



What's at Stake for States? The Lines are Drawn in *Gobeille v. Liberty Mutual*

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On December 2nd, the U.S. Supreme Court will take up *Gobeille v. Liberty Mutual*,¹ a case which could limit states' ability to collect essential data to advance payment reforms, address cost and quality and assure consumers have information and access to care. At issue is whether or not a state can compel a self-insured employer to submit health care claims - data that shows how much was paid for health care services - to the state's all-payer claims data system (APCD). Eighteen states have enacted laws to create all-payer claims data systems and 20 more are considering doing so.²

Background

Regulation of health insurance is bifurcated – states regulate coverage that is fully insured – where an insurance company accepts all the risk for covered lives; the federal government, under the Employee Retirement Income Security Act of 1974 (ERISA), regulates self insured plans where the employer bears some or all of the risk for providing benefits. Importantly, three out of five workers covered by employer-sponsored insurance are in self-funded plans.³ Vermont, the petitioner in this case, is engaged in health reform designed to change how care is delivered and paid for, to rein in costs, and to improve quality for all Vermonters. Vermont's APCD system provides critical information to support these reform efforts by requiring claims data from payers⁴ in the state, a state with a large proportion of self-funded plans.

Liberty Mutual is a self –funded employer plan in Vermont. Arguing that the federal government regulates it, not Vermont, the company objects to providing claims data to the state, maintaining the requirement violates federal ERISA law. ERISA pre-empts any state law if compliance with the state law would conflict with it or if a state law imposed a burden on ERISA plans regarding plan design, operation, functions or benefits.

A Second Circuit decision, upon which this case is based, ruled that all reporting, not just that related to plan benefits and administration, is a core ERISA function and supported Liberty Mutual's refusal to submit claims to Vermont's APCD.

The U.S. Supreme Court will hear oral arguments on *Gobielle v. Liberty Mutual* on December 2, 2015.

The Case Before the US Supreme Court – The Lines are Drawn

Eleven amicus briefs were filed in support of Vermont. They include briefs filed by the Solicitor General of the United States; the National Association of Health Data Organizations, et. al.; the State of New York for itself and 16 states and the District of Columbia; Harvard Law School Center for Health Law and Policy Innovation, et. al.; AARP, Families USA, and U.S. Public Interest Research Group; Connecticut Health Insurance Exchange; The American Hospital Association and Association of American Medical Colleges; The National Governors' Association, National Conference of State Legislatures, Council of State Governments, National Association of Insurance Commissioners, and Association of State and Territorial Health Officials; the State of New Hampshire; and American Medical Association and Vermont Medical Association.

Four amicus briefs were filed in support of Liberty Mutual, including by: American Benefits Council, America's Health Insurance Plans, the ERISA Industry Committee, the National Business Group on Health, and the U.S. Chamber of Commerce; New England Legal Foundation; the National Coordinating Council for Multiemployer Plans; and the Blue Cross and Blue Shield Association.

Two amici were filed in support of neither party; one raised issues of privacy and another called on the Court to more broadly address and define when state laws are preempted by ERISA. [See chart of all amicus briefs.](#)

In a nutshell, Vermont and its supporters argue that APCD laws should be retained and are not trumped by ERISA – they do not impose a burden on the benefits, operation or enrollees of ERISA plans. Their reporting requirements are constructed for a fundamentally different purpose than ERISA and do not conflict with that law.

ERISA reporting requirements relate to the financial stability and management of those self-funded plans and their benefits. By contrast, state laws requiring APCD reporting from every payer

relate broadly to the state's historic role in promoting public health and are vital to help the state achieve critical reform goals, including improving population health and health care costs and utilization statewide.

Liberty Mutual and its supporters argue that the two reporting laws (Vermont's APCD law and ERISA) are in conflict. ERISA is designed to assure consistency across the country, reduce administrative burden and thus lower costs to the benefit of enrollees. They argue that allowing state variation in reporting requirements and methods imposes new requirements and a financial burden on self funded plans – variation that ERISA was designed to avoid. ERISA, they argue, was enacted to guarantee employers uniformity of regulation across state lines. As such, allowing states to impose unique and different reporting requirements undermines Congress' intent because it allows states to act in an area that Congress intended to exclusively occupy at the federal level. Some commenters argued that APCDs force plans into the service of states for their own purposes in ways not intended by Congress.

Supporters of Vermont's case noted that the data collected by APCDs are already collected by payers and reported by self-funded companies in other states with APCDs. In fact, they argue, the third party administrator responsible for managing Liberty Mutual's claims in Vermont is Blue Cross Blue Shield of Massachusetts which does report claims and eligibility for other self-funded plans. It was noted that the APCD Council, a national organization that supports state APCD programs, has developed model legislation that supports cross-state harmonization of data and analytic activities.

Why This Case Matters to States

Increasingly, states are at work with local providers, consumers and payers, to fundamentally restructure how care is delivered and paid in the states and across payers. They aim to improve the quality, cost and effectiveness of care, to reward value, not volume and invest not just in medical care but in addressing the social

determinants of health. Reliable, all-payer data is critical to these efforts. Supported by significant funding from HHS's Center for Medicare and Medicaid Innovation, states are implementing multi-payer State Innovation Models (SIM) to test new ways to deliver and pay for care and many rely on APCDs to inform that work. As states contemplate the possibilities of the ACA's 1332 waivers to test new approaches to affordable coverage, all-payer data could be useful to weigh decisions about proposed options and their costs.

The presence of an APCD provides states the data to benchmark performance. With this data, states can answer such questions as— what are we spending now, on what services, and through which providers. States can also track progress over time to measure the success of payment reform initiatives on bending the cost curve. States can and do provide comparative pricing information that can fuel market competition and inform consumers. They can identify access problems and target health care cost drivers, including identifying potential abuse of opioids, for example. Coupled with clinical data, available through health information exchanges, states can measure both cost and quality over time. States are using APCDs to support rate review and evaluate public health education campaigns. Minnesota's APCD data informed a study of preventable health care events, hospital admissions and readmissions. In Connecticut, the state exchange is using its APCD to populate a provider directory to provide real time information to consumers seeking to know which providers are in their insurers' networks. Massachusetts and Colorado are developing quality and patient safety reports.

States are also using APCD data to analyze continuing and emerging policy questions. How can coverage and care be more affordable? How will new systems of delivering care affect cost, quality and access? As providers integrate to provide more seamless care to patients, research warns that those health care consolidations can drive up costs.⁶ How will states provide oversight and consumer protection in a new and emerging delivery system? States, working with all parties, need robust data to address such questions.

The stakes are high in this decision. While APCDs could continue without self-funded plan data, that data would be less useful without including the self-funded plans, a large and critical portion of those paying health care claims. Without those data, Medicare and Medicaid claims that account generally for a poorer and sicker population, will skew the data and make it less valuable and complete. The stakes are high, not just for states but for all those who can use the APCD data.

And as states watch this challenge to their ability to engage self-funded plans in data collection, reformers wonder what this portends for the future. Will self-funded plans invoke ERISA preemption to avoid other state-initiated reforms?

The briefs supporting Vermont made clear that the purpose of the APCD database is to help states regulate health and safety by providing resources for research related to costs, utilization, trends, transparency, efficacy, efficiency and access. Such analyses could not be accurately performed without the inclusion of self-funded payer data since those plans cover the majority of commercially insured workers. The briefs argue that these are not core ERISA concerns but rather a part of the "historic police powers of the state:" the regulation of matters of health and safety.⁷

As states take on new initiatives that address population health and delivery and payment of care across payers, access to comprehensive data will be critical. All eyes are again on the U.S. Supreme Court. A decision against Vermont's APCD will likely weaken an important and still evolving tool states have to guide their reforms – independent, complete claims data that includes all payers, whether regulated by the state or the federal government.

Endnotes:

1. Gobeille is the chair of Vermont's Green Mountain Care Board.
2. Erin Fuse Brown, The Double Edged Sword of Health Care Integration: Consolidation and Cost Control: NASHP, October 19, 2015.
3. <http://kff.org/report-section/ehbs-2015-section-ten-plan-funding/>
4. Only insurers with 200 or more covered members living or receiving services in Vermont are required to report.
5. Erin Fuse Brown, The Double Edged Sword of Health Care Integration: Consolidation and Cost Control: NASHP, October 19, 2015.
6. Brief for The United States at 17 (citing De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 814 (1997)); Brief for Nat'l Governors Ass'n at 24-26; Brief for AARP, et al. as Amici Curiae Supporting Petitioners, Gobeille v. Liberty Mutual Ins. Co. (No. 14-181) at 23-24; Brief for NAHDO at 21; Brief for American Medical Ass'n and VT Medical Society as Amici Curiae Supporting Petitioners, Gobeille v. Liberty Mutual Ins. Co. (No. 14-181) at 9; Brief for Connecticut Health Ins. Exchange at 14; Brief for American Hospital Ass'n, et al; Brief for the State of New Hampshire at 28.

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