefits to more than 80,000 individuals nationwide (the Plan). Pet. App. 7. The documents that govern the Plan recite that the "Plan has been established for the exclusive benefit of Participants" and that "all contributions under the Plan may be used only for such purpose." Pet. App. 8. The Plan also represents that participants' medical records are kept "strictly confidential." *Id.*

Liberty Mutual uses a third-party administrator, Blue Cross Blue Shield of Massachusetts, Inc. ("Blue Cross") to handle processing, reviewing, and paying claims for Vermont participants in the Plan. Pet. App. 8. Liberty Mutual has a contract with Blue Cross that requires Blue Cross to use information it receives from Liberty Mutual solely for purposes of administering the Plan and to guard against unauthorized disclosure of the information. Pet. App. 51.

Both Liberty Mutual and Blue Cross are considered "health insurers" and are subject to Vermont's reporting requirements. Pet. App. 54. Although Liberty Mutual has fewer than 200 participants or beneficiaries in Vermont and is thus a voluntary reporter, Blue Cross is a mandatory reporter and must therefore report, for participants in the Plan, the claims data that are in its possession. Pet. App. 8.

2. In 2011, the Commissioner, exercising his authority under 8 V.S.A. § 13(a), issued a subpoena to Blue Cross seeking medical and pharmacy claims files, as well as other information, for use in Vermont's health care database. App. 3a. Liberty Mutual directed Blue Cross not to comply with the subpoena and

filed a complaint against the Commissioner, seeking a declaration that Vermont's reporting regime is preempted by ERISA to the extent it requires the reporting of data relating to plan participants and an injunction against enforcement of the subpoena. Pet. App. 9. The district court granted summary judgment for the Commissioner, concluding that Vermont's law and regulations are not preempted by ERISA. Pet. App. 61-79.[2]

3. Liberty Mutual appealed to the Second Circuit. While the case was pending on appeal, the Vermont Legislature transferred some of the Commissioner's responsibilities under the Database Statute to the Chair of the Vermont Green Mountain Care Board. 18 V.S.A. § 9410 (2013 version). The Commissioner retained the authority to enforce the subpoena at issue in this case, however, and no attempt was made to substitute the Chair of the Vermont Green Mountain Care Board for the Commissioner as the proper party to this case. Nor did the Chair of the Board move to intervene.

The court of appeals reversed and remanded the case with instructions to enter judgment for Liberty Mutual. Pet. App. 1-47. The court held that ERISA preempts Vermont's reporting requirements as applied to compel the reporting of Liberty Mutual's plan data. Pet. App. 4, 9-10.

For guidance, the court looked to the "modern ERISA preemption test" set forth in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983): "[A]state law is

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[2] The district court also ruled that Liberty Mutual had Article III standing to bring suit. Pet. App. 56-61. The court of appeals affirmed that ruling. Pet. App. 9-10.

preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (emphasis omitted). The court then observed that, in *Shaw*, this Court had "treated as obvious that ERISA preempted 'state laws dealing with the subject matters covered by ERISA—*reporting*, *disclosure*, fiduciary responsibility, and the like.'" *Id.* (quoting *Shaw*, 463 U.S. at 98).

The court of appeals did take note of this Court's "caution" in *Shaw* that "[s]ome state actions may affect employee benefits plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Pet. App. 14 (quoting *Shaw*, 463 U.S. at 100 n.21). And it observed that decisions subsequent to *Shaw*, including *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995), "marked something of a pivot in ERISA preemption." Pet. App. 18. *Travelers*, the court explained, stated a "'starting presumption that Congress does not intend to supplant state law.'" *Id.* (quoting *Travelers*, 514 U.S. at 655). Nonetheless, the court observed that *Travelers* itself reaffirmed that ERISA alone "'controls the administration of benefit plans, as by imposing *reporting and disclosure mandates*.'" Pet. App. 19-20 (quoting *Travelers*, 554 U.S. at 651). Thus, the court explained, recent precedents have not changed two constants: "(1) recognition that ERISA's preemption clause is intended to avoid a multiplicity of burdensome state requirements for ERISA plan administration; and (2) acknowledgement that 'reporting' is a core ERISA administrative function." Pet. App. 3-4.

Applying those principles, the court concluded that Vermont's reporting requirements are preempted as applied to ERISA plans because those requirements have a "'connection with' ERISA plans." Pet. App. 23.

The court relied on "the principle (undisturbed in *Travelers*) that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id.* The court acknowledged that "[n]ot every state law imposing a reporting requirement is preempted" and that ERISA tolerates "laws that create no impediment to an employer's adoption of a uniform benefit administration scheme and with too tenuous, remote, or peripheral an effect on employee benefit plans." Pet. App. 24 (internal quotation marks, citations, and brackets omitted). But, the court stressed, Vermont has required the reporting of "information about the essential functioning of employee health plans." Pet. App. 29 n.13.

The court also found preemption to be supported here by the need "to avoid proliferation of state administrative regimes" that would subject Liberty Mutual to overlapping and potentially conflicting requirements. Pet. App. 21. In response to the argument that preemption should not apply to Vermont's reporting requirements because they differ from the reporting requirements in ERISA, the court observed 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. The court concluded that the burden of Vermont's reporting requirements, when "considered as one of several or a score of uncoordinated state reporting regimes," was "obviously intolerable." Pet. App. 25.

In sum, the court concluded that ERISA "does not allow one of ERISA's core functions—reporting—to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense." Pet. App. 29. The

court accordingly reversed the district court's judgment and remanded with instructions to enter judgment for Liberty Mutual. Pet. App. 30.[3]

ARGUMENT

The court of appeals correctly ruled that ERISA preempts a state law that requires ERISA plans to report to the state data about claims paid under the terms of the plan. That decision faithfully applies this Court's precedents on ERISA preemption and was informed by the same factors that this Court has invoked when it has held state laws preempted by ERISA. That decision also does not conflict with the decision of any other court of appeals. Petitioner's dire warnings about the potential implications of the court of appeals' decision are overstated and were largely anticipated and rebutted by the court of appeals. This Court's intervention is therefore not necessary.

Review should also be denied because this Court lacks jurisdiction over the petition. The petition was filed by the Chair of the Green Mountain Care Board, but that officer was not a party to the proceedings in the court of appeals. Petitioner claims to have been automatically substituted for the defendant below, the Commissioner of the Department of Financial Regulation, but the Commissioner retains the sole authority to enforce the subpoena at issue, and the Commissioner has not petitioned for review in this Court. No proper petitioner is therefore before this Court. Should the issues raised by the petition prove to have long-lasting

[3] Judge Straub dissented in part. He would have concluded that the Vermont reporting requirements are not preempted by ERISA. Pet. App. 30-47.

significance, this Court can consider them in a case not presenting these serious jurisdictional difficulties.

I. THIS CASE IS A POOR VEHICLE FOR REVIEW BECAUSE NO PROPER PETITIONER IS BEFORE THE COURT

This Court has jurisdiction to review cases in the court of appeals "[b]y writ of certiorari granted upon the petition of *any party* to any civil or criminal case." 28 U.S.C. § 1254(1) (emphasis added). The petitioner here, the Chair of the Vermont Green Mountain Care Board, was not a "party" to this case when it was in the court of appeals and did not move to intervene in the case. The defendant-appellee in the court of appeals was the Commissioner of the Vermont Department of Financial Regulation. The Commissioner has not joined the petition. Moreover, any attempt by the Commissioner to petition for certiorari at this stage would be untimely. S. Ct. R. 13. Accordingly, this Court lacks jurisdiction over the petition unless the petitioner is properly substituted for the Commissioner. But substitution is not proper, because the Commissioner of the Department of Financial Regulation, not the Chair of the Vermont Green Mountain Care Board, retains the authority to take the action that is at the core of this dispute—to enforce the subpoena that the Commissioner issued to Blue Cross.

Petitioner claims to have been substituted for the Commissioner under this Court's Rule 35.3 "because the Vermont Legislature shifted responsibility for the unified health care database to the Green Mountain Care Board, effective June 7, 2013." Pet. ii; *see* Pet. 5 n.1. In fact, the Chair of the Green Mountain Care Board has not succeeded to the Commissioner's en-

forcement function at issue in this case: the Commissioner's issuance of a subpoena to Liberty Mutual.[4] At the very least, there are serious questions surrounding the Chair's party status, and thus this Court's jurisdiction under § 1254(1), that counsel against granting certiorari in this case. Should the decision below have the serious ramifications that petitioner ascribes to it—which is not the case in any event (*see infra* pp. 29-32)—there will doubtless be later cases, not presenting these jurisdictional difficulties, in which this Court can examine the application of ERISA preemption principles in this context.

Vermont has shifted authority for maintaining Vermont's health care database to the Green Mountain Care Board. The Board has authority under Title 18 of the Vermont Statutes to enforce compliance with the Database Statute. *See* 18 V.S.A. § 9410(g). But the subpoena that Liberty Mutual has sought to enjoin in this case was issued by the Commissioner pursuant to a different provision. The subpoena was issued by the Commissioner under 8 V.S.A. § 13(a), a part of the title

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[4] Both Fed. R. App. P. 43(c) and S. Ct. R. 35.3 provide that "[w]hen a public officer who is a party … in an official capacity dies, resigns, or otherwise ceases to hold office, the action does not abate" and that the public officer's successor "is automatically substituted as a party." Neither rule specifically addresses substitution in situations where the relevant enforcement responsibilities are transferred between two different offices, but it has been suggested that such a transfer renders the transferee officer the "successor" for purposes of both rules. Wright et al., *Federal Practice and Procedure* § 1960, at 715 & n.6 (3d ed. 1997). As discussed above, the relevant enforcement responsibilities at issue here have not been transferred from the Commissioner of the Department to the Green Mountain Care Board and thus no transfer that might implicate the rules governing substitution has occurred.

of the Vermont statutes covering regulation of insurance. App. 3a. That provision, which remains in place, authorizes the Commissioner "to issue subpoenas, examine persons, administer oaths and require production of papers and records" to enforce various statutory provisions, including "18 V.S.A. chapter 221," which includes the Database Statute. App. 1a. The authority to issue and enforce subpoenas under Title 8, including the subpoena in this case, remains with the Commissioner of the Department and was never transferred to the Green Mountain Care Board.[5]

The Chair of the Green Mountain Care Board does have a separate subpoena power, under Title 18 of the Vermont Code (18 V.S.A. § 9374(i)), but the subpoena involved in this case was not issued under that statute. Moreover, the Chair does not have the same power to punish noncompliance with a subpoena as does the Commissioner. Whereas the Commissioner can suspend the authority to do business of any person who fails to comply with a subpoena under Title 8, the Chair may only "recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months." *Id.* § 9374(j).

Under these circumstances, the Commissioner's relevant enforcement function has not been transferred to the Chair of the Green Mountain Care Board. The

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[5] The Commissioner also retains separate authority, under Chapter 221 of Vermont Code Title 18, "in the case of health insurers, [to] enforce a violation of a provision of this subchapter [which includes the Database Statute], or a rule adopted pursuant to a provision of this subchapter, as a violation of a requirement of Title 8 relating to health insurers." 18 V.S.A. § 9412(b). Thus, not all of the Commissioner's responsibilities under the Database Statute were transferred to the Board.

Chair therefore cannot be substituted for the Commissioner as a party to this case. And as the Chair of the Board has not been substituted for the Commissioner, he is not a "party" entitled to petition for certiorari under 28 U.S.C. § 1254(1). "A 'party' to litigation is one by or against whom a lawsuit is brought." *United States ex rel. Eisenstein* v. *City of New York*, 556 U.S. 928, 933 (2009). The Chair was not named as a defendant to the complaint, nor did he participate in the appeal before the Second Circuit, even after the Green Mountain Care Board assumed responsibility for Vermont's health care database.[6] The Chair also did not seek leave to intervene in the court of appeals on the ground that the Board's functions might be affected by the decision. This Court therefore lacks jurisdiction over the petition for certiorari.[7]

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[6] The petition for rehearing in the court of appeals was filed on February 18, 2014, well after Vermont shifted responsibility to the Green Mountain Care Board, yet the petition was still filed by the Commissioner of the Department of Financial Regulation, not the Chair.

[7] This conclusion that the Chair of the Board is not a "party" to this case is not altered by the fact that Liberty Mutual sought declaratory relief in its complaint as well as an injunction against the Commissioner from seeking to enforce the subpoena. Had the Chair thought that declaratory relief implicated the Board's interests beyond the subpoena at issue in this case, he was free to move to intervene in the court of appeals. *See Goodman* v. *Heublein, Inc.*, 682 F.2d 44, 47 (2d Cir. 1982); *ABB Industrial Sys., Inc.* v. *Prime Tech., Inc.*, 120 F.3d 351 (2d Cir. 1997). Having failed to do so, the Chair cannot now assert that he is a party to this case. *See Eisenstein*, 556 U.S. at 936 ("The fact that the Government is bound by the judgment is not a legitimate basis for disregarding this statutory scheme [requiring the government to intervene to become a party].").

II. THE COURT OF APPEALS' DECISION IS CORRECT

ERISA provides that it "'shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by ERISA." *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 146 (2001) (quoting 29 U.S.C. § 1144(a)). Under this Court's precedents, "a state law relates to an ERISA plan 'if it has a connection with or reference to such a plan.'" *Id.* at 147 (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)).

Petitioner does not and cannot claim that the Second Circuit failed to apply *Shaw*'s two-part test when it held that Vermont's reporting requirements "have a 'connection with' ERISA plans." Pet. App. 23. Rather, petitioner claims that the court adopted an "expansive and literal" approach inconsistent with this Court's application of the "connection with" test for ERISA preemption. Pet. 16. In fact, the Second Circuit faithfully applied this Court's ERISA decisions and reached a conclusion that reflects the proper scope of ERISA's preemption provision.

A. The Decision Below Reflects A Proper Application Of ERISA Preemption Principles Under This Court's Precedents

The court of appeals ruled in this case that a state law that requires an ERISA plan to report to the state data about claims paid under the terms of a plan is preempted by ERISA. That decision is consistent with this Court's precedents stating that ERISA, at a minimum, preempts "state laws dealing with the subject matters covered by ERISA." *Shaw*, 463 U.S. at 98. Vermont's requirements fall squarely within the realm that Congress reserved exclusively to the federal regime governing ERISA plans, for they require ERISA

plans to account and report to the state what the plan has paid out to whom as part of the plan's operations.

1. This Court has repeatedly stated that record-keeping and reporting by employee benefit plans are core matters covered by ERISA. *See California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (listing "reporting" as an area with which ERISA is centrally concerned); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 661 (1995) ("reporting" is a subject matter covered by ERISA); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990) (same); *Shaw*, 463 U.S. at 98 (same); *see also Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987) (identifying "keeping appropriate records in order to comply with applicable reporting requirements" as an obligation of employee benefit plans). Relying on those well-established principles, the Second Circuit correctly concluded that Vermont's reporting requirements—which mandate the "reporting of health claims, pharmacy claims, etc., information about the essential functioning of employee health plans" (Pet. App. 29)—implicate "a core ERISA function shielded from potentially inconsistent and burdensome state regulation" (Pet. App. 23).[8]

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[8] The Second Circuit's decision is also consistent with this Court's summary affirmance of the Ninth Circuit's decision in *Standard Oil Co. of California* v. *Agsalud*, 633 F.2d 760 (1980), and this Court's later statements about that case in *Fort Halifax*. In *Agsalud*, the Ninth Circuit affirmed a district court decision which held that ERISA preempted a Hawaii statute that "required workers in the State to be covered by a comprehensive prepaid health care plan" and imposed "certain reporting requirements which differ[ed] from those of ERISA." 442 F. Supp. 695,

Although petitioner argues that the court of appeals held that "any type of state reporting requirement must intrude on a core ERISA concern" and thus face preemption (Pet. 19), the Second Circuit made no such ruling. To the contrary, the court of appeals expressly recognized that "[n]ot every state law imposing a reporting requirement is preempted" and noted that ERISA's preemption provision allows for laws that "create no impediment to an employer's adoption of a uniform benefit administration scheme" and have "too tenuous, remote or peripheral an effect on employee benefit plans." Pet. App. 24. As the court made clear, however, Vermont's reporting requirements are different from such laws because they "implicate an ERISA core administrative concern" by requiring ERISA plans to report "information about the essential functioning of employee health plans." Pet. App. 29 n.13.

Taking issue with the court of appeals' conclusion that recordkeeping and reporting about claims payments are core ERISA matters, petitioner argues that Congress's primary concern when it enacted ERISA "was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds" (Pet. 19 (quoting *Dillingham*, 519 U.S. at 326-227)), whereas "Vermont seeks claims data to improve health care

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696 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980). After this Court summarily affirmed the Ninth Circuit's decision, *Agsalud* v. *Standard Oil Co. of California*, 454 U.S. 801 (1981), Congress amended ERISA to exempt portions of the Hawaii statute from preemption. But, as this Court observed in *Fort Halifax*, "[t]he amendment did not exempt from pre-emption those portions of the law dealing with reporting, disclosure, and fiduciary requirements." 482 U.S. at 13 n.7.

quality, affordability, and effectiveness" (Pet. 20). According to petitioner, the Vermont reporting requirements do not intrude on an area of core ERISA concern because "Vermont's health care database … is unrelated to ERISA's core concern with plan administrators' fiduciary responsibilities to beneficiaries." *Id.*

That is an improperly cramped view of both the purpose of ERISA in general and ERISA preemption principles more specifically. When Congress enacted ERISA, it was not just concerned with plan administrators' fiduciary responsibilities. In addition to protecting the interests of beneficiaries, Congress intended to protect plans and employers with self-funded plans (and, ultimately, employees and beneficiaries as well) from the burdens of complying with conflicting state laws by reserving the field of employee benefit plans for federal regulation. *See Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004) (purpose of ERISA was to "provide a uniform regulatory regime over employee benefit plans"); *Fort Halifax*, 482 U.S. at 10 (ERISA preemption was intended to minimize interference with the administration of ERISA plans by conflicting state law requirements "so that employers would not have to 'administer their plans differently in each State in which they have employees.'" (quoting *Shaw*, 463 U.S. at 105)). The Vermont reporting requirements operate within that field by requiring the reporting of information "about the essential functioning of employee health plans" (Pet. App. 29 n.13), including the medical claims data and member eligibility data for plan participants (Pet. App. 117-118 (Regulation H-2008-01 §§ 4(D), 5)).

Nor is it relevant, for preemption purposes, that Vermont may have enacted its requirements in order to improve the quality of the State's information about

the availability and cost of health care rather than with the specific purpose of regulating employee benefit plans. Preemption analysis is not restricted to determining whether ERISA and the state law have the same purpose; it also examines the state law's effects on ERISA plans. *See Egelhoff*, 532 U.S. at 147 ("[T]o determine whether a state law has the forbidden connection, we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." (internal quotation marks and citations omitted)).

A state law with a purpose quite different from the purpose that animated Congress can still be preempted if it operates in the same area as a federal law. *Cf. Gade* v. *National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 107 (1992) ("Whatever the purpose or purposes of the state law, pre-emption analysis cannot ignore the effect of the challenged state action on the pre-empted field."). And even if there is no direct conflict between Vermont's reporting requirements and the reporting requirements in ERISA, that does not mean that there is no preemption. ERISA's preemption provision "was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements." *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), *overruled in part on other grounds by Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329 (2003); *see also District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 129-130 (1992).

2. This Court has also emphasized that ERISA preempts state laws that "interfere[] with nationally uniform plan administration." *Egelhoff*, 532 U.S. at 147. Following that precedent, the court of appeals rightly

concluded that Vermont's reporting scheme imposes "myriad requirements" on ERISA plans. Pet. App. 21, 27. The court recited the litany of requirements that a plan must meet when it reports claims information to Vermont—including requirements governing the content, timing, coding, and encryption of the reports—and properly recognized that those requirements were "burdensome, time-consuming, and risky." Pet. App. 25-27. Thus, the court concluded that, although "[e]ven considered alone, the Vermont scheme triggers preemption," when "considered as one of several or a score of uncoordinated state reporting regimes" Vermont's reporting requirement is "obviously intolerable." Pet. App. 25.

Petitioner claims that the court's focus on the administrative burdens created by the Vermont law was "mistaken[]" (Pet. 21), but the Second Circuit's consideration of those burdens—and the potential that those burdens would be multiplied by the existence of uncoordinated state reporting regimes in different states—is fully consistent with this Court's approach to ERISA preemption.[9] As this Court has recognized, "[o]ne of

[9] Petitioner also claims that the burdens created by Vermont's reporting requirements do not meet what petitioner considers to be the threshold for preemption under ERISA. Petitioner quotes from this Court's decision in *De Buono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997), to contend that administrative burdens are only relevant if they are "so acute 'as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.'" Pet. 21. That argument does not reflect a fair reading of the Court's decision in *De Buono*. The quoted language from *De Buono* was a discussion of the circumstances under which preemption might occur as a result of the *economic effects* of a law that addressed a subject area outside of an ERISA plan's core functions. The Court

the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.'" *Egelhoff*, 532 U.S. at 148 (quoting *Fort Halifax*, 482 U.S. at 9). Accordingly, "differing state regulations affecting an ERISA plan's 'system for processing claims and paying benefits' impose 'precisely the burden that ERISA preemption was intended to avoid." *Id.* at 150 (quoting *Fort Halifax*, 482 U.S. at 10).

Petitioner also contends that the court of appeals' description of the burdens imposed by Vermont's reporting requirements was "factually unsupported and wrong." Pet. 22. To the contrary, the court's recognition of the burdens created by Vermont's reporting requirements reflects a common sense assessment of the administrative realities of ERISA plans. ERISA plans "are faced with the task of coordinating complex administrative activities," including "making disbursements" and "keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9, 11. Reporting requirements like Vermont's, which require ERISA plans to provide states with specific information in a prescribed format and at prescribed intervals on every claim processed by the plans, directly affect those activities. The burdens that ERISA plans will face from such laws, which differ from state to state and will require ERISA plans to familiarize themselves with the reporting obligations in

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was not addressing the standard for preemption when a state law, such as the Vermont reporting requirements at issue here, imposes direct administrative burdens on the essential functions of an ERISA plan.

each state, should be obvious.[10] *See Egelhoff*, 532 U.S. at 149-150 ("Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators—burdens ultimately borne by beneficiaries." (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990))); *Fort Halifax*, 482 U.S. at 11 ("A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Indeed, comparing Vermont's reporting requirements to those of other states reveals differences in who is required to report,[11] as well as the timing[12] and content[13] of the required reports.

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[10] Pet. App. 7 ("Data submission requirements vary."); C.A. App. A376 ("[C]urrently each state is collecting different data by different methods and with different definitions").

[11] *Compare* Pet. App. 113 (insurers with 200 or more enrolled or covered members living or receiving services in Vermont are mandatory reporters) *with* Md. Code Regs. tit. 10, § 25.06.03 (reporting entities include payors whose total lives covered exceeds 1,000).

[12] *Compare* Pet. App. 127-128 (§ 6(I)) (varying from monthly to quarterly to annually) *with* Md. Code Regs. tit. 10, § 25.06.05 (quarterly) *and* Utah Admin. Code r. 428-15-3 (monthly).

[13] For example, some states require the reporting of dental claims, while Vermont does not. *Compare*, *e.g.*, 90-590-243 Me. Code R. § 2 *with* Pet. App. 117; *see also* All-Payer Claims Database Council data for Vermont, http://apcdcouncil.org/state/vermont (last visited Nov. 6, 2014) (types of data collected do not include dental).

3. The Second Circuit's decision is also consistent with this Court's recognition that ERISA preempts state laws that conflict with ERISA's requirement that "the fiduciary 'shall' administer the plan 'in accordance with the documents and instruments governing the plan.'" *Egelhoff*, 532 U.S. at 151 n.4. The court of appeals recognized that Vermont's reporting requirements affect the documents governing Liberty Mutual's ERISA plan by "impair[ing] or (at least) reassign[ing] the obligation in the Plan documents to keep medical records strictly confidential, as well as the undertaking by Blue Cross as [third-party administrator] to use information solely for Plan administration purposes and to prevent unauthorized disclosure." Pet. App. 27. Under the Vermont reporting regime, Vermont makes the data it collects from ERISA plans "available as a resource for insurers, employers, providers, purchasers of health care, and state agencies" and itself decides how much disclosure is appropriate under HIPAA and maintains the "confidentiality code" applicable to the collected information.

Vermont's reporting requirements have an even greater impact on ERISA plans than the law at issue in *Egelhoff*. In *Egelhoff*, the Court held preempted a state statute that allowed employers to opt out of the law by including specific language in the plan documents, because such a statute still "dictate[d] the choices facing ERISA plans with respect to matters of plan administration" as plan administrators had to either follow the beneficiary designation scheme set out in the statute "or alter the terms of their plan so as to indicate that they will not follow it." 532 U.S. at 150. The Court concluded that the statute at issue conflicted with ERISA's command that the plan should be administered in accordance with the plan documents because,

under the state law, the only way the fiduciary could administer the plan according to its terms was to "change the very terms he is supposed to follow." *Id.* at 150-151 n.4. Whereas the law in *Egelhoff* gave ERISA plans a choice between complying with its requirements *or* opting out of the law by including specific language in plan documents, here plan administrators must comply with the reporting obligations imposed by Vermont *and* accept what amounts to an effective amendment of the terms of their plans.

4. Finally, petitioner makes much of a footnote to the Second Circuit's decision in which the court, in a discussion of the presumption against preemption, observed that "state health data collection laws do not regulate the safe and effective provision of health care services" and that "collecting data can hardly be deemed 'historic'" because "most such laws were enacted only within the last ten years." Pet. App. 18-19 n.8. Petitioner claims that, by making those observations, the Second Circuit did not adhere to the presumption against preemption when evaluating Vermont's reporting requirements and thus departed from this Court's precedents.

Those arguments are misguided and in any event identify nothing worthy of this Court's review, for they relate to an issue that ultimately had no impact on the court of appeals' decision. Although the court of appeals remarked that state health data collection laws do not fall within states' historic police powers, it did not hold that such laws are not entitled to the presumption against preemption. Pet. App. 18 n.8. Indeed, at the beginning of its opinion, the court made clear that this Court's precedents had set "a rebuttable presumption against preemption of state health care regulations" but that its conclusion was based on considerations that

remained notwithstanding that presumption. Pet. App. 3-4. Moreover, the court went on to explain that, "[i]n any event, the Supreme Court has repeatedly found the presumption overcome if the state laws upset the deliberate balance central to ERISA, even if those laws implement policies and values lying within the traditional domain of the States." Pet. App. 19 n.8.

Those statements, read in context, make clear that the court concluded that ERISA preempts Vermont's reporting regime even if the Vermont law is entitled to a presumption against preemption. The Second Circuit's comments on the issue of the presumption against preemption are therefore dicta and do not merit review. *See Black* v. *Cutter Labs.*, 351 U.S. 292, 297 (1956) ("This Court reviews judgments, not statements in opinions."); *Halbert* v. *Michigan*, 545 U.S. 605, 632 (2005) (Thomas, J., dissenting) ("[T]his Court would be unlikely to grant certiorari in a case to announce a rule that could not alter the case's disposition, or to correct an error that had not affected the proceedings below.").

B. The Decision Below Does Not Conflict With This Court's Decisions In *Travelers*, *Dillingham*, And *De Buono*

Notwithstanding all the foregoing, petitioner argues that the decision below conflicts with this Court's decisions in *Travelers*, *Dillingham*, and *De Buono*, which, petitioner argues, hold that a mere burden on a plan cannot be sufficient to establish preemption. As the Second Circuit recognized, however, those cases stand for a different principle—that ERISA does not disturb state laws of general applicability that do *not* fall within areas of core concern to ERISA merely because those laws might have an incidental economic impact on employee benefit plans. Thus, although the

Second Circuit recognized that *Travelers* "marked something of a pivot in ERISA preemption" (Pet. App. 18), it also observed that "*Travelers* and its progeny do not disturb the longstanding principle that 'state statutes that mandate[] employee benefits structures *or their administration*' have a 'connection with' ERISA plans and are therefore preempted" (Pet. App. 20 (quoting *Dillingham*, 519 U.S. at 328)).

In *Travelers*, this Court considered whether ERISA preempted a state law that required hospitals to collect surcharges on hospital bills paid by commercial insurers but not on hospital bills paid by Blue Cross and Blue Shield Plans. 514 U.S. at 649. The Court recognized that the surcharge would have an "indirect economic effect on choices made by insurance buyers, including ERISA plans" because it would make Blue Cross and Blue Shield plans more attractive than commercial insurance plans. *Id.* at 659. The Court observed, however, that an "indirect economic influence … does not bind plan administrators to any particular choice" or "preclude uniform administrative practice." *Id.* at 659-660. The Court ultimately concluded that "laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State" do not trigger preemption under ERISA. *Id.* at 662.

Dillingham involved a state prevailing wage law that allowed contractors to pay a lower-than-prevailing wage to workers participating in a state certified apprenticeship program. 519 U.S. at 319-321. The law thus provided an incentive for ERISA-covered apprenticeship programs to obtain state certification, but did not require them to do so. *Id.* at 332. The Court observed that the law did "not bind ERISA plans to anything" but "merely … provide[d] some measure of eco-

nomic incentive to comport with the State's requirements." *Id.* Ultimately, the Court noted that the effect of the law was substantially similar to the effect of the surcharge at issue in *Travelers*, in that it "alter[ed] the incentives, but [did] not dictate the choices, facing ERISA plans." *Id.* at 334. The Court thus held that the law did not have a "connection with" ERISA plans and was not preempted by ERISA. *Id.*

In *De Buono*, the Court held that ERISA did not preempt the application of a state law "imposing a gross receipts tax on the income of medical centers" to medical centers operated by ERISA funds. 520 U.S. at 809. In doing so, the Court observed that the law was "a tax on hospitals," and that "[m]ost hospitals are not owned or operated by ERISA funds." *Id.* at 816. The Court went on to observe that "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *Id.*

Travelers, *Dillingham*, and *De Buono* stand for the proposition that state laws of general applicability that address subject areas outside an ERISA plan's core functions are not preempted merely because they might have some economic impact on ERISA plans. But that principle has no application here, because Vermont's reporting requirements do not merely have an economic impact on ERISA plans. Vermont has imposed a reporting mandate that requires the reporting of information about core ERISA activities: the payment of claims under the plan. "In other words, unlike generally applicable laws regulating areas where ERISA has nothing to say, which [this Court has] upheld notwithstanding their incidental effect of ERISA

plans," Vermont's reporting regime affects "a central matter of plan administration," *Egelhoff*, 532 U.S. at 147 (internal quotation marks and citations omitted). The court of appeals was thus correct to conclude that the *Travelers* principle does not save Vermont's requirements from preemption.

III. The Question Presented Is Not The Subject Of A Circuit Split

Petitioner also contends that the decision below is inconsistent with the Sixth Circuit's decision in *Self-Insurance Institute of America, Inc.* v. *Snyder*, 761 F.3d 631 (2014) (*SIAA*). To the contrary, there is no conflict between the two circuits on the question presented by the petition, and any supposed "disagreement" (Pet. 14) between them does not warrant this Court's review.

SIAA involved a Michigan law requiring third party administrators and "carriers," which as defined included the sponsors of group health plans set up under ERISA, to pay a one-percent tax on paid claims to health care providers. 761 F.3d at 632. Incidental to the tax, the law imposed recordkeeping requirements and required carriers and third-party administrators to submit quarterly returns to the Michigan Department of the Treasury. The Sixth Circuit held that ERISA did not preempt enforcement of the law against ERISA-covered entities. In so ruling, the Sixth Circuit compared the Michigan law to the surcharges this Court upheld in *Travelers* and *De Buono*, noting that "[t]he Act's only potential effects are to cut the plans' profits" and "to create work independent of the core functions of ERISA." *Id.* at 636.

With respect to the reporting and record-keeping requirements in the Michigan law, the Sixth Circuit observed that those requirements applied "only when the carriers compute the tax—a function entirely divorced from plan administration." 761 F.3d at 636. The Sixth Circuit also read *Travelers* and *De Buono* as implicitly approving the reporting requirements that were "essential parts of the tax schemes" at issue in those cases, and noted that ERISA does not "bar states from imposing additional administrative burdens unrelated to the plans' core functions." *Id.* at 638. The court went on to conclude that the reporting and record-keeping requirements in the Michigan law existed solely "to guarantee that the carriers pay the correct amount of tax" and that "such record-keeping requirements accompany all taxes and remain in force despite ERISA." *Id.* at 639.

The Sixth Circuit's judgment with respect to the Michigan law does not conflict with the Second Circuit's decision in this case. Unlike the record-keeping and reporting requirements in the Michigan law, Vermont's reporting requirements are related to the core functions of an ERISA plan. Whereas the requirements in the Michigan law were directed at an activity (tax payments) that did not implicate a core ERISA function, Vermont requires ERISA plans to report on their primary ERISA activity: providing plan participants with benefits.

Although petitioner makes much of language in the Sixth Circuit's decision purporting to "disagree" with the "literal approach to preemption" that the Sixth Circuit believed the Second Circuit had employed in reaching its decision below, 761 F.3d at 639, those statements in the Sixth Circuit's opinion do not warrant review of the Second Circuit's judgment. Notwithstanding any difference that the Sixth Circuit might have perceived

between the two courts' approaches to ERISA preemption, the Sixth Circuit ultimately *agreed* with the Second Circuit's conclusion that ERISA preempts Vermont's reporting requirements as applied here.

The Sixth Circuit distinguished Vermont's reporting requirements from the Michigan law it was reviewing by observing that "[t]he Vermont scheme actually affects the administration of the plans; it does not just create additional administrative work unrelated to the processing of the claims, as the [Michigan] Act involved here does." 761 F.3d at 639. The Sixth Circuit further explained that the Vermont reporting requirements would force Liberty Mutual to make an unacceptable choice on how to administer the plan. *Id.* Under the Vermont reporting requirements, Liberty Mutual must either direct Blue Cross not to comply with the requirements, which would require Liberty Mutual to indemnify Blue Cross for the ensuing civil penalties, or it must allow Blue Cross to turn over the data in violation of its plan documents. *Id.*; *see also* Pet. App. 10. The Sixth Circuit concluded that, "[u]nder our conception of the ERISA preemption provision, state laws cannot put this choice to ERISA-covered entities." 761 F.3d at 639.

The Sixth Circuit thus ultimately recognized in *SIAA* that there were fundamental differences between the Michigan law at issue there and Vermont's reporting requirements, and it suggested that Vermont's reporting requirements would be preempted under its view of ERISA preemption. This case would therefore likely have been decided the same way had it arisen in the Sixth Circuit. Accordingly, there is no conflict between the circuits warranting this Court's review.

IV. PETITIONERS AND AMICI OVERSTATE THE IMPACT OF THE COURT OF APPEALS' DECISION

Both petitioner and amici suggest that exempting self-insured plans from the mandatory reporting of medical claims data for use in Vermont's database threatens similar programs in other states by rendering all-payer claims databases ineffective as a tool for developing health care policy. Pet. 30; States of N.Y. et al. Amicus Br. 3, 7-8. Contrary to those claims, the Second Circuit's decision does not threaten either the existence or the effectiveness of such databases. Nor does it "cast[] a shadow over a wide range of other state regulations." Pet. 15, 26.

First, the Second Circuit's decision will not prevent states from obtaining an accurate picture of the health care services provided within their borders. In this respect, it is noteworthy that several of the states that petitioner and amici claim will be affected by the Second Circuit's decisions have not joined the amici in supporting petitioner, including Connecticut, which is within the Second Circuit. Moreover, neither the petitioner nor the amici explain why the medical claims information of participants in ERISA plans could not be readily obtained from the health care providers that service those participants. Indeed, the enabling legislation in several of the states with claims databases, including Vermont, allow for the collection of information from health care providers.[14]

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[14] *See* Pet. App. 94 (requiring '[h]ealth insurers, health care providers, health care facilities, and governmental agencies' to 'file reports, data schedules, statistics, or other information" (18 V.S.A. § 9410(c))); *see also* Kan. Stat. Ann. § 65-6805 (listing health care providers among entities that must file health care data); R.I. Code § 23-17.17-10 ("health providers … shall file reports"); Utah

Moreover, any contention that claims databases will be unreliable absent mandatory reporting by self-insured plans is belied by the fact that not all such databases require self-funded ERISA plans to report claims information. Indeed, not all of the sixteen states that amici have identified as "creating health-care data collection programs of this type" require self-funded insurance plans to report medical claims data for use by the State.[15] And amici do not mention that, in addition to the sixteen states that they identify as having implemented health-care data collection programs, voluntary claims databases exist in several other states that do not rely on mandatory reporting requirements.[16]

Finally, there is no substance to petitioner's overwrought assertion that the Second Circuit's decision "casts a shadow over a wide range of other state regulations" and "provides a basis for challenging state health care regulations, taxes, licensing, and safety rules—all of which typically require recordkeeping and reporting of compliance information." Pet. 15. Nothing in the Second Circuit's decision provides a footing for this speculation. As already discussed, the Second Circuit did not hold Vermont's regime preempted merely

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Code Ann. § 26-33a-102 (defining "data supplier" to include health care facilities and providers).

[15] Va. Code Ann. § 32.1-276.7:1(B) ("The Commissioner … *may* collect paid claims data for covered benefits … from entities *electing* to participate as data suppliers." (emphasis added)).

[16] Pet. App. 7 ("Some states provide only for voluntary reporting."); C.A. App. A368-374 (identifying Louisiana, Washington, and Wisconsin as states with voluntary APCDs); *see also* All-Payer Claims Database Council data for California, http://apcdcouncil.org/state/california (last visited Nov. 6, 2014) (discussing California's voluntary database).

because it contains reporting requirements, and the court expressly recognized that not every state law imposing a reporting requirement is preempted.

In fact, the panel specifically pointed to prior Second Circuit decisions that upheld reporting requirements unrelated to core ERISA plan functions. Pet. App. 22-24. Those prior decisions involved one of the areas of state regulation—state prevailing wage laws—that petitioner now claims is under threat as a result of the decision below. *See HMI Mech. Sys., Inc.* v. *McGowan*, 266 F.3d 142 (2d Cir. 2001); *Burgio & Campofelice, Inc.* v. *New York State Dep't of Labor*, 107 F.3d 1000, 1009 (2d Cir. 1997); *cf.* Pet. 34-35 (suggesting that under the Second Circuit's decision a challenge to a prevailing wage statute could "easily be recast as objections to reporting or recordkeeping requirements"). The panel did not question those decisions; rather, it distinguished them, precisely because they are not like Vermont's law in that they do not operate in an area of core ERISA concern. Pet. App. 18-21. The court thus made clear that its decision below does not threaten ordinary state regulations that have incidental recordkeeping and reporting requirements, and petitioner's speculation that the decision will cut a wide swath through state law provides no basis for this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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NOVEMBER 2014

APPENDICES

RELEVANT STATUTORY PROVISIONS

Vermont Statutes Annotated
Title Eight. Banking and Insurance
Part 1. General Administrative Provisions
Chapter 1. Policy and Administration
§ 13. Powers and penalties

(a) In addition to any other penalties, and in order to enforce this title, 9 V.S.A. chapters 131 and 150, Title 9A, and 18 V.S.A. chapter 221, the Commissioner may issue subpoenas, examine persons, administer oaths and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the Commissioner. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the Commissioner may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the Commissioner under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to regulation under this title shall not be eligible to receive fees or mileage under this section.

(b) A person who fails or refuses to appear, to testify or to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of Financial Regulation of not more than $2,000.00 for each day of noncompliance and proceeded

against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

(c) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Commissioner under this title, or 18 V.S.A. chapter 22, the Commissioner may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be recorded, enforced, or satisfied in the same manner as a judgment of the court.

(d) In addition to any other penalties or powers, the Commissioner may order a person to make restitution or provide disgorgement of any sums shown to have been obtained in violation of provisions of this title and 18 V.S.A. chapter 221, plus interest at the legal rate.

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc.
AND Blue Cross and Blue Shield of Massachusetts, Inc.

Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to Onpoint Health Data, duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED Exhibit "A" on or before August 10, 2011 and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes, facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S W Kimbell
STEPHEN W. KIMBELL, COMMISSIONER
Vermont Department of Banking, Insurance, Securities and Health Care Administration

EXHIBIT A

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.
    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, April, May, June

- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.
   - Eligibility files for the following months of incurred services for 2011: April, May, June
   - Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
   - Pharmacy claims files for the following months of incurred services for 2011: April, May, June