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

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts, as applied to self-insured health benefit plans or their third-party administrators, a Vermont statute that requires healthcare payers to report claims and healthcare-services data to a state agency.

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INTEREST OF THE UNITED STATES

This case concerns whether the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, preempts a state law imposing certain reporting requirements on healthcare payers, including ERISA plans. The Secretary of Labor has primary authority for administering ERISA. 29 U.S.C. 1002(13), 1132-1135. In response to an invitation from the Court, the United States filed an amicus brief in this case at the petition stage.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The pertinent statutory and regulatory provisions are reproduced in the appendix to this brief. See App., *infra*, 1a-59a.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is designed to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b). The statute governs both pension plans and "employee welfare benefit plan[s]," *i.e.*, plans that, "through the purchase of insurance or otherwise," provide medical, disability, unemployment, vacation, or certain other benefits. 29 U.S.C. 1002(1). ERISA requires every plan to be established and maintained pursuant to a written instrument and to have named fiduciaries who have authority to control and manage the administration of the plan and its assets. 29 U.S.C. 1102(a)(1), 1103(a). With specified exceptions, ERISA preempts "any and all State laws insofar as they * * * relate to any employee benefit plan." 29 U.S.C. 1144(a).

Plan administrators generally must file detailed financial and actuarial information with the Secretary of Labor (Secretary) and submit reports upon the occurrence of specific events, although the Secretary has exempted most welfare plans from the majority of those requirements. 29 U.S.C. 1021-1024; 29 C.F.R. Pt. 2520. In addition, the Secretary has authority to

investigate plans for ERISA violations by inspecting plan documents, administrative contracts, and claims records. 29 U.S.C. 1134. ERISA also authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." 29 U.S.C. 1143(a)(1).

ERISA includes certain provisions governing "group health plan[s]," *i.e.*, ERISA welfare plans that provide medical benefits, 29 U.S.C. 1191b(a), that were originally enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, § 101(a), 110 Stat. 1939. See 29 U.S.C. 1181-1191c. In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, which imposes a number of new requirements on the group health-insurance market, such as a prohibition on charging different premiums based on health status. See § 1001, 124 Stat. 130; see also 42 U.S.C. 300gg *et seq.* In a section setting out "conforming amendments," ACA § 1563, 124 Stat. 264, 911 (capitalization and emphasis omitted), the ACA also amended ERISA to provide that those new provisions generally apply to group health plans and that, in the event of a conflict between those ACA provisions and the sections of ERISA addressing group health plans, the ACA provisions govern. See *id.* § 1563(e), 124 Stat. 270, 911 (29 U.S.C. 1185d). The new ACA provisions applicable to group health plans include reporting and disclosure requirements related to such matters as claims-payment policies, out-of-network coverage, data on enrollment and denied claims, financial information, and information on the existence of any quali-

ty initiatives or wellness programs under the plan. See 42 U.S.C. 300gg-15a (incorporating provisions of 42 U.S.C. 18031(e)(3)); 42 U.S.C. 300gg-17(a) and (b).

Those provisions of the ACA have not yet been implemented. The Department of Labor has informed this Office, however, that pursuant to the authority granted by ERISA and the ACA, and in consultation with the Department of Health and Human Services (HHS) and the Department of the Treasury, it is currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings.

2. The Vermont Legislature has enacted a comprehensive health law designed to "[m]aintain and improve the quality of health care services offered to Vermonters," "[u]tilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services," and "[e]ncourage regional and local participation in decisions about health care delivery, financing, and provider supply." Vt. Stat. Ann. tit. 18, § 9401(b)(1)-(3) (2012). One provision of the statute requires the Green Mountain Care Board (Board), a state agency, to develop and maintain a database of information about healthcare expenditures in the State and out-of-state healthcare expenditures involving Vermont residents. See *id.* § 9410 (Supp. 2014) (Database Statute). The database is designed to help "identify[] health care needs," "compar[e] costs between various treatment settings and approaches," "determin[e] the capacity and distribution of existing resources," and "provid[e] information to consumers and purchasers of health care." *Id.* § 9410(a)(1) (Supp. 2014).

The database must "reflect all health care utilization, costs, and resources" for medical services provided to Vermont residents or by Vermont facilities. Database Statute § 9410(b) (Supp. 2014). To that end, the Database Statute authorizes the Board to require "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to submit "reports, data, schedules, statistics, or other information." *Id.* § 9410(c)-(d) (Supp. 2014). The information may include "health insurance claims and enrollment information" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* § 9410(c)(1) and (3) (Supp. 2014). The law's definition of "[h]ealth insurer" includes any health-insurance company and, "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities," Vt. Stat. Ann. tit. 18, § 9402(8) (2012), as well as any third-party administrator that a self-insured health plan employs to handle such functions as claims processing, bill review, and claims payments, Database Statute § 9410(j)(1)(A) and (B) (Supp. 2014).

The Database Statute provides that, "[t]o the extent allowed by HIPAA, the [collected] data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont." § 9410(h)(3)(B) (Supp. 2014); see *id.* § 9410(h)(3)(C) (Supp. 2014). It also requires the Board to establish "a consumer health care price and quality information system" to "empower individuals, including uninsured individuals, to make economically sound and medically appro-

priate decisions." *Id.* § 9410(a)(2)(A) (Supp. 2014). In addition, the statute directs that "[r]ecords of information * * * required by law to be held confidential[] shall be filed in a manner that does not disclose the identity of the protected person," *id.* § 9410(e) (Supp. 2014), requires the Board to "adopt a confidentiality code," *id.* § 9410(f) (Supp. 2014), and prohibits the disclosure of "any data that contains direct personal identifiers," *id.* § 9410(h)(3)(D) (Supp. 2014). Knowing violations of the statute or implementing rules promulgated by the Board are punished through financial penalties. *Id.* § 9410(g) (Supp. 2014).

The Board's predecessor promulgated a regulation implementing the statute's requirements with respect to healthcare payers. See Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) (Database Regulation). (The Board also administers a separate database for hospital-discharge data that is not at issue here. See Pet. Br. 7 & n.6.) The Database Regulation provides that "Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities." § 4(D). The claims data comprise only information about "non-denied adjudicated [medical and pharmacy] claims." *Id.* § 3(Ac); see *id.* § 3(Ak); see also *id.* § 5(A)(8). The data include information about "member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes." *Id.* § 3(Ac). The regulation establishes requirements for how the data must be formatted, when it must be submitted, and under what circumstances different types of data will be released

to the public or to specific requestors, such as researchers. *Id.* §§ 5-8. It exempts health insurers with fewer than 200 enrolled or covered members in Vermont from the reporting requirements, although they may voluntarily report. *Id.* § 3(Ab) and (As).

The Board uses the claims database in fulfilling its statutory responsibilities, such as approving insurance rates and reviewing hospital budgets. See Pet. Br. 15-16, 33-35. In 2014, HHS issued a grant to the Board to expand its use of the database in connection with Vermont's rate-review authority under the ACA. *Id.* at 49-50 & n.29; see 42 U.S.C. 300gg-94(c)(1)(C). In addition, HHS supplies Medicare data to the Board, see 42 U.S.C. 1395kk(e), and has authorized the Board to include Medicaid data, see Pet. Br. 10. Over a dozen other States have enacted legislation to build similar databases. See N.Y. et al. Cert. Amicus Br. 1 & n.3.

3. Respondent is the named fiduciary and administrator of an ERISA self-insured health plan for its employees. Pet. App. 7. A self-insured plan is one in which the plan sponsor pays claims out of its own assets or from a trust, rather than contracting with an insurance company to pay claims under an insurance policy. Because only 137 persons covered by respondent's health plan live in Vermont, respondent is not itself required to report healthcare-expenditure information to the Board. *Id.* at 7-8. But respondent's plan is administered by a third-party administrator—Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross)—that qualifies as a mandatory reporter under the Database Regulation because it administers claims for thousands of individuals in Vermont. *Id.* at 8; see J.A. 205. In August 2011, the Board's predeces-

sor issued a subpoena to Blue Cross, seeking eligibility information and medical- and pharmacy-claims files for Vermont residents covered by respondent's plan, which had not been reported as required by the Database Statute and Regulation. J.A. 30-33. Respondent, believing that the request was preempted by ERISA, instructed Blue Cross not to comply with the subpoena. Pet. App. 9.

Respondent then filed suit in the United States District Court for the District of Vermont against the Board's predecessor. J.A. 12-28. Respondent sought a declaratory judgment that the Database Statute and Regulation "are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to [respondent's health] [p]lan or its participants and beneficiaries." J.A. 27. Respondent also sought to enjoin the Commissioner "from attempting to obtain, from [Blue Cross] or any other source, any medical records or data relating to the [p]lan or its participants and beneficiaries." J.A. 28.

The district court dismissed the complaint, holding that the Vermont reporting requirements are not preempted by ERISA. Pet. App. 48-80. The court explained that although "[c]ompliance with the reporting requirements * * * may have some indirect effect on health benefit plans," the possible "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." *Id.* at 78. The court emphasized that respondent had "not submitted any information about any actual burden suffered by

itself or [Blue Cross] in producing this information." *Id.* at 73 n.5.

4. The court of appeals reversed, holding that ERISA preempts the Vermont reporting requirements. Pet. App. 1-30. The court explained that under this Court's interpretation of ERISA's preemption provision, 29 U.S.C. 1144(a), "a state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (brackets in original) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court concluded that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" because "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id.* at 23. The court noted that Vermont could change the requirements at any time, *id.* at 27, and it postulated that if respondent were subject to "one of several or a score of uncoordinated state reporting regimes," the burden would be "obviously intolerable," *id.* at 25.

Judge Straub dissented in relevant part. Pet. App. 30-47. "Many state laws," he wrote, "may have an impact on the administration of an ERISA plan—for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Id.* at 42. Although "[s]uch laws may impose additional costs," he concluded, "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Ibid.* Judge Straub also found that "on the record before [the court,]" no basis existed to conclude that the Vermont reporting requirements would "hin-

der the national administration of employment benefit plans in any way." *Id.* at 44; see *id.* at 41-42.

SUMMARY OF ARGUMENT

ERISA does not preempt the Vermont reporting requirements.

A. Under this Court's precedents construing ERISA's preemption provision, 29 U.S.C. 1144(a), the Vermont reporting requirements do not "relate to" ERISA plans because they have neither a "reference to" nor a "connection with" such plans. *Egelhoff* v. *Egelhoff*, 532 U.S. 141, 147 (2001) (citation omitted). As the court of appeals acknowledged, the requirements do not have a "reference to" ERISA plans because they operate on many healthcare payers, not only on ERISA plans, and the existence of an ERISA plan is not logically necessary to their operation. Pet. App. 23 n.9 (citations omitted). Preemption therefore turns on whether the requirements have a forbidden "connection with" ERISA plans. Although this Court has not defined that concept with great precision, it has evaluated the preemption question by "look[ing] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and "to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147 (citations and internal quotation marks omitted). Under that approach, the requirements are not preempted.

1. The Database Statute and ERISA serve different purposes. ERISA governs the design and administration of employee benefit plans, including vesting requirements, health-benefit mandates, fiduciary duties, and remedies for breach. Its reporting and disclosure requirements further those purposes. The

Database Statute, in contrast, is designed to improve the quality, utilization, and cost of healthcare in Vermont by providing consumers, government officials, and researchers with comprehensive data about the healthcare-delivery system. Although those data are reflected in claims paid by various entities, including ERISA plans, the focus of the Vermont statute has nothing to do with the claims-payment process. That is why Vermont does not seek information on denied claims.

Because the Vermont reporting requirements operate in the traditional state sphere of health and safety, while ERISA is principally concerned with the distinct subject of ensuring that plans provide covered benefits, the reporting requirements are entitled to a presumption of validity under Section 1144(a). As this Court has cautioned, it would be "unsettling" to conclude that ERISA squelches an entire area of state regulation about which ERISA itself says little. *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (citation omitted). That discomfiting result would be particularly harmful here, because the data collected by the Vermont reporting requirements are integral to achieving the objectives of other federal statutory provisions.

2. The Vermont reporting requirements do not exert impermissible effects on the design or administration of ERISA plans. ERISA generally preempts those laws that prescribe binding rules for "a central matter of plan administration," such as "the payment of benefits," *Egelhoff*, 532 U.S. at 148, but it does not guarantee "cost uniformity" among different States where a plan might operate, *New York State Confer-*

ence of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 662 (1995). The Vermont reporting requirements do not impose binding obligations with respect to any core matter of plan administration, such as the vesting of benefits, claims processing, or the designation of beneficiaries. Respondent's contrary argument essentially rests on the view that all reporting of information acquired or generated during the administration of a plan qualifies as a central matter of plan administration. But that argument conflicts with this Court's prior decisions and, taken to its logical conclusion, would sweep away virtually all state-law reporting requirements incident to laws of general applicability. And although this Court has suggested in dicta that a law imposing costs that are so acute as to effectively dictate how a plan is designed or administered would be preempted, no such extreme economic effects have been established here.

B. Some Justices have suggested in separate opinions that this Court should clarify its ERISA preemption jurisprudence by holding that Section 1144(a) merely calls for the application of ordinary principles of field and conflict preemption. Under those principles, the Vermont reporting requirements are not preempted. The requirements do not invade the exclusive federal field of the design and administration of ERISA plans. Nor do they conflict with any specific provision of ERISA or with Section 1144(a)'s basic objective to establish a uniform body of employee-benefits law.

ARGUMENT

THE VERMONT REPORTING REQUIREMENTS ARE NOT PREEMPTED BY ERISA

A. The Vermont Reporting Requirements Do Not Fall Within ERISA's Express Preemption Provision

Section 1144(a) of ERISA expressly preempts state statutes and regulations that "relate to" an ERISA plan, except for "any law * * * which regulates insurance, banking, or securities," "any generally applicable criminal law," and other specified categories of state laws. 29 U.S.C. 1144(a), (b)(2)(A), (4), and (c)(1). Under this Court's precedents construing that provision, "[a] law 'relates to' an employee benefit plan * * * if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983); see, *e.g.*, *Egelhoff* v. *Eglelhoff*, 532 U.S. 141, 147 (2001); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*Travelers*).

The court of appeals correctly concluded (and respondent has not contested) that the Vermont reporting requirements do not have a "reference to" ERISA plans. Pet. App. 23 n.9 (citations omitted). A law has a "reference to" ERISA plans if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 325-326 (1997) (*Dillingham*). The Vermont reporting requirements apply to many healthcare payers, not only to ERISA plans. Database Statute § 9410(c) (Supp. 2014); see Database Regulation §§ 3(X), 4. And they could function independently of the existence of ERISA plans, though excluding ERISA plans would

render Vermont's database far less comprehensive and thus less useful. For these reasons, the reporting requirements do not resemble the state laws that this Court has held to have a specific "reference to" ERISA plans. Those laws have targeted ERISA plans with specificity. See *District of Columbia* v. *Greater Wash. Bd. of Trade*, 506 U.S. 125, 128, 129-133 (1992) (workers' compensation law that required employee benefits "set by reference to [ERISA] plans") (citation omitted); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 135-136, 140 (1990) (common-law claim for wrongful discharge to prevent attainment of ERISA benefits); *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 828 & n.2, 829-830 (1988) (exemption from garnishment statute for ERISA plans).

Accordingly, whether Section 1144(a) preempts the Vermont reporting requirements turns on whether the requirements have an impermissible "connection with" ERISA plans. This Court has acknowledged that the phrase "'connection with' is scarcely more restrictive than 'relate to'" and has therefore "cautioned against an uncritical literalism that would make pre-emption turn on infinite connections." *Egelhoff*, 532 U.S. at 147 (citation and internal quotation marks omitted). To avoid such an expansive breadth, the Court has "look[ed] both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive" and "to the nature of the effect of the state law on ERISA plans." *Ibid.* (citations and internal quotation marks omitted); see *Travelers*, 514 U.S. at 655-656.

Much like ordinary field preemption, the first inquiry essentially asks whether the challenged state law is directed at "an area of core ERISA concern":

the design and administration of employer-sponsored pension and welfare plans. *Egelhoff*, 532 U.S. at 147; see, *e.g.*, *Dillingham*, 519 U.S. at 330-331. The second inquiry asks whether, even if the law is not overtly directed at that field, its application would frustrate the purpose of ERISA's preemption provision "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law," *Ingersoll-Rand*, 498 U.S. at 142, by prescribing binding rules for the design or administration of ERISA plans. See *Egelhoff*, 532 U.S. at 148-149. In this case, the answer to each inquiry is no.

1. The Vermont reporting requirements serve objectives distinct from the basic purposes of ERISA

The Vermont reporting requirements operate in an area of traditional state regulation and bear only an attenuated relation to the purposes of ERISA. As such, they are entitled to a presumption of non-preemption under Section 1144(a)—a presumption fortified by the requirements' important role in achieving the goals of other federal legislation.

a. As discussed above, ERISA imposes a number of reporting requirements on plans, such as the submission of financial and actuarial information to the Secretary. See pp. 2-3, *supra*. Those requirements serve ERISA's basic purposes: to prevent the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds," *Dillingham*, 519 U.S. at 326-327 (quoting *Massachusetts* v. *Morash*, 490 U.S. 107, 115 (1989)), by enforcing "fiduciary standards on persons whose actions affect the amount of benefits * * * plan participants will receive," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust &*

Sav. Bank, 510 U.S. 86, 96 (1993). See 29 U.S.C. 1001(b). Any state-law reporting requirements for the same purposes would raise a substantial preemption question. See *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760, 763-766 (9th Cir. 1980) (holding preempted Hawaii reporting requirements incident to law requiring employers to provide prepaid health plan), summarily aff'd, 454 U.S. 801 (1981); see also *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 12-13 & n.7 (1987). That is because such requirements would effectively invade the field exclusively governed by ERISA and alter the approach that Congress adopted to ensure that plans are administered according to appropriate legal requirements.

The Vermont reporting requirements, however, have a different focus. The requirements are designed to populate a state database to be used to achieve a variety of general healthcare-related goals, including identifying the State's healthcare needs, enhancing resource utilization, comparing treatment costs and approaches, improving patient outcomes, and "mak[ing] available to consumers transparent health care price information, quality information, and such other information as * * * is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions." Database Statute § 9410(a)(1) and (2)(A) (Supp. 2014). The Vermont reporting requirements, in other words, focus on the quality, cost, and transparency of medical treatment in the State. Those goals are part of an overall statutory scheme intended to "[m]aintain and improve the quality of health care services offered to Vermonters" and achieve other ends. Vt. Stat. Ann. tit. 18, § 9401(b) (2012).

That purpose is "quite remote from the areas with which ERISA is expressly concerned." *Dillingham*, 519 U.S. at 330; see 29 U.S.C. 1001(a) and (b). The purpose of Vermont's data collection is not to ensure that ERISA plans are sufficiently funded, pay benefits covered under the plan or required by federal law, or are administered in accordance with fiduciary standards. Indeed, the Database Regulation does not even seek information about all claims submitted by participants in ERISA welfare plans, but only about claims that are *paid*. See § 3(Ac) and (Ak); see also *id.* § 5(A)(8). That is because the focus of the regulation is not the claims processes of employee benefit plans, but rather healthcare expenditures, utilization, and cost. Vermont thus does not collect information about claims that are denied by ERISA plan administrators—a matter of central importance to ensuring that ERISA plans are being administered in accordance with their terms and with statutory requirements, but of relatively little importance to evaluating how healthcare dollars are spent in Vermont.

The Vermont reporting requirements, moreover, operate in an area squarely within the "historic police powers of the State": "the regulation of matters of health and safety," *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997). Although state collection and analysis of healthcare data is a relatively recent phenomenon, the basic objectives of the data analysis—improving healthcare quality, reducing healthcare costs, and helping Vermonters make informed medical decisions—reflect the long-standing interest of States in promoting the health of their citizens, including through information-collection efforts. See Pet. Br. 4-7, 32-34. And precisely be-

cause ERISA does not focus on analyzing general data about medical treatment across payers, ERISA does not establish a federal scheme for collecting and aggregating a broad set of data about medical treatment or provide any alternative mechanism by which state and local governments can do so. Cf. *Pegram* v. *Herdrich*, 530 U.S. 211, 214, 237 (2000) (explaining that medical-treatment decisions are not ERISA fiduciary acts despite their close relationship to decisions about what a health plan covers).

b. Because there exists little overlap between the objectives of ERISA and the objectives of the Vermont scheme, and because the Vermont scheme operates in an area of traditional state regulation, the reporting requirements are entitled to "the presumption that ERISA did not intend to supplant [them]." *Dillingham*, 519 U.S. at 331-332. As this Court has explained, "[a] reading of [Section 1144(a)] resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling.'" *Id.* at 330 (quoting *Travelers*, 514 U.S. at 665). Congress does not typically enact legislation in one substantive field with the intention to "squelch * * * state efforts" in a distinct sphere that has historically been regulated at the state and local levels and that the federal statute does not address. *Travelers*, 514 U.S. at 665. That is especially true "in the field of health care," where "there is no ERISA preemption without [a] clear manifestation of congressional purpose." *Pegram*, 530 U.S. at 237 (citing *Travelers*, 514 U.S. at 654-655).

Applying preemption so broadly would be particularly troublesome here because it would create a vacuum in a critically important area for the future of

healthcare. If reporting requirements like Vermont's were held invalid, States would be foreclosed from collecting information from employer-sponsored plans that are self-insured (except on a voluntary basis),* despite the fact that over a dozen States have determined that such informational efforts can improve their citizens' healthcare, lower costs, and enhance consumer choice. Pet. App. 7. That would create a significant gap; one study estimated that in 2011, 58.5% of workers were covered by self-insured health plans. Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, Emp. Benefit Res. Inst. Notes, Nov. 2012, at 2. Respondent has pointed to no evidence that Congress intended ERISA to thwart States' analytical initiatives. Particularly given that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation" by the States, *Travelers*, 514 U.S. at 661, this Court should be extremely reluctant to read such a broad preemptive scope into Section 1144(a).

c. There is another reason for caution before holding that the Vermont reporting requirements are preempted: Such a ruling would frustrate the objectives of other important federal statutory provisions.

In construing Section 1144(a), this Court has carefully attended to the objectives of other federal statutes, particularly in light of Section 1144(d), which provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair,

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* The court of appeals had no occasion to address whether its preemption holding applies to companies that insure ERISA plans, in light of Section 1144(b)(2)'s exemption from preemption for insurance regulation.

or supersede any law of the United States." Thus, for example, in *Travelers*, *supra*, the Court held a New York statute non-preempted in part because a federal statute subsequently enacted by the same Congress that enacted ERISA was "simply incompatible with pre-emption" of the state law. 514 U.S. at 666-667; see also *id.* at 667 n.6. Similarly, in *Shaw*, *supra*, the Court held that a New York law was not preempted "to the extent that the [law] provides a means of enforcing Title VII's commands." 463 U.S. at 102. The Court explained that the contrary view "would frustrate the goal of encouraging joint state/federal enforcement of Title VII." *Ibid.*

Here, provisions of the ACA rely on or encourage state data-collection efforts similar to Vermont's. Section 3021(a) of the ACA established the Center for Medicare and Medicaid Innovation (CMMI). See 124 Stat. 389 (42 U.S.C. 1315a). CMMI's charge is "to test innovative payment and service delivery models" that reduce costs "while preserving or enhancing the quality of care." 42 U.S.C. 1315a(a)(1). The ACA encourages CMMI to evaluate a variety of models, see 42 U.S.C. 1315a(b)(2)(B), including by "[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State," 42 U.S.C. 1315a(b)(2)(B)(xi). The ACA requires each model that CMMI tests to be evaluated by analyzing "the quality of care furnished under the model" and "the changes in spending under [Medicare, Medicaid and the Children's Health Insurance Program (CHIP)] by reason of the model." 42 U.S.C. 1315a(b)(4). In part because models may shift costs among different payers or have health effects that are not reflected in the Medicare, Medicaid, and CHIP

databases, access to comprehensive state-level databases is important for evaluating models. Accordingly, holding that initiatives like Vermont's are invalid would impede CMMI's statutory mission.

Congress also expressly recognized the importance of efforts to collect and analyze healthcare data in Section 10332 of the ACA. 124 Stat. 968 (42 U.S.C. 1395kk(e)). That provision requires the Secretary of HHS to make Medicare data available to entities that use claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. 1395kk(e)(2)(A). It is unlikely that Congress would have encouraged the development of such analytical efforts by making Medicare data available if it believed that States were prohibited by ERISA from obtaining data from other healthcare payers.

As discussed above (see pp. 3-4, *supra*), the ACA established new reporting requirements that apply to group health plans and insurance companies. 42 U.S.C. 300gg-15a, 300gg-17; see 29 U.S.C. 1185d(a). Respondent has not suggested that these new reporting requirements expand the scope of ERISA preemption in a way that is relevant to this case. Any such argument would conflict with the express terms of the ACA, which provides that "[n]othing in [ACA Title I, which includes the relevant provisions,] shall be construed to preempt any State law that does not prevent the application of the provisions of [ACA Title I]," 42 U.S.C. 18041(d). It would also conflict with ERISA itself. See 29 U.S.C. 1191(a)(2) ("Nothing in this part [29 U.S.C. 1181-1191c] shall be construed to affect or modify the provisions of section 1144 of [ERISA] with respect to group health plans."); see also 42 U.S.C.

300gg-23(a)(2). And in any event, those ACA reporting requirements focus on *plans* as such, seeking information on such matters as claims-payment policies, cost sharing for out-of-network coverage, enrollment figures, and whether certain types of benefits are being included in healthcare plans. 42 U.S.C. 300gg-15a (incorporating provisions of 42 U.S.C. 18031(e)(3)); 42 U.S.C. 300gg-17(a). They therefore would not fill the void left by invalidating state-level efforts to compile databases of healthcare-expenditure information across the board.

2. The Vermont reporting requirements do not exert an impermissible effect on the design or administration of ERISA plans

Because the Vermont reporting requirements operate in an area of traditional state regulation that is remote from the basic purposes of ERISA, they are entitled to a presumption against preemption under Section 1144(a). *Dillingham*, 519 U.S. at 330-332. That presumption could be overcome if the Vermont scheme, though not overtly directed at ERISA plans, nevertheless operated to prescribe binding rules for the design or administration of ERISA plans or exerted such powerful economic effects as to practically bind plan administrators to a particular course of conduct. But neither type of forbidden effect has been demonstrated here.

a. The purpose of ERISA's preemption provision is "to ensure that plans and plan sponsors [are] subject to a uniform body of benefits law" so that they are not required to "tailor[] * * * plans and employer conduct to the peculiarities of the law of each jurisdiction." *Ingersoll-Rand*, 498 U.S. at 142. That animating purpose "reflect[s] recognition of the administra-

tive realities of employee benefit plans": If multi-state plans were governed by different legal rules for core administrative functions, it "would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels." *Fort Halifax*, 482 U.S. at 9-10.

For that reason, this Court has held that state laws "relate to" ERISA plans under Section 1144(a) if they "bind[] ERISA plan administrators to a particular choice of rules" for "a central matter of plan administration." *Egelhoff*, 532 U.S. at 147-148. For example, this Court has held that laws "relate to" ERISA plans when they designate beneficiaries of ERISA plans, *id.* at 143; "forbid[] a method of calculating pension benefits that federal law permits," *De Buono*, 520 U.S. at 814-815 (citing *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)); or "require[] employers to provide certain benefits," *id.* at 815 (citing *Shaw*, *supra*, and *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985)).

Conversely, this Court has held that laws of general applicability that merely influence the choices made by ERISA sponsors or fiduciaries, but do not prescribe binding rules governing plan design or administration, are not preempted. See *Dillingham*, 519 U.S. at 329; *Travelers*, 514 U.S. at 657, 660, 664. If such laws were preempted, this Court has explained, the courts would "scarcely see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit nothing." *Dillingham*, 519 U.S. at 329. The Court accordingly has sustained laws that "increase[] [the] costs of providing certain benefits, and thereby potentially affect[] the choices made by ERISA plans," *ibid.*, or that exert only an "indirect economic

influence" by making certain plan-administration choices more economically attractive, *Travelers*, 514 U.S. at 659. ERISA thus does not guarantee "cost uniformity" among States where a plan might operate. *Id.* at 662. After all, ordinary tax, wage, property, and health laws can vary from State to State and entail substantial administrative costs.

b. The Vermont reporting requirements do not exert an impermissible effect on ERISA plans because they do not prescribe binding rules for a central matter of plan administration. The reporting provisions do not dictate features of ERISA plans—vesting requirements, benefit levels, and so forth—nor do they impose rules on plan administrators for how claims should be processed and paid. See Pet. App. 72. They do not enhance or alter plan administrators' fiduciary duties or supplement ERISA's remedial scheme. See *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 214-215 (2004). The Vermont scheme does not, in other words, dictate how a plan must be administered. It therefore differs fundamentally from, for example, state-law rules governing beneficiary designations, which, if sustained, would demand that a fiduciary maintain familiarity with every relevant State's laws just to complete the basic functions of plan administration. Cf. *Egelhoff*, *supra*.

The court of appeals rested its contrary holding on the notion that *all* "reporting"—which the court defined as "plan record-keeping[] and filing with a third-party"—is "a core ERISA function." Pet. App. 23-24. Based on that premise, the court held that any state law that imposes a reporting obligation on an ERISA plan that is more than "slight" is preempted. *Ibid.* (citing *Shaw*, 463 U.S. at 98).

That conclusion was erroneous, even accepting the court of appeals' belief that the burden here is more than "slight" (but see pp. 28-29, *infra*). ERISA imposes reporting and disclosure obligations that further the regulation of the design and administration of employee benefit plans. Those obligations are integral to achieving ERISA's purposes, because they enable the Department of Labor and plan participants to ensure that the plan is being administered properly. But that does not mean that all reporting incident to state laws of general applicability that operate in disparate fields—taxes, property, wages—qualify as "core ERISA function[s]." And while decisions of this Court and the legislative history of ERISA identify "reporting" and "disclosure" as a central ERISA subject matter, those brief general statements, read in context, are best understood to refer to reporting ancillary to the areas that ERISA governs, not to any reporting obligation that might be imposed on an ERISA plan incident to enforcing an otherwise applicable state law. *E.g.*, *Dillingham*, 519 U.S. at 330 (quoting *Travelers*, 514 U.S. at 661); see, *e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973).

Any other reading would be untenable in light of the many types of general state laws to which ERISA plans are subject and would conflict with the Court's holdings in other cases that state laws containing reporting or record-keeping requirements are not preempted. In *De Buono*, for example, this Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, see 520 U.S. at 809-810, 816, even though the administration of the tax required the filing of quarterly reports, see U.S. Amicus Br. at 2-3,

De Buono, *supra* (No. 95-1594). And in *Dillingham*, the Court held that California's prevailing-wage law was not preempted as applied to apprenticeship programs established as ERISA plans. See 519 U.S. at 319. Prevailing-wage laws typically require employers to keep records of the wages paid to employees and make them available for review by state authorities. See, *e.g.*, Cal. Lab. Code § 1776 (West 1989) (prevailing-wage law in *Dillingham*); see also, *e.g.*, *Keystone Chapter, Associated Builders & Contractors, Inc.* v. *Foley*, 37 F.3d 945, 962-963 (3d Cir. 1994), cert. denied, 514 U.S. 1032 (1995). And as petitioner points out (Pet. Br. 41), "ERISA contemplates that plans may offer * * * day care centers, training programs, and legal services"—activities that undoubtedly may be subject to state regulation and reporting requirements. 29 U.S.C. 1002(1). The court of appeals thus erred in concluding that any state-law reporting obligation that is more than "slight" is preempted.

For its part, respondent distinguishes (Br. in Opp. 26) other generally applicable state-law reporting obligations imposed on ERISA plans on the ground that the Vermont law "requires the reporting of information about core ERISA activities: the payment of claims under the plan." Cf. Pet. App. 29 n.13. Respondent essentially contends that all reporting that involves information acquired or generated during the administration of a plan qualifies as a core matter of plan administration.

That cannot be the test. Many generally applicable reporting requirements that apply to ERISA plans might seek for tax or other purposes information acquired or generated in the course of administering the plan—such as information about claims payments,

pension disbursements, employer contributions, or assets held in trust. An ERISA plan, after all, is not likely to have much information about matters not related to the administration of the plan. The gross-receipts reporting in *De Buono*, for example, concerned the amount of money that the plan was taking in through the medical centers that the plan was operating. The logical consequence of respondent's argument, therefore, is that almost no state-law reporting obligation would survive preemption, even those incident to otherwise valid laws of general applicability. Such a broad rule of preemption would conflict with this Court's reluctance to invalidate state laws that operate in areas to which ERISA does not speak and would reflect an unrealistic view of Congress's intent when it made reporting and disclosure in areas regulated by ERISA an exclusively federal concern.

c. This Court has suggested in dicta that "there might be a state law whose economic effects, intentionally or otherwise, were so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and such a state law might indeed be pre-empted." *De Buono*, 520 U.S. at 816 n.16 (quoting *Travelers*, 514 U.S. at 668) (internal quotation marks omitted). It is therefore conceivable that a state-law reporting obligation that does not impose binding legal requirements on the design or administration of ERISA plans could be so costly as to be preempted. And in considering whether such an extreme economic effect exists, it is appropriate to consider the effect of a potential patchwork of state laws imposing different requirements. See *Egelhoff*, 532 U.S. at 149-150.

But in the posture of this case, no sound basis exists to conclude that the Vermont reporting requirements burden ERISA plans in a qualitatively different or more substantial way than "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. Indeed, there is no reason to conclude that the reporting requirements impose anything more than a de minimis financial burden, because respondent made no effort to quantify those costs in its filings below. As the district court explained after reviewing respondent's summary-judgment submissions, "[t]here is no evidence that the law * * * creates an economic effect so acute as to dictate certain administrative choices." Pet. App. 72.

The court of appeals nevertheless stated that "the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky," particularly when considered "as one of several or a score of uncoordinated state reporting regimes." Pet. App. 25. Respondent contends (Br. in Opp. 20) that the court of appeals' view "reflects a common sense assessment of the administrative realities of ERISA plans."

The supposition that Vermont's requirements impose a substantial burden, however, is not obvious, or even particularly plausible, without any factual support. The Database Regulation essentially requires Blue Cross to take information generated in the ordinary course of its claims-payment operations and report that information in a prescribed format to the Board. Respondent has not suggested, let alone established, that Blue Cross has changed any aspect of its administration of the claims process because of

that reporting obligation. While organizing and formatting the data requires some administrative resources, it is implausible to assume that the additional cost would meaningfully alter the claims-payment process or any other aspect of the plan's administration. Indeed, Blue Cross presumably already has such procedures in place, given that it reports data to the Board for over 7000 individuals, see J.A. 205.

If the cost of compliance were in fact so significant as to alter Blue Cross's administration of claims, respondent could have submitted a declaration quantifying, or at least estimating, the burden, and explaining ways in which the reporting obligation has changed how its plan operates. Or it could have submitted evidence estimating or describing the burden for ERISA plans generally. Respondent's contentions then could have been subject to adversarial testing in the district court. But respondent's only factual submission was a "fact sheet" printed from the Internet stating that it would be less costly if States with similar statutes standardized their data formats—which says nothing about whether the cost is so great as to fundamentally affect plan administration. See J.A. 217-225; D. Ct. Doc. 59, at 2 (Oct. 7, 2012). Thus, as Judge Straub explained, "[o]n the record before [the court of appeals], there is no basis to find that the Vermont statute would cause [respondent] to increase its costs more than a *de* [*minimis*] amount to cover the cost of sending information to the state, much less that it would cause a fiduciary to change a plan in any way." Pet. App. 40-41 (dissenting in part and concurring in part).

B. The Vermont Reporting Requirements Are Valid If Reviewed Under General Principles Of Field And Conflict Preemption

In separate opinions, four Justices have called for this Court to clarify that its framework for analyzing ERISA preemption questions essentially applies ordinary principles of field and conflict preemption. Under that view, "the 'relate to' clause of the pre-emption provision is meant, not to set forth a *test* for pre-emption, but rather to identify the field in which ordinary *field pre-emption* applies—namely, the field of laws regulating 'employee benefit plan[s] described in section 1003(a) of this title and not exempt under section 1003(b) of this title,' 29 U.S.C. § 1144(a)." *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring, joined by Ginsburg, J.) (brackets in original); see *Egelhoff*, 532 U.S. at 152-153 (Scalia, J., concurring, joined by Ginsburg, J.); *id.* at 153 (Breyer, J., dissenting, joined by Stevens, J.). And in *Boggs* v. *Boggs*, 520 U.S. 833 (1997), the Court held a state law preempted "by simply asking if [the] state law conflicts with the provisions of ERISA or operates to frustrate its objects," without "inquir[ing] whether the statutory phrase 'relate to' provides further and additional support for the pre-emption claim." *Id.* at 841; cf. *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 375-377 (1999) (*UNUM*) (applying conflict-preemption analysis to state law falling within ERISA's insurance savings clause).

If the Court applies ordinary field and conflict preemption principles here as a means of giving content to (or checking the applicability of) the "relate to" language in Section 1144(a), the Vermont reporting requirements likewise are not preempted.

1. When a federal statute occupies a field of substantive regulation, the test for preemption "is whether the matter on which the State asserts the right to act is in any way regulated by the Federal Act." *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 236 (1947). If so, the state law is preempted, even if it is consistent with federal objectives. See *ONEOK, Inc.* v. *Learjet, Inc.*, 135 S. Ct. 1591, 1595 (2015); accord *Metropolitan Life Ins. Co.*, 471 U.S. at 739 ("[ERISA's] pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements."). But this Court has also kept "in mind that not every state law that in some remote way may affect the [subject matter of the federal statute] can be said to fall within the pre-empted field." *English* v. *General Elec. Co.*, 496 U.S. 72, 85 (1990).

Largely for the reasons given in Point A above, the Vermont reporting requirements do not improperly invade a field governed exclusively by ERISA. They do not target ERISA plans for special treatment. They have a different purpose and function than ERISA, focusing on the quality, utilization, and cost of medical services themselves, from a healthcare-delivery perspective, rather than the design of employee benefit plans or fiduciary conduct in delivering promised benefits to ERISA participants and beneficiaries. And the requirements have not been shown to exert more than a de minimis effect on the design or administration of ERISA plans.

2. a. Under conflict-preemption principles, a state law is invalid (as applied to ERISA plans) if "compliance with both [the state law] and [ERISA] is impossible, or when the state law stands as an obstacle to

the accomplishment and execution of the full purposes and objective of [ERISA]." *United States* v. *Locke*, 529 U.S. 89, 109 (2000) (citation and internal quotation marks omitted); see *Boggs*, 520 U.S. at 844. Thus, in *Boggs*, this Court held that a state law permitting a non-participant to effect a testamentary transfer of her spouse's undistributed pension benefits was preempted after finding a "direct clash between [the] state law and the provisions and objectives of ERISA" with respect to the designation of beneficiaries of survivor annuities. 520 U.S. at 843-844. Similarly, in a line of cases, this Court has held that certain state laws conflict with the objectives of ERISA's exclusive remedial scheme. See *Aetna Health*, 542 U.S. at 214-215. A law would also be preempted if it frustrated the central purpose of Section 1144(a) itself, which is to avoid "the prospect that an employer's administrative scheme would be subject to conflicting requirements." *Fort Halifax*, 482 U.S. at 9-10.

It is not impossible to comply with both ERISA's requirements and the Vermont reporting requirements. And for the reasons given above (see pp. 22-29, *supra*), no sound basis exists to conclude that the requirements would pose an obstacle to the uniform administration of ERISA plans.

b. Respondent has contended (Br. in Opp. 22-23) that the Vermont scheme conflicts with ERISA's requirement that fiduciaries follow plan documents, 29 U.S.C. 1104(a)(1)(D), because the plan documents in this case required respondent and Blue Cross to maintain the confidentiality of the medical records of participants and beneficiaries. Respondent essentially argues that a plan sponsor can evade a state legal obligation by drafting an incompatible plan term. But

this Court rejected a materially identical argument in *UNUM*, where it held that an otherwise non-preempted state insurance law did not conflict with Section 1104(a)(1)(D) merely because a plan sponsor had "insert[ed] a contrary term in plan documents," finding that argument to "make[] scant sense." 526 U.S. at 375-376; see *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54-65 (1990) (analyzing whether ERISA preempted a state law prohibiting a particular plan term under the normal ERISA preemption framework).

As support for its anomalous position, respondent cites a footnote in *Egelhoff*, *supra* (Br. in Opp. 22-24), but respondent misunderstands the import of that discussion. *Egelhoff* held preempted, as applied to ERISA plans, a Washington statute providing that the designation of a spouse as a beneficiary of a nonprobate asset was revoked automatically upon divorce. 532 U.S. at 144 (citing Wash. Rev. Code § 11.07.010(1) (1994)). The Court rejected the argument that the Washington statute was saved from preemption because employers could opt out of the automatic-revocation rule through an express plan term. See *id.* at 150-151. In the cited footnote, the Court merely observed that a State could not save an otherwise preempted law from invalidation by permitting ERISA plan sponsors to opt out by changing the terms of their plans, see *id.* at 151 n.4, and the Court went on to highlight the significant burden for fiduciaries in "maintain[ing] a familiarity with the laws of all 50 States so that they can update their plans as necessary," *id.* at 151. Nothing in the Court's discussion, however, supports the view that a state law that is otherwise *not* preempted could be circumvented by

a contrary term in a particular plan, an argument this Court rejected in *UNUM*.

In any event, there is no evident conflict between the terms of respondent's plan and the Vermont reporting requirements. No provision of respondent's plan documents states that the plan will refuse to report claims information to state authorities in compliance with state law. To the contrary, the primary plan document expressly provides that "[t]he Plan shall comply with all * * * state and federal law to the extent not preempted by ERISA." J.A. 57. Respondent appears to rely on two statements in a summary plan description stating that information relating to "well-baby programs" and "pharmagenomics" will be kept confidential. J.A. 117-120 (capitalization and emphasis omitted); see Resp. C.A. Br. 7. But respondent's primary plan document states that it trumps conflicting statements in the summary plan description, J.A. 40; the cited statements relate only to very specific medical programs; and, in any event, the extensive confidentiality protections of the Vermont scheme (see p. 6, *supra*) preserve the confidentiality of reported information, see Database Statute § 9410(e) and (h)(2) (Supp. 2014). Accordingly, even if ERISA called on courts to conduct the sort of plan-by-plan preemption analysis that respondent suggests—in which the validity of state law would be entirely subordinate to plan terms—preemption would not be warranted here.

c. Finally, respondent argued below that by complying with state-law reporting requirements, an ERISA fiduciary would violate its statutory duty to act "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); see Resp. C.A. Br. 39-40. If accepted, that argument not only would preclude States from imposing any reporting requirements, but would also bar States from imposing taxes and other generally applicable obligations on ERISA plans that serve purposes other than providing benefits and defraying administrative expenses. Congress could not have intended ERISA's fiduciary-duties provision to have that sweeping preemptive effect. And like respondent's other arguments, it cannot be squared with this Court's more circumscribed understanding of ERISA preemption or its decisions upholding state laws imposing obligations on ERISA plans.

* * * * *

For the foregoing reasons, whether under this Court's established framework for analyzing preemption questions under Section 1144(a), or viewed through the lens of ordinary field and conflict preemption, the Vermont reporting requirements are not preempted. Thus, like other record-keeping and reporting requirements incident to state tax, wage, property, and health laws, the Vermont reporting requirements are among the "myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *De Buono*, 520 U.S. at 815 (citation and internal quotation marks omitted).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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SEPTEMBER 2015

APPENDIX

1. 29 U.S.C. 1001 provides:

Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax

treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

2. 29 U.S.C. 1002(1) provides:

Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section

186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

3. 29 U.S.C. 1021(a) and (b) provide:

Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 1022(a)(1)[1] of this title; and

(2) the information described in subsection (f) and sections 1024(b)(3) and 1025(a) and (c) of this title.

(b) Reports to be filed with Secretary of Labor

The administrator shall, in accordance with section 1024(a) of this title, file with the Secretary—

(1) the annual report containing the information required by section 1023 of this title; and

(2) terminal and supplementary reports as required by subsection (c) of this section.

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[1] See References in Text note below.

4. 29 U.S.C. 1023 provides in pertinent part:

Annual reports

(a) Publication and filing

(1)(A) An annual report shall be published with respect to every employee benefit plan to which this part applies. Such report shall be filed with the Secretary in accordance with section 1024(a) of this title, and shall be made available and furnished to participants in accordance with section 1024(b) of this title.

(B) The annual report shall include the information described in subsections (b) and (c) and where applicable subsections (d), (e), and (f) and shall also include—

(i) a financial statement and opinion, as required by paragraph (3) of this subsection, and

(ii) an actuarial statement and opinion, as required by paragraph (4) of this subsection.

* * * * *

(3)(A) Except as provided in subparagraph (C), the administrator of an employee benefit plan shall engage, on behalf of all plan participants, an independent qualified public accountant, who shall conduct such an examination of any financial statements of the plan, and of other books and records of the plan, as the accountant may deem necessary to enable the accountant to form an opinion as to whether the financial statements and schedules required to be included in the annual reports by subsection (b) of this section are presented fairly in conformity with generally accepted

accounting principles applied on a basis consistent with that of the preceding year.

* * * * *

(4)(A) The administrator of an employee pension benefit plan subject to the reporting requirement of subsection (d) of this section shall engage, on behalf of all plan participants, an enrolled actuary who shall be responsible for the preparation of the materials comprising the actuarial statement required under subsection (d) of this section.

* * * * *

(b) Financial statement

An annual report under this section shall include a financial statement containing the following information:

(1) With respect to an employee welfare benefit plan: a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other

matters necessary to fully and fairly present the financial statements of the plan.

* * * * *

(3) With respect to all employee benefit plans, the statement required under paragraph (1) or (2) shall have attached the following information in separate schedules:

(A) a statement of the assets and liabilities of the plan aggregated by categories and valued at their current value, and the same data displayed in comparative form for the end of the previous fiscal year of the plan;

(B) a statement of receipts and disbursements during the preceding twelve-month period aggregated by general sources and applications;

(C) a schedule of all assets held for investment purposes aggregated and identified by issuer, borrower, or lessor, or similar party to the transaction (including a notation as to whether such party is known to be a party in interest), maturity date, rate of interest, collateral, par or maturity value, cost, and current value;

(D) a schedule of each transaction involving a person known to be party in interest, the identity of such party in interest and his relationship or that of any other party in interest to the plan, a description of each asset to which the transaction relates; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expense incurred in connection with the transaction; the cost of the asset, the

current value of the asset, and the net gain (or loss) on each transaction;

(E) a schedule of all loans or fixed income obligations which were in default as of the close of the plan's fiscal year or were classified during the year as uncollectable and the following information with respect to each loan on such schedule (including a notation as to whether parties involved are known to be parties in interest): the original principal amount of the loan, the amount of principal and interest received during the reporting year, the unpaid balance, the identity and address of the obligor, a detailed description of the loan (including date of making and maturity, interest rate, the type and value of collateral, and other material terms), the amount of principal and interest overdue (if any) and an explanation thereof;

(F) a list of all leases which were in default or were classified during the year as uncollectable; and the following information with respect to each lease on such schedule (including a notation as to whether parties involved are known to be parties in interest): the type of property leased (and, in the case of fixed assets such as land, buildings, leasehold, and so forth, the location of the property), the identity of the lessor or lessee from or to whom the plan is leasing, the relationship of such lessors and lessees, if any, to the plan, the employer, employee organization, or any other party in interest, the terms of the lease regarding rent, taxes, insurance, repairs, expenses, and renewal options; the date the leased property was purchased and its cost, the date the property was leased and its approximate value at such date, the gross rental receipts during the

reporting period, expenses paid for the leased property during the reporting period, the net receipts from the lease, the amounts in arrears, and a statement as to what steps have been taken to collect amounts due or otherwise remedy the default;

(G) if some or all of the assets of a plan or plans are held in a common or collective trust maintained by a bank or similar institution or in a separate account maintained by an insurance carrier or a separate trust maintained by a bank as trustee, the report shall include the most recent annual statement of assets and liabilities of such common or collective trust, and in the case of a separate account or a separate trust, such other information as is required by the administrator in order to comply with this subsection; and

(H) a schedule of each reportable transaction, the name of each party to the transaction (except that, in the case of an acquisition or sale of a security on the market, the report need not identify the person from whom the security was acquired or to whom it was sold) and a description of each asset to which the transaction applies; the purchase or selling price in case of a sale or purchase, the rental in case of a lease, or the interest rate and maturity date in case of a loan; expenses incurred in connection with the transaction; the cost of the asset, the current value of the asset, and the net gain (or loss) on each transaction. For purposes of the preceding sentence, the term "reportable transaction" means a transaction to which the plan is a party if such transaction is—

(i) a transaction involving an amount in excess of 3 percent of the current value of the assets of the plan;

(ii) any transaction (other than a transaction respecting a security) which is part of a series of transactions with or in conjunction with a person in a plan year, if the aggregate amount of such transactions exceeds 3 percent of the current value of the assets of the plan;

(iii) a transaction which is part of a series of transactions respecting one or more securities of the same issuer, if the aggregate amount of such transactions in the plan year exceeds 3 percent of the current value of the assets of the plan; or

(iv) a transaction with or in conjunction with a person respecting a security, if any other transaction with or in conjunction with such person in the plan year respecting a security is required to be reported by reason of clause (i).

(4) The Secretary may, by regulation, relieve any plan from filing a copy of a statement of assets and liabilities (or other information) described in paragraph (3)(G) if such statement and other information is filed with the Secretary by the bank or insurance carrier which maintains the common or collective trust or separate account.

(c) Information to be furnished by administrator

The administrator shall furnish as a part of a report under this section the following information:

(1) The number of employees covered by the plan.

(2) The name and address of each fiduciary.

(3) Except in the case of a person whose compensation is minimal (determined under regulations of the Secretary) and who performs solely ministerial duties (determined under such regulations), the name of each person (including but not limited to, any consultant, broker, trustee, accountant, insurance carrier, actuary, administrator, investment manager, or custodian who rendered services to the plan or who had transactions with the plan) who received directly or indirectly compensation from the plan during the preceding year for services rendered to the plan or its participants, the amount of such compensation, the nature of his services to the plan or its participants, his relationship to the employer of the employees covered by the plan, or the employee organization, and any other office, position, or employment he holds with any party in interest.

(4) An explanation of the reason for any change in appointment of trustee, accountant, insurance carrier, enrolled actuary, administrator, investment manager, or custodian.

(5) Such financial and actuarial information including but not limited to the material described in subsections (b) and (d) of this section as the Secretary may find necessary or appropriate.

(d) Actuarial statement

With respect to an employee pension benefit plan (other than (A) a profit sharing, savings, or other plan, which is an individual account plan, (B) a plan described in section 1081(b) of this title, or (C) a plan described both in

section 1321(b) of this title and in paragraph (1), (2), (3), (4), (5), (6), or (7) of section 1081(a) of this title) an annual report under this section for a plan year shall include a complete actuarial statement applicable to the plan year which shall include the following:

* * * * *

(e) Statement from insurance company, insurance service, or other similar organizations which sell or guarantee plan benefits

If some or all of the benefits under the plan are purchased from and guaranteed by an insurance company, insurance service, or other similar organization, a report under this section shall include a statement from such insurance company, service, or other similar organization covering the plan year and enumerating—

(1) the premium rate or subscription charge and the total premium or subscription charges paid to each such carrier, insurance service, or other similar organization and the approximate number of persons covered by each class of such benefits; and

(2) the total amount of premiums received, the approximate number of persons covered by each class of benefits, and the total claims paid by such company, service, or other organization; dividends or retroactive rate adjustments, commissions, and administrative service or other fees or other specific acquisition costs paid by such company, service, or other organization; any amounts held to provide benefits after retirement; the remainder of such premiums; and the names and addresses of the brokers, agents, or other persons to whom commissions or fees were paid, the amount paid

to each, and for what purpose. If any such company, service, or other organization does not maintain separate experience records covering the specific groups it serves, the report shall include in lieu of the information required by the foregoing provisions of this paragraph (A) a statement as to the basis of its premium rate or subscription charge, the total amount of premiums or subscription charges received from the plan, and a copy of the financial report of the company, service, or other organization and (B) if such company, service, or organization incurs specific costs in connection with the acquisition or retention of any particular plan or plans, a detailed statement of such costs.

(f) Additional information with respect to defined benefit plans

(1) Liabilities under 2 or more plans

(A) In general

In any case in which any liabilities to participants or their beneficiaries under a defined benefit plan as of the end of a plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under 2 or more pension plans as of immediately before such plan year, an annual report under this section for such plan year shall include the funded percentage of each of such 2 or more pension plans as of the last day of such plan year and the funded percentage of the plan with respect to which the annual report is filed as of the last day of such plan year.

* * * * *

5. 29 U.S.C. 1024 provides in pertinent part:

Filing with Secretary and furnishing information to participants and certain employers

(a) Filing of annual report with Secretary

(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing). The Secretary shall make copies of such annual reports available for inspection in the public document room of the Department of Labor.

(2)(A) With respect to annual reports required to be filed with the Secretary under this part, he may by regulation prescribe simplified annual reports for any pension plan which covers less than 100 participants.

(B) Nothing contained in this paragraph shall preclude the Secretary from requiring any information or data from any such plan to which this part applies where he finds such data or information is necessary to carry out the purposes of this subchapter nor shall the Secretary be precluded from revoking provisions for simplified reports for any such plan if he finds it necessary to do so in order to carry out the objectives of this subchapter.

(3) The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this subchapter, or may provide for simplified reporting and disclosure if

he finds that such requirements are inappropriate as applied to welfare benefit plans.

* * * * *

6. 29 U.S.C. 1104(a)(1) provides:

Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

7. 29 U.S.C. 1134(a) provides in pertinent part:

Investigative authority

(a) Investigation and submission of reports, books, etc.

The Secretary shall have the power, in order to determine whether any person has violated or is about to violate any provision of this subchapter or any regulation or order thereunder—

(1) to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this subchapter, and

(2) to enter such places, inspect such books and records and question such persons as he may deem necessary to enable him to determine the facts relative to such investigation, if he has reasonable cause to believe there may exist a violation of this subchapter or any rule or regulation issued thereunder or if the entry is pursuant to an agreement with the plan.

* * * * *

8. 29 U.S.C. 1143(a) provides:

Research, studies, and reports

(a) Authorization to undertake research and surveys

(1) The Secretary is authorized to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and sta-

tistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans, and types of plans not subject to this chapter.

(2) The Secretary is authorized and directed to undertake research studies relating to pension plans, including but not limited to (A) the effects of this subchapter upon the provisions and costs of pension plans, (B) the role of private pensions in meeting the economic security needs of the Nation, and (C) the operation of private pension plans including types and levels of benefits, degree of reciprocity or portability, and financial and actuarial characteristics and practices, and methods of encouraging the growth of the private pension system.

(3) The Secretary may, as he deems appropriate or necessary, undertake other studies relating to employee benefit plans, the matters regulated by this subchapter, and the enforcement procedures provided for under this subchapter.

(4) The research, surveys, studies, and publications referred to in this subsection may be conducted directly, or indirectly through grant or contract arrangements.

9. 29 U.S.C. 1144 provides in pertinent part:

Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of

this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

* * * * *

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

* * * * *

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede

any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

10. 29 U.S.C. 1185d provides:

Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act [42 U.S.C. 300gg-16, 300gg-18] (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to

such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

11. 29 U.S.C. 1191(a) provides:

Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

12. 29 U.S.C. 1191b(a)-(b) provides in pertinent part:

Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term "group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) Medical care

The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

* * * * *

13. 42 U.S.C. 300gg-15a provides:

Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and

the State insurance commissioner, and make such information available to the public.

14. 42 U.S.C. 300gg-17 provides in pertinent part:

Ensuring the quality of care

(a) Quality reporting

(1) In general

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602[1] of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge

[1] See References in Text note below.

planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) Reporting requirements

(A) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

* * * * *

(b) Wellness and prevention programs

For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of

the program's participants, and which may include the following wellness and prevention efforts:

(1) Smoking cessation.

(2) Weight management.

(3) Stress management.

(4) Physical fitness.

(5) Nutrition.

(6) Heart disease prevention.

(7) Healthy lifestyle support.

(8) Diabetes prevention.

* * * * *

(d) Regulations

Not later than 2 years after March 23, 2010, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

(e) Study and report

Not later than 180 days after the date on which regulations are promulgated under subsection (c),[2] the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact

[2] So in original. Probably should be "subsection (d),".

the activities under this section have had on the quality and cost of health care.

15. 42 U.S.C. 300gg-23(a) provides:

Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part and part C of this subchapter insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of title 29 with respect to group health plans.

16. 42 U.S.C. 1315a provides in pertinent part:

Center for Medicare and Medicaid Innovation

(a) Center for Medicare and Medicaid Innovation established

(1) In general

There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the "CMI") to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable subchapters while preserving or enhancing the quality of care furnished to individuals under such subchapters. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

* * * * *

(b) Testing of models (phase I)

(1) In general

The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable subchapter (as defined in subsection (a)(4)(B)) on program expenditures under such subchapters and the quality of care received by individuals receiving benefits under such subchapter.

(2) Selection of models to be tested

(A) In general

The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

(B) Opportunities

The models described in this subparagraph are the following models:

* * * * *

(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

* * * * *

(4) Evaluation

(A) In general

The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

(ii) the changes in spending under the applicable subchapters by reason of the model.

* * * * *

17. 42 U.S.C. 1395kk(e) (as amended by Pub. L. No. 114-10, § 105(c), 129 Stat. 137) provides in pertinent part:

Administration of insurance programs

(e) Availability of data

(1) In general

Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data described in paragraph (3) for the evaluation of the performance of providers of services and suppliers.

(2) Qualified entities

For purposes of this subsection, the term "qualified entity" means a public or private entity that—

(A) is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

(B) agrees to meet the requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(3) Data described

The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for items and services furnished under such parts for one or more specified geographic areas and time periods requested by a qualified entity. Beginning July 1, 2016, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under subchapters XIX and XXI for assistance provided under such subchapters for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts or under subchapters[2] XIX or XXI.

* * * * *

[2] So in original. Probably should be "subchapter".

18. 42 U.S.C. 18031(e)(3) provides:

Affordable choices of health benefit plans

(e) Certification

(3) Transparency in coverage

(A) In general

The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under this title.[3]

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[3] See References in Text note below.

(ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language

The information required to be submitted under subparagraph (A) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency

The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans

The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accu-

rate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

19. 42 U.S.C. 18041(d) provides:

State flexibility in operation and enforcement of Exchanges and related requirements

(d) No interference with State regulatory authority

Nothing in this title[1] shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[1]

20. Vt. Stat. Ann. tit. 18, § 9401 (2012) provides:

Policy

(a) It is the policy of the state of Vermont that health care is a public good for all Vermonters and to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

(b) It is further the policy of the state of Vermont that the health care system should:

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[1] See references in Text note below.

(1) Maintain and improve the quality of health care services offered to Vermonters.

(2) Utilize planning, market, and other mechanisms that contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Vermonters' incomes or the moneys available for other services required to insure the health, safety, and welfare of Vermonters.

(3) Encourage regional and local participation in decisions about health care delivery, financing, and provider supply.

(4) Utilize planning, market, and other mechanisms that will achieve rational allocation of health care resources in the state.

(5) Facilitate universal access to preventive and medically necessary health care.

(6) Support efforts to integrate mental health and substance abuse services with overall medical care.

21. Vt. Stat. Ann. tit. 18, § 9402(8) (2012) provides:

Definitions

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organizations, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

22. Vt. Stat. Ann. tit. 18, § 9410 (Supp. 2014) provides:

Health care database

(a)(1) The Board shall establish and maintain a unified health care database to enable the Commissioner and the Board to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) determining the capacity and distribution of existing resources;

(B) identifying health care needs and informing health care policy;

(C) evaluating the effectiveness of intervention programs on improving patient outcomes;

(D) comparing costs between various treatment settings and approaches;

(E) providing information to consumers and purchasers of health care; and

(F) improving the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) The Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this State to file with the Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the Commissioner.

(C) The Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this State, and health care utilization and costs for services provided to Vermont residents in another state.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed.

(d) The Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation.

The Board may impose an administrative penalty of not more than $10,000.00 each for those violations the Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the Board in accordance with standards and procedures adopted by the Board by rule:

(A) their health insurance claims data, provided that the Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be

governed exclusively by the regulations adopted thereunder in 45 C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the Board in a form and in a manner prescribed by the Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The Board shall collaborate with the Agency of Human Services and participants in the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited-use data sets, the criteria and procedures to ensure that HIPAA compliant limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, de-

mographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the Board may prescribe by rule, the Vermont Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont Program for Quality in Health Care shall agree to abide by the rules and procedures established by the Board for access to the data. The Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the Commissioner shall submit a recommendation to the General Assembly for conducting a survey of the health insurance status of Vermont residents. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subsection.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the State of Vermont or an agency or instrumentality of the State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The Board may adopt rules to carry out the provisions of this subsection, including criteria for the required filing of such claims data, eligibility data, provider files, and other information as the Board determines to be necessary to carry out the purposes of this section and this chapter.

23. Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) provides in pertinent part:

Section 1. Purpose.

The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care Administration and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of 18 V.S.A. § 9410.

* * * * *

Section 3. Definitions.

As used in this Rule

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I. "Data set" means a collection of individual data records, whether in electronic or manual files.

* * * * *

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health infor-

mation is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

* * * * *

P. "Health benefit plan" means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Q. "Healthcare claims data" means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. "Healthcare claims data" does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

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T. "Health care" means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dis-

pensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR § 160.103].

U. "Health care facility" shall be defined as per 18 V.S.A § 9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. § 9432.

W. "Health information" means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR § 160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§ 9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may

also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

* * * * *

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

* * * * *

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. § 9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any non-residents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

* * * * *

Ag. "Payer" means a third-party payer or third-party administrator.

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Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

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Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.

* * * * *

Aq. "Third-party Administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contribu-

tions or premiums for, or adjusts or settles claims on or for residents of this State or Vermont health care providers and facilities.

Ar. "Vermont Healthcare Claims Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting of eligibility, claims and related data submitted pursuant to 18 V.S.A. § 9410.

As. "Voluntary Reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.

Section 4. Reporting Requirements.

Registration and Reporting Requirements

A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides third party admin-

istration services, a third party administrator or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. § 9410. See Appendix G.

C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. § 9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont enrollees or beneficiaries. 18 V.S.A. § 9471. See Appendix H.

D. Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and nonresidents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the data submission requirements contained in the appendices to this Rule.

E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and

submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.

Section 5. Required Healthcare Data Files.

Mandated Reporters shall submit to BISHCA or its designee health care claims data for all members who are Vermont residents and all non-residents who received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless such subcontractor is already submitting the identical data as a Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes.

A. General Requirements for Data Submission

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(5) Codes and Encryption Requirements

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryp-

tion methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

* * * * *

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

* * * * *

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Non-required text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and

decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a)

(1) Member Eligibility File Specifications —Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats—Appendix C-2

(b)

(1) Medical Claims File Specifications—Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats—Appendix D-2

(c)

(1) Pharmacy Claims File Specifications—Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats—Appendix E-2

Section 6. Submission Requirements.

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the regis-

tration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files. Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and E-mail address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter shall submit to BISHCA or its desigee a data set for comparison to

the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section.

F. Rejection of Files. Failure to conform to subsections A, B, or C of this Section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to BISHCA or its designee within 10 days.

* * * * *

Section 8. Procedures for the Approval and Release of Claims Data.

The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall depend upon the requestor and the characteristics of the particular information requested, all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research

Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance.

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C. Limited Use Health Care Claims Research Data Sets—Release and Availability

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(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

* * * * *

Section 10. Enforcement.

Violations of data submission requirements, confidentiality requirements, data use limitations or any other provisions of this rule shall be subject to sanction by the Commissioner as set out in 18 V.S.A. § 9410 in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies.

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