

Respondent Amici – Gobeille v Liberty Mutual Insurance Company

Amici	Principal Arguments
<p>American Benefits Council; America’s Health Insurance Plans; The ERISA Industry Committee; The National Business Group on Health; The Chamber of Commerce of the United States of America</p>	<ol style="list-style-type: none"> 1. Self-funded employer plans are desirable because they streamline administrative processes, thereby increasing benefits to plan participants. Self-funded plans are a “win-win” proposition for employers and their employees because they result in greater benefits. ERISA preempts state laws that interfere with this objective. 2. State APCD laws are growing, and each state law has different requirements, different reporting formats, and different reporting schedules. Subjecting self-funded plans to the “complex web” of state APCD regulations thus would interfere with ERISA’s core tenets by complicating the administration of plans and plan benefits. These burdens are not relieved by outsourcing administration to TPAs, because outsourcing does not resolve the impact of Vermont’s law on plans, which must be operated “solely for the purpose of paying benefits to participants”. To allow APCD laws to apply repurposes plans to serve an entirely different purpose – collecting participants’ medical data to support state programs and initiatives. This further undermines one of the advantages of self-funded plans, namely their lower costs and defeats ERISA preemption doctrine, which exempts self-funded plans from a patchwork of state regulation. 3. The “exclusive purpose of ERISA benefit plans is to provide benefits, not to be laboratories for state experimentation. State APCD laws increase costs and “conscript plans into the service of the states”.
<p>New England Legal Foundation</p>	<ol style="list-style-type: none"> 1. In this situation, the general principle against federal preemption of state laws promulgated pursuant to their historic regulatory police powers does not apply in this case, no matter how strong the principle. In this case, the ERISA statute contains an express preemption provision where data collection and reporting are concerned. Presumption doctrine is unnecessary, since preemption is established as a fact. 2. Narrowing this interpretation of preemption to allow a state law to stand in an area expressly addressed by federal law would be contrary to the Court’s longstanding federalism doctrine.
<p>The National Coordinating Committee for Multiemployer Plans</p>	<ol style="list-style-type: none"> 1. The Vermont APCD law is expressly preempted under <i>Travelers</i> because it deals with core ERISA functions that are expressly addressed by the ERISA statute itself. 2. Furthermore, the Vermont statute imposes a mandate on plan administration and thereby strips multiemployer plans of the protections of uniform federal law. imposes onerous data collection, organization, tracking, reporting, and economic burdens that vary significantly from state to state and are not already a part of the regular course of business for self-funded plans. ERISA was designed to protect employers from “conflicting and multiplicative state regulation” in order to minimize the financial burden on plans.
<p>Blue Cross and Blue Shield Association</p>	<ol style="list-style-type: none"> 1. This is a case of express preemption rather than one involving the broad preemption doctrine set forth in <i>the Travelers</i> decision, and it offers the Court an opportunity to update its preemption doctrine. 2. In express preemption cases, the presumption against preemption does not apply. Instead the standard is aligned with ordinary conflict preemption doctrine. Thus the presumption against preemption should be discarded in a case such as this, and any situation in which a state law explicitly references ERISA plans should trigger preemption as a law that “references” ERISA plans. 3. Even were the Court to retain its current doctrinal approach to ERISA preemption and treat this case as one in which the presumption against preemption applies, in this case preemption would exist because Vermont’s law interferes with national uniformity, a core purpose of ERISA. Indeed, under the ACA, federal ERISA reporting obligations in fact include an obligation to report medical claims data, thereby setting up a direct conflict between ERISA reporting requirements and those of variable state APCD laws. This overlap can be found in the ACA’s requirement that ERISA plans report “claims payment policies and practices” and other provisions related to participant enrollment and coverage.



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The United States	<ol style="list-style-type: none"> 1. Vermont’s ACPD law does not fall within ERISA’s express preemption provision. 2. Preemption analysis turns on whether the requirements have an impermissible “connection with” ERISA plans. They do not. The Vermont law serves objectives distinct from those of ERISA. 3. Applying preemption so broadly would create a vacuum in a critically important area for the future of healthcare. Such a ruling would also frustrate the objectives of other important federal statutory provisions. Examples of such an adverse impact on other important federal objectives are the ACA’s efforts to encourage state data collection, as well as the work of the Center for Medicare and Medicaid Innovation, which has an express purpose of testing and evaluating state all-payer payment reforms in connection with medical care for all residents. Other evidence of Congress’ desire to ensure APDC efforts can be found in ACA provisions making Medicare data available to states undertaking such efforts. 4. The Second Circuit was incorrect in resting its holding on the notion that all “reporting” is a “core ERISA function.” 5. The Vermont APCD laws would survive preemption under ordinary field and conflict preemption principles. The reporting requirements operate in an area of traditional state regulation that is remote from ERISA’s basic purpose and thus is entitled to a presumption against preemption. Because Vermont’s law does not prescribe binding rules for the design or administration of ERISA plans or bind administrators to a particular course of conduct, none of the forbidden effect that triggers preemption is present.
The National Association of Health Data Organizations (NAHDO), et al.	<ol style="list-style-type: none"> 1. No new or unique recordkeeping is required. The data sought by the state is already collected and retained by payers in the routine course of business. Thus, ERISA’s core objective of national uniformity is not at issue here. BCBS already provides the required data to Vermont’s APCD on behalf of other payers. 2. The Vermont statute does not interfere with nationally uniform plan administration by requiring administrators to offer substantively different plans in different states; it merely calls for data aggregation after the data already have been collected. 3. Individual privacy concerns are not implicated by the Vermont reporting requirement, since the data are not personally identifiable and cannot be “decrypted.” Vermont’s APCD regulations closely parallel national HIPAA transaction standards. 4. There is broad bipartisan support for data collection and aggregation across payers at the state level, as evidenced by the Medicare Access and CHIP Reauthorization Act (MACRA), which exemplify the level of federal support for greater health data aggregation and transparency. Broad provider coalitions such as the Pacific Business Group on Health support aggregated all-payer data. The Affordable Care Act’s State Innovation Model (SIM) program is further evidence of this support, through federal legislation aimed at supporting state efforts to develop and test all-payer reporting systems. These efforts would be defeated were ERISA read to preempt such state-centered data initiatives.
State of New York, et al. (NY, CO, CT, HI, IL, KS, ME, MD, MA, MN, NB, OR, RI, TN, TX, UT, WA, DC)	<ol style="list-style-type: none"> 1. ACPDs should be afforded a strong presumption against preemption. Their principal purpose is to strengthen the quality of health care while controlling costs. 2. The purpose of the ACA is to encourage states to adopt ACPDs as part of performing insurance rate review tasks and to improve the quality and efficiency of health care as part of regulating local insurance markets. 3. The presumption against preemption cannot be overcome here because APCD laws do not implicate or interfere with ERISA objectives. 4. APCD laws do not even apply to ERISA plans as plans – they require the submission of individual medical data after benefits have already been administered. 5. Here, the economic burden is even less than the indirect influences saved from preemption in <i>De Buono</i> and <i>Travelers</i>. The economic burden is negligible because plans through their TPAs already have collected the data in the normal course of business; they simply must be electronically transmitted. Further, excluding data from self-funded plans would likely increase administrative costs for TPAs, since they would have to sort through all of their claims to separate insured from self-insured plans.



	<ol style="list-style-type: none"> ERISA data reporting requirements relate to information needed to oversee plan fiscal stability. APCD laws serve an entirely distinct state health law policy, oversight of medical care itself. APCD laws thus operate in an area completely separate from ERISA itself.
Harvard Law School Center for Health Law and Policy Innovation, et al.	<ol style="list-style-type: none"> ERISA was not intended to shield self-funded insurance plans from all state regulation. The Vermont statute aims to collect health care claims data for policymaking consideration, not for investigating into the financial soundness of self-funded plans, which is the purpose of federal regulatory reporting. ACPDs are vital to health services research because they provide population-wide data that cannot be obtained in other ways and is crucial to health care policy decision making. To lose self-funded insurance plans from the data base would be to irreparably skew the data to present a sicker population.
AARP; Families USA; U.S. Public Interest Research Group	<ol style="list-style-type: none"> The main purpose of APCDs is to help consumers by promoting health care cost transparency. States need comprehensive and accurate information about the health care market to achieve policy goals. To lose self-insured payers from APCD systems would frustrate the goal of quality and affordable health care for all state residents. APCDs are specifically targeted at public health regulation, not monitoring plan beneficiary rights. They are designed to help states study the quality of health care and identify approaches to reducing cost and inefficiency in care These purposes are separate from the purpose of ERISA's disclosure requirements, which is to arm plan participants with knowledge regarding their plan rights and remedies. Federal plan filings focus on finances, investments, actuarial assumptions, and other economic information all related to plan soundness. Under traditional preemption concepts, both federal and state laws can survive. Vermont's law survives a normal conflict preemption test, and unless the law fails under field preemption principles, it would survive. Here, the state law, which is a traditional police powers law to protect population health, does not frustrate the objectives of federal law and can coexist. The Vermont law does not bind ERISA plan administrators to any particular design or administration choices, thereby precluding nationally uniform practice. ERISA reporting guards against problematic plan administration and protects participant rights. Vermont's law is designed to ensure the quality and efficiency of the health care market itself.
Connecticut Health Insurance Exchange D/B/A Access Health CT	<ol style="list-style-type: none"> APCDs fall squarely within the legitimate realm of traditional State policing authority not subject to ERISA preemption Connecticut uses its APCD as an integral part of its State Innovation Model (SIM). The Court of Appeals' decision jeopardizes not only Connecticut's health care reform efforts, which are designed to improve the quality and efficiency of health care for all residents. The Second Circuit's ruling threatens health reform more broadly if self-funded plans data becomes unavailable, because the state will be unable to engage in population-wide data analysis. A ruling on behalf of Liberty Mutual would threaten state efforts to monitor and measure the quality and efficiency of health care on a population-wide basis, a central aim of the ACA. The damage will be particularly great in states with a large proportion of self-insured ERISA plans. The Vermont statute, and APCD statutes generally, are not preempted by ERISA. ERISA creates a presumption that Congress did not intend to preempt traditional areas of state regulation. The Second Circuit failed to understand that the purpose of state APCD law is to regulate the quality and efficiency of health care as a matter of health and safety. APCD laws are not state laws that seek to affect the uniform nationwide administration of ERISA plans or bind plan administrators to particular plan or administrative choices.
American Hospital Association and Association of American Medical Colleges	<ol style="list-style-type: none"> APCD claims data bases are an important public policy tool, with 11 states maintaining such a tool and 5 in the implementation phase as of March 2014. APCD collect data from all payers, public and private and the data base include information on various types of health care services across. Collection procedures conform to HIPPA requirements. The purpose of such tools is to advance public health and safety, advance patient safety, and address preventable health care events. APCD laws also can advance efforts to reduce racial and ethnic disparities in health care by allowing researchers to stratify analyses across health systems, thereby enabling the design of system level health interventions. . The APCD resources identify health care needs and inform health policy with data unavailable through other sources, making them an invaluable a valuable health policy tool



	<ol style="list-style-type: none"> 4. Inclusion of self-insured plans in an all-payers database is critical to the sustainability and efficacy of the database. 5. It is no burden for self-insured plans to produce claims data since it is the TPA not the plan itself that collects and provides the information. Indeed, the subpoena in this case was directed at the TPA, not at Liberty Mutual. Even were a self-funded plan to also self-administer, there would be no burden given nationally standardized codes and formats that enable an efficient reporting system. This standardization is a basic element of Vermont’s law as well as a basic recommendation of the APCD Council, which advises states on APCD systems. National standardization of data simplifies submission. .
<p>National Governors Association; National Conference of State Legislatures; Council of Governments; National Association of Insurance Commissioners; Association of State and Territorial Health Officials</p>	<ol style="list-style-type: none"> 1. 18 states currently collect and analyze health care claims data to regulate the safe and effective delivery of health care services. Without data from all payers (up to 70 million people participate in self-insured plans), the completeness and usefulness of the data would be compromised. 2. State health care data collection laws fill an area of critical need for states. States need universal, standardized data to support effective policy development, understand health system use, and drive delivery reform. States historically have collected such data on a limited basis through specific registries, but these data cannot be aggregated and analyzed to answer many basic population-wide questions. Of critical importance is cost comparison data to enable consumers to make spending choices. 3. Data are collected for many purposes, none of which is reflected in the underlying reasons that DOL collects data on plan soundness and participant rights. Questions answered through such data bases relate to price, travel time, specialist access, available of health care in rural areas, high-cost patient and readmission drivers, variations in ED use by insurance status, questions regarding testing and treatment of communicable disease, use of preventive benefits such as mammography, management of serious conditions such as depression. 4. Data completeness is essential, and standardization minimizes burden. Despite this fact the Second Circuit cited burden without citing any evidence to support the assertion. Indeed, the TPA was “happy” to provide the data. 5. APCD laws require no separate recordkeeping and only require plans to report information already in their possession. APCD laws mandate no benefit structures and provide no alternative enforcement mechanisms. ERISA preemption is inappropriate. The presumption against preemption applies, because Congress does not intend to supplant state laws in areas of traditional state regulation. The Second Circuit dispensed this presumption in a footnote without citation. 6. The Second Circuit mistakenly categorized “reporting” as a core ERISA function, but did not analyze the distinctions between the type of data required reported to the DOL versus the type reported to APCDs. DOL made clear that it does not collect the data sought by the states and there is no overlap in reporting requirements. (DOL 2nd Cir. Brief at 13)
<p>The State of New Hampshire</p>	<ol style="list-style-type: none"> 1. State APCD laws fall outside of the state laws regulating insurance that Congress intended ERISA to preempt. They are a part of a state’s regulation of insurance markets, but unlike typical insurance laws, they do not regulate the content or administration of insurance plans. 2. A ruling that the Vermont law is preempted would have devastating effects on other states that have ACPD laws.
<p>American Medical Association and Vermont Medical Society</p>	<ol style="list-style-type: none"> 1. Vermont’s APCD law falls squarely within the realm of “general health care regulation” and is codified as a public health statute designed to improve residents’ health, control health care costs, enhance the health care experience, retain health care professionals, and simplify health care financing. The database created by the Vermont law is a resource to continually review health care utilization, expenditures, and performance. 2. Under established ERISA precedents, there can be no preemption where there simply is no overlap, let alone conflict, between state and federal requirements. 3. Liberty Mutual fails to demonstrate the existence of a substantial burden on its self-insured plan such that ERISA preemption would be implicated. BCBS readily possesses the required information and merely needs to electronically upload the data to transmit it to the state, and is “happy to provide the data... and does so for other clients.” 4. Amici propose refining ERISA 514(a)’s preemption analysis to more clearly separate the areas occupied by ERISA’s exclusive federal regulation from other areas of state regulation (like health care).



Professor Edward A. Zelinsky	<ol style="list-style-type: none"> 1. The Court should use this case to confront the tension between the Court’s ERISA key precedents, <i>Shaw v Delta</i> and <i>Travelers</i>. Properly read, ERISA preemption statute creates a presumption against preemption, this reading is inconsistent with the actual wording of the statute, which should be read as a presumption in favor of preemption. The ERISA statute contains no preservation clause. 2. The statute makes more sense if read as a presumption of preemption, because its exceptions then make sense. ERISA defines “matter[s] of local concern” that should be considered exempt from preemption; health care is not identified as such a matter.
Association of American Physicians and Surgeons, Inc., and The Vermonters for Health Care Freedom	<ol style="list-style-type: none"> 1. The Second Circuit’s decision protects individual medical privacy. Likewise, ERISA preemption should be construed as advancing these concerns against state laws that would violate individual privacy. . 2. Vermont’s APCD does not protect individual medical record privacy. Transferring voluminous records at one time increases the likelihood of privacy breach. Moreover, scholars have disproven the notion that removing direct personal identifiers in medical records protects patient privacy. 3. The writ of certiorari should be dismissed as improvidently granted because this would leave the Second Circuit’s decision protecting the privacy of Vermont residents in place.

