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 Writ of Certiorari To The
United States Court of Appeals
For The Second Circuit

BRIEF AMICI CURIAE OF AARP, FAMILIES USA, AND U.S. PUBLIC INTEREST RESEARCH GROUP IN SUPPORT OF PETITIONER

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INTEREST OF AMICI CURIAE[1]

AARP is a nonprofit, nonpartisan organization with a membership that strengthens communities and fights for the issues that matter most to families such as health care, employment, income security, retirement planning, affordable utilities and protection from financial abuse. Since its founding in 1958, AARP has advocated for affordable and accessible health care as well as for controlling its costs without compromising quality. In its efforts to foster the health and economic security of individuals as they age, and in response to the growing number of older people who lacked health care services or faced financial burdens due to unaffordable and inaccessible insurance and other health care costs, AARP has sought legislative reforms – both in state legislatures and Congress – to lower costs and increase the quality of health care. To these ends, AARP supports reforms that aim to, among other things, lower drug and health costs, lower the incidence of fraud and waste, assess health system performance, adopt effective health information technology, develop methods for aligning payment

[1] Pursuant to Supreme Court Rule 37, counsel of record received timely notice of the intent to file this brief and, on behalf of the parties, have consented to the filing of this brief. No counsel for a party authored this brief, in whole or in part; and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No party other than amicus or its counsel made a monetary contribution to its preparation or submission. Letters from the parties consenting to the filing of amicus briefs have been filed with the Clerk of the Court.

incentives with quality and reduced costs, and promote innovative service delivery systems. Lower health care costs and higher quality health care not only benefit individuals, but also serves businesses, and governments.

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care for all. It is a non-profit, non-partisan organization located in Washington, DC. Families USA advances its mission through public policy analysis, advocacy, and collaboration with partner organizations to promote a patient-and community-centered health system. It provides technical policy assistance to advocates at the state and federal levels to promote and advance value-based payment and delivery of health care, evidence-based medicine that links quality metrics to costs, and price transparency.

U.S. PIRG, the federation of state Public Interest Research Groups ("PIRGs"), is a non-profit, non-partisan advocacy organization that works on behalf of American consumers through public outreach to advocate for policies and strategies to advance the public interest, including bringing down the high cost of health care. U.S. PIRG's mission is to deliver results-oriented public interest activism that protects consumers, encourages a fair, sustainable economy, and fosters responsive, democratic government. U.S. PIRG regularly advocates before state and federal regulators and legislators on issues of health care transparency and cost containment. U.S. PIRG has participated as

amicus curiae in numerous cases involving health care and prescription drug costs.

As part of its health care reform efforts, Vermont requires all entities that pay for health care to provide claims data in order to build a comprehensive all-payer claims database to better assess health care spending, service, quality, and access. Many other states have implemented all-payer claims databases as well. The data collected is used to better inform the public, policymakers, and regulators and influence necessary health care system changes. Amici support efforts to study payer data that are designed to improve health care quality and delivery and lower costs.

Amici's members and other participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans.[2] 29 U.S.C. § 1001 *et seq*. Unfortunately, contrary to ERISA's purpose, a statute that was designed to safeguard employee benefits has too frequently been used to deprive employees of rights and protections they previously

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[2] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as amicus curiae in numerous cases involving the breadth of ERISA's preemption clause. *See, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997); *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86 (1993).

enjoyed under state law. Attempts to use ERISA to undercut health care regulation are contrary to this Court's recognition that such regulation is a traditional area of State concern. *See generally N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (*Travelers*), 514 U.S. 645, 654-55 (1995); *Boyle v. Anderson*, 68 F.3d 1093, 1102 (8th Cir. 1995) (ERISA preemption challenge to MinnesotaCare health reforms).

The Court's decision in this case will bear directly on the ability of working Americans to obtain the information they need to evaluate health care options as well as states' ability to provide better consumer protections, higher quality health care, and more affordable health care for their citizens. Thus, the decision here will have a direct and vital bearing on the health and economic security of millions of American consumers, including AARP's members and other older Americans. In light of the significance of the issues presented by this case, amici respectfully submit this brief to facilitate a full consideration by the Court of these issues.

SUMMARY OF ARGUMENT

Vermont – like thirteen other states – requires all entities that pay for health care to provide claims data in order to build a comprehensive all-payer claims database to better assess health care spending, service, quality, and access. Vt. Stat. Ann. tit. 18 § 9410(a)(2)(A) (App. 93). The data collected is used to better inform the public, policymakers, and regulators and influence necessary health care

system changes. *Id.* Transparency in health care cost, quality, and utilization information to the consuming public is important so that they can make informed choices about doctors, hospitals, drugs, health insurance, and other health care services, before they purchase these services – especially since price is not necessarily correlated with quality. *See* Nicolaus Henke et al., *Transparency – the most powerful driver of health care improvement?*, 2011 HEALTH INT'L 65, 72-73 (2011). Indeed, transparency may be the most important precondition to improving quality and reducing costs in the health care system. *Id.*

In contrast to the Vermont law, the general objectives of ERISA are to protect participants and beneficiaries and to ensure that they obtain the plan benefits to which they are entitled. *See* ERISA § 2(b), 29 U.S.C. § 1001(b). One of the methods that Congress devised to achieve that goal was a robust disclosure structure so that individuals would know exactly where they stood with respect to their plan – the benefits to which they are entitled, the circumstances which may preclude them from obtaining those benefits, the procedures necessary to obtain benefits, and who is responsible for managing the plan's assets. S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863; H.R. Rep. No. 93-533 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, 4649.

ERISA expressly preempts "any and all State laws insofar as they relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). The

Court must, therefore, determine whether Vermont's all-payer claims database enabling statute is one of such laws that "relates to any employee benefit plan" – in other words, did Congress intend to preempt this type of state law. *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992).

In determining the intended scope of ERISA preemption, the Court has frequently used the traditional preemption analytical frameworks of conflict preemption and field preemption. *See John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that, Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."). Indeed, the Court has explicitly adopted the traditional preemption presumption that "the historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Travelers,* 514 U.S. at 655, 661 ("nothing in the language of ERISA or the history of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr.*, 519 U.S. 316, 331 (1997) (there must be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law). To overcome this presumption, the Court must determine that the actual operation of the challenged state statute greatly impacts employee benefit plans. *See Dillingham*, 519 U.S. at 324-25.

ERISA's reporting structure works to police the behavior of plan administrators and fiduciaries and ensure participants receive the benefits to which they are entitled. In contrast, the Vermont all-payer claims reporting structure works to influence the future behavior of health care market players. Hence, the Vermont law is clearly not the type of state health care regulation that Congress intended ERISA to preempt and the presumption against preemption has not been overcome. *Travelers*, 514 U.S. at 655, 661.

ARGUMENT

I. ALL-PAYER CLAIMS DATABASES HELP CONSUMERS BY COLLECTING DATA THAT IS USED TO PROMOTE COST TRANSPARENCY AND LOWER HEALTH CARE COSTS.

The United States is the second highest health care spender in the world, with health care costs representing 17 percent of its GDP. *See* The World Bank, *Health Expenditure, Total (percent of GDP) 2013*, http://goo.gl/pG3IDT (last visited Sept. 1, 2015) (data compiled from the World Health Organization's Global Health Expenditure Database). Yet, the cost of health care in the U.S. does not correlate with the quality of that care. Research shows that nations that spend less on health care than the United States have a healthier populace and better quality health care. *See* Karen Davis et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund

(June 16, 2014), http://goo.gl/UTUecw. Moreover, the rate of health care spending in the U.S. is projected to grow to almost 20 percent of GDP by 2024. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2014-2024 – Forecast Summary*, https://goo.gl/zg3X9R (last visited Sept. 1, 2015). For these reasons, many Americans have long been concerned about and desire to arrest the continually rising cost of health care.

Though the primary purpose of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), was to make health insurance more affordable for those with little or no coverage, it also included provisions designed to reduce the overall cost of health care. *See* Robert Wood Johnson Found., *How Does the Affordable Care Act Attempt to Control Health Care Costs?* (July 2011), http://www.rwjf.org/en/library/research/2011/07/how-does-the-affordable-care-act-attempt-to-control-health-care-.html (noting that policymakers disagree about just how much these reforms will reduce health care costs). Recognizing that there are myriad methods to achieve health care savings, many states began attempts to control health care costs via different mechanisms even before the ACA was passed. *E.g.*, *Boyle v. Anderson*, 68 F.3d 1093, 1097 (8th Cir. 1995). One such mechanism is to collect from all health care providers information about paid health care claims, and to use that information to develop policies that reduce costs and improve quality. Fourteen states including Vermont require the establishment of such health claims databases; two other states have launched voluntary databases.

See Interactive State Report Map, APCD Council, http://www.apcdcouncil.org/state/map (last visited Sept. 1, 2015). The ACA acknowledges the potential cost-reducing benefits of these databases and thus encourages their use.[3] These databases, known as "all-payer claims databases," have been a useful tool for state regulators and consumers, but their utility is limited if not all payer information is reported.

A. The Purposes Of Vermont's All-Payer Claims Database – To Ensure Quality And Affordable Health Care Services For Its Citizens – May Not Be Fully Realized If Self-Insured Payers Do Not Comply With Its Reporting Requirements.

Similar to the thirteen other states which have established all-payer claims databases, the data collected in Vermont's all-payer claims database are used to: assess existing health care resources, identify health care needs and inform health care policy, evaluate the effectiveness of programs

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[3] The ACA established the Center for Medicare and Medicaid Innovation (CMI) for the purpose of "test[ing] innovative payment and service delivery models to reduce program expenditures . . . ." 42 U.S.C. § 1315a(a)(1). Among the models from which the CMI shall choose to test are models "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State …." *Id.* § 1315a(b)(2)(B)(xi). It is not surprising that states have chosen to establish their own all-payer claims databases given that individual state health care markets are different than the national market. *See generally* Jonathan Skinner, *Causes and Consequences of Regional Variations in Healthcare*, *in* HANDBOOK OF HEALTH ECON. (2012).

designed to improve patient outcomes, compare costs between treatment settings and approaches, provide information to consumers of health care, and improve the quality and affordability of health care services and insurance. *See* Vt. Stat. Ann. tit. 18 § 9410(a)(1)(A)-(F) (App. 92). The state must have accurate information about the health care market in order to achieve these goals.

The free market system is efficient at setting fair and accurate prices only when certain conditions are present. One of those key conditions is information about the price of services and products. In our health care system, however, consumers lack information about the comparative price of health care services and health insurance. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMER. ECON. REV. 941, 944 (Dec. 1963) (making the case that the free market economic model for efficiency cannot be applied to the health care market because it lacks several key conditions). Without this information, consumers and regulators cannot know if health care services are offered at a fair price, and whether and what type of regulation is needed to protect consumers in a market that heavily favors the seller. Vermont's all-payer claims database is designed to fill this information gap.

B. Vermont's All-Payer Claims Database Helps Consumers By Giving The State Opportunities To Study The Health Care System And Develop Ways To Reduce Health Care Costs.

Vermont's all-payer claims database allows state regulators, state agencies, contractors, and academic researchers to conduct population-based analyses of the health care system, including analyses of health care access, spending, utilization, and quality. *See* Green Mountain Care Bd., *2015 Annual Report to the General Assembly* 1, 16, http://goo.gl/IUU5xB (last visited Sept. 1, 2015). The data collected in the all-payer claims database has been used, for example, by the Vermont Blueprint for Health program in the Department of Vermont Health Access to inform the development of a statewide health service model. *See* Vt. Blueprint for Health, *2014 Annual Report* 1, 53 (July 31, 2015), http://goo.gl/sHTr08. The Blueprint evaluates a wide range of health care system data to make policy recommendations regarding provider networks, payment modifications, health care delivery models, recognized best practices, health outcomes, health information technology, and myriad other health care issues that can only be fully evaluated with robust data. *Id*. at 4-6.

Vermont's all-payer claims data has been used to study the health care spending growth drivers so that policy makers may be better equipped to develop strategies to slow it down. *See* Truven Health

Analytics, Brandeis University, *Vermont Health Spending Growth Drivers Commercial and Medicaid, 2008-2012*, Presentation to the Green Mountain Care Board (Apr. 16, 2015), http://goo.gl/613wiC. This data has also been used to study the utilization and cost of health care for Vermonters with employer sponsored insurance, *see* Health Care Cost Inst., *2007-2011 Vermont Health Care Cost and Utilization Report* (Dec. 2014), http://goo.gl/uwvgKg, and to report to the public, taxes paid by health insurers on all claims paid. *See, e.g.*, Annual Paid Claims and Enrollment Report 2014, http://goo.gl/DtbkzA (last visited Sept. 1, 2015). The all-payer claims data has been useful for a number of analyses and reports that help the consumer by keeping lawmakers and policy makers well informed of health care system trends. *See generally*, Green Mountain Care Bd., *VHCURES Analytics & Reports*, http://www.gmcboard.vermont.gov/VHCURES/Analytics_and_Reports (last visited Sept. 1, 2015).

C. Transparency In The Health Care System Is Of Paramount Importance To Consumers And To All Stakeholder Efforts To Improve System Value And Performance.

In addition to using the Vermont all-payer claims database to study the health care system, inform policy and regulation, and develop cost containment strategies, the enabling legislation provides transparency for the consumer by mandating that the program:

> [S]hall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

Vt. Stat. Ann. tit. 18 § 9410(a)(2)(A) (App. 93).

To this end, the enabling legislation states that the data collected from all payers "shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance." *Id.* § 9410(h)(3)(B). The implementing regulations set out procedures and parameters for classification and release of data for public use. *See* Regulation H-2008-01, 12-040-021 Vt. Code R. §§ 8-9.

The value of transparency in health care cost, quality, and utilization information to the consuming public cannot be overstated. Patients usually do not know the price of health care until after they have received it and price is often not a good indicator for quality. Consumers, therefore, need information to make informed choices about doctors, hospitals, drugs, health insurance, and other health care services, before they purchase these services – just as

they would to make any other major purchase. They also need to know the quality of the services they are receiving and whether they are getting the best value for their dollar. In turn, providers and insurers can use this information, and consumers' feedback, shown through choice, to determine what needs improvement. Indeed, transparency may be the most important precondition to improving quality and reducing costs in the health care system. *See* Nicolaus Henke et al., *Transparency – the most powerful driver of health care improvement?*, 2011 HEALTH INT'L 65, 72-73 (2011) (noting that one study estimated that the United States health care system could realize $300 billion in savings by utilizing health care data to, for example, spot disease trends, improve supply chains, and anticipate the demand for future services).

II. THE MAIN PURPOSE OF ERISA'S DISCLOSURE REQUIREMENTS IS TO ARM PLAN PARTICIPANTS WITH SPECIFIC KNOWLEDGE OF THEIR RIGHTS AND REMEDIES WITH RESPECT TO THEIR PLANS.

A. ERISA's Legislative History Reveals That Congress's Rationale For The Disclosure Structure That It Ultimately Enacted Was To Provide Participants With Comprehensive Information About Their Plans And Plan Administration.

ERISA's relevant legislative history illuminates Congress's reasons for mandating full disclosure to and for the benefit of participants. Congress's purpose in enacting the ERISA disclosure provisions allow:

> the individual participant [to] know[] exactly where he stands with respect to the plan – what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted.

S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863; H.R. Rep. No. 93-533

(1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, 4649; *accord Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 118 (1989). Undeniably, Congress's intent in establishing ERISA's reporting and disclosure provisions was to increase the scope and detail of information and data available to participants. *See Firestone*, 489 U.S. at 118.

A look at the Welfare and Pension Plans Disclosure Act of 1958 (WPPDA), Pub. L. No. 85-836, 72 Stat. 997, the precursor to ERISA, aids in a proper understanding of ERISA. *See* 2A *Sutherland Statutes and Statutory Construction* § 48.03 (7th ed. 2007) (court should consider development of statutory scheme over time "including prior statutes on the same subject"). The 1958 Act required disclosure only of "a description of the plan" and "an annual financial report." 72 Stat. at 999 (§ 5(a)). Congress amended the WPPDA in 1962 to provide for more effective sanctions for violations, impose more detailed disclosure duties, and require plan administrators to retain supporting documentation. Pub. L. No. 87-420, 76 Stat. 35. Congress ultimately determined that even these measures were ineffective to adequately protect the rights of employees. Finding that the WPPDA was "weak in its limited disclosure requirements," and "inadequate" in "protecting rights and benefits due to workers," H.R. Rep. No. 93-533 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4642, Congress enacted broader disclosure requirements in ERISA, noting:

> It was expected [under the WPPDA] that the information disclosed would

> enable employees to police their plans. But experience has shown that the limited data available under the [WPPDA] is insufficient. Changes are therefore required to increase the information and data required in the reports both in scope and detail. Experience has also demonstrated a need for a more particularized form of reporting so that the individual participant knows exactly where he stands with respect to the plan. . . . The safeguarding effect of the fiduciary responsibility section will operate efficiently only if fiduciaries are aware that the details of their dealings will be open to inspection, and that individual participants and beneficiaries will be armed with enough information to enforce their own rights as well as the obligations owed by the fiduciary to the plan in general.

Id. at 11.

Congress intended participants to be full partners with the Secretary of Labor to enforce the statute. In order to police their plans and vindicate their rights, participants must have the ability both to obtain needed information, S. Rep. No. 93-127 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4838, 4863, as well as the right to bring suit for benefits owed to them and fiduciary breaches. ERISA § 502(a)(1)(B),

(a)(2), 29 U.S.C. § 1132(a)(1)(B), (a)(2). ERISA's disclosure requirements thus serve to reinforce ERISA's fiduciary duties by requiring transparency of the fiduciary's actions – both in determining eligibility and the amount of benefits and investment of plan assets. H.R. Rep. No. 93-533, at 11 (1974), *as reprinted in* 1974 U.S.C.C.A.N. 4639, 4649.

B. ERISA's Statutory Structure Demonstrates That Plan Disclosure Was Intended As A Tool For Participants To Police The Administration Of Their Plan And Protect Their Benefits.

The general objectives of ERISA are to protect participants and beneficiaries and to ensure that they obtain the plan benefits to which they are entitled. *See Boggs v. Boggs*, 520 U.S. 833, 845 (1997); ERISA § 2(b), 29 U.S.C. § 1001(b). In its findings and declaration of policy, Congress stated that due "to the lack of employee information and adequate safeguards concerning" the operation of employee plans, it was "requiring the disclosure and reporting to participants and beneficiaries of financial and other information" "with respect to the establishment, operation and administration of such plans." ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b). ERISA's disclosure and reporting structure gives effect to this purpose.

Congress mandated that basic information concerning participants' rights – that is, summaries of the plan document and the annual report, written

in easily understandable language – must be disclosed to all plan participants automatically. ERISA §§ 101(a), 102(a)(1), 104(b)(1), 104(b)(3), 29 U.S.C. §§ 1021(a), 1022(a)(1), 1024(b)(1), 1024(b)(3). Additional automatic disclosures depend on the type of plan at issue. *See generally* ABA Section of Labor and Emp't Law, *Reporting and Disclosure*, *in* EMPLOYEE BENEFITS LAW, 4-26, 51-54 (Jeffrey Lewis et al. eds., 3d ed. 2012) (detailing different disclosures for pension and welfare plans). Furthermore, Congress decided that the plan must disclose to the participant other specified documents – the plan document itself, the collective bargaining agreement, trust agreement, annual, and any terminal report plans – upon a participant's written request. ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4). Another method of disclosure is inspection of governing plan documents at the plan administrator's "principal office" and other designated locations. *See* ERISA § 104(b)(2), 29 U.S.C. § 1024(b)(2). Plan administrators have a fiduciary responsibility to administer the plan in accordance with the governing plan documents. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

Congress also mandated filings with the government in order to determine plan compliance with the labor and tax provisions of ERISA. All ERISA covered plans – retirement, health and other types of welfare plans – are required to file an annual report. ERISA § 103(a)(1)(A), 29 U.S.C. § 1023(a)(1)(A). This annual report provides the government with significant information about the plan's finances, investments and actuarial

assumptions. It also includes information on funding policies, description of liabilities, and tax rulings and determination letters. ERISA § 103, 29 U.S.C. § 1023. All of the information filed in the annual report is available to the public for inspection, I.R.C. § 6104(b); ERISA §§ 104(a)(1), 106, 29 U.S.C. §§ 1024(a)(1), 1026.

III. ERISA DOES NOT PREEMPT THE REPORTING REQUIREMENTS OF VERMONT'S ALL-PAYER CLAIMS DATABASE STATUTE.

The Supremacy Clause provides that "the Laws of the United States" (as well as treaties and the Constitution itself) "shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Accordingly, under this principle, Congress has the power to enact federal laws that preempt state laws. *See Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000). It may do so through express statutory language or implicitly. *See Sprietsma v. Mercury Marine*, 537 U.S. 51, 64 (2002). ERISA contains language that expressly preempts "any and all State laws insofar as they . . . relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). The Court must therefore determine whether Vermont's all-payer claims database enabling statute is one of such laws that "relates to any employee benefit plan" – in other words, did Congress intend to preempt this type of state law.

In determining whether there is Congressional intent to supersede state laws, the Court has stressed that the "historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947); *accord Arizona v. United States*, 567 U.S. ___, ___, 132 S. Ct. 2492, 2500 (2012). The Court has always recognized the careful balance between federalism and states' power and authority to protect their citizens. Accordingly, the Court has identified that "'the purpose of Congress is the ultimate touchstone' of pre-emption analysis." *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); *see* U.S. Const. art. VI, cl. 2.

A. The Court Has Looked To Traditional Preemption Concepts To Determine The Reach of ERISA's Preemption Clause.

In its search to better define the parameters of the "relates to" portion of ERISA's express preemption clause,[4] and to ascertain Congress's intent to preempt state law, the Court has revisited the traditional preemption analytical frameworks of conflict preemption and field preemption. *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (Travelers*), 514 U.S. 645, 654-55 (1995); *Cal. Div. of Labor Standards Enf't v. Dillingham Constr.*

[4] ERISA § 514(a), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."

(*Dillingham*), 519 U.S. 316 (1997); *accord John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that, Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."); *Egelhoff v. Egelhoff*, 532 U.S. 141, 152–53 (2001) (Scalia, J., concurring) (normal field and conflict preemption principles should be applied in place of "relates to" test). Under conflict preemption, if "compliance with both state and federal law is impossible" or if "the state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress,'" then the state law is preempted. *California v. ARC America Corp.*, 490 U.S. 93, 100-101 (1989) (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)); *accord Travelers,* 514 U.S. at 654. Under field preemption, a court can determine that Congress intended to totally displace state law by inferring from a framework of regulation "so pervasive…that Congress left no room for the States to supplement it" or where there is a "federal interest…so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject." *Rice*, 331 U.S. at 230. In either situation, federal law must prevail. *Accord Oneok, Inc. v. Learjet, Inc.*, 135 S. Ct. 1591, 1594 (2015); *Arizona*, 132 S. Ct. at 2502. Accordingly, in its ERISA preemption analysis, the Court has adopted the long-established presumption that "the historic police powers of the States" are not superseded "unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655 (quoting *Rice*, 331 U.S. at 230). *Dillingham* reaffirmed this statement by holding that there must

be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to pre-empt" a traditionally state-regulated area of law. 519 U.S. at 331.

B. The Court Has Recognized That ERISA Was Not Intended To Invade The States' Traditional Power To Regulate Health Care.

State or local governments have several reasons to assert their police powers to enact programs to ensure that their citizens have affordable, quality health coverage: to improve the quality and life expectancy for individual citizens; to stabilize the labor pool and maintain productivity in the business community; to maintain and increase access to health care facilities and other resources; and to promote the general well-being of the community at large. *See* Karen Davis, The Commonwealth Fund, *The Costs and Consequences of Being Uninsured*, MED. CARE RES. AND REV. 60 (2) (June 2003), http://goo.gl/A4CXTL. The power of state and local governments to enact laws designed to ensure the health and welfare of the state's residents and workers is well-established and within the traditional police power of state and local governments. *See Sherlock v. Alling*, 93 U.S. 99, 103 (1876) (states' traditional role to regulate "subjects relating to the health, life, and safety of their citizens"); *Huron Portland Cement Co. v. City of Detroit*, 362 U.S. 440, 442 (1960) ("promoting the health and welfare of the city's inhabitants . . . clearly falls within the exercise of even the most

traditional concept of what is compendiously known as the police power").

Indeed, the well-settled authority of states to regulate in certain areas has evolved into a presumption that, when federal laws overlap with areas traditionally within the local police power, both local and federal law may have concurrent application. *See Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 205 (1983); *Huron Portland Cement Co.*, 362 U.S. at 442. In *Pacific Gas*, the Court rejected the contention that a federal law concerning the regulation of new nuclear power plants preempted state regulation of "all things nuclear," explaining "the States retain their traditional responsibility in the field of regulating electrical utilities for determining questions of need, reliability, cost, and other related state concerns." 461 U.S. at 205. Thus, federal preemption of one aspect of nuclear power did not preclude state regulation of peripheral matters, within the traditional realm of local police power where the federal law did not clearly intend to displace state law so broadly. Furthermore, *Huron* noted that "[i]n the exercise of [their police power], the states and their instrumentalities may act . . . concurrently with the federal government." 362 U.S. at 442. These decisions demonstrate how crucial it is to analyze the Congressional purpose in enacting the federal statute.

The Court also has conscientiously applied this presumption where the state uses its historic police powers to regulate in matters of health and safety

that are at the heart of the state's authority and obligation to protect its residents. *See Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715 (1985) (federal blood plasma regulations promulgated by the Food and Drug Administration do not pre-empt county laws imposing additional requirements beyond the federal law). The Court has not treated ERISA otherwise. *E.g.*, *Travelers*, 514 U.S. at 661 (courts "start with the assumption that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress"). Accordingly, the Court generally has held that ERISA does not preempt state laws regulating in the health care arena.[5] *See id.* ("nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997) (finding state tax on hospitals not preempted because ERISA does not supplant presumption that state law is not preempted); *Dillingham*, 519 U.S. at 325 (prevailing wage statute is within state's traditional power to regulate). "[I]f ERISA were concerned with any state action – such as medical-care quality standards or hospital workplace regulations – that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could

[5] Applying the historic presumption in claims of ERISA preemption makes particular sense because health plans were not the main focus of Congress's concern during the enactment of ERISA. *See generally* ABA Section of Labor and Emp't Law, EMPLOYEE BENEFITS LAW, at lxviii-lxix (Jeffrey Lewis et al. eds., 3d ed. 2012).

scarcely see the end of ERISA's pre-emptive reach." *Dillingham*, 519 U.S. at 329; *accord Egelhoff*, 532 U.S. at 147. Consequently, the Vermont all-payer claims database reporting requirements should be treated no differently than these other health care regulations.

C. There Is No Conflict Between ERISA And The Vermont All-Payer Claims Database Reporting Requirement.

Following traditional preemption analysis, the Court in *Boggs* stated that the first question in ERISA preemption analysis is when "state law conflicts with the provisions of ERISA or operates to frustrate its objects." 520 U.S. at 841. The Court further stated that if a court determined that a state law directly conflicted with ERISA's provisions, no further analysis was necessary. Not surprisingly, the Court also recognized that state laws that conflict with the substantive provisions of ERISA obviously "relate to an employee benefit plan." *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *accord Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990) (state law conflicts with ERISA § 510).

In *Boggs*, the Court held that ERISA preempts state community property and succession laws insofar as they apply to retirement plans because the state laws directly conflicted with ERISA's provisions regarding spousal rights (*i.e.*, the provision for a joint and survivor form of annuity) and operated to frustrate ERISA's purpose to ensure a stream of

income to surviving spouses. 520 U.S. at 843. Similarly, in *Egelhoff*, the Court found that ERISA preempted a state statute which, upon a person's divorce, caused any previous beneficiary designations of non-probate assets including life insurance policies and employee benefit plans designating the former spouse to be automatically revoked. 532 U.S. at 147-48. The Court stated that this state law directly conflicts with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents. *Id*. at 150. Moreover, laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits are preempted because of a direct conflict with ERISA's civil enforcement provisions. *Aetna Health Inc. v. Davila,* 542 U.S. 200, 217-18 (2004); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Applying this conflict preemption analytical framework, there is no question that Vermont's all-payer database reporting requirements do not directly conflict with any ERISA provisions. Compliance with both state and federal law is possible and the state law does not stand as an obstacle to the accomplishment and execution of ERISA's purpose to provide full disclosure to participants concerning the type of benefits, the eligibility for benefits, and the methods to protect those benefits.

D. In Enacting ERISA, Congress Did Not Intend To Preempt State Laws – Like Vermont's All-Payer Claims Database Reporting Requirement – That Regulate Quality And Affordability Of Health Care.

In determining the field of preemption for employee benefit plans, a court must determine that Congress intended to totally displace state law by inferring from a framework of regulation "so pervasive . . . that Congress left no room for the States to supplement it" or where there is a "federal interest . . . so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject." *Rice*, 331 U.S. at 230. Accordingly, a court must look 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." *Dillingham*, 519 U.S. at 325. At bottom, the inquiry is how does the actual operation of the challenged state statute effect employee benefit plans. *See id.* at 324-25; *De Buono*, 520 U.S. at 815.

Here, that examination is revealing. As Congress clearly indicated, *see supra* Part II, ERISA's reporting and disclosure for health plans concern participants' right to, and eligibility for, certain specific benefits as well as the procedures to obtain those benefits. This is so because ERISA's purpose for disclosure is to ensure that participants obtain the benefits they were promised. In addition,

ERISA's reporting and disclosure to participants and the government ensures that fiduciaries administer the plan in line with their fiduciary responsibilities including prudently investing and managing plan assets.

In contrast, the reporting requirements of Vermont's all-payer claims database seek information about the actual utilization, cost, and delivery of health care services so that the State, insurers, providers, policymakers, and consumers, among others, can make data-driven, evidence-based decisions about health care.[6] For example, enabling statute's implementing regulations require payers to report annually whether they have paid claims for Vermont citizens or for citizens of other states that have obtained health care services from Vermont providers. *See* Regulation H-2008-01, 12-040-021 Vt. Code R. § 4.A. If claims have been paid for Vermonters or for care provided in Vermont, payers are required to report detailed information about the claims paid, such as: amount paid, deductible, co-pay, co-insurance, premiums, health care information about the insured, what type of provider rendered services, and in what type of setting the care was provided. *See id.* § 3 (definitions); § 4.D. (listing the

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[6] ERISA was not designed to address health care costs or quality of care; indeed, in the 1970's, these were not on Congress's radar screen because they were not issues in the general economy. Kaiser Family Foundation, *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, Exh. 3, 4A, 4B (Apr 12, 2011), http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/.

types of data that shall be reported); § 5 (Required Health Care Data Files); Apps. C-1, C-2, D-1, D-2, E-1, E-2 (detailing specific data to be reported). Not only is the type of information required by the all payer claims database statue and regulations not of the same type as those required in ERISA disclosures, but it is also not used for the same purpose. All-payer claims data is not used to determine whether beneficiaries received the benefits to which they were entitled, as ERISA disclosures are used. For example, the regulations do not require information about whether claims should have been paid. *See*, *e.g.*, *id.* § 5.A(5)(8) (denied medical claims are exempted from reporting requirements). Only information about what type of insurance a person was eligible for at the time of reporting is sought. *See id.* Apps. C-1, C-2. ERISA, of course, does not mandate the reporting of costs or utilization of benefits.[7]

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[7] Obviously, ERISA requires reporting and disclosure from employee benefit plans concerning specific information about the plan. This does not mean that all state laws requiring reporting and disclosure from employee benefit plans are automatically preempted by ERISA. Indeed, if the Second Circuit and Respondents are correct, state laws requiring any reporting and disclosure regardless if the plan is operating like any other commercial entity would be preempted. This position would essentially not only overrule *Travelers* and its progeny, but earlier ERISA preemption jurisprudence as well. *E.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 828-830 (1988). The Court has been much more nuanced in its ERISA preemption analysis – again harkening back to the purposes of ERISA and the effect of the state law on ERISA plans.

This is not a case in which Vermont has mandated employee benefit structures or their administration, *e.g.*, *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (workers' compensation law prohibiting termination of health benefits of workers receiving workers' compensation benefits is preempted), forbidden a method of calculating pension benefits that federal law permits, *e.g.*, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-525 (1981) (preempted state law eliminating federally permitted integration of pension benefits with Social Security), or required employers to provide certain benefits. *E.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (preempted state law requiring the provision of pregnancy benefits); *Metro. Life Ins.*, 471 U.S. at 724 (preempted state law requiring plans to include minimum mental health benefits).

Nor does the Vermont all-payer database reporting requirements bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself. *E.g., Boggs*, 520 U.S. at 841-42; *Egelhoff,* 532 U.S. at 147-48. It contains no provisions that expressly refer to ERISA or ERISA plans. *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 828-830 (1988) (an explicit reference to ERISA in defining the scope of the state law's application is pre-empted); *Greater Washington Bd. of Trade*, 506 U.S. at 130-131 (same). And, Vermont's statute does not provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. *E.g., Davila*, 542 U.S. at 217-

18; *Dedeaux*, 481 U.S. at 54. *See generally Travelers*, 514 U.S. at 668 (recognizing that laws having direct effects on plans are preempted).

ERISA's reporting structure works to police the behavior of plan administrators and fiduciaries and ensure participants receive the benefits to which they are entitled. The Vermont all-payer claims reporting structure works to influence the future behavior of health care market players. Accordingly, a consideration of the actual operation of the Vermont law demonstrates that while it may impose some burdens on the administration of ERISA plans, it is not the type of state law that Congress intended ERISA to preempt.

CONCLUSION

Though the Court has recognized that health care regulation is an area of traditional state concern, *Travelers*, 514 U.S. at 654-55, there have been ongoing attempts to use ERISA to undercut state efforts to regulate health care. *See, e.g.*, *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1044-45 (9th Cir. 1998) (ERISA did not preempt health care regulation); *Boyle v. Anderson*, 68 F.3d 1093, 1099 (8th Cir. 1995) (same). Respondent similarly attempts to skirt Vermont's all-payer claims database reporting requirement by incorrectly invoking ERISA preemption. In so doing, Respondent not only advances an incorrect reading of ERISA's preemption clause and interpretive jurisprudence, but also jeopardizes the utility of Vermont's all-payer claims database. Respondent

thus denies consumers the benefits of transparency, choice, reduced costs, and better informed health care policy.

For the above reasons, amici urge the Court to reverse the Second Circuit's decision and hold that ERISA does not preempt Vermont's all-payer database reporting requirements.

Respectfully Submitted,

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September 4, 2015