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 *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

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The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax exempt organization that has participated for over thirty years in the development of employee benefits legislation and regulations promulgated to implement the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and other laws affecting multiemployer plans.[1] The NCCMP's

[1] Counsel for both the Petitioner and the Respondent have filed with the Clerk of this Court blanket consents to the filing of *amicus curiae* briefs. Pursuant to Rule 37.6 of the Rules of this

primary purposes are to assure an environment in which multiemployer plans can continue their vital role in providing medical, pension, and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations, and policy.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts, and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base, are affiliated with the NCCMP. Affiliated plans are active in every segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile, and trucking industries. Congress has recognized that the continued well-being and security of employees, retirees, and their dependents are directly impacted by multiemployer plans and that interference with the maintenance and growth of such plans is contrary to the national public interest. *See* 29 U.S.C. § 1001a(a)(1), (3), (c)(2).

The Vermont health care database statute, Vt. Stat. Ann. tit. 18, § 9410 ("Act"), imposes significant burdens on self-funded multiemployer health plans

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Court, the undersigned hereby state that no counsel for Petitioner or Respondent authored any part of this brief. Moreover, no person or entity other than the NCCMP made a monetary contribution to the preparation or submission of this brief.

throughout the country, regardless of where they are based, so long as they have 200 participants and beneficiaries who reside and/or receive medical treatment in Vermont. The Act imposes extensive record-keeping and reporting obligations regarding health care claims and subjects plans to administrative oversight by the State. These obligations intrude on the core functions of employee health plans, an exclusively federal sphere of regulation under ERISA. Allowing the State of Vermont to overlay its own requirements upon the comprehensive, and exclusive, scheme of federal administration of ERISA plans will significantly burden trustees and plan administrators in performing their ERISA-mandated functions of reporting and disclosure.

If Petitioner's position prevails, the result will be to impair the historical ability of multiemployer health plans to operate under "a uniform body of benefits law," thereby undermining the goal of ERISA preemption "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). Furthermore, if the Petitioner's position prevails, the door will be wide open for other states to impose their own additional requirements on the essential plan functions of reporting and disclosure.[2] A multiplicity of incompatible and varying demands will place increasing stress on the administra-

[2] Although certain other states have enacted health care data collection legislation, several do not currently require information from self-insured ERISA plans. *See* J.A. 207- 216, Summary Table of State Health Reporting Laws.

tion of plans and will force plan fiduciaries to divert plan assets from their exclusive statutory purpose: "providing benefits to participants and beneficiaries; and . . . defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A). This will come at huge expense to the plans, a cost which will ultimately be reflected in the benefit levels payable to participants and beneficiaries. The NCCMP submits that such a result cannot be reconciled with the statutory requirement of reasonableness.

Accordingly, the NCCMP and its constituent groups have a strong interest in supporting affirmance of the decision below. The NCCMP believes that the Second Circuit's decision properly ensures that multiemployer plans will retain their rights, guaranteed under ERISA's express preemption provision, to maintain a uniform administrative scheme for reporting and disclosure and, by extension, fulfill the statute's requirement to efficiently administer the plans. The NCCMP urges this Court to enforce ERISA's broad preemption provision and to ensure that the core functions of ERISA plans continue to be subject exclusively to federal regulation.

INTRODUCTION

The question in this case is whether ERISA's express preemption provision continues to have the teeth that the statute itself, and this Court's interpretation of the statute, provide. ERISA's preemption provision is extremely broad: ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This Court has explained that

ERISA preempts "state laws that mandate employee benefit structures or their administration." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995). In *Travelers*, the Court described certain ways in which ERISA comprehensively regulates plan administration, preempting state laws. "The federal statute . . . controls the administration of benefit plans, as by imposing reporting and disclosure mandates, participation and vesting requirements, funding standards, and fiduciary responsibilities for plan administrators." *Id.* at 651 (internal citations omitted) (citing provisions of the statute). While the outer limits of ERISA preemption may be undefined, reporting and disclosure are its bread and butter. The Court has stated in no uncertain terms that "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," are unquestionably preempted. *Id.* at 661 (alterations in original) (quoting *Shaw v. Delta Air Lines*, 463 U.S. 85, 98 & n.19 (1983)).

And with good reason. A principal goal of ERISA was to enable plan sponsors to establish a nationally uniform administrative scheme for processing claims and disbursing benefits. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9 (1987). In order to operate, plans determine the information they need to be able to process claims, disburse benefits, and comply with federal reporting requirements. Plans develop systems tailored to meet those needs and carefully collect and maintain the information. Because many multiemployer plans are regional, if not national, in scope, uniformity among the states with regard to collection, reporting, and disclosure re-

quirements is critical to efficient plan administration. As this Court has recognized, such uniformity is impossible if plans are subject to different legal requirements in different parts of the country. *Egelhoff v. Egelhoff ex. rel. Breiner*, 532 U.S. 141, 148 (2001). Accordingly, different state regulations upending an ERISA plan's reporting and disclosure requirements "impose 'precisely the burden that ERISA preemption was intended to avoid.'" *Id.* at 150 (quoting *Fort Halifax*, 482 U.S. at 10).

Trustees and administrators of multiemployer plans, including those affiliated with NCCMP, heavily rely on ERISA's guarantee of national uniformity in their claims processing systems and recordkeeping and reporting requirements. Multiemployer plans are not profit-making entities. They are the product of the collective bargaining process, and they serve as a vehicle for providing health benefits for working men and women and their families. Often, the participants in the plans work in industries characterized by physically demanding work, such as construction and related crafts, which leads to more medical claims than in other industries. The plans' survival is conditioned upon the parties' ability to negotiate agreements which meet the wage and benefit requirements of workers while enabling their employers to remain profitable, allowing the employers to provide jobs and the benefits which are a byproduct of such employment and the focus of this case. Requiring multiemployer plans to capture data which they have no need to collect in order to fulfill their claims processing, benefits-providing functions, and then to record and report such data in accordance with each state's desires, will di-

vert plan assets from the employee benefits that the plans exist to provide.

Multiemployer plans are run by joint boards of trustees appointed by participating employers and labor organizations. Trustees are, therefore, acutely aware of the limited ways in which plans can keep up with ever-increasing health care costs: employers can contribute more money toward the plans, which may make the cost of their products or services less competitive in the market; employees can take cuts in pay; or plans may be forced to make cuts in benefits.

ERISA requires that plan assets be held in trust for the exclusive purpose of providing benefits to participants and beneficiaries and defraying the reasonable expenses of administering the plans. 29 U.S.C. § 1103. For multiemployer plans in particular, it is critical that every possible penny go to the payment of benefits. Petitioner neither considers these realities nor acknowledges the underlying reach of ERISA preemption. If Petitioner prevails, it will directly and significantly impact multiemployer plans' core functions under ERISA—claims processing, reporting, disclosure, and recordkeeping—at the expense of plans' abilities to provide adequate benefits to their participants and beneficiaries.

SUMMARY OF THE ARGUMENT

The Court of Appeals properly held that the Vermont Act is preempted under Section 514 of ERISA, 29 U.S.C. § 1144, because, by establishing detailed and onerous reporting and disclosure requirements for health care

claims, it impermissibly relates to self-funded employee benefit plans. The Vermont Act regulates a subject matter expressly covered by ERISA: plan reporting and disclosure. This Court has repeatedly held that reporting and disclosure requirements are a function of plan administration, and that state laws imposing mandates on plan administration are preempted because they frustrate ERISA's essential goals of national uniformity, as well as efficiency and cost effectiveness, in the administration of ERISA plans. The lower court's decision, therefore, followed the Court's holding in *Travelers* and other precedent and should be affirmed.

The data collection, recordkeeping, and reporting requirements of the Vermont Act strip multiemployer plans of the protections of uniform federal law. The Act requires collection of hundreds of data elements for member eligibility and health care claims, including scores of elements which must be captured on a claim-by-claim basis, thus requiring self-insured multiemployer plans with participants or beneficiaries living in or receiving health care in Vermont to adopt different, additional procedures for collecting data on health care claims. The Act also mandates that multiemployer plans establish special recordkeeping procedures relating to claims, thus requiring plans to adopt different, and additional, recordkeeping procedures in Vermont that apply nowhere else in the country. The Act forces plans to report all of this data in strict compliance with meticulous coding, encrypting, formatting, and filing requirements, which again apply only in Vermont. Finally, the Act vests state agencies with administrative oversight over aspects of paid claims, thus subjecting ERISA plans with a Vermont connection to both federal and state enforcement schemes.

If the decision below is overturned it will significantly weaken ERISA preemption, opening the door for every state to impose its own invasive requirements on plan administration. It is contrary to the national interest to allow the states to trigger the imposition of such a substantial administrative burden and expense on hundreds of self-insured multiemployer plans.

ARGUMENT

I. THE VERMONT STATUTE IMPOSES HEAVY BURDENS ON MULTIEMPLOYER PLANS, CONTRARY TO ERISA'S CENTRAL AIM OF ALLOWING PLANS TO OPERATE UNDER A NATIONALLY UNIFORM SYSTEM OF ADMINISTRATION.

Petitioner argues that the Vermont Act should not be preempted because it regulates an area—reporting and disclosure—where "ERISA has nothing to say." Pet'r Br. 25, 30 (quoting *Travelers*, 514 U.S. at 661; *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., Inc.*, 519 U.S. 316, 330 (1997)). But *Travelers*, the primary case Petitioner cites for this proposition, expressly recognizes that ERISA does have something to say about reporting and disclosure, recognizing that state laws are preempted when they "deal[] with the subject matters covered by ERISA, *reporting, disclosure*, fiduciary responsibility, and the like." *Travelers*, 514 U.S. at 661 (citation omitted) (emphasis added); *see also, e.g.*, 29 U.S.C. §§ 1021-1031 (addressing plans' reporting, recordkeeping and disclosure obligations to the Department of Labor). As the decision below correctly noted, reporting and disclosure are matters of plan administration, and "'state statutes that man-

date employee benefit structure *or their administration*' have a 'connection with' ERISA plans and are therefore preempted." *Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497, 507 (2d Cir. 2014) (quoting *Dillingham*, 519 U.S. at 328) (emphasis added by Second Circuit).

Certain laws that "creat[e] no impediment to [a plan's] adoption of a uniform benefit administration scheme" **might** survive a preemption challenge. *Fort Halifax*, 482 U.S. at 14; *see also Shaw*, 463 U.S. at 100 n. 21 (finding no preemption when a state statute has "too tenuous, remote, or peripheral" an effect on employee benefit plans). The Vermont Act, however, creates impediments which are neither tenuous, remote nor peripheral. It imposes painstaking and stringent data collection, recordkeeping, and reporting requirements on multiemployer plans, inflicting impermissible mandates on plan administration. Accordingly, it is preempted.

A. The Vermont Act's Data Collection Requirements Impose a Mandate on Plan Administration.

The Act and its accompanying regulations require plans to report "healthcare claims data" in minute detail for members who reside or receive health care services in Vermont. Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. The regulations contain over twenty pages of appendices, which list hundreds of data elements plans must provide regarding member eligibility as well as the details of each health care claim. *See id.* H-2008-01, Appendices B-1 through D-1; J.A. 155-177. Pro-

viding partial data is not enough. The State's official guidance instructs that "[s]ubmissions with data elements failing the completeness threshold for one or more fields will be rejected in their entirety." J.A. 134 (Vermont Frequently Asked Questions (FAQs) for the Collection of Commercial Claims Data, Answer 13). And if a plan fails to provide data required by the Act, the State may impose fines of up to $10,000 per violation. *See* Vt. Stat. Ann. tit. 18, § 9410(g).

Contrary to Petitioner's bald assertion, multiemployer plans do not in each instance "already . . . generate" this data "in the ordinary course of business." Pet'r Br. 4. This statement proceeds from the mistaken assumption that self-funded multiemployer plans function like health care providers. They do not. Multiemployer plans exist solely to administer a plan of benefits to their participants: working men and women, retirees, and their dependents and beneficiaries. Plans, especially smaller plans, are not in the business of big data. To the contrary, they seek to preserve plan assets and to reduce resources spent on data entry, storage and management to the minimum necessary to process claims, disburse benefits and comply with national recordkeeping and reporting requirements. ERISA's broad preemption provision, intended to protect plans from conflicting and multiplicative state regulation, was enacted to "minimize the administrative and financial burden" on plans. *Ingersoll-Rand*, 498 U.S. at 142.

Many multiemployer plans are self-funded and self-administered, and work with a variety of vendors who provide different levels of administrative services for mental/behavioral, prescription, dental, and medical benefits. In addition to different claims forms and ad-

ministrative paperwork for each of these types of benefits, a plan may also have to process claims both within and outside of the plan's networks of providers, which again may vary based on the type of benefit. Because of the variety and complexity of data provided to the plans, many plans create proprietary software which contains only the information needed to properly adjudicate claims in accordance with the plan of benefits and to meet ERISA's reporting requirements.

As a result, many of the NCCMP's constituent plans likely capture only about 70-80% of the data required by the Vermont Act. For example, these plans may have no reason, ability, or need to capture inpatient admission hour, type, source, discharge hour, or status, as required in Appendix D-1 to the regulations, data fields M-019 through 023. J.A. 167-68. Plans may not capture or record service provider specialty, type of bill, or site of service, particularly at the level of specificity required by the Act. J.A. 169-72 (Appendix D-1, M-032, M-036, M-037). And plans may not obtain or use Diagnostic Code Related Groupings ("DRG") codes, DRG versions, Ambulatory Patient Classifications ("APC"), or National Drug Code ("NDC") information as mandated by the Act. J.A. 176 (Appendix D-1, MC-071 through 075). These plans simply have no need for this information in order to fulfill their claims processing, benefits-providing functions, nor do they need it to comply with federal law. They therefore do not collect it.

Compliance with the Vermont reporting scheme would force self-funded plans to alter their claims data gathering procedures, a function integral to the administration of the plans. These mandated changes would

require plans to seek different and additional information from various providers, vendors and third parties with whom they work, forcing significant changes to their claims recording and processing software, and imposing new costs for the input of more data. For plans that are self-funded and self-administered, the cost of such changes is shouldered directly by the plan. For plans that contract with a third party administrator ("TPA"), the TPA pays the initial costs, then seeks reimbursement from the plan directly or passes the costs along to the plan indirectly by raising its fees or cutting other services.[3] Either way, the costs are ultimately borne by the participants and beneficiaries in the form of reduced benefit levels or more money taken from their wages to maintain current benefit levels.

B. The Vermont Act's Recordkeeping Requirements Permit the State to Interfere with Plans' Core Functions, Contrary to ERISA's Express Preemption Provision.

Separate and apart from requiring multiemployer plans to capture data elements which they would not otherwise collect, the Act also forces plans to alter

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[3] As the facts of this case illustrate, a multiemployer plan with a TPA may be subject to the cost of compliance with the Vermont Act even if the plan has fewer than two hundred covered members residing or receiving services in the state of Vermont. *See Liberty Mutual*, 746 F.3d at 501-02 (although Liberty Mutual only provided benefits to 137 individuals in Vermont, its data was subject to the Act because its TPA qualified as a mandatory reporter). If all the plans the TPA serves meet the 200 person threshold in the aggregate, the TPA will be subject to the Act and will almost certainly pass those costs on to the plan.

their recordkeeping functions to conform to Vermont's protocol.

For example, the Act requires plans to maintain separate—and previously unnecessary—records based on the residency of participants and their eligible dependents, and the location of the provider. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. This leaves multiemployer plans with a number of practical difficulties. First, unlike an employee benefit plan sponsored by a single Vermont employer, where most participants, beneficiaries and providers are located in the State, many large multiemployer plans have a regional or nationwide base of employers, participants, beneficiaries, and medical providers. Second, some health care providers contract with out of state billing agencies. Adding to the confusion, billing arrangements may provide for payment to be remitted to yet a different address, leading to the complicated—but not unusual—situation in which a participant gets sick in Vermont and the plan receives a bill from New Jersey with instructions to remit payment to a post office box in Ohio. Third, NCCMP constituent plans cover many employees in the building and construction trades and those in the maritime and trucking industries, who commonly travel out of state to work for either limited or extended periods of time. Thus, a participant may live temporarily, work and receive needed medical treatment in one state, while his or her family members continue to reside and receive medical treatment in Vermont. Fourth, with the extension of dependent coverage to age twenty six under the Affordable Care Act, many plans cover adult children residing in other states while they work or attend school. Under each

of these circumstances, the Vermont Act requires multiemployer plans to determine, and to keep records of, where each medical service was rendered and for which member of the family, and to pair this information with each person's domicile. Nothing in ERISA requires plans to maintain these records or to configure them in this fashion;[4] accordingly, plans subject to the Act are forced to revise their claims-processing procedure to maintain separate claims-based records for residents of Vermont and for all services provided in Vermont. These superimposed recordkeeping obligations make uniformity of plan administration impossible to achieve and frustrate the purpose of Congress in legislating ERISA preemption.

C. The Vermont Act's Reporting Obligations Place an Unacceptable Administrative Burden on Multiemployer Plans to the Detriment of Plan Participants.

Petitioner suggests that the information requested by the Act "may be transmitted with a few key

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[4] ERISA requires plans to maintain records and file reports to support their expenditures, including the Form 5500 Series (the form itself and multiple schedules), in order to satisfy the annual reporting requirements set forth in 29 U.S.C. §§1023 and 1024. *See* Form 5500 Series, *available at* http://www.dol.gov/ebsa/5500main.html. While these forms and schedules require a tremendous amount of information, including the total amount of claims paid annually by the plan, nothing in ERISA requires plans to either compile or report information on a state-by-state basis, much less on the granular claim-by-claim basis required by the Vermont Act. *Id.* More fundamentally, ERISA does not require plans to track the location of services rendered at all.

strokes." Pet'r Br. 55. Even assuming that plans already captured and recorded the information required by the statute and in the form required by the statute, which as discussed *supra* they do not, this statement is simply untrue. Petitioner and particularly his *amici* cite the All-Payer Claims Database ("APCD") Council, an all-payer database advocacy group, for the purported benefits of all-payer claims databases. *See, e.g.*, Pet'r Br. 32; Brief of *Amici Curiae* American Medical Ass'n and Vermont Medical Society 11-12; Brief of *Amici Curiae* National Governors Ass'n et al. 14-16. However, the APCD Council itself admits that "each state is collecting different data by different methods and with different definitions." J.A. 219 (Amy Castello & Mary Taylor, APDC Council, *Standardization of Data Collection in All-Payer Claims Databases* (Jan. 2011)); *see also* APCD Council, *All-Payer Claims Database Development Manual* at 7 (Mar. 2015), *available at* https://www.apcdcouncil.org/file/29/download?token=EoozDsLJ (recognizing ongoing "payers' burden" to submit different data, to different states, in different formats). The Council recognizes that as these databases "are required in more states, the cost to payers will become significant," as will "the challenges for payers to provide the required data." J.A. 220. "Payers need a minimum of nine months to make systems changes and program the initial . . . data sets," in the form and structure required for a state's data submission. J.A. 221. By Petitioner's and *amici*'s own advocacy group's admission, the reporting requirements attendant to all-payer claims databases impose significant burdens on plans.

The Vermont Act's reporting requirements are detailed and exhaustive. The Act requires plans or their TPAs to file monthly, quarterly or annual submissions with the State depending on the number of covered members residing or receiving services in Vermont, regardless of whether the plans are based in the State. *See, e.g.*, Vt. Stat. Ann. tit. 18, § 9410(b), (j)(1); Vt. State Reg. H-2008-01, §§ 1, 3.Q, 3.X, 3Ab. It grants broad authority to the Vermont Green Mountain Care Board to require plans to submit "information determined by the Board to be necessary," and to establish "the time and place and the manner in which such information shall be filed." *Id.* § 9410(c), (d).

As set forth above, the regulations and their appendices require plans to report hundreds of data fields, including scores of fields for each individual claim. Completion of some of these data fields requires plans to obtain certain prior approvals from a State administrative body charged with implementing and enforcing the law. For example, multiemployer plans do not fit within one of the prescribed categories for the "Coverage Type" or "Market Category Codes" fields, and may not report using the "other" code without prior approval from the State. *See* J.A. 161-62 (Appendix D-1, ME029 through ME030).

In addition to the sheer volume of data to be reported, the Act and its regulations contain onerous requirements for the manner in which the reports must be filed. The data must be coded, encrypted, contain the correct file specifications, headers and trailers, and formatted in microscopic detail. *See, e.g.*, Vt. State Reg. H-2008-01 § 5(A)(1)-(16), 5(B)(1)–(4)(c)(2). The complexity inherent in the Act's re-

porting systems is clearly illustrated by one piece of State guidance: Vermont's Frequently Asked Questions for the Collection of Commercial Claims Data, which contains fifty-five questions not including subparts. J.A. 122-154. As the State makes clear, failure to comply with any of these requirements may cause the plan's entire data submission to be rejected. *See* J.A. 146-149 (FAQ, Answer 37.a – 37.l) (listing the twelve "most common" reasons for rejection). Failure to comply with the Act subjects plans to State enforcement mechanisms, including "investigation, subpoena, fine[s]," of up to $10,000 per violation, or "other legal and equitable remedies." Vt. State Reg. H-2008-01 §10.

The Court below examined the burdens imposed by the Act and correctly concluded that "even considered alone, the Vermont scheme triggers preemption; considered as one of several or a score of uncoordinated state reporting regimes, it is obviously intolerable." *Liberty Mutual*, 746 F.3d at 509. In view of the trend toward states establishing health care databases, a proliferation of state laws imposing incompatible and varying demands on ERISA plans is not merely hypothetical: it is imminent.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to affirm the decision of the Court of Appeals.

Respectfully submitted,

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