Op-Ed

Clash of the Titans: State All-Payer Claims Reporting Systems Meet ERISA Preemption

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DURING ITS TERM THAT BEGINS IN OCTOBER 2015, THE UNITED States Supreme Court will hear *Gobeille v Liberty Mutual Insurance Company*, a case that will test whether self-insuring employers can refuse to comply with state all-payer claims reporting laws. Without a uniform, nationwide strategy to comprehensively address health care costs and quality—notably absent from the Affordable Care Act (ACA)—the stakes could not be greater for states that seek to take action.

Over the past decade, a number of states have established all-payer claims reporting systems that support more comprehensive efforts to address issues of access, quality, and cost for their populations. The ACA does not create such a reporting system. But the law arguably attempts to stimulate more broadly conceived approaches to cost and quality through delivery system reform initiatives such as medical homes and accountable care organizations, as well as initiatives that encourage Medicare and Medicaid to be active participants in multi-payer quality improvement reform efforts, which have begun to gain traction.

In 2003, Maine established the nation's first all-payer claims system. By 2014, 11 states had some form of all-payer reporting framework in place, and more than 30 states had either implemented such systems or had indicated an interest in doing so. Most of the state systems established to date provide for mandatory reporting.¹

Vermont's mandatory reporting law creates a "unified health care database" whose stated purposes are to identify health care needs, evaluate the effectiveness of health interventions, provide information to consumers and health care purchasers, and improve health care and coverage quality and affordability.² Vermont's law requires health insurers, health care providers, and government agencies to supply health insurance claims information and "any other information relating to health care costs, prices, quality, utilization, or resources." The state's

Department of Banking and Insurance enforces the law, violation of which can result in stiff financial penalties. The law defines “health insurer” to include insurance companies, regardless of whether the employer plans they administer are fully insured (plans for which the insurer assumes the financial risk) or self-insured (plans in which the insurer acts as a third-party administrator for an employer that self-insures). As of 2011, more than 58% of all employees with workplace health insurance were covered through self-insured plans. Even in Vermont, which tends to have smaller employers that are less likely to self-insure, nearly 50% of employees are covered through self-insured plans.³

The Employee Retirement Income Security Act (ERISA) regulates the health, welfare, and pension plans offered by private employers other than churches. In an extraordinary exercise of its constitutional power to displace state laws that could impede the flow of interstate commerce, Congress built a preemption provision into ERISA that has virtually no parallel in US health policy.⁴ ERISA’s preemption rule displaces state laws that “relate to” employer-sponsored health plans, and although state laws regulating insurance are “saved” from preemption, they are not saved with respect to plans that self-insure.

The US Supreme Court has grappled with the meaning and extent of this preemption provision virtually since ERISA was enacted in 1974. Over this time, the Court has moved from a literal interpretation of ERISA preemption as a law that displaces vast swaths of state regulation to a more tempered approach more in line with the strong federalism principles that undergird the US Constitution. This strategy, set forth by the Court in a seminal case—*N.Y. State Conference of Blue Cross and Blue Shield v Travelers Ins. Co.*, 514 U.S. 645 (1995)—begins with the presumption that Congress did not intend to displace areas of traditional state regulation. It then considers both ERISA’s broader purpose—to create a national and uniform system of plan administration—and weighs the extent to which any particular state law interferes with ERISA’s central purpose—a national and uniform approach to plan administration. State laws whose impact is considered “too remote and tenuous” to interfere with these goals are not preempted.

Liberty Mutual Insurance Company, which self-insures, employs fewer than 150 Vermont residents. In response to the Vermont law, Liberty Mutual instructed Blue Cross, its third-party plan administrator, to withhold the claims data sought by the state, claiming that as a self-insured employer, the company is shielded by ERISA’s preemption rule.

Liberty Mutual then sued in federal court to prevent Vermont's insurance department from imposing sanctions.

Applying *Travelers*, the *Liberty Mutual* trial court ruled in favor of Vermont. On appeal, in a surprising 2-to-1 decision given *Traveler's* sweep and scope, the US Court of Appeals for the Second Circuit reversed (*Liberty Mutual Ins. Co. v Donegan*, 746 F3d 497 [2014]), ruling that ERISA preempts Vermont's law.⁵ Its ruling was notable, since it was the Second Circuit whose *Travelers* decision favoring preemption 20 years ago ultimately led to a reversal by the Court in its landmark ruling.

Given the principles that lie at the heart of *Travelers*—a presumption against displacing state health and welfare laws, coupled with a careful effort to balance state law against the need for national and uniform plan administration—how did the Second Circuit arrive at its holding? The answer lies in how the court dealt with the fact that, like any regulatory law, ERISA has certain reporting requirements whose purpose is to ensure compliance with federal plan administration standards. The *Liberty Mutual* majority essentially interpreted the existence of *any* federal compliance reporting regarding ERISA requirements as evidence of Congress's intent to displace *all* state reporting laws applicable to ERISA health plans, regardless of either the purpose of the state law or whether the law interferes with the uniform, nationwide administration of ERISA-governed health plans.

As the dissent argued, the information sought by Vermont is not related to ERISA's plan administration requirements; instead, Vermont seeks information related to the cost and quality of health care, a matter squarely within its power to protect the health and welfare of its population. Furthermore, the dissent noted, the record shows that the information sought by Vermont (medical, dental, hospital, pharmacy, and other health care claims) was readily available to Blue Cross (the plan's administrator), which routinely reports this information to the state on behalf of all the other Vermont employers whose plans it administers.

Although its custom is to wait for a split in the circuits, the Supreme Court has decided to hear the case. Perhaps the Court's decision to act swiftly is not surprising given its longstanding focus, under *Travelers*, on striking a careful balance between Congress's federal power to regulate commerce and states' powers to protect population health. Indeed, the Second Circuit's *Liberty Mutual* decision contravenes the type of

considered legal balancing that lies at the heart of national health reform in a federal system.

References

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5. In June, the US Supreme Court granted certiorari. *Gobeille v Liberty Mutual Ins. Co.*, 135 S Ct 2887 (2015).

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