

12-4881

In the United States Court of Appeals
for the Second Circuit

Liberty Mutual Insurance Company,
Plaintiff-Appellant,

v.

Susan L. Donegan, in her capacity
as the Commissioner of the Vermont
Department of Financial Regulation
Defendant-Appellee,

On Appeal from the United States District Court for the District of Vermont
(Hon. William K. Sessions III)

BRIEF FOR AMICUS CURIAE ACTING SECRETARY OF THE UNITED
STATES DEPARTMENT OF LABOR IN SUPPORT OF DEFENDANT-
APPELLEE REQUESTING AFFIRMANCE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES	iii
STATEMENT OF INTEREST	1
STATEMENT OF THE ISSUE.....	1
STATEMENT OF THE CASE.....	1
SUMMARY OF ARGUMENT	5
ARGUMENT	6
ERISA DOES NOT PREEMPT THE VERMONT LAW'S REPORTING REQUIREMENTS	6
A. The ERISA Preemption Standard.....	6
B. The Vermont Law Is Subject To The Presumption Against Preemption Because It Operates In A Field Traditionally Regulated By The States.....	9
C. The Vermont Law Is Not Preempted Because It Does Not Interfere With The Uniform Administration Of Employee Benefit Plans, Impermissibly Dictate Plan Choices, Or Conflict With ERISA's Terms Or Purposes.....	11
D. ERISA's Legislative History Does Not Support Preemption Of The Vermont Law	20
E. The History Of The Hawaii Prepaid Health Act Is Irrelevant To Determining The Scope Of Reporting Laws Preempted by ERISA....	25
F. Liberty Mutual Does Not Run Afoul Of ERISA Section 404(a)(1)(A) Or The Plan Document Rule By Complying With Vermont's Reporting Law	28

TABLE OF CONTENTS—(cont'd)

CONCLUSION30

CERTIFICATE OF COMPLIANCE

CERTIFICATE OF SERVICE

TABLE OF AUTHORITIES

Federal Cases:

<u>Aetna Health Inc. v. Davila</u> , 542 U.S. 200 (2004).....	7
<u>Aetna Life Ins., Co. v. Borges</u> , 869 F.2d 142 (2d Cir. 1989).....	12
<u>Boggs v. Boggs</u> , 520 U.S. 833 (1997).....	7, 13
<u>Burgio and Campofelice, Inc. v. New York State Dept. of Labor</u> , 107 F.3d 1000 (1997).....	15
<u>California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc.</u> , 519 U.S. 316 (1997).....	7 & passim
<u>CIGNA Corp. v. Amara</u> , 131 S.Ct. 1866 (2011).....	12
<u>De Buono v. NYSA-ILA Med. & Clinical Servs. Fund</u> , 520 U.S. 806 (1997).....	6 & passim
<u>DeFelice v. Aetna U.S. Healthcare</u> , 346 F.3d 442 (3d Cir. 2003).....	21
<u>Engelhoff v. Engelhoff.</u> , 532 U.S. 141 (2001).....	15 n.4
<u>FMC Corp. v. Holliday</u> , 498 U.S. 52 (1990).....	20, 28
<u>Fort Halifax Packing Co. v. Coyne</u> , 482 U.S. 1 (1987).....	11, 12, 14, 17, 18, 27

Federal Cases--(continued):

<u>General Elec.Co. v. New York State Dept. Of Labor,</u> 891 F.2d 25 (2d Cir. 1989).....	16, 16 n.6, 17
<u>Gerosa v. Savasta & Co., Inc.,</u> 329 F.3d 317 (2d Cir. 2003).....	7 n.2
<u>Golden Gate Restaurant Ass'n v. City & County of San Francisco,</u> 546 F.3d (9th Cir. 2008).....	27
<u>Hattem v. Schwarzenegger,</u> 449 F.3d 423 (2d Cir. 2006).....	7, 8
<u>Hillsborough County v. Automated Medical Laboratories, Inc.,</u> 471 U.S. 707(1985)	9
<u>HMI Mech. Sys., Inc. v. McGowan,</u> 266 F.3d 142 (5th Cir. 1994).....	16, 16 n.7, 17
<u>Hook v. Morrison Milling Co.,</u> 38 F.3d 776 (8th Cir. 1988).....	29
<u>Howard v. Gleason Corp.,</u> 901 F.2d 1154 (2d Cir. 1990).....	16 n.6
<u>Illinois Bd. of Elections v. Socialist Workers Party,</u> 440 U.S. 173 (1979).....	26
<u>Ingersoll-Rand Co. v.McClendon,</u> 498 U.S. 133 (1990).....	8

Federal Cases--(continued):

<u>John Hancock Mut. Life Ins. Co. v. Harris Trust,</u> 510 U.S. 86 (1993)	8, 14
<u>Kentucky Ass'n of Health Plans v. Miller,</u> 538 U.S. 329 (2003)	25 n.11
<u>Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley,</u> 37 F.3d 945 (3rd Cir. 1994)	15
<u>Mackey v. Lanier Collection Agency & Serv.,</u> 486 U.S. 825 (1988)	7, 8, 10, 18
<u>Mobil v. Allapattah Serv., Inc.,</u> 545 U.S. 546 (2005)	21
<u>New York State Conference of Blue Cross v. Travelers Ins.,</u> 514 U.S. 645 (1995)	6 & passim
<u>Rebaldo v. Cuomo,</u> 749 F.2d 133 (2d Cir. 1984)	7, 7 n.2
<u>Schulz v. Williams,</u> 44 F.3d 48 (2d Cir. 1994)	26
<u>Shaw v. Delta Air Lines, Inc.,</u> 463 U.S. 85 (1983)	6
<u>Standard Oil, Co. of Cal. v. Agsalud,</u> 633 F.2d 790 (9th Cir. 1989), <u>aff'd mem.</u> , 454 U.S. 801(1981)	25, 26, 27
<u>Steel Institute v. City of New York,</u> 716 F.3d 31 (2d Cir. 2013)	13 n.3

Federal Cases--(continued):

United Wire, Metal & Mach. Health & Welfare fund v. Morristown Memorial Hosp.,
995 F.2d 1179 (3d Cir. 1993)..... 7, 7 n.2

Statutes:

18 VSA § 9410(a)(1).....1

National Health Planning and Resources Development Act of 1974,
Pub. L. 93-641, § 1513(b), 88 Stat. 2225 (1975)..... 21, 22, 22 n.8, 23 n.10

Patient Protection and Affordable Care Act of 2010,
Pub. L. 111-148, § 1332(c) (2010)..... 22 n.9

Employee Retirement Income Security Act of 1974,
as amended, 29 U.S.C. 1001 et seq:

Section 2, 29 U.S.C. § 10011

Section 3(13), 29 U.S.C. § 1002(13).....1

Section 101, 29 U.S.C. § 102112

Section 102, 29 U.S.C. § 102212

Section 103, 29 U.S.C. § 102312

Section 104, 29 U.S.C. § 102412

Section 105, 29 U.S.C. § 102512

Section 106, 29 U.S.C. § 102612

Section 107, 29 U.S.C. § 102712

Section 108, 29 U.S.C. § 102812

Statutes--(continued):

Section 109, 29 U.S.C. § 1029.....12

Section 110, 29 U.S.C. § 1030.....12

Section 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A)28

Section 506, 29 U.S.C. § 1136.....1

Section 513(a)(1), 29 U.S.C. § 1143(a)(1).....13

Section 514(a), 29 U.S.C. § 1144(a)6

Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)..... 6, 25 n.11

Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) 25 n.11

Section 514(d), 29 U.S.C. § 1144(d).....6

Miscellaneous:

Fed. R. App. P. 29(a)1

Application, Review, and Reporting Process for Waivers for State Innovation,
76 Fed. Reg. 13553 (proposed Mar. 14, 2011) 22 n.9

S. Rep. No. 93-127, (1973)
as reprinted in 1974 U.S.C.C.A.N. 4838, 487120

H. R. Rep. No. 93-533, (1973)
as reprinted in 1974 U.S.C.C.A.N. 4639, 465520

M. Jensen, Is ERISA Preemption Superfluous In The New Age Of Health Care Reform?, 2011 Colum. Bus. L. Rev. 464 (2011)..... 22 n.9

STATEMENT OF INTEREST

This case raises an important question of whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., as amended, preempts the reporting requirements imposed on administrators of self-insured plans by Vermont's "Health Care Database" statute, 18 VSA § 9410(a)(1). The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b), and has participated as amicus curiae in many ERISA preemption cases. The Secretary has authority to file this brief under Fed. R. App. P. 29(a).

STATEMENT OF THE ISSUE

Whether ERISA preempts the provisions of Vermont's "Health Care Database" statute, 18 VSA § 9410(a)(1), requiring self-insured plans and their third party administrators, among other entities, to provide the state with participant eligibility and claims data.

STATEMENT OF THE CASE

1. In October 2011, the state of Vermont enacted a statute requiring the establishment and maintenance of a health care database to enable it to carry out duties related to improving health care delivery in Vermont. [SPA-4] The database is designed to enable the Department of Financial Regulation to determine the capacity of existing resources, identify health care needs, evaluate

effectiveness, compare costs, provide information to consumers and purchasers of health care, and improve the quality and affordability of patient health care and health care coverage. [SPA-5] The statute requires health insurers, providers, facilities, and governmental agencies to "file reports, data, schedules, statistics, or other information determined by the commissioner¹ to be necessary to carry out the purposes of this section." [SPA 37] The term "health insurer" is defined broadly to include third party administrators, pharmacy benefit managers, Vermont government and federal government health plans, health insurance companies, nonprofit hospitals and medical service corporations. [SPA-45] Most importantly for this case, the definition includes any administrator of a self-insured benefit plan. [SPA-45] "Health insurers" are required to provide Vermont with enrollment and claims information and "any other information relating to health care costs, prices, quality, utilization, or resources." [SPA 37]

Regulation H-2008-01 implements the Vermont health care database and establishes the Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES"). [SPA-5] The regulation "sets forth the requirements for submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont

¹ Commissioner of the Department of Financial Regulation (formerly known as the Banking, Insurance, Securities and Health Care Administration).

health care providers and facilities." [SPA-41] These requirements include specific formats and intervals for the reporting of claims data to the state. [SPA 48-49] The statute and regulation contain provisions for the protection of confidential information, including a prohibition on submitting and publishing data files that contain direct personal identifiers. [SPA 7-8]

2. Liberty Mutual, an insurance company with offices in Vermont, established the Liberty Mutual Medical Plan, a self-funded ERISA welfare plan, for the benefit of its employees. [SPA-2-3] The plan provides medical benefits to 137 Vermont residents. [SPA-3] Blue Cross Blue Shield of Massachusetts ("BCBSMA") is Liberty Mutual's third party administrator (TPA). [SPA-3] BCBSMA handles the processing, bill review, and payment of the medical claims of plan participants in Vermont. [SPA-3] Under the statute, BCBSMA is a "mandated reporter" of information to the state because it has two hundred or more enrolled or covered members in Vermont. [SPA 6-7] Liberty Mutual is a voluntary reporter and does not have to report to the state. [SPA 6-7]

3. On August 5, 2011, Vermont issued a subpoena to BCBSMA that sought eligibility information and medical and pharmacy claims files for Vermont residents covered by Liberty Mutual's self-insured plan. [A-25] Liberty Mutual instructed BCBSMA not to comply, and sued the state to enjoin enforcement of the

subpoena on the grounds that ERISA preempted the statute's reporting requirements. [SPA-8] Both parties sought summary judgment. [SPA-14]

The district court granted summary judgment to Vermont. The court concluded that the Vermont law operates in the health care field, a traditional area of state regulation to which the presumption against preemption applies. [SPA 18] Rejecting Liberty Mutual's argument that ERISA preempts any state law that imposes a reporting requirement on ERISA plans, the court stated that the appropriate inquiry was "whether a state reporting requirement dictates or disrupts the activities or operations of an ERISA plan, or compromises the administrative integrity of an ERISA plan, or in some way creates state oversight of the administration of an ERISA plan." [SPA 28] The court found that the Vermont law does none of these things to warrant preemption: the state's efforts to enforce its health care statute are not directed toward, and have only a peripheral effect on, ERISA's core functions of plan administration or allocation of benefits. [SPA 31] The court also found that ERISA does not preempt the Vermont law because the law does not act immediately and exclusively on ERISA plans and the existence of ERISA plans is not essential to the law's operation. [SPA 31]

SUMMARY OF THE ARGUMENT

ERISA does not preempt the state-law reporting requirements at issue here. The starting presumption in ERISA preemption cases is that ERISA, like other federal statutes, does not supersede regulation in traditional areas of state concern unless the regulation non-tangentially intrudes upon core concerns of the federal statute. Here, the Vermont law promotes the state's legitimate interest in gathering information on the provision of health care to its citizens and other residents. The presumption against preemption is not overcome because the Vermont law does not relate to ERISA plans in any way that dictates benefit choices or interferes with plan administration or structure. Moreover, while imposing some costs on plans, the law does not otherwise burden the uniform, multi-state administration of plans, and does not conflict with, or frustrate the purposes of, ERISA's reporting requirements. Nor are ERISA plans treated differently than any of the other numerous entities, including other non-ERISA covered plans, which have to report claims information to the state. Accordingly, Vermont is free to pursue its legitimate interest in obtaining the information necessary to effectively discharge its own independent responsibility to regulate and improve the provision of health care to residents of Vermont.

ARGUMENT

ERISA DOES NOT PREEMPT THE VERMONT LAW'S REPORTING REQUIREMENTS

A. The ERISA Preemption Standard

Pursuant to section 514(a), ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan" covered by the statute, 29 U.S.C. § 1144(a). "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983); accord, e.g., N.Y. State Conference of Blue Cross v. Travelers Ins., 514 U.S. 645, 656 (1995). Congress created exceptions to preemption for state insurance, banking, and securities laws. 29 U.S.C. § 1144(b)(2)(A). ERISA also does not supersede other federal law. Id. § 1144(d).

The Supreme Court's decisions since Travelers have narrowed the scope of "connection with" preemption by: (1) highlighting the presumption that Congress does not intend to supplant state law, particularly in fields of traditional state regulation; and (2) focusing on whether the state law binds plan administrators to particular choices or interferes with the nationally uniform administration of employee benefit plans through the threat of conflicting and inconsistent regulation. See Travelers, 514 U.S. at 655, 657; accord, e.g., De Buono v. NYSA-

ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 814-15 (1997); Cal. Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc., 519 U.S. 316, 334 (1997); and Hattem v. Schwarzenegger, 449 F.3d 423, 429 (2d. Cir. 2006). The presumption against preemption may be overcome if the state law implicates a core ERISA concern by, for instance, mandating particular plan benefits or preventing uniform plan administration from state to state. Id. at 429. The presumption may also be overcome when the state law conflicts with ERISA requirements or remedies. Boggs v. Boggs, 520 U.S. 833, 841 (1997); Aetna Health Inc. v. Davila, 542 U.S. 200, 211-13 (2004). However, the presumption is not overcome where the state law is one of general applicability that, without targeting ERISA plans, merely imposes some additional cost affecting plan incentives or choice or imposes some administrative compliance burdens on ERISA plans comparable to those imposed on the other affected entities. Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 834-36 (1988). A governing principle guiding ERISA preemption analysis, therefore, is that ERISA was not intended to place ERISA plans in a "fully insulated legal world." United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, 1193 (3d Cir. 1993) (citing Rebaldo v. Cuomo, 749 F.2d 133, 139 (2d Cir. 1984)).² Instead, plans do

² In reversing the Second Circuit's holding that ERISA preempts a differential surcharge on hospital rates that plans pay, the Supreme Court in its seminal

not have broad immunity from the same generally applicable laws that govern the conduct of other commercial actors. Thus, in regulatory areas of overlapping federal and state interest – the regulation of insured plans is one example, employer-provided health care is another – "ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy [only] when the two regimes cannot be harmonized or accommodated." John Hancock Mut. Life Ins. Co. v. Harris Trust, 510 U.S. 86, 98 (1993).

Additionally, state laws that single ERISA plans out for special treatment, Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 140 (1990), or exclude them altogether from a law of general operation, Mackey, 486 U.S. at 841, are preempted under the "reference to" prong. Dillingham, 519 U.S. at 325. Thus, a state law is preempted by ERISA section 514 if an ERISA plan is "essential to the law's operation" or the law acts "immediately and exclusively" upon an ERISA plan. Id. But a mere reference to ERISA plans within a series of similarly described regulated entities does not, by itself, trigger preemption. Hattem, 449 F.3d at 433.

Travelers' decision reaffirmed the analyses of the Rebaldo/United Wire line of cases. See Travelers, 514 U.S. at 653-54; Gerosa v. Savasta & Co., Inc., 329 F.3d 317, 328 (2d Cir. 2003) (post-Travelers Second Circuit decision citing Rebaldo principle that "ERISA does not create a 'fully insulated legal world' for plans").

B. The Vermont Law Is Subject To The Presumption Against Preemption Because It Operates In A Field Traditionally Regulated By The States

As the district court found, in enacting the "health care database" statute, "the State's intention is to improve the administration of health care services, and it has determined that it is in need of better health care data to ensure the delivery of quality health services at an affordable cost." [SPA 31] The Vermont law requires ERISA plans, among other entities, to report claims, eligibility and other data to the state, which then uses the information to create a unified health care database. [SPA 36] The purpose of the database is to enable the state to improve the quality and affordability of patient health care by comparing costs between treatment settings and approaches, determining the capacity and distribution of existing health care resources, and evaluating the effectiveness of intervention programs on improving patient outcomes. [SPA 36] The Vermont law also contemplates the development of a "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 commissioner determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions." [SPA 36]. The state law, therefore, regulates matters of health and thus operates in a field that "has been traditionally occupied by the states." Hillsborough County v. Automated

Medical Laboratories, Inc., 471 U.S. 707, 715 (1985); see Travelers, 514 U.S. at 661 ("[N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.").

Contrary to the presumption against preempting traditional state regulatory functions, exempting self-insured plans from the law's requirements would leave a large hole in the data collection the state has fashioned to further its state healthcare policies and thus seriously stymie Vermont's efforts to improve medical outcomes for its residents. Moreover, such a targeted ERISA-specific exemption would raise its own significant preemption problem. See Mackey, 486 U.S. at 841 (preempting state law that specifically exempted ERISA plans from generally applicable state garnishment procedures but not preempting general garnishment statute as applied to ERISA plans).

Liberty Mutual argues that the presumption against preemption applies only to laws regulating the provision of health care services by hospitals, physicians, or other providers. [Doc. 50 at *12] This view conflicts with the Supreme Court's finding in De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, (1997), that a revenue-raising measure imposed by New York on hospitals, including hospitals owned and operated by ERISA plans, "clearly operate[d] in a field that 'has been traditionally occupied by the States,'" even though it did not

involve regulation of health care services or providers. Id. at 814. De Buono rejected the conclusion that the presumption against preemption did not apply to the health care industry because it is "by definition, the realm where ERISA welfare plans must operate." Id. at 811, 814 n.10. Instead, the Court found the fact that the law "targets only the health care industry" supported the application of the presumption. Id. at 814 n.10. Here, similarly, the Vermont law targets the health care industry by seeking cost information and medical data from health care providers, health care facilities and health insurers – a grouping that includes, but by no means is limited to, self-insured ERISA plans. [SPA 31] Liberty Mutual thus bears the "considerable burden" of overcoming the presumption that "Congress does not intend to supplant state law." Id. at 814.

C. The Vermont Law Is Not Preempted Because it Does not Interfere with the Uniform Administration of Employee Benefit Plans, Impermissibly Dictate Plan Choices, or Conflict with ERISA's Terms or Purposes

To determine whether the starting presumption against preemption is overcome, courts must look "both to objectives of the ERISA statute" and to the "nature of the effect of the state law on ERISA plans." Dillingham, 519 U.S. at 325. The district court correctly held that Liberty Mutual cannot overcome the presumption against preemption because the Vermont law does not regulate the structures or core functions of ERISA plans, identified in Fort Halifax as

"determining the eligibility of claimants, calculating benefit levels, making disbursements, [and] monitoring the availability of funds for benefit payments." Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987).

Nor does the law conflict with ERISA reporting requirements or interfere with plan efforts to "keep[] appropriate records in order to comply with applicable [ERISA] reporting requirements." Id. ERISA reporting requirements, also identified as a core function, are limited primarily to the furnishing of a summary plan description to participants and an annual report to the Secretary. See 29 U.S.C. §§ 1021-30. The former, as its name suggests, is essentially a plain-English summary of key plan terms, id. §§ 1021-1022; CIGNA Corp. v. Amara, 131 S. Ct. 1866, 1877-78 (2011), while the latter is principally concerned with the financial soundness of the plan. 29 U.S.C. § 1023. The focus and purpose of Vermont's data collection, however, are quite different. In requiring covered entities to report claims data the state needs to improve its healthcare systems and to provide consumers with quality and pricing information, the state law is like any other "tenuous, remote or peripheral" law that requires information from businesses or other entities for regulatory purposes. Travelers, 514 at 661; Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 146 (2d Cir. 1989) ("laws of general application," which are "often traditional exercises of state power or regulatory authority," are not preempted if their "effect upon ERISA plans is incidental"). At most, the law

might draw upon data that plans already keep for their own recordkeeping purposes, but does not impose conflicting data collection or reporting requirements, does not include disclosure requirements affecting the employer-employee or plan-participant relationship, and does not appreciably add to the burdens of complying with ERISA reporting requirements or serve the same purpose as ERISA's reporting regime. Cf. Boggs, 520 U.S. at 841 (state law that "conflicts with the provisions of ERISA or operates to frustrate its objects" is preempted as a matter of conflict preemption). Accordingly, Vermont's collection and use of claims data for the purpose of assessing health outcomes is "quite remote from the areas with which ERISA is expressly concerned." Dillingham, 519 U.S. at 332.³

Liberty Mutual incorrectly suggests that the Vermont law conflicts with ERISA section 513(a)(1), 29 U.S.C. § 1143(a)(1). [Doc. 50 at *6] In its view, the

³ Focusing on their general applicability, this Court recently held that crane regulations issued under the Occupational Safety and Health Act did not preempt New York City's crane regulations despite the fact that the two sets of regulations applied to substantially the same entities and behavior. Steel Institute v. City of New York, 716 F.3d 31, 39 (2d Cir. 2013). The Court noted that unlike OSHA's regulations, the city's regulations aimed to protect crane workers as members of the general public rather than as a separate class. Here, similarly, the Vermont law is directed at any and all entities, including plans, with claims data involving Vermont residents for the purpose of regulating the cost and quality of healthcare in the state rather than the operation of the plans. Like the employers in Steel Institute, plans are directly affected by the regulation but are peripheral, as a class, to the regulation's purpose and focus.

Secretary's authority under section 513 to ""undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics" relating to employee benefit plans, is exclusive of any state authority to request data from covered plans for its own research purposes. [Doc. 50 at *14-15] However, section 513 says nothing about states' ability to collect data from plans or about specific state reporting requirements. Even if the Secretary collected the same data from plans as does Vermont, which is not the case, plans could comply with both sets of requirements. Section 513, therefore, adds nothing to the preemption analysis, but, rather, "leaves room for complementary or dual federal and state regulation." John Hancock, 510 U.S. at 98.

Moreover, nothing in this facial challenge supports a conclusion that the Vermont law's reporting requirements pose the sort of threat to "the nationally uniform administration of employee benefit plans" that would trigger ERISA preemption. Travelers, 514 U.S. at 657; see Fort Halifax, 482 U.S. at 11 (finding Congress's concern with a "patchwork scheme of regulation [that] would introduce considerable inefficiencies in benefit programs"). The Vermont law does not threaten the uniformity of plan administration across states because it does not meaningfully regulate plans' benefit programs or affect plans' administration of

benefits.⁴ In Burgio and Campofelice v. NYS Dep't of Labor, 107 F.3d 1000 (2d Cir. 1997), this Court considered whether a New York state law that required contractors to provide records showing that they had paid employees the prevailing wage, including ERISA-covered benefits, was preempted. The Court held that the law, including its reporting requirements, was not preempted because the state employed a "total package" approach which did not require the employer to establish or contribute to any particular type of pension or welfare plan in any particular amount. Id. at 1009.⁵ See also Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley, 37 F.3d 945, 962 (3rd Cir. 1994) (law requiring employers to calculate benefits paid was not preempted because it did not influence "decisions regarding the internal design and structure of benefit plans")

⁴ Unlike in Egelhoff v. Egelhoff, 532 U.S. 141 (2001), for example, where plan administrators would have to familiarize themselves with state statutes so that they could determine whether the named beneficiary's status had been "revoked" by operation of law, plans covered by the Vermont law would carry out their operations, including processing claims and maintaining records, in the same way regardless of Vermont's claims data requests and regardless of whether other states enact similar laws. Id. at 148-49. Moreover, because the Vermont law requires the reporting of data that the plans or their third-party administrators can already be expected to keep or readily derive from existing records, its enforcement does not interfere with any ERISA reporting or recordkeeping obligations or affect plan benefits, structure or administration.

⁵ The Court also noted that the state did not require reporting in any particular format. Id. While the Vermont law, as implemented by regulation, may be more prescriptive in this regard, that difference should not be considered dispositive.

and was not unduly burdensome). Compare General Elec. Co. v. New York State Dept. of Labor, 891 F.2d 25, 29 (2d Cir. 1989) (finding that ERISA preempted earlier New York state prevailing wage law because the state employed a "line item" approach in prescribing prevailing benefits levels for each individual type of wage supplement, and required employers to report on and make up any deficit based on particular benefits).⁶

This Court examined the threat to uniform plan administration posed by New York's prevailing wage law for a third time in HMI Mech. Sys., Inc. v. McGowan, 266 F.3d 142, 149-52 (2d Cir. 2001). The Court found the law to be preempted in some respects but not preempted in others. Significantly, the Court rejected the plaintiffs' argument that ERISA preempted the state's demand for information about employer contributions to a plan. The Court viewed that request as consistent with the permissible total package approach, which allowed the state to consider aggregate and non-specific benefit and wage information. Id. at 151 ("The state is not through its inquiry mandating a particular benefit structure for

⁶ Like General Elec. Co., Howard v. Gleason Corp. is distinguishable from this case because it involved a state law that affected plan operation and design. Howard, 901 F.2d 1154, 1158 (2d Cir. 1990). Howard involved a requirement that plan administrators provide notice of life insurance conversion privileges to participants and beneficiaries. Id. The Court found the law preempted because it set forth a different scheme from ERISA for providing notice of plan benefits to participants and "it is this difference that puts [the two laws] in conflict." Id. Unlike the law at issue in Howard, the Vermont law does not impose an administrative mandate on plans or conflict with ERISA's reporting requirements.

ERISA plans, which was the crucial issue in General Elec. NYSDOL does not require employers or ERISA plans to provide specific benefits, and it does not require plans to exclude participants who perform work on private projects.").⁷

Liberty Mutual is therefore incorrect that "Vermont is seeking precisely what this Court said it could not – information regarding the benefits that Liberty Mutual employees receive under the Plan." [Doc. 50 at *36] Vermont is seeking information regarding the quality and cost of benefits provided to its residents, but it is not doing what the HMI Court found impermissible, *i.e.*, regulating plan benefits or administration by seeking to discover or influence the internal workings of individual benefit plans. Accordingly, the administrative burden imposed by the Vermont law is predictably "so slight that the law 'creates no impediment to an employer's adoption of a uniform benefit administration scheme.'" Id. (citing Fort Halifax, 482 U.S. at 14). Even a "patchwork scheme of regulations" enacted in multiple states and requiring claims reports in specific formats (Fort Halifax, 482

⁷ Plaintiffs also argued that ERISA preempted the state's demand for information about allocation of contributions and the identity and payout of employees that benefited from contributions to ERISA plans but were not listed on public works payrolls. Id. at 150. The Court agreed that the state's requests for information about actual benefits received by employees were improperly focused on the internal allocation and adequacy of benefits and therefore akin to the prohibited "line item" approach. Id. It also concluded that the state's attempt to use information requests about benefits received as a way to deter employers from spreading benefits over hours worked on private projects was tantamount to an impermissible regulation of plan benefits or administration. Id.

U.S. at 11) would not change that conclusion. For this reason, the Vermont law does not threaten "considerable inefficiencies in benefit programs," as described in Fort Halifax. Id.

Instead, the Vermont law resembles the non-preempted laws in Travelers, De Buono, Dillingham and Mackey, where the Supreme Court found that laws imposing incidental economic effects on plans were insufficient to cause ERISA preemption as long as they did not dictate plan benefits or administration. In Dillingham, the Court explicitly rejected the argument that it should adopt a general rule preempting state laws that increased the cost of benefits, finding that "if ERISA were concerned with any state action – such as medical-care quality standards or hospital workplace regulations – that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's preemptive reach, and the words 'relate to' would mean nothing." Dillingham, 519 U.S. at 334. See also De Buono ("Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute."); Mackey, 486 U.S. at 831 (implicitly rejecting plan costs and administrative burdens as a basis for preemption of state garnishment procedures).

Liberty Mutual and amicus Chamber of Commerce argue that the costs imposed by Vermont's reporting requirements, in light of other state claims data laws that impose different reporting requirements, are sufficiently onerous to prevent uniform plan administration. [Doc. 50, at *27; Doc. 64, at *10] They note that the All Payer Claims Database ("APCD") Council has found that the "non-uniform approach to developing APCDs . . . is raising costs for payers submitting data." Id. The extent to which the differing state reporting requirements place economic burdens on plans is purely speculative, however, since defendants failed to submit "any information about any actual burden suffered by itself or BCBSMA in producing this information." [SPA-11] Without such evidence, the Court has no factual record on which to find that the burden on plans meets the "acute" effect that Travelers hypothesized would be sufficient for preemption. Travelers, 514 U.S. at 668 (acknowledging that a state law might be preempted if its compliance costs "force[d] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers") (citation omitted). This is particularly true considering the presumption against preemption that has particular force in this area of traditional state regulation, and the district court's observation (SPA-25 at n. 5) that BCBSMA willingly provides the data on behalf of other self-funded plans.

D. ERISA's Legislative History Does Not Support Preemption of the Vermont Law

Liberty Mutual asserts that the Travelers' line of cases does not directly govern this case because that line of cases addresses state tax and other laws that do not involve reporting requirements. [Doc. 50, at *34-35] In Liberty Mutual's view, the Court's broad references to reporting as an ERISA subject matter, in addition to legislative history, indicate that ERISA preempts all state reporting requirements, regardless of their effect on plans or whether they implicate an area of core ERISA concern. [Doc. 50, at *22-24] (citing Travelers, 514 U.S. at 66 (indicating that ERISA preempts "state laws dealing with the subject matters covered by ERISA [,] reporting, disclosure, fiduciary responsibility, and the like"); FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (indicating that laws "dealing with . . . [ERISA-covered] reporting [and] disclosure" fall within ERISA's preemptive reach).

Liberty Mutual places more weight on the legislative history and on such isolated and selected quotes than they can reasonably bear. While the legislative history indicates that Congress intended to create a single federal reporting and disclosure system, see, e.g., S. Rep. No. 93-127, at 35 (1973), as reprinted in, 1974 U.S.S.C.A.N. 4838, 4871 (Committee believes it is "essential to provide for . . . creating a single reporting and disclosure system in lieu of burdensome multiple reports"); H.R. Rep. No. 93-533, at 17 (1973), as reprinted in, 1974 U.S.S.C.A.N.

4639, 4655 (same); 120 Cong. Rec. 29942 (1974) (Statement of Sen. Javits on Conf. Rep.) ("State laws compelling disclosure from private welfare or pension plans . . . will be superseded"), it provides no insight into the scope or type of reporting laws Congress intended to preempt. The lack of clarity surrounding the legislative history of ERISA's preemption provision has been highlighted by a number of courts, see, e.g., DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 446 (3rd Cir. 2003), and is further reflected in the Supreme Court's acceptance of a disproportionate number of ERISA preemption cases in an effort to resolve how the provision should be applied. See De Buono, 520 U.S. 806 at 809 n.1 ("The boundaries of ERISA's preemptive reach have been the focus of considerable attention from this Court. . . . In the 16 years since we first took up the question, we have decided no fewer than 13 cases"). See also Mobil v. Allapattah Serv., Inc., 545 U.S. 546, 568 (2005) ("legislative history is itself often murky, ambiguous and contradictory").

Moreover, Liberty Mutual's expansive reading of the legislative history is at odds with the fact that Congress, in the same year that ERISA was enacted, also passed legislation (the National Health Planning and Resources Development Act of 1974 ("NHPRDA")) encouraging states to collect data for the purpose of

analyzing information relevant to the cost of medical services.⁸ [SPA-27] As the district court observed, it is unlikely that "Congress would have precluded the states' gathering of cost information from ERISA plans even as Congress was authorizing such activity with the NHPDA." Id. This observation is reinforced by the conclusion in Travelers regarding the contemporaneous passage of a law encouraging state laws establishing health maintenance organizations that "Congress never envisioned ERISA preemption as blocking state health care cost control, but rather meant to encourage and rely on state experimentation." Travelers, 514 U.S. at 667 n.6. By seeking to improve the quality and affordability of care through the collection of claims data, the Vermont law exemplifies the kind of experimentation in healthcare cost control explicitly contemplated by Congress at the time of ERISA's enactment.⁹ And like the NHPDA, the Vermont law

⁸ The NHPDA authorized state health agencies, which included local governments, to collect a broad range of data: (1) the status (and determinants) of the health of the residents of its health service area; (2) the status of the health care delivery system in the area and the use of that system by residents of the area; (3) the effect the area's health care delivery system has on the health of the residents of the area; (4) the number, type and location of the area's health resources, including health services, manpower and facilities; (5) the patterns of utilization of the area's health resources, and (6) the environmental and occupational exposure factors affecting immediate and long-term health conditions. Sec. 1513(b) of the NHPDA, PL 93-641, 88 Stat. 2225 (1975).

⁹ As evidenced by the passage of the Affordable Care Act (ACA), Congress continues to view states as playing a central role in health care reform. States will be responsible for implementing key aspects of the law, including "the insurance

reflects the need to obtain data about health care costs and quality on a state level, making the law's preemption incompatible with Congress's view at the time of the role states could play in managing health care costs.¹⁰ Thus, Congress's intent with respect to reporting laws that do not conflict with ERISA's reporting requirements or purposes is ambiguous at best and cannot be read to preempt all reporting requirements regardless whether they implicate core ERISA relationships or concerns.

Accordingly, particularly in light of the presumption against preemption in areas of traditional state control, the inconclusive legislative history should not supersede the preemption framework developed by the Supreme Court in Travelers. Travelers and the other Supreme Court ERISA preemption cases

exchanges, the expansions to Medicaid and SCHIP, and new programs to stem waste in, and abuse of, the healthcare system, expand workforce training, reform insurance, and develop better long-term care resources." M. Jensen, Is ERISA Preemption Superfluous In the New Age of Health Care Reform?, 2011 Colum. Bus. L. Rev. 464 (2011). The ACA also contains a "waiver for innovation" provision allowing states to implement their own reforms in lieu of the ACA reforms as long as the cost is neutral to the federal government and the coverage is comparable. Pub. L. No. 111-148, § 1332(c); see also Application, Review, and Reporting Process for Waivers for State Innovation, 76 Fed. Reg. 13553 (proposed Mar. 14, 2011).

¹⁰ Contrary to Liberty Mutual's assertion, [Doc. 50 at *29 n.19], Congress's 1986 repeal of the NHRPDA provides no insight into Congress's intentions with respect to state reporting requirements like those imposed by Vermont. Liberty Mutual has not shown that the repeal was in any way related to concerns about state reporting requirements.

present an approach, applicable to all preemption inquiries, grounded in an understanding of the statute and its purposes and focused on the law's impact on core ERISA concerns regardless of the specific state law's subject matter. In applying ERISA's preemption provision, the Court has explicitly refused to distinguish between state laws covering different subject matters despite legislative history indicating that Congress may have viewed specific categories of laws as more susceptible to preemption. De Buono at 815 n.11 ("we are unconvinced that a stricter standard of preemption should apply to state tax provisions than to other state laws"). Similarly, state reporting laws should not be subject to a higher degree of preemption scrutiny.

The common denominator in the Travelers' categories is that, to be preempted, a state law must not merely affect the costs to plans of operating in a particular market or state; they must regulate plans by limiting what they can or cannot do in providing benefits that an employer gives its employees in addition to wages. Significantly, the Court looked primarily to its non-ERISA case law in articulating the starting presumption against preemption of traditional state regulation and to its ERISA case law in identifying the categories of core concern that require preemption notwithstanding this presumption. In discerning Congressional intent, the Court was not constrained by broad pronouncements in the legislative history that could be read (as Liberty Mutual does) as underpinning

or reinforcing the "unhelpful text." Travelers, 514 U.S. at 656. Under this analysis, collection of existing (or readily available) claims data properly falls outside the Travelers line for preemption because – unlike a law mandating disclosure of the same information to participants or altering claims procedures – its effect on plans is not regulatory, nor limited to plans in a way that treats them differently from other entities with the same data.¹¹

E. The History of the Hawaii Prepaid Health Act is Irrelevant to Determining the Scope of Reporting Laws Preempted by ERISA

Liberty Mutual also relies [Doc. 50 at *31] on the Supreme Court's summary affirmance of the Ninth Circuit's decision in Standard Oil Co. of Cal. v. Aghsalud, 633 F.2d 760, 763 (9th Cir.1980), aff'd mem., 454 U.S. 801 (1981), for its conclusion that the Court interprets ERISA as preempting all state reporting laws. Aghsalud involved a preemption challenge to Hawaii's Prepaid Health Care Act

¹¹ If the Vermont law applied only to insured plans, we would not consider the law to be within the exception for insurance regulation, because, although directed at insurers, it would not have an effect on risk-pooling. See Kentucky Ass'n of Health Plans v. Miller, 538 U.S. 329, 334, 338-39 (2003) (establishing the test for the "regulat[ion of] insurance" under the insurance saving clause, 29 U.S.C. § 1144(b)(2)(A)). By the same token, the law, as applied to self-insured plans does not "deem" them to be insurers, and is not preempted for that reason. See 29 U.S.C. § 1144(b)(2)(B). Instead, whether applied only to insured plans or to all plans, among other health care providers, the law is not preempted because it does not "relate to" ERISA plans in a way that Travelers and its progeny would consider to be preempted. Moreover, there is no impermissible "reference to" plans because it does not act exclusively on ERISA plans or single them out for special treatment. See Dillingham, 519 U.S. at 325.

("Hawaii Act"). The Hawaii Act imposed reporting and disclosure requirements on ERISA-covered plans, in addition to requiring that employers establish ERISA plans and provide particular benefits to participants. The Ninth Circuit struck down the Hawaii Act without discussing its reporting or disclosure requirements, and the Supreme Court summarily affirmed the Ninth Circuit's decision. In 1983, Congress amended ERISA to exempt the Hawaii Act's plan and benefits mandates from preemption. Congress did not exempt from preemption the reporting or disclosure requirements.

Liberty Mutual's reliance on the history of the Hawaii Prepaid Health Act is misguided. The Court's Agsalud "decision" was unaccompanied by any opinion, pre-dates Travelers by more than a decade, and has never been cited in any of the many Supreme Court preemption cases since. As Liberty Mutual notes, the precedential weight of the Supreme Court's one-line summary affirmance in Agsalud is limited to the "precise issues presented and necessarily decided" by the Ninth Circuit. See Schulz v. Williams, 44 F.3d 48, 60 (2d Cir. 1994); Illinois Bd. of Elections v. Socialist Workers Party, 440 U.S. 173, 182-83 (1979) ("A summary disposition affirms only the judgment of the court below, and no more may be read into our action than was essential to sustain that judgment."). Given that the Ninth Circuit's opinion did not discuss the reporting requirements contained in the Act, the Supreme Court's summary affirmance is irrelevant to the question in this case.

Moreover, the Ninth Circuit has characterized its Agsalud decision as having been prompted by the Hawaii Act's healthcare mandate, without any discussion of the Hawaii Act's reporting requirements. Golden Gate Restaurant Ass'n v. City & County of San Francisco, 546 F.3d 639, 655 (9th Cir. 2008), cert. denied, 130 S. Ct. 3497 (2010) ("the Hawaii statute was preempted because it required employers to have health plans, and it dictated the specific benefits employers were to provide through those plans."). See also Fort Halifax, 482 U.S. at 12-13 (noting that Hawaii Prepaid Health Act was preempted because it contained a benefits mandate).

Congress's effort after Agsalud to preserve only the non-reporting and disclosure portions of the Hawaii law likewise has no effect on the analysis of the very different Vermont law. [Doc. 50 at *31] In addition to not containing any benefits or administration mandate, the Vermont law's reporting requirements do not resemble those contained in the Hawaii Act. The Hawaii Act required employers to provide the state with a record of employer and employee healthcare contributions, as well as the plan's liability for benefits. [A-252] The Vermont law, on the other hand, focuses on individual claims data (with personal identifiers removed).

F. Liberty Mutual does not Run Afoul of ERISA Section 404(a)(1)(A) or the Plan Document Rule by Complying with Vermont's Reporting Law

Liberty Mutual argues that Vermont's reporting requirements thwart Congress's intention that plans be used exclusively for the benefits of plan members. [Doc. 50 at *39-40] (citing 29 U.S.C. § 1104(a)(1)(A)). In Liberty Mutual's view, the Vermont law requires plans to violate the duty of loyalty by ordering them to serve the state's interest. However, section 404(a)(1)(A) cannot be read so broadly. Just as there is no inconsistency between a fiduciary's duty to participants and complying with federal reporting requirements, there is nothing disloyal about complying with state data collection requirements or with the numerous other state regulations to which plans and their fiduciaries are subject on the same basis as other marketplace participants.

Liberty Mutual's argument that transferring claims data to Vermont constitutes a violation of the summary plan description's promise of confidentiality is equally unavailing. [Doc. 50 at *33-34] The Vermont law contains confidentiality protections, including the requirement that personal identifiers be removed before the data is provided to the state or published. [SPA-7] Even if the protections are not sufficient to comply with the plan's promises of confidentiality, however, nonconformity with a plan provision does not provide a basis for preemption. See FMC Corp. v. Holliday, 498 U.S. 52 (1990) (implicitly rejecting

negation of a plan provision as a sufficient basis for preemption). Plans cannot alter the scope of ERISA preemption merely by inserting provisions in governing plan documents that instruct fiduciaries to disregard otherwise valid state laws. See Hook v. Morrison Milling Co., 38 F.3d 776, 785 (5th Cir. 1994) (fact that employer inserted waiver of right to bring common-law negligence claim into its ERISA plan did not render employee's negligence claim preempted by ERISA). Nor would a rule permitting plans to opt out of state laws in this manner have any clear stopping point or limiting principle.

CONCLUSION

For the foregoing reasons, the decision of the district court should be affirmed.

Dated: July 3, 2013

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(d) because it contains 6,955 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in 14-point Times New Roman font, a proportionally spaced typeface, using Microsoft Word 2010.

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CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of July, 2013, true and correct copies of the foregoing Brief of the Secretary of Labor as Amicus Curiae in Support of Defendants-Appellees Requesting Affirmance were filed electronically with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system, and served electronically via email to the following counsel at the addresses set forth below:

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