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 OF THE AMERICAN BENEFITS COUNCIL, AMERICA'S HEALTH INSURANCE PLANS, THE ERISA INDUSTRY COMMITTEE, THE HR POLICY ASSOCIATION, THE NATIONAL BUSINESS GROUP ON HEALTH, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

BRIAN D. NETTER
MATTHEW A. WARING
Mayer Brown LLP
1999 K Street NW
Washington, DC 20006
(202) 263-3000

NANCY G. ROSS
Counsel of Record
Mayer Brown LLP
71 S. Wacker Drive
Chicago, IL 60606
(312) 782-0600
nross@mayerbrown.com

Counsel for Amici Curiae
(additional counsel listed in signature block)

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INTEREST OF THE *AMICI CURIAE*[1]

The American Benefits Council (the Council) is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

America's Health Insurance Plans (AHIP) is the national association representing nearly 1,300 member companies that collectively provide health insurance coverage to more than 200 million Americans. The vast majority of individuals insured by AHIP

[1] Pursuant to Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici*, their members, and their counsel made a monetary contribution intended to fund its preparation or submission. Counsel of record for the petitioner and the respondent have both filed blanket consents to the filing of *amicus curiae* briefs with the Clerk of this Court.

members are participants in, or beneficiaries of, employee benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001 *et seq*. The association's goal is to provide a unified voice for the health care financing industry, to expand access to high quality, cost-effective health care to all Americans, and to ensure Americans' financial security through robust insurance markets, product flexibility and innovation, and an abundance of consumer choice.

The ERISA Industry Committee (ERIC) is a nonprofit organization representing America's largest employers that maintain ERISA-covered pension, healthcare, disability, and other employee benefit plans. These employers provide benefits to millions of active workers, retired persons, and their families nationwide. For this reason, ERIC frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration.

The HR Policy Association represents the most senior human resource executives in more than 370 of the largest corporations doing business in the United States. Collectively, these companies employ more than ten million employees in the United States, nearly nine percent of the private sector workforce. As America's largest employers, HR Policy Association member companies provide health benefits to employees, retirees, and their dependents that are regulated under ERISA.

The National Business Group on Health (NBGH) is a non-profit organization devoted to representing large employers' perspectives on national health policy issues. With 429 members, NBGH is the national voice of large employers dedicated to finding innova-

tive and forward-thinking solutions to the nation's most important health care issues. NBGH facilitates communications between large employers and national policymakers on key health care issues and participates actively in national health policy debates.

The Chamber of Commerce of the United States of America (the Chamber) is the world's largest business federation, representing an underlying membership of over three million businesses and organizations of every size, in every industry sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA.

INTRODUCTION AND SUMMARY OF ARGUMENT

When Congress enacted ERISA, it wanted to encourage employers to offer benefit programs for their employees. In the case of healthcare benefits, companies could choose either to purchase individual insurance policies, which would be subject to regulation by the States, or to self-fund a nationwide plan, which would be subject to a uniform, federal program of regulation.

This case is about whether a company that has elected to create a self-funded plan for the exclusive purpose of providing healthcare benefits to its employees and their families—a plan that, under ERISA, is subject to uniform federal regulation—

may nevertheless be forced by the States to function as a clearinghouse for state data-collection efforts. The Court's answer to this question has important implications not only for self-funded employer health plans, but for all other employer benefit plans. The more States are empowered to impose burdensome regulatory requirements on employers, the more they will do so. This slippery slope presents a serious threat to the viability of welfare benefit plans, and thus to the purposes of ERISA.

State programs such as Vermont's all-payer claims database (APCD) undercut ERISA's objectives by subjecting self-funded plans to a morass of state reporting requirements that Congress neither intended nor allowed in enacting ERISA.

A.

Self-funded employer plans provide medical benefits to some 93 million Americans. Employers large and small rely on such plans because of the benefits of self-funding, which include flexibility in fashioning benefits to suit an employer's workforce; the ability to pay claims after they are incurred, instead of prepaying insurance premiums; and reductions in regulatory burdens and administrative costs.

The advantages of self-funding inure not only to benefit employers, but to participants in those employers' health insurance plans. To put it simply, an employer that can reduce the costs of administering benefit plans can provide more generous benefits to its employees. Congress sought through ERISA to encourage employers to establish self-funded plans, so that more plans and plan participants would reap the benefits of self-funding.

B.

Laws that require self-funded employer plans to report data on medical claims to state APCDs impose considerable compliance burdens on plans. Plan costs necessarily increase, and Congress's plan for uniform regulation is compromised notwithstanding its essential role in the passage of the Act. No two state APCDs are the same; each requires that a plan (or its agent) report somewhat different data, concerning differently defined patient populations, at different times, and in different file formats. A plan operating in multiple states would need to devote substantial time and resources to navigating this complex web of regulations—resources that Congress intended should be spent on paying benefits to plan participants. APCD laws thus have an impermissible effect on self-funded employer plans and are expressly preempted by ERISA. See 29 U.S.C. § 1144(a). Petitioner touts the fact that, under the peculiar circumstances of this case, it is technically the employer's third-party administrator that must comply with Vermont's APCD law. That is immaterial, however, for it cannot be the case that Congress intended to protect sponsors from piecemeal regulation but to expose their plans to a different regime of burdensome requirements if they choose to use a third-party administrator.

C.

APCD laws also frustrate one of ERISA's core mandates: that plans must be operated *solely* for the purpose of paying benefits to plan participants. APCD laws contemplate that plans will serve an entirely different purpose—namely, collecting participants' medical data to support state programs and initiatives. Commandeering ERISA plans for that

use, or the other infinite possibilities of state use that await on the horizon, necessarily undermines the objectives of ERISA and the goals that Congress sought to achieve through the statute. Vermont's APCD law expands the purpose and function of benefit plans contrary to ERISA's dictates, and is therefore preempted.

ARGUMENT

Using self-funded welfare benefit plans as data clearinghouses is incompatible with ERISA.

State APCDs impose real burdens on self-funded plans. Those plans that operate across state lines are subject to onerous requirements that require plan sponsors or their agents to develop state-by-state data-collection systems and reporting mechanisms. APCD laws disrupt the uniform regulatory scheme that Congress sought to create for employer benefit plans and frustrate Congress's desire that ERISA plans' resources be used efficiently to pay benefits and plan expenses. ERISA preempts state laws that so directly interfere with Congress's design. Thus, this Court should affirm the judgment below.

A. SELF-FUNDED EMPLOYER PLANS ARE MUTUALLY BENEFICIAL FOR EMPLOYERS AND EMPLOYEES

1. Self-Funded Employer Plans Provide Benefits To Millions Of Americans

An employer can structure the health benefits it provides to its employees in two different ways. The first is for the employer to purchase an insurance policy from an insurance company, paying a premium to the insurance company for every employee

who is covered. This type of plan is referred to as a "fully insured" plan, since the insurance company assumes the full risk of covering employees' medical claims. See Employee Benefit Research Institute, *Health Plan Differences: Fully-Insured vs. Self-Insured* (Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf.

Alternatively, an employer can choose to establish a "self-funded" or "self-insured" plan. An employer with a self-funded plan pays for employees' medical claims out of its own assets and thus bears the entire risk associated with employees' medical claims, although it may purchase a "stop-loss" insurance policy to cover its losses when its aggregate costs grow unexpectedly high. Some employers with self-funded plans—though not all—choose to contract with third-party administrators (TPAs) rather than control the day-to-day operations of their health plans themselves. A typical TPA "administers the health plan by processing the claims, issuing ID cards, handling customer questions and performing other tasks." Cigna White Paper, *Advantages and Myths of Self-Funding* 2 (Feb. 2014), http://www.cigna.com/assets/docs/business/small-employers/841956_b_self_funding_whitepaper_v8.pdf.

Although the fully insured model was the traditional means by which employers provided health insurance benefits to employees, self-funded employer plans are now overwhelmingly prevalent among large and mid-size employers and have become more popular with smaller employers in recent years. Indeed, self-funded employer plans now cover more employees than fully insured plans. A recent survey found that 147 million Americans—"over half of the

non-elderly population"—receive employer-sponsored health benefits. See Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey: Summary of Findings* 1 (Sept. 22, 2015), http://kff.org/report-section/ehbs-2015-summary-of-findings/. Of those individuals, 63%—approximately 93 million—participate in self-funded employer plans, including 94% of workers in firms with at least 5,000 employees. Henry J. Kaiser Family Foundation, *2015 Employer Health Benefits Survey: Section Ten: Plan Funding* (Sept. 22, 2015), http://kff.org/report-section/ehbs-2015-section-ten-plan-funding/. In 2000, by contrast, only 49% of workers participated in self-funded employer plans. *Ibid.*

2. Self-Funded Employer Plans Provide Many Advantages Over Fully Insured Plans

Employers have increasingly turned to self-funded employer plans because, in comparison to fully insured health plans, self-funded employer plans are often more flexible and less expensive. Self-funded employer plans thus improve both employers' bottom lines and the level of benefits that they can provide to their employees.

Self-funded employer plans offer employers and employees four principal advantages over fully insured health plans:

First, *self-funded employer plans give employers—particularly small employers—much more choice as to which benefits their plans will provide.* Employers who opt for a fully insured plan are limited to the insurance policies approved for sale in the state where the employer is located. By contrast, when

employers self-insure, they can customize their plans by tailoring their benefit packages (above and beyond any applicable statutory requirements) to match the needs of their workforce. Cigna White Paper, *supra*, at 3. The ability to customize benefits is especially valuable to smaller businesses, which often have specialized workforces whose needs differ from those of most larger companies. *Ibid.*

Second, *employers who self-fund save money because they do not need to prepay insurance companies for health costs that may never be incurred.* When an employer opts to provide fully insured medical benefits, it pays to an insurer the expected cost of benefits plus a risk premium and also typically owes insurance premium taxes to each State where it does business. By contrast, so long as it can absorb or spread the risks, an employer with a self-funded plan can avoid the risk premium and the premium taxes, and does not need to pay in advance. It can keep the cash used to pay medical expenses in its own reserves, where the money can earn interest for the plan. See The Alliance, *When You're Considering Self-Funding* 3 (Aug. 2014), http://www.the-alliance.org/uploadedFiles/Downloads/WhenYoureConsideringSelfFunding.pdf.

Third, *self-funded plans are typically less expensive to operate than fully insured plans.* Self-funded plans generally have lower administrative costs than fully insured plans. See The Alliance, *supra*, at 4 ("Employers frequently find that administrative costs for a self-funded program through a TPA are lower than those charged by an insurance carrier."). The lower overhead of self-insurance allows more of an employer's resources to be spent on paying benefits to employees and less on plan expenses.

Fourth, *employers offering self-funded plans are not subject to conflicting regulations in each of the states in which they operate.* Fully insured plans are subject to state and local insurance laws and thus must comply with differing mandates in each state (and perhaps every different locality) in which they operate. Self-funded plans, by contrast, are covered by ERISA and subject only to ERISA's regulatory standards. See 29 U.S.C. § 1144(b)(2)(B) (exempting employee benefit plans from state insurance and banking regulations). Thus, self-funded plans are able to streamline their operations by offering one uniform set of benefits everywhere they operate. This lowers plans' administrative costs and ensures that employees who move from place to place but stay with the same employer can enjoy the same benefits no matter where they reside. See The Alliance, *supra*, at 3-4; Cigna White Paper, *supra*, at 3.[2]

Self-funded plans are a win-win proposition for employers and their employees. Self-funding lowers employers' costs by allowing them to retain control over the terms and features of their own benefit plans and enabling them to manage how risks are liquidated. And by lowering employers' costs, self-

[2] The flexibility of self-funded employer plans also enables them to experiment more easily with innovative, evidence-based benefit designs and then implement those designs on a national scale. For example, recent research has shed considerable light on which treatments for children with autism work better than others. Self-funded employer plans can easily adapt their nationwide benefit packages to reflect these new findings. See P. Rich & D. Landers-Nelson, National Business Group on Health, *Benefit Manager Guide: Therapies for Children with Autism Spectrum Disorder* (Oct. 2014) (excerpted summary for public).

funding helps plan beneficiaries, who enjoy greater benefits than they otherwise would. One of the principal goals of ERISA is to ensure that sponsors and beneficiaries can experience the benefits of uniform federal regulation.

B. APCD STATUTES LIKE VERMONT'S IMPOSE A SUBSTANTIAL AND UNWARRANTED BURDEN ON SELF-FUNDED EMPLOYER PLANS

Vermont and many other states require self-funded employer plans to report data on participants' medical claims to state-run "all-payer claims databases," or APCDs. Each of these States requires that different data be reported in a different format and on a different schedule, meaning that an employer that offers a health benefit plan in more than one State is potentially subject to a complex web of regulations. Complying with these varied data-reporting requirements is a costly and burdensome undertaking for self-funded employer plans. If forced to comply with the dizzying array of APCD requirements, self-funded employer plans would be required either to dedicate personnel to the task of mastering and satisfying the various requirements or to pay outside parties to do the same. Either approach obviously diverts resources away from the payment of benefits to plan participants. Congress enacted ERISA precisely to protect plans from this sort of overwhelming regulatory burden.

1. An Increasing Number Of States Are Adopting Mandatory APCD Laws, Many Of Which Have Conflicting Requirements

Though APCDs are a relatively new phenomenon, they are proliferating rapidly across the coun-

try. Since 2003, when Maine established the first APCD in the United States, twenty other states have created their own APCDs. Eighteen of these twenty-one state databases are "mandatory" APCDs that require all payers of medical claims—including self-funded health benefit plans—to report data on their customers or plan participants. See N.Y. Br. 4-5.

Thus, a large number of states already purport to subject self-funded plans that operate nationally to claims reporting requirements. And that number is likely to increase in the near future: *nineteen* additional states are either considering legislation that would create a mandatory APCD or are otherwise exploring the idea. NY. Br. 5.

Although state APCDs share certain features in common, each State's database is distinctive. States calibrate the features of their APCDs to match their idiosyncratic policy goals, creating significant differences between each database's requirements. To cite only a few examples of these differences:

a. *Different APCDs require different claims to be reported*. The coverage of each state APCD's reporting requirement varies because states do not take the same approach in determining which claims are subject to reporting. Vermont, for example, requires reporting of all medical care that is provided to Vermont residents *and* all care provided within the State of Vermont (even to nonresidents). Vt. Dep't of Banking, Ins., Secs. & Health Care Admin., Regulation H-2008-01, § 4(D). Rhode Island, by contrast, requires reporting only of care provided to Rhode Island residents; care provided in the state to nonresidents is not covered. See R.I. Dep't of Health, Rules and Regulations Pertaining to the Rhode Island All-Payer Claims Database §§ 1.18, 1.20, 4.1(a),

http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7305.pdf.

States also lack a uniform approach to determining who qualifies as a "resident" for APCD reporting purposes. Colorado and Utah, for example, consider students attending in-state colleges to be residents subject to APCD reporting, no matter where they officially reside for other purposes. See Colorado Center for Improving Value in Health Care, Colorado All-Payer Claims Database Data Submission Guide 5, http://www.civhc.org/getmedia/29f43b37-b39d-4373-85f5-1c1232f2d9c7/Data-Submission-Guide-V7-June-2015.pdf.aspx/; Utah Department of Health, Utah All-Payer Claims Database Data Submission Guide 3, http://health.utah.gov/hda/apd/UT%20APCD%20DSG%20v2.1.pdf. Vermont, on the other hand, appears *not* to treat students as residents. See Vt. Regulation H-2008-01, § 4(D).

The States' conflicting requirements as to which claims must be reported and who qualifies as a "resident" mean that many claims may have to be reported to multiple states at once. A claim involving care provided in Vermont to a Rhode Island resident must be reported to both states, for example. An employer plan that operates in more than one state likely must keep track of many such overlapping reporting requirements.

b. *Different APCDs have different schedules for reporting data.* State APCDs do not all require submission of data on the same timetable. On the contrary, at least *four* different reporting schedules are in use by APCDs around the country. Maryland and Oregon require that data be submitted quarterly. But Colorado, Massachusetts, and Tennessee require that data be submitted every month. Maine, New

Hampshire, and Vermont's APCDs take a third approach, requiring that different plans report data at *different* intervals depending on the number of covered lives in the plan. And finally, Minnesota allows reporters simply to choose between monthly and quarterly data reporting. See Washington Office of Financial Management, WA-APCD Rules Background Paper #4: Deadlines for Submission of Claim Files 4-5 (Sept. 2015), http://www.ofm.wa.gov/healthcare/pricetransparency/pdf/paper_4.pdf. Thus, a plan that operates in multiple states would be unable to have one internal schedule for reporting all of its claims data.

c. *Different APCDs require that data be submitted in different formats*. State APCD laws prescribe not only what data must be reported and when, but also what format that data must be in. And here, too, the requirements of each state's APCD vary: different states require that data be submitted in "considerably different data file formats." Al Prysunka, Milliman Healthcare Analytics Blog, *APCDs: Moving Toward Standardization of Data Collection* (Nov. 30, 2012), http://info.medinsight.milliman.com/2012/11/apcds-moving-toward-standardization-of-data-collection/. As a result, employers operating in more than one state must develop different programs and protocols for data submission in each state.

2. Reporting Health Care Claims Data To All The States That Require It Is Burdensome For Self-Funded Employer Plans

The task of reporting medical claims data to state APCDs would be costly and difficult enough for self-funded employer plans if every state's requirements were exactly the same. Collecting health care data for thousands of covered plan members, format-

ting it, and submitting it to an APCD is a time- and labor-intensive undertaking—one that has only become more difficult over time, as state regulators have requested that more and more data points be reported for each claim. Minnesota Community Measurement, *Health Care Data Collection: Exploring the Root Causes of Provider Burden in Minnesota* 1 (2015), http://mncm.org/wp-content/uploads/2015/03/MNCM_WhitePaper_PrvdrBrdn_Final.pdf (noting that due to the proliferation of health quality measures among state regulators, "there is growing concern in the [medical] community that the burden of collecting and submitting data—represented primarily by the cost of additional human resources—is beginning to outweigh the benefits").

Yet the multiplicity of conflicting and overlapping reporting requirements in different states has made the burden on plans even greater. For one thing, self-funded plans that operate in multiple states must deal with the sheer technical challenge of reporting data to numerous states at different times and in different formats. As one prominent technology advocacy group has noted, it is simply "burdensome and costly for plans to set up and secure multiple large data submissions to different entities in various locations, especially if those entities require different data formats." Center for Democracy & Technology, *Decentralizing the Analysis of Health Data* 9 (Mar. 22, 2012), https://cdt.org/files/pdfs/Decentralizing-Analysis-Health-Data.pdf. Indeed, even the strongest proponents of the creation of APCDs acknowledge that the States' varying requirements for data reporting impose a significant technical burden on plans. *See, e.g.*, APCD Council, *Standardization of Data Collection in All-Payer Claims Databases* 1 (Jan. 2011), https://

www.apcdcouncil.org/file/83/download?token=R4vbK7Xf (noting that "each state is collecting different data by different methods and with different definitions," which "rais[es] costs for payers submitting data to the states (especially those payers that are operating in multiple states)"); *id.* at 2 ("As APCDs are required in more states, the cost to payers will become significant."); see also Patrick B. Miller, State Coverage Initiatives, Robert Wood Johnson Foundation, *All-Payer Claims Databases: An Overview for Policymakers* 8 (May 2010), https://www.apcdcouncil.org/publication/all-payer-claims-databases-overview-policymakers (noting that payers who operate in numerous states must "bear the compounded costs of responding to unique state reporting requirements").

In addition to the technical burden of reporting, plans operating in multiple states must invest time and resources in keeping track of each State's requirements, or assuring that a third-party administrator is doing so.[3] Most state APCDs' requirements are spelled out in regulations rather than in statutory law, allowing those requirements to change without the need for legislative action. And in some states, certain changes to APCD regulations can be made without even needing to go through notice-and-comment rulemaking. For example, the Arkansas Insurance Department is authorized to change the technical formatting requirements for data "at any time," without taking public comment. Arkansas Ins. Dep't Rule 100, § 7(B). After the new formatting re-

[3] A plan fiduciary has a duty to make sure the plan is administered prudently, which includes compliance with applicable laws. See 29 U.S.C. § 1104(a).

quirements are revised, payers can be required to comply with the new requirements in as little as four months. *Ibid.* The potential for rapid change in state data reporting requirements means that self-funded plans and other reporters must *constantly* monitor state regulations and be prepared to revamp their reporting procedures quickly.

In short, the burden of reporting claims data to state APCDs is anything but minor. On the contrary, reporting to APCDs is an onerous obligation that self-funded employer plans must expend considerable financial and human resources in order to meet. And as more and more states create APCDs, that burden is likely to worsen.

3. Congress Enacted ERISA To Prevent Self-Funded Plans From Being Subject To Patchwork State Regulation

The application of so many conflicting and overlapping state regulations to employer benefit plans was precisely what Congress sought to prevent when it enacted ERISA. Congress intended that employer benefit plans would be administered in a single and uniform way across the entire country. Central to that uniform administrative process are the reporting obligations that plans must satisfy. Resp. Br. 17-24. There can be no doubt that state APCD laws—which require that a plan report its participants' medical claims data differently in every state in which the plan operates—"relate to" self-funded employer plans in an impermissible manner and are expressly preempted by ERISA. See 29 U.S.C. § 1144(a).

As *amici* explain *infra* (at pp. 24-29), Congress's primary concern when it enacted ERISA was to en-

sure that plans would be able to meet their obligations to participants and their beneficiaries. One of the most important ways in which ERISA advances this objective is by protecting plans from regulatory requirements that vary from state to state—or even from city to city. Congress believed that complying with many differing state and local regulations would burden plans with high compliance costs. See *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983) (quoting a sponsor of ERISA who explained on the House floor that the legislation would "'eliminate[e] the threat of conflicting and inconsistent State and local regulation'"). These higher costs, in turn, would eventually fall on beneficiaries in the form of reduced benefits. See, *e.g.*, *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 149 (2001) ("Requiring ERISA administrators to master the relevant laws of 50 States * * * would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators—burdens ultimately borne by the beneficiaries.") (quoting *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 142 (1990) (brackets omitted)); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."); *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 11 (1987) ("ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those

employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Subjecting employer benefit plans to only a single set of national regulations would reduce plan expenses and hence would foster greater healthcare coverage for beneficiaries.

This Court thus has "not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *FMC Corp.*, 498 U.S. at 59. Indeed, this Court has repeatedly struck down state laws that have that undesirable effect. See, *e.g.*, *Egelhoff*, 532 U.S. at 148-49 (holding that a state statute interfered with "nationally uniform plan administration" because it required plan administrators to "familiarize themselves with [different] state statutes" and created the possibility that plan payments would be "subject to conflicting legal obligations"); *FMC Corp.*, 498 U.S. at 60 (holding that a state antisubrogation law was preempted because "[a]pplication of differing state subrogation laws to plans would * * * frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide").

The Court should do the same in this case. The multifarious regulations found in state APCD laws burden self-funded employer plans—particularly national plans—with cumbersome and inefficient reporting requirements, the cost of which ultimately falls on plan beneficiaries. And these reporting requirements relate directly to the core function of self-funded employer plans: their provision of benefits to plan participants. This sort of onerous burden on a core function of self-funded plans was exactly what Congress sought to prevent.

Moreover, if the Court were to hold that APCD laws were not preempted by ERISA, States and municipalities would have no barrier holding back new laws that similarly intrude on plan administration, increasing the regulatory burden on self-funded employer plans even more. Perhaps States would require retirement and pension plans to report data on their investments' performance, for example.

Such a confusing patchwork of state regulations would threaten to "create a system that is so complex that administrative costs * * * unduly discourage employers from offering * * * benefit plans in the first place." *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996). Congress enacted ERISA to prevent that undesirable result. See *Fort Halifax*, 482 U.S. at 11 ("ERISA's pre-emption provision was prompted by recognition that * * * [a] patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). This Court should abide by Congress's intent to encourage private welfare plans by holding that Vermont's APCD reporting requirement impermissibly invades the province of ERISA and is expressly preempted.

4. The Decision To Use A Third-Party Administrator Does Not Protect Vermont's APCD Law From Preemption.

In his attempts to argue that state APCD laws like Vermont's do not impose a burden on self-funded employer plans that triggers ERISA preemption, Petitioner relies to a surprising extent on the fact that it is Liberty Mutual's TPA—rather than Liberty Mutual itself—that is subject to reporting requirements

under Vermont's law. See Pet. Br. 1, 23, 31, 38 & n.21, 53-55. Petitioner's position appears to be that because Liberty Mutual's TPA is the party that actually reports data to Vermont's APCD, Liberty Mutual itself cannot possibly be burdened by the reporting requirement.

That position is incorrect, for two reasons. First, as explained *supra*, although Liberty Mutual employs a TPA to operate its self-funded employer plan, some employers do not.[4] And under Vermont's law (and the APCD laws of other states), even companies that do not retain TPAs are responsible for satisfying burdensome reporting requirements. See, *e.g.*, Vt. Regulation H-2008-01, § 3(X); 957 Mass. Code Regs. 2.02. Thus, the burden of state APCD laws—including Vermont's—clearly falls on *some* self-funded employer plans directly, which suffices to make those laws preempted.

Second, from the standpoint of ERISA, there is no legal distinction between legal obligations that fall on a plan sponsor and those that fall on its delegate, such as a TPA. Common sense and basic economics both suggest that the burden of complying with such obligations is ultimately borne by the plan sponsor, irrespective of which party is subject to the obligations in the first instance: if the TPA is responsible for reporting, it will pass on the cost of report-

[4] *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,322, 72,340 (Dec. 2, 2013) ("We recognize that some self-insured group health plans self-administer the benefits and services provided under the plan, and do not use the services of a third party administrator.").

ing to its client in the form of a higher price.[5] And even when a plan sponsor delegates a duty (such as data reporting) to a TPA, it retains a fiduciary duty to oversee and monitor the TPA's performance of its tasks. See 29 U.S.C. § 1104(a); see also, *e.g.*, *Jackson* v. *Truck Drivers' Union Local 42 Health & Welfare Fund*, 933 F. Supp. 1124, 1141 (D. Mass. 1996) ("[A] delegating [ERISA] fiduciary retains an obligation to oversee and monitor the activities of his delegate."). This monitoring takes both time and effort on the plan sponsor's part. Either factual scenario, therefore, subjects plan sponsors to the costs of state regulation from which Congress sought to shield them in enacting ERISA.

No principle in ERISA, moreover, suggests that plans can be subjected to inconsistent jurisdiction-by-jurisdiction obligations just because they have sought outside assistance. On the contrary, this Court has held that state laws may not "bind plan administrators to [a] particular choice" about how to structure their plan—such as the choice whether or not to employ a TPA. See *N.Y. State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 659 (1995). Thus, Petitioner's interpretation of ERISA preemption—which would essential-

[5] The IRS acknowledged this "pass-through" dynamic in its proposals for implementing the Patient Protection and Affordable Care Act's excise tax on high-cost employer health plans. In the notice laying out the proposals, the agency acknowledged that if the excise tax on a self-insured employer plan is paid by its TPA, the TPA is likely to "pass through all or part of the amount of the excise tax to the employer." IRS, Notice 2015-52, *Section 4980I—Excise Tax on High Cost Employer-Sponsored Health Coverage* at 7, https://www.irs.gov/pub/irs-drop/n-15-52.pdf.

ly coerce plans into forgoing TPAs by subjecting them to APCD reporting only when they use TPAs—is surely wrong. ERISA preemption should not and does not depend on whether a plan opts to employ a TPA.

5. APCDs Can Obtain Information From Other Sources—Such As Providers—Without Needing To Burden Self-Funded Plans

Petitioner and his *amici* devote considerable space in their briefs to arguments why APCDs are a useful regulatory tool for states and explanations of the potential benefits they offer to state policymakers. See, *e.g.*, Pet. Br. 12; Am. Hosp. Ass'n & Ass'n of Am. Med. Colls. Br. 16-23. But none of this information is relevant to the issue before this Court—*i.e.*, whether ERISA preempts state APCD laws. If APCD laws impose the sort of burden on self-funded employer plans that Congress sought to avert (and they do), those laws are preempted no matter how high-minded a purpose they serve.

Noticeably missing from Petitioner's brief is any meaningful explanation as to why data from self-insured plans is so critical to Vermont's goals. In fact, Petitioner contradicted that position when he told the district court that self-insured plans account for only a small percentage of the total data collected. Def.'s Opp. to Mot. for Summ. J. 12, *Liberty Mut. Ins. Co.* v. *Kimbell*, No. 2:11-cv-204 (D. Vt. Aug. 17, 2012), ECF No. 48 ("[A]t least two-thirds of Blue Cross' reporting in Vermont pertains to non-ERISA plan members."); see also Pet. App. 69a. It should be noted, however, that if States truly think it important to obtain data on medical care provided to participants in self-funded employer plans, they can

obtain those data from other sources—including, most importantly, the providers who deliver that care.[6] The choice that Petitioner and his *amici* present, between allowing States to maintain comprehensive APCDs on the one hand and respecting ERISA's goal of protecting plans from conflicting state regulations on the other, is therefore a false choice. States can obtain the data they need without imposing regulatory costs on self-funded employer plans—the entities that Congress singled out for special protection in ERISA.

C. THE EXCLUSIVE PURPOSE OF ERISA BENEFIT PLANS IS TO PROVIDE BENEFITS, NOT TO BE LABORATORIES FOR STATE EXPERIMENTATION

State APCD laws not only increase costs for self-funded employer plans; they also conscript plans into the service of the States, turning them into laboratories in which States collect data for their own purposes. This conscription of self-funded plans, whether well-intentioned or not, undermines the goals of ERISA. Congress specified in ERISA that the sole, exclusive purpose of employee benefit plans is to provide benefits to beneficiaries. By forcing plans to divert resources to serve a different and unrelated

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[6] The Centers for Medicare and Medicaid Services (CMS), for example, has made efforts in recent years to collect Medicare claims data from providers and to make those data publicly available for study. See Centers for Medicare and Medicaid Services., *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* (June 1, 2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html. States could compile similar datasets on non-Medicare claims.

purpose chosen by the state, APCD laws interfere with the legislative scheme that Congress crafted in ERISA.

1. Congress Enacted ERISA In Order to Protect The Interests Of Plan Beneficiaries

In the early 1970s, Congress conducted "a comprehensive and exhaustive study of the private pension plan system in the United States" to investigate concerns about the number of private-sector pension and benefit plans that were becoming insolvent and unable to pay their beneficiaries. This study revealed that many retirement plans did not "meet the obligation[s] promised [to employees] * * * after many years of service." S. Rep. No. 93-127, at 11-12 (1973), reprinted in 1974 U.S.C.C.A.N. 4838, 4847-48. Congress found that "despite the enormous growth in [employee benefit] plans[,] many employees with long years of employment [were] losing anticipated retirement benefits," and that "owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits [was] endangered." 29 U.S.C. § 1001(a). In Congress's view, the precarious financial situation of employee benefit plans was a threat to the "continued well-being and security of millions of employees and their dependents" and, thus, to the "national public interest." *Ibid.*

ERISA was Congress's response to these problems. As its text proclaimed, the statute's animating purpose was "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001 (b); see also, *e.g.*, *Shaw*, 463 U.S. at 90 ("ERISA is a comprehensive statute designed to promote the interests of

employees and their beneficiaries in employee benefit plans."); H.R. Rep. No. 93-533, at 1 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4639 ("The primary purpose of the bill is the protection of individual pension rights"). Each of ERISA's safeguards—from requiring plan administrators to disclose more information, to holding fiduciaries to stricter standards of conduct, to requiring plan termination insurance—was designed to further the purpose of protecting plan participants and their beneficiaries. See 29 U.S.C. § 1001(b)-(c). Vermont's plan reporting obligations do not further that purpose.

2. ERISA Mandates That Plans Be Operated For The Exclusive Purpose Of Providing Benefits To Participants

The most important safeguard Congress included in ERISA was the "exclusive purpose" rule of Section 404(a). This rule requires a plan fiduciary to "discharge his duties with respect to a plan *solely* in the interest of the participants and beneficiaries" and "for the *exclusive purpose* * * * of providing benefits to participants and their beneficiaries[,] and defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1) (emphases added). Section 403(c) of the statute provides a corollary to the "exclusive purpose" rule, by providing that plan assets are to be used "for the *exclusive purposes* of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." *Id.* § 1103(c)(1).

The "exclusive purpose" rule is quite stringent: it makes plan participants' interests the *sole* relevant consideration in plan decisionmaking and resource allocation. See, *e.g.*, *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (noting that the exclusive

purpose rule requires that plan trustees' decisions "be made with an eye single to the interests of the participants and beneficiaries."). Indeed, Congress intended that the exclusive-purpose rule would hold plan fiduciaries to an even higher standard than ordinarily applies under state trust law, because Congress "determin[ed] that the common law of trusts did not offer completely satisfactory protection" to beneficiaries. *Varity Corp.*, 516 U.S. at 497. Federal courts have accordingly developed a specialized common law of fiduciary obligations under ERISA "'bearing in mind the special nature and purpose of employee benefit plans.'" *Ibid.* (citing *Firestone Tire Co.* v. *Bruch*, 489 U.S. 101, 110-11 (1989)). In short, the "exclusive purpose" rule is an exceedingly exacting standard—one that reflects Congress's special solicitude for the welfare of participants in employer benefit plans.

3. State APCD Statutes Interfere With Congress's Purpose By Commandeering ERISA Plans For A Different Purpose: Data Collection

State APCD laws like Vermont's are irreconcilable with the "exclusive purpose" rule's clear requirement that plan resources be expended solely for the benefit of participants and beneficiaries, less any incidental expenses of plan administration. APCD laws require plans to expend resources on wholly different priorities that the State has chosen: *i.e.*, collecting, formatting, and reporting data in compliance with the requirements of each State's database. This expenditure of resources does not inure to the sole benefit of plan participants, as ERISA requires; on the contrary, it *harms* beneficiaries, since every dollar spent on data reporting is a dollar that cannot be

spent to meet the plan's obligations to its participants. And it layers on another regulatory scheme requiring distraction from the plan's exclusive purpose of providing benefits.

Petitioner and his *amici* respond to this point by suggesting that the costs imposed on self-funded employer plans by APCD laws are no different from those imposed by any other generally applicable state regulation. See Pet. Br. 27; N.Y. Br. 31, 34. Not so. The expenses of reporting data to APCDs are not akin to taxes or other costs that a plan might ordinarily be expected to incur under state law. On the contrary, APCD reporting is an extraordinary obligation targeted at plans (and a very few other kinds of healthcare enterprises) as a means of conscripting them for the pursuit of specific state policy objectives. See 18 Vt. Stat. Ann. § 9401 (listing policy goals of Vermont's APCD statute). APCD reporting is far from an ordinary cost of doing business in a particular state; it is a deadweight loss that Vermont and other States require plans to absorb for the States' convenience.

This Court should therefore hold that state APCD laws are preempted by ERISA because they "operate[] to frustrate [ERISA's] objects." *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997). Congress's considered judgment in enacting ERISA was that maintaining a strong and financially sound employee benefit system is crucial to the well-being of millions of American employees and their families and to the strength of the national economy. And Congress concluded that the best way to keep employee benefit plans sound is to ensure that plans are administered for the single and exclusive purpose of providing benefits to participants and their beneficiaries.

When States attempt to use ERISA plans as tools for pursuing their own agendas, ERISA preempts such regulations, irrespective of how high-minded the state's purposes for commandeering the plan's resources or of whether the state's regulatory scheme would be "less useful," Pet. Br. 33, if ERISA plans were excluded from it.

The *only* acceptable use of an ERISA plan is to provide benefits to participants. Vermont's law, which uses ERISA health plans for an entirely different purpose chosen by the State, is therefore preempted.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

BRIAN D. NETTER
MATTHEW A. WARING
Mayer Brown LLP
1999 K Street NW
Washington, DC 20006
(202) 263-3000

NANCY G. ROSS
Counsel of Record
Mayer Brown LLP
71 S. Wacker Drive
Chicago, IL 60606
(312) 782-0600
nross@mayerbrown.com

Counsel for Amici Curiae

KATHRYN WILBER
American Benefits Council
1501 M Street NW
Suite 600
Washington, DC 20005
Counsel for American Benefits Council

THOMAS WILDER
America's Health Insurance Plans
601 Pennsylvania Ave NW
South Building, Ste. 500
Washington, DC 20004
Counsel for America's Health Insurance Plans

ANNETTE GUARISCO FILDES
ERISA Industry Committee
1400 L Street NW
Suite 350
Washington, DC 20005
Counsel for ERISA Industry Committee

KATHRYN COMERFORD TODD
WARREN POSTMAN
U.S. Chamber Litigation Center
1615 H Street, N.W.
Washington, DC 20062
Counsel for the Chamber of Commerce of the United States of America

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