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Supreme Court Rules that ERISA Preempts Vermont Claims Reporting Requirement

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The Employee Retirement Income Security Act of 1974 (ERISA) made the regulation of employee benefit plans principally a matter of Federal concern. ERISA broadly and generally preempts—or renders inoperative—state laws that "relate to" employee benefit plans. Since 1974, the Supreme Court has developed a robust ERISA preemption jurisprudence in nearly two dozen cases.

On March 1, the Supreme Court handed down its most recent ERISA preemption decision. The case, *Gobeille v. Liberty Mutual Insurance Company*, struck down a Vermont law that required certain public and private entities (including health insurers) that provide and pay for health care services to report claims information to a state agency. Laws of this sort are sometimes described as establishing an "all-payer claims data base." According to a "friend-of-the-court" brief filed by the National Governors Association, some 17 states (Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Tennessee, Utah, Virginia, Washington, and West Virginia) have enacted such laws. This post examines *Gobeille's* place in the Court's established body of ERISA preemption jurisprudence.

Case Overview

Gobeille involved a challenge to the Vermont all-payer claims data base law by Liberty Mutual Insurance Company on behalf of its group health plan. The plan, which covers employees and provides benefits to more than 80,000 active and former employees and their beneficiaries in all 50 states, is regulated under ERISA as an "employee welfare benefit plan." The plan is self-funded. This means that Liberty Mutual does not pass health care claims risk on to a third-party insurance company. As is the case with most self-funded group health plans, the plan's day-to-day operations are outsourced to a third-party administrator—in this case, Blue Cross Blue Shield of Massachusetts.

Concerned that the disclosure of claims data might violate its fiduciary duties, Liberty Mutual directed Blue Cross not to comply with the Vermont rules. When the State of Vermont issued a subpoena seeking to enforce the law, Liberty Mutual filed suit in Federal district court, seeking a declaration that ERISA preempts application of the Vermont statute. Liberty Mutual also asked the court to issue an injunction prohibiting Vermont from trying to acquire data about the plan or its members.

The district court ruled in Vermont's favor, concluding that the State's reporting scheme was not preempted. Liberty Mutual appealed to the Second Circuit, which reversed. Vermont then appealed to the Supreme Court. The Supreme Court affirmed in a 6 to 2 decision (with the death of Justice Scalia, there are currently only eight Justices). Justice Kennedy authored the opinion, joined by Justices Roberts, Breyer, Alito, and Kagan; Justices Thomas and Breyer filed concurring opinions; and Justices Ginsberg and Sotomayor dissented.

The Vermont Law

In 2005, the Vermont legislature established the Vermont Health Care Uniform Reporting and Evaluation System, a database populated by information on healthcare claims paid by insurers and other coverage providers. The law requires health insurers, health care providers, health care facilities, and governmental agencies to report to a state agency, the Green Mountain Care Board, "information relating to health care costs, prices, quality, utilization, or resources required," including data relating to health insurance claims and enrollment. Health insurers must submit claims data on members, subscribers, and policyholders.

Entities covered by the law (referred to as "reporters") are required to register with the State and must submit data monthly, quarterly, or annually, depending on the number of individuals that an entity serves. The more people served, the more frequently the reports must be filed. Entities with fewer than 200 members need not report at all. Reporters can be fined for not complying with the statute or the

regulation.

Of importance to *Gobeille* is that the Vermont law defines "health insurer" to include a "self-insured . . . health care benefit plan," as well as "any third party administrator" and any "similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident." Thus, the statute envisions the imposition of reporting requirements on self-funded ERISA-covered group health plans and their third party administrators—including the Liberty Mutual group health plan. The particulars of the Vermont reporting requirements were at the epicenter of the holding in the case, and they figured prominently in the dissent.

ERISA Preemption

The text of ERISA's preemption clause (which the Court characterizes as "terse but comprehensive") says that ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This provision makes ERISA the sole source of rules governing the maintenance and operation of employee benefit plans by preempting, or rendering inoperative, all state laws relating to such plans. (ERISA does, however, include an exception under which state laws regulating insurance, banking, and securities are saved from preemption.)

The early Supreme Court cases construed the term "relates to" expansively. In ***Shaw v. Delta Air Lines*, 463 U.S. 85 (1983)**, the Supreme Court stated that the term "relates to" was to be given its broad common sense meaning, such that a state "law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." But a state law would survive a preemption-based challenge where the relationship between the state law and ERISA is "tenuous, remote or peripheral." *Shaw* identified, and later cases fleshed out, two categories of state laws that ERISA preempts:

- State laws that have a reference to ERISA plans. Thus where a State's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation, such reference will result in preemption.
- State laws that have "an impermissible connection with" ERISA plans. Thus, a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration would fail this test.

A state law also might have an impermissible connection with ERISA plans if acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers. According to the majority opinion, the Vermont law is described in the second bullet above, i.e., a state law that has an impermissible connection with ERISA plans because it purports to govern "a central matter of plan administration or interferes with nationally uniform plan administration." Applying this test, the court below held that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" and are therefore preempted.

In ***N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)**, the Supreme Court held that ERISA did not preempt a state hospital surcharge statute because the statute's indirect economic influence did not bind plan administrators to any particular choice and thus did not function as a regulation of an ERISA plan itself. *Travelers* curbed the Court's earlier, expansive reading of ERISA preemption. (The court below referred to the Supreme Court's pivot in the matter of ERISA preemption.) The *Travelers* Court was worried that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course." 514 U.S. at 655. The Court also expressed concern for the role of the states, noting that there is nothing in the language of the ERISA statute "or the context of its passage" that "indicates that Congress chose to displace general health care regulations, which historically has been a matter of local concern."

Travelers was followed by two other cases, ***California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 328 (1997)** and ***De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997)**. These three cases, which are sometimes referred to as the "Travelers Trilogy," established a new test under which a state law has the requisite connection with an employee benefit plan only if it affects the plan's structure or administration, binds plans to particular choices, or establishes alternative remedies.

The Majority Opinion

The majority opinion was quick to conclude that reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA. In the majority view, the Vermont law intrudes upon, and interferes with, nationally uniform plan administration. The State of Vermont argued that the law was not all that burdensome and that the law's objectives were different from those of ERISA. The majority was unimpressed. According to the Court:

> The State argues that respondent [Liberty Mutual] has not demonstrated that the reporting regime in fact has caused it to suffer economic costs . . . But respondent's challenge is not based on the theory that the State's law must be pre-empted solely because of economic burdens caused by the state law . . . Respondent argues, rather, that Vermont's scheme regulates a central aspect of plan

> administration and, if the scheme is not pre-empted, plans will face the possibility of a body of disuniform state reporting laws and, even if uniform, the necessity to accommodate multiple governmental agencies. A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs.

On the subject of the law's purpose, the Court was also unpersuaded:

> The perceived difference here in the objectives of the Vermont law and ERISA does not shield Vermont's reporting regime from pre-emption. Vermont orders health insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner. This is a direct regulation of a fundamental ERISA function. Any difference in purpose does not transform this direct regulation of "a central matter of plan administration" . . . into an innocuous and peripheral set of additional rules.

The Concurring Opinions

Taking a cue from an **amicus brief** filed by the American Benefits Council, America's Health Insurance Plans, the ERISA Industry Committee, the HR Policy Association, the National Business Group on Health Care, and the U.S. Chamber of Commerce, Justice Breyer opined that:

> If each State is free to go its own way, each independently determining what information each plan must provide about benefits, the result could well be unnecessary, duplicative, and conflicting reporting requirements, any of which can mean increased confusion and increased cost.

But he then offers a solution, suggesting that the Secretary of Labor establish additional claims reporting requirements for ERISA plans. This would include, in his view, delegation by the Department of Labor of the authority to obtain data related to the states.

Separately, Justice Thomas agreed with the majority based on the Court's current view of ERISA preemption, but his concurrence takes an unexpected turn:

> I write separately because I have come to doubt whether §1144 [the section of the law containing the ERISA preemption provision] is a valid exercise of congressional power and whether our approach to ERISA pre-emption is consistent with our broader pre-emption jurisprudence.

To be clear, Justice Thomas is saying that Congress overstepped its bounds when it enacted the ERISA preemption rule some 40+ years ago! This view strikes us as radical. He is questioning whether any provision of Article I of the Constitution authorizes Congress to prohibit states from applying a host of generally applicable civil laws to ERISA plans. Here is how he frames his concern:

> If the Federal Government were to take over the regulation of entire areas of traditional state concern, including areas having nothing to do with the regulation of commercial activities, then the boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory. *United States v. Lopez*, 514 U. S. 549, 577 (1995) (Kennedy, J., concurring)(quotation marks omitted).

He next invokes the Commerce Clause, saying "Just because Congress can regulate some aspects of ERISA plans pursuant to the Commerce Clause does not mean that Congress can exempt ERISA plans from state regulations that have nothing to do with interstate commerce" (citation omitted).

The Dissenting Opinion

The dissent written by Justice Ginsburg and joined by Justice Sotomayor objected on both policy and legal grounds. As a matter of policy, the law holds down health care costs and improves the quality of health care. And as legal matter, the law does not substantially interfere with the administration of ERISA plans. As to the latter, Justice Ginsburg explains:

> Amici supporting Liberty point to several allegedly burdensome features of compliance with Vermont's law, but they appear to be no more than everyday facets of modern regulatory compliance: installing and maintaining a software system to collect and remit data to the State, seeking variances from state regulators when health providers do not submit required information to the plan or its administrator, and reformatting data to comply with state-database formatting and encryption standards.

This is universally not the experience reported to us by our self-funded plan clients. Software systems do not "collect and remit data" intuitively or automatically. Rather, the requirements of each particular state law must be understood at a granular level, then coded, tested, debugged, adopted, monitored, and (critically) continuously protected from intrusion. It is this last requirement that drove Liberty Mutual to seek the protection of the Federal courts.

The dissent is also persuaded that the purpose of the Vermont law is entirely different from that of ERISA and should therefore be spared from preemption.

The majority holding and the dissents' views frame the case's central question: Does the Vermont law or any all-payers claims law affect "plan structure or administration" as the Court intended in *Travelers*? Or is the law qualitatively similar to "myriad state laws in areas traditionally subject to local regulation [such as health and safety] which Congress could not possibly have intended to eliminate"? *Travelers*, 514 U.S. at 668.

The Aftermath of Gobeille

While some might claim that *Gobeille* expands the ERISA preemption rule, we disagree. The standard first enunciated in *Travelers* remains intact: a state law has the requisite connection with an employee benefit plan if it affects the plan's structure or administration, binds plans to particular choices, or establishes alternative remedies. The majority merely held that all reporting requirements are or at least can be integral to plan administration, while the dissent would have read the term "administration" more narrowly.

The concurring opinions are alternatively unsettling and odd. The suggestion by Justice Breyer to the effect that the Department of Labor might get to the same result as the Vermont law by empowering the states seems reckless if by that he means he is willing to have different rules in each state. While the Labor Department does appear to have the sufficient authority to compel claims reporting, would that be a wise use of its regulatory power? It seems to us that mandating a nationwide, all claims payer data base is something best handled by Congress.

It is impossible to offer a critique of the majority opinion (and of the outcome of the case) that is free from bias. One is likely to agree or disagree with the decision based on one's relationship to ERISA-covered entities. Plan sponsors of self-funded plans, concerned that the protections offered by ERISA preemption are crumbling, will be elated by the decision. State regulators and proponents of all-claims payer data bases, not so much. They will see the case as a setback in a just cause.

Gobeille, at bottom, held that plans cannot be subject to conflicting state regulation with regard to their primary operations—here, reporting. In the Court's view, this differs from laws like those considered in *Travelers* that impose purely monetary obligations—there, the payment of taxes. According to the majority, reporting is central to the efficient and effective operation of ERISA-covered employee benefit plans, particularly those that operate across state lines (as many do). *Gobeille* ensures that these plans will not be subject to conflicting legal duties and potentially expensive compliance obligations by virtue of having to comply with each state's unique reporting requirements. We think this is the better outcome.

Authors