No. 14-181

In the Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION AND VERMONT MEDICAL SOCIETY IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether ERISA's preemption provision, 29 U.S.C. §1144(a), preempts application of a state health-care data collection statute to a self-funded ERISA welfare benefit plan when the law does not regulate the financial disclosures required by ERISA, and, more generally, whether this Court should modify its analysis for determining whether state laws "relate to" employee benefit plans under Section 1144(a).

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and the Vermont Medical Society ("VMS") submit this brief as *amici curiae* in support of Petitioner Alfred Gobeille, in his official capacity as Chair of the Vermont Green Mountain Care Board ("Board").[1]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups in the AMA's House of Delegates, substantially all United States physicians, residents, and medical students are represented in the AMA's policy-making process. The AMA promotes the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty in all fifty states.

For over a decade, the AMA has litigated to address and correct the flawed databases used by the insurance industry to determine the amounts patients are reimbursed when they obtain medical care from providers outside their health benefit plan's

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part. *Amicus* AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies ("Litigation Center"). No entity or person, other than *amici*, its members, and the Litigation Center made a monetary contribution to the preparation of this brief. Pursuant to Rule 37.3, the parties have consented to the filing of this brief. The parties' letters of consent have been lodged with the Court.

network. These efforts have led to, *inter alia*, investigations by the Attorney General for the State of New York and the United States Senate, substantial reform in insurers' out-of-network reimbursement practices, and hundreds of millions of dollars in settlements from the insurance industry.

More generally, the AMA works for its members to establish equitable procedures and relationships with the nation's health insurers and third-party administrators regarding issues affecting the economic aspects of health care and the practice of medicine.

VMS is a professional association representing over 2,000 physicians, residents, and medical students in Vermont. Founded over 200 years ago, VMS is dedicated to advancing the practice of medicine by advocating for Vermont's doctors and their patients and communities. VMS' mission is to serve the public by facilitating and enhancing physicians' individual and collective commitments, capabilities, and efforts to improve the quality of life for Vermonters by providing accessible, appropriate health care services. VMS physicians represent every medical specialty in every practice setting.

The Litigation Center, which the AMA and VMS represent here, expresses the viewpoint of organized medicine in the courts consistent with the AMA's policies and objectives.

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Historically, States have regulated both the clinical and economic aspects of the provision of health care, which are often "inextricably mixed." *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000). The Employee Retirement Income Security Act of 1974, 29 U.S.C.

§§1001 *et seq.* ("ERISA"), on the other hand, does not regulate health care, including the practice of medicine. Therefore, insofar as ERISA preempts state regulation in this area, a regulatory void inevitably is created. Where to draw the line between areas of traditional state regulation, like health care, and the exclusive federal regulation of employee benefit plans has bedeviled lower courts and even this Court seemingly since ERISA's enactment.

This case presents another instance of this conundrum. It examines whether Vermont's effort to create an all-payer claims database ("APCD") to compile and analyze medical claims information from all health-care payers and providers within the State "relates to" ERISA-regulated employee benefit plans. *Amici* believe, under this Court's current jurisprudence, Vermont's statute does not "relate to" employee benefit plans. APCDs, like Vermont's, and other independent databases of medical claims information, provide important information to consumers, providers, and policymakers about health care options, outcomes and costs that enable these stakeholders to make more informed decisions about obtaining and paying for medical treatment. *See* Vt. Stat. Ann. tit. 18, §9410(a)(2)(A) (statute provides "transparent health care price information, quality information," and other information to "empower" individuals to "make economically sound and medically appropriate decisions"). As such, statutes creating these databases fall within the ambit of "general health care regulation, which historically has been a matter of local concern." *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995) ("*Travelers*"). Therefore, under this

Court's ERISA preemption analysis, Vermont's statute should not be preempted by ERISA.

This case also highlights the difficulty lower courts, state legislatures, and practitioners have had with ERISA's preemptive scope since its enactment in 1974, even after the Court's effort to re-frame that inquiry twenty years ago in *Travelers*. This case provides the chance to underscore that "[n]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation." *Id.*; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997) ("historic police powers of the State include the regulation of matters of health and safety").

Cases like this are particularly important to physicians and other medical providers because their profession stands at the intersection of the traditional exercise of a State's police power to regulate medicine and contractual relationships and the increasing dominance of the economics of medicine by health benefit plans which often are regulated by ERISA. The interplay between these regulatory regimes, and particularly ERISA preemption, can have profound economic consequences on the medical profession, particularly as the proportion of workers with health coverage through self-insured (or self-funded) plans increases.[2]

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[2] The percentage of private-sector employees in self-insured plans has increased from 40.9% in 1998 to 58.2% in 2013. Most of that increase has been private sector employees in firms of 1,000 employees or more. In 1998, 57% of those employees had health coverage through self-insured plans. In 2013, that figure

Amici suggest that this case allows the Court to re-examine Section 514(a) and articulate that ERISA §514(a) is really another manifestation of traditional field preemption which simply provides that ERISA supersedes state laws to the extent they "relate to" covered employee benefit plans. Doing so could avoid unnecessary regulatory gaps like the one created by the Second Circuit's decision.

Amici believe ERISA §514 should be reexamined to establish properly the line between regulation of health care (and other traditional state regulatory areas) and the exclusively federal regulation of employee benefit plans. *Amici* propose that the Court refine what it means for a state law to "relate to" an employee benefit plan. 29 U.S.C. §1144(a). *Amici* suggest an analysis that will provide clearer guidance for lower courts faced with ERISA §514(a) preemption issues and will properly restrict field preemption to the area of ERISA's regulatory concerns.

SUMMARY OF ARGUMENT

This case highlights the need to closely examine ERISA's text along with its underlying structure and objectives when deciding whether a state law "relate[s] to" an employee benefit plan. Congress' goal

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rose to 85.6%. *See* Employee Benefit Research Institute, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996-2013*, at 7-8. As discussed *infra* at fn.11, while insured plans remain subject to state insurance regulation through ERISA's "insurance savings clause," 29 U.S.C. §1144(b)(2)(A), self-funded plans are not if that regulation "relates to" employee benefit plans because of ERISA's "deemer clause." 29 U.S.C. §1144(b)(2)(B).

in enacting ERISA was to provide: (1) disclosure and other safeguards for establishing, operating, and administering employee benefit plans; and (2) minimum standards to ensure the equitable character of such plans and their financial soundness. 29 U.S.C. §1001(a).

ERISA's preemption provision, ERISA §514(a), states that ERISA "shall supersede any and all State laws insofar as they ... relate to any employee benefit plan." 29 U.S.C. §1144(a). With this provision, Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government," and prevent "the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Travelers*, 514 U.S. at 656-57 (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

The Second Circuit held, 2-1, that ERISA preempts application of Vermont's APCD statute to Liberty Mutual's self-funded health benefit plan, as administered by Blue Cross Blue Shield of Massachusetts ("Blue Cross"). *Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497, 500 (2d Cir. 2014). It concluded that the statute did not regulate "health care" but instead required reporting by various health care-related entities, including third-party administrators ("TPAs") of self-funded ERISA plans, like Blue Cross, which, according to the court, intruded on "one of ERISA's core functions." *Id.* at 506, n.6, 510. Because of the administrative "burdens" the majority

surmised the statute imposed, which presumably created "financial burdens that will be passed from the TPA to the Plan and from the Plan to the beneficiaries," *id.* at 510, n.10, the majority concluded that the APCD statute was preempted, as applied to ERISA-regulated self-funded plans. *Id.* at 500.

In dissent, Judge Straub concluded that the court should have applied the *Travelers* presumption against preemption. *Donegan*, 746 F.3d at 512-13 (Straub, J., dissenting). He then explained that the majority "misse[d] the nuance of what 'reporting' means in the context of ERISA, and ignore[d] the case law's focus on whether the *administration of benefits to beneficiaries* is impacted," which Liberty Mutual failed to show. *Id.* at 512. The "reporting" Vermont's statute required is "wholly distinct" from ERISA's reporting requirements in 29 U.S.C. §§1020-30, which focus on the financial soundness of ERISA plans. *Id.* at 514.[3] By contrast, Vermont sought "after-the-fact information which plan administrators

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[3] Furthermore, the Secretary of Labor has exempted welfare benefit plans from the reporting requirements at issue if the plan pays benefits from the plan sponsor's general assets (as most do). *See* 29 U.S.C. §1024(a)(3) ("The Secretary may by regulation exempt any welfare benefit plan from all or part of the reporting and disclosure requirements of this subchapter."); 29 C.F.R. §2520.104-44(a)(1), (b)(1) (exemption where plan benefits are paid "solely from the general assets of the employer"); *id.*, §2520.103-1 (annual report requirement exemption); *id.*, §2520.104-20 (same). Liberty Mutual's Plan is self-funded, and its "health care claims are paid from Liberty Mutual's general assets." *Donegan*, 746 F.3d at 501. Therefore, the Plan is generally exempt from the reporting obligations that required preemption.

[like Blue Cross] already have in their possession" and which Blue Cross was not only "happy to provide" but which it did provide for other clients. *Id.* at 515. Any administrative or financial burdens imposed on the Plan's TPA, or derivatively on the Plan (because an ERISA plan and its insurer or TPA are distinct), were simply "indirect economic effects" that do not "preclude uniform administration practice or the provision of a uniform interstate benefit package." *Id.* (quoting *Travelers*, 514 U.S. at 660). Because the APCD statute "regulates health care within that state, while imposing a purely clerical burden on ERISA plans," the dissent concluded that Vermont's statute was not preempted. *Id.* at 518.

The dissent's view follows this Court's jurisprudence, particularly since *Travelers*. The statute is simply a "general health care regulation" that regulates numerous participants in the health care industry, including physicians (and other health care professionals) and "health insurers" as defined by the Vermont legislature. The Vermont statute has, at most, the "indirect" effect on employee benefit plans this Court has held does not require ERISA §514(a) preemption. *Travelers*, 514 U.S. at 659.

For these reasons, *amici* urge this Court to reverse the Second Circuit's judgment. *Amici* also suggest that this Court re-articulate, and perhaps reformulate, its interpretation of ERISA §514(a) preemption to correspond more closely to traditional field preemption. Adopting such a methodology will fulfill ERISA's regulatory concerns while better allowing states to regulate traditional areas of state concern, including health care and avoid creating regulatory gaps where Congress did not intend to create them.

ARGUMENT

I. Independently Created And Maintained Medical Claims Databases Serve Important Health Care Functions.

According to the majority, Vermont's APCD statute "do[es] not regulate the safe and effective provision of health care services, which is among the states' historic police powers." *Donegan*, 746 F.3d at 506, n.8. This conclusion served as a springboard for the majority's conclusion that the statute was preempted. *Id.* That view of the statute, however, glosses over the statutory language, the Vermont legislature's purpose, and the legal environment in which these databases were created. From these perspectives, the APCD statute serves multiple important health care functions and fits squarely within the State's "historic police powers" to regulate "matters of health and safety." *De Buono*, 520 U.S. at 814.

A. The APCD Statute's Text And Purpose Demonstrate It Regulates Health Care.

Title 18 of Vermont's statutes is entitled "Health." Vt. Stat. Ann. tit. 18. According to Vermont's legislature, "[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." *Id.*, §9401(a). The legislature identified numerous overarching principles regarding health care in Vermont, including: (1) "[e]very Vermonter should be able to choose his or her health care providers"; (2) health care costs should be "transparent and easy to understand"; (3) "[t]he financing of health care in Vermont

must be sufficient, fair, predictable, transparent, sustainable, and shared equitably"; and (4) "[t]he system must consider the effects of payment reform on individuals and on health care professionals." *Id.*, §§9371(5), (6), (11), and (12).

Pursuant to these policy goals, the legislature created the Board to improve citizens' health, control health care costs, "enhance[] the patient and health care professional experience of care," retain health care professionals, and simplify health care financing and delivery. *Id.*, §9372. The Board's responsibilities include "establish[ing] and maintain[ing] a unified health care database" to assist the Board and Petitioner in "improving the quality and affordability of patient health care and health care coverage," "improving patient outcomes," and "providing information to consumers and purchasers of health care." *Id.*, §9410(a)(1)(C)-(F). The database is a "resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont." *Id.*, §9410(h)(3)(B).

The APCD statute requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies"[4] to electronically submit "health

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[4] "Health insurer" includes "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 Vermont resident[s]." *Id.*, §9410(j)(1)(B). The statute imposes no obligation directly on employee benefit plans. Regulation H-2008-01, §3(X). The Court has distinguished repeatedly between regulating plans

insurance claims and enrollment information used by health insurers" for services provided to Vermont residents; "other information relating to health care costs, prices, quality, utilization or resources"; and "member, subscriber, or policyholder information necessary to determine third party liability for benefits provided." *Id.*, §§9410(c)(1), (3); §9410(h)(1)(C).

It is difficult to square the majority's conclusion that the statute "do[es] not regulate the safe and effective provision of health care services," *Donegan*, 746 F.3d at 506, n.8, with the Vermont legislature's expressed explanation of the APCD statute's purpose within its text, along with the overall statutory framework regulating health care. *Marx v. General Revenue Corp.*, 133 S. Ct. 1166, 1173 (2013) ("As in all statutory construction cases, we assume that the ordinary meaning of the statutory language accurately expresses the legislative purpose.") (internal alterations omitted).

Other States' experiences creating APCDs confirm that they improve health care.[5] They "fill critical information gaps," "support health care and payment reform initiatives," and "address the need for transparency in health care" to help consumers, providers, and policymakers make better decisions. *Id.* APCDs

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and regulating entities, like insurers or service providers, for plans. *See, e.g.*, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985); *see also infra*, fn. 11.

[5] Jo Porter, *et al.*, APCD Council, *The Basics of All-Payer Claims Databases: A Primer for States*, at 1 (January 2014). Maine implemented the first APCD in 2003. By 2010, nine more states, including Vermont, did. *Id.*

are a "rapidly emerging … essential source of information about outpatient services and healthcare payments." National Ass'n of Health Data Organizations, *Key State Health Care Databases for Improving Health Care Delivery*, at 2 (February 2011). They "describe the health care use of the insured population" and "provide information about actual payments – both patient liability and provider payment." *Id.* According to experts, APCDs help "capture" information which States use to "[m]easur[e] and improv[e] health system performance, both clinical and financial, and control[] costs. *Id.* at 4.

The information APCDs compile also provides important data for the evidence-based medicine methodology providers use to help "improve[] patient outcomes." Vt. Stat. Ann. tit. 18, §9401(a)(1)(C); Ariel L. Zimmerman, *Evidence-Based Medicine: A Short History of a Modern Medical Movement*, 15 AMA Journal of Ethics, No. 1: 71-76 (January 2013) (describing importance of quantification and statistics). For example, such evidence helps compare how particular medical procedures are used in different populations or geographic areas, which helps practitioners choose appropriate courses of treatment for their patients. *See* Mark R. Chassin, MD, *et al.*, *How Coronary Angiography Is Used: Clinical Determinants of Appropriateness*, 258 Journal of the American Medical Ass'n No. 18, 2543 (Nov. 13, 1987).

APCDs also help consumers and providers address the opacity surrounding payment for health care. *Amici*, and the federal government, have long asserted that increasing pricing transparency enables more efficient delivery of health care. *See* U.S. Gov't Accountability Office, *Health Care Price Transparency:*

Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care, GAO-11-791, at 28 (September 2011) ("Transparent health care price information – especially estimates of consumers' complete costs – can be difficult for consumers to obtain prior to receiving care.").

B. State Medical Data Collection Efforts Are General Health Care Regulation.

To support its position that ERISA preempted the APCD statute, the majority stated, without citation, that "state health data collection laws do not regulate the safe and effective provision of health care services," and "collecting data can hardly be deemed 'historic'" because APCD laws were only recently adopted. *Donegan*, 746 F.3d at 506, n.8. This focuses the inquiry too narrowly. Even the majority recognized that, when state law "operates in a field that has been traditionally occupied by the States," or when the State employs its "historic police powers" to regulate "matters of health and safety," *id.* (quoting *De Buono*, 520 U.S. at 814), state law presumptively is not preempted. The majority simply believed "state health data collection laws," which require collecting data about medical conditions, practices, and outcomes, did not qualify.

In actuality, health care regulation sweeps more broadly than simply "regulat[ing] the safe and effective provision of health care services." *Donegan*, 746 F.3d at 506, n.8. Title 18, in its entirety, is Vermont's effort to regulate health care within its borders. Its provisions contain everything from public health regulation, to the Board's responsibilities, to health facil-

ity planning, to hospital budget review. *See* Vt. Stat. Ann. tit. 18.

As the dissent explained, the APCD statute "operates in [the] field" of health and safety at least as much as "a revenue raising measure" directed at patient services by certain health care providers. *Donegan*, 746 F.3d at 512-13 (quoting *De Buono*, 520 U.S. at 814). The same logic applies for the unpreempted statute in *Travelers* which made health insurance from Blue Cross entities more cost-effective and the entities more financially viable. *Travelers*, 514 U.S. at 659. Both these statutes are "general health care regulation" Congress did not intend ERISA to displace. *Id.* at 661.

However, even on its own terms, the majority's rationale conflicts with the historical record. States (and colonies) regulated health care and the medical profession according to their police power since before the Revolution. *See* Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS OF HEALTH LAW 201, 202-03 (1999); *Gibbons v. Ogden*, 22 U.S. 1, 205 (1824) ("quarantine and health laws … are considered as flowing from the acknowledged power of a State, to provide for the health of its citizens."). Even before the Constitution, state and local regulation of health care included gathering information about citizens' medical conditions to protect and improve public health, such as to determine the need for quarantines, and the efficacy of certain medical treatments, like inoculation. *See* Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of*

the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267, 287-92 (1993). Historically, then, collecting health care data falls within even a narrow view of "general health care regulation."

C. Independent Medical Claims Databases Are Particularly Important For Health Care Pricing Transparency

Independently created and maintained medical claims databases, like Vermont's APCD, also increase transparency for health care costs which benefits both health care consumers and providers. *Amici*'s litigation experience demonstrates the need for such independently maintained databases. Indeed, *amici*'s experience, along with the 2008 New York Attorney General's Office's "industry-wide investigation" into health insurance industry practices concluding that the health insurance industry systematically underpaid benefits to "over 100 million Americans" who received out-of-network medical care, potentially spurred the subsequent proliferation of APCD statutes like Vermont's. *Deceptive Health Insurance Industry Practices: Are Consumers Getting What They Paid For? – Part I Before the S. Comm. on Commerce, Science, and Transportation*, 111th Cong. 4-5 (March 26, 2009) ("*Deceptive Practices, Pt. I*") (statement of Linda A. Lacewell, Counsel, Office of the New York Attorney General).

In 2000, *amicus* AMA and others filed a class-action against United HealthCare ("UHC"), the nation's second largest health insurer, and its wholly-owned subsidiary, Ingenix, asserting that insurers systematically relied on skewed data, created and maintained in an Ingenix database, to determine out-

of-network payment rates to patients or their providers.[6] *See Deceptive Practices, Pt. I*, *supra*, at 6, 13 (statement of Dr. Nancy H. Nielsen, President, AMA); *American Med. Ass'n v. United HealthCare*, 588 F.Supp.2d 432 (S.D.N.Y. 2008). When consumers are reimbursed, or providers are paid, for out-of-network services, insurers (or plans) pay them a percentage of the usual, customary, and reasonable ("UCR") rate providers charge when they have not negotiated a lower in-network rate. *Deceptive Practices, Pt. I*, *supra*, at 5, 7. The consumer then typically remains responsible for the balance of the bill. *Id.* at 7.

At the time, this database was essentially the *only* national database of information about medical claims and charges. Insurers provided data for the database which was then used by the insurance industry to determine the UCR rates on which insurers would base their provider payments. Plaintiffs alleged that this data was inaccurate and manipulated to artificially reduce rates insurers paid by deleting high charges, using outdated data, and co-mingling retail charges with lower, negotiated rates. *Id.* at 13.

The AMA's litigation prompted investigations by the New York Attorney General's office in 2008 and a United States Senate subcommittee in 2009. Each reached scathing conclusions about the health insurance industry's use of the flawed database. *See* Office of the Attorney General, State of New York, *Health*

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[6] In 2009, 70% of insured Americans had a health benefit plan that allowed them to choose an out-of-network doctor, paid for with higher premiums and usually higher co-pays or co-insurance. *Id.* at 5.

Care Report – The Consumer Reimbursement System is Code Blue (January 13, 2009);[7] Staff Report for Chairman Rockefeller, *Underpayments to Consumers By The Health Insurance Industry*, S. Comm. on Commerce, Science, and Transportation, Office of Oversight and Investigations (June 24, 2009) ("*Senate Report*").

The New York Attorney General found that the health insurance "industry use[d] a conflict-laden database riddled with errors at the expense of the consumer." *AG Report*, *supra*, at 6. The database created an "industry-wide problem" and a "rigged system" that was "fraudulent" and "critically ill." *Id.* at 6, 22. In essence, insurers' use of the database to determine UCR amounts was "unreliable, inadequate, and wrong – often forcing consumers to bear an even greater burden of the cost of care." *Deceptive Practices, Pt. I*, *supra*, at 8.

The Attorney General's report concluded that insurers' use of the data the industry compiled and maintained to calculate UCR rates created "conflicts of interest from top to bottom" because every insurer "had a financial incentive to manipulate the data they provided" "so that the pooled data would skew reimbursement rates downward." *Id.* at 8. The report ultimately found that this system resulted in, "insurers systematically under-reimburs[ing] New Yorkers" up to 20%. *Id.*

The Senate Report reached similar conclusions, finding that the industry's database was used "to un-

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[7] http://www.ag.ny.gov/health-care/report ("*AG Report*").

der-pay millions of valid insurance claims" "without providing even the most basic information about [it] to consumers or health care providers." *Senate Report*, *supra*, at i. Because of the data inaccuracies, the database "consistently skewed reimbursement rates downwards – in a direction that allowed insurers to reduce their claims payments" by "as much as 30% lower" than market rates. *Id.* at ii.

Ultimately, insurers settled with the Attorney General and *amicus* AMA for over $450 million collectively. *Deceptive Practices, Pt. I*, *supra*, at 9, 13, 25. The Attorney General also required two structural reforms. "First, the [UCR] rates for health care charges should be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database. … Second, before consumers choose an out-of-network doctor, they should have a range or estimate of what it will cost them. … A website tool available to the public, showing at least common health care services and the market rates in relevant geographic areas, would help transparency in health care." *AG Report*, *supra*, at 3.

The Attorney General therefore required the database to be transferred to an independent non-profit, FAIR Health, Inc., which would develop a "conflict-free, robust, trusted and transparent source of data to support the adjudication of healthcare claims and to promote sound decision-making by all participants in the healthcare industry."[8] FAIR Health has now cre-

[8] http://www.fairhealthus.org/About-FH.

ated the National Private Insurance Claims Database, the nation's largest independent private claims collection. *See* Sean Nicholson, *Research Opportunities of a New Private Health Insurance Claims Data Set*. But even that only includes approximately 23.4% of national payments for privately insured patients by their insurers, to say nothing of patients insured by non-private insurance or government programs, like Medicare or Medicaid. *Id.* Because this new database collects only some of the existing medical claims data nationwide, state-wide efforts, like Vermont's, are more important than ever.

II. ERISA Does Not Preempt The Vermont Statute Because It Does Not "Relate To" Employee Benefit Plans Under ERISA §514(a).

This Court established twenty years ago that the "starting presumption" for ERISA §514(a)'s preemption analysis is that "Congress does not intend to supplant state law," especially when the "state action [occurs] in fields of traditional state regulation," like health care. *Travelers*, 514 U.S. at 654-55. Section 514 did not "alter [the] ordinary assumption that the historic police powers of the States were not to be superseded by [ERISA]," *California Div. of Labor Stds. Enforcement v. Dillingham Constr*, 519 U.S. 316, 331 (1997), absent the "clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655. Therefore, "relates to" does not "extend to the furthest stretch of indeterminacy." *Id.*

With this starting point, the Vermont statute does not "relate to" employee benefit plans so it is not preempted. 29 U.S.C. §1144(a). Instead, the state statute regulates health care – a traditional area of

state concern. The Vermont statute lies far afield from ERISA's regulatory scope and concerns.

A. The Vermont Statute Regulates Health Care, A Traditional State Concern.

Vermont's APCD statute requires numerous participants that provide and pay for medical care, including "health insurers," to submit electronically "health insurance claims and enrollment information used by health insurers," information about "health care costs, prices, quality, utilization or resources," and information needed to "determine third party liability for benefits provided." Vt. Stat. Ann. tit. 18, §§9410(c)(1), (3); §9410(h)(1)(C).

As enacted, Vermont's APCD statute falls squarely within the realm of "general health care regulation" that remains viable despite ERISA §514(a). This Court has explained repeatedly that "[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." *Travelers*, 514 U.S. at 661; *Pegram*, 530 U.S. at 237 ("in the field of health care, … there is no ERISA preemption without [a] clear manifestation of congressional purpose."); *Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985) (regulating health and safety "is primarily, and historically, a matter of local concern."); *De Buono*, 520 U.S. at 808 ("hospitals operated by ERISA plans are subject to the same laws as other hospitals.").

This Court also has held that the economic regulation of health care does not "relate to" employee benefit plans pursuant to ERISA § 514(a), although such

regulation may have an indirect, or even direct, economic effect on ERISA plans. *Travelers*, 514 U.S. at 659 ("indirect economic effect" of hospital bill surcharges does not "relate to" ERISA plan); *De Buono*, 520 U.S. at 815-16 (tax on hospital run by ERISA plan does not "relate to" plan despite direct impact on plan). "[C]ost uniformity was almost certainly not an object of pre-emption." *Travelers,* 514 U.S. at 662.

Like the state laws in *Travelers* and *De Buono*, the Vermont statute is another health care regulation that at most (and only hypothetically) "increase[s] the cost of providing benefits to covered employees [and so] will have some effect on the administration of ERISA plans." *De Buono*, 520 U.S. at 816. However, that effect alone "simply cannot mean" that the statute "relate[s] to" ERISA plans and is preempted by ERISA §514(a). *Id.* Even if "added compliance cost … may ultimately be passed on to the ERISA plan, ... such 'indirect economic effects,' are not enough to preempt state regulation even outside of the insurance context." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 399, n.11 (2002) (quoting *Travelers*, 514 U.S. at 659).

B. The Vermont Statute Does Not "Relate To" ERISA Plans.

"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." *Travelers*, 514 U.S. at 656 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)). "[R]eference to" only applies if a statute "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S.

at 325. Vermont's statute applies to health care providers, government agencies, and other entities other than health insurers (including, but not limited to TPAs for self-funded plans like Liberty Mutual's). Vt. Stat. Ann. tit. 18, §§9410(c), (j)(1).[9] Therefore, the statute has no impermissible "reference to" employee benefit plans.

The question, therefore, is whether the statute has an impermissible "connection with" such plans. The majority concluded that the APCD statute does, as applied to Blue Cross' administration of Liberty Mutual's self-funded ERISA plan, because the statute intruded on a "core ERISA function," *i.e.*, "reporting," which is "shielded from potentially inconsistent and burdensome state regulation." *Donegan*, 746 F.3d at 508.

The majority, however, misperceived the appropriate ERISA §514(a) inquiry. This Court examines both "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress under-

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[9] Since Blue Cross provides administrative services to plans exempt from ERISA (like government or church plans), those plans are still subject to the statute. *See* 29 U.S.C. §§1003(b)(1), (2). For Blue Cross' insured plans, the APCD statute presumably is saved from preemption by the insurance savings clause. 29 U.S.C. §1144(b)(2)(A). So, multiple categories of employee benefit plans remain subject to the APCD statute. As the record reflects, other self-insured ERISA plans Blue Cross administers abide by the statute voluntarily. *Donegan*, 746 F.3d at 515. This further suggests that any "burden" on Blue Cross, or the plan derivatively, is largely theoretical. It also highlights the difference between the employee benefit plan and the TPA or insurer that provides services or insurance to the plan.

stood would survive,'" and "the nature of the effect of the state law on ERISA plans," to "determine whether [the] state law has the forbidden connection" with ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). Examining ERISA's objectives and the "effect of the state law on ERISA plans," *id.*, demonstrates that §514 does not preempt the APCD statute's application to self-insured plans.

"[I]n enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-27 (quoting *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). Therefore, Congress "established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Id.* (quotation omitted).

ERISA's preemption provision addresses this primary concern by preempting several types of state regulation, particularly state laws that "mandate[] employee benefit structures or their administration," *Travelers*, 514 U.S. at 658, "provid[e] alternative enforcement mechanisms" for procuring plan benefits, *id.*, or "require[] employers to provide certain benefits" or govern the calculation of benefits. *De Buono*, 520 U.S. at 815. The APCD statute mandates nothing like these prohibited activities.

Focusing on ERISA's reporting requirement leads to the same conclusion. As the dissent explained, "under ERISA, plans must report information that goes to the financial integrity of the plan." *Donegan*,

746 F.3d at 514. Even this requirement is typically "limited to the furnishing of a summary plan description to plan participants and an annual report to the Secretary." *Id.* (citing 29 U.S.C. §§1021-30).

The APCD statute neither addresses nor impinges on these obligations, particularly for self-funded plans. As an initial matter, the Secretary of Labor has exempted Liberty Mutual's Plan (and other welfare benefit plans that pay benefits from the plan sponsor's general assets) from these reporting requirements. *See* 29 U.S.C. §1024(a)(3); *see also supra* at fn.3. But assuming *arguendo* that these reporting requirements governed the Liberty Mutual Plan, they are far afield from the statute's requirement that health insurers, including TPAs, provide "after-the-fact information" which they "already have in their possession." *Donegan*, 746 F.3d at 515. Vermont's APCD statute does not ask for information about the plan's "financial integrity," *id.* at 514, and ERISA's reporting requirements do not address anything like the topics sought pursuant to the APCD statute. *See Self-Insurance Institute of America, Inc. v. Snyder*, 761 F.3d 631, 638 (6th Cir. 2014) (ERISA only preempts "state laws requiring ERISA entities to file reports related to the plans' financial stability"). Therefore, there should be no preemption where there simply is no overlap, let alone conflict,[10] be-

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[10] The lack of conflict between the APCD statute and ERISA demonstrates that traditional conflict preemption does not apply, and the majority's reliance on *Boggs v. Boggs*, 520 U.S. 833, 840 (1997), is misplaced. *Donegan*, 746 F.3d at 506, n.8 (citing *Boggs*). This Court decided *Boggs* using conflict preemption principles and did not "inquire whether the statutory phrase

tween the state and federal requirements which do not even address the same types of information. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 16 (1987) ("It would make no sense for pre-emption to clear the way for exclusive federal regulation, for there would be nothing to regulate.").

Examining the "effect of the state law on ERISA plans," *Egelhoff*, 532 U.S. at 147, compels the same conclusion. The "basic thrust of the preemption clause … was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. The APCD statute does not impair the nationally uniform administration of employee benefit plans. As the dissent noted, "[t]he distinction between general administration and administration of plans, claims, and benefits is important." *Donegan*, 746 F.3d 516. "Many state laws 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.* Even though "[s]uch laws may impose additional costs, or require additional administrative resources," "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Id.* (citing *Dillingham*, 519 U.S. at 319).

Having "some effect on the administration of ERISA plans" does not require preemption, *De Buo-*

'relate to' provides further and additional support for the preemption claim." *Boggs*, 520 U.S. at 841.

no, 520 U.S. at 816, particularly when the law simply "alters the incentives, but does not dictate the choices, facing ERISA plans." *Dillingham*, 519 U.S. at 334. This is particularly so for economic "burdens." As discussed in *Travelers*, imposing indirect economic costs on ERISA plans does not merit preemption. Only if the "state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," would the state law be pre-empted. *Travelers*, 514 U.S. at 668.

Here, there is no evidence, except rhetorical, of burden, let alone evidence that the APCD statute "force[s] an ERISA plan to adopt a certain scheme or substantive coverage," *id.*, or "dictate[s] the choices" of ERISA plans. *Dillingham*, 519 U.S. at 334.

To the contrary, the evidence showed that Blue Cross (and other similarly-situated TPAs) "already have in their possession" the required information. *Donegan*, 746 F.3d at 515 (Straub, J., dissenting). Indeed, Blue Cross is "happy to provide the data Vermont has asked for, and it does so for other clients." *Id.* Blue Cross also presumably provides the same type of information for its insured plans (because of ERISA's insurance savings clause, 29 U.S.C. §1144(b)(2)(A)), or for plans exempt from ERISA, like church plans or governmental plans. 29 U.S.C. §§1003(b)(1), (2). Thus, it would plausibly create more "burden" on a TPA/insurer like Blue Cross to exempt the self-insured plans it administers from the statute's requirements while requiring those same obligations for its insured and ERISA-exempt plans.

It is also important to understand modern-day commercial realities. The unsubstantiated "burden" about which Liberty Mutual complains (since Blue Cross does not complain about it) does not involve collecting new information, creating new records, or amassing, compiling, and retaining piles of paper documents that would not otherwise be generated. Rather, it involves simply uploading digital documents that health care providers and insurers (or plan TPAs) already have to the Vermont database's website. *Donegan*, 746 F.3d at 515. Health providers and insurers perform virtually the same tasks, with these same records, countless times daily as providers submit claims for payment electronically to health insurer/TPAs and insurer/TPAs communicate with providers regarding these claims and/or electronically remit payment for them.

Because Vermont's statute does not "relate to" employee benefit plans under this Court's jurisprudence, particularly post-*Travelers*, the Second Circuit's analysis should be reversed.[11]

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[11] Though appropriately interpreting "relates to" makes a savings clause analysis unnecessary, another basis for reversing the majority's decision is that it is saved from preemption by the insurance savings clause. 29 U.S.C. §1144(b)(2)(A). The APCD statute does not attempt to regulate self-funded ERISA plans; instead, it regulates, *inter alia*, insurers and TPAs, like Blue Shield, who process claims for self-funded ERISA plans. This Court has distinguished between permissible regulation of service providers to self-funded plans and impermissible direct regulation of ERISA plans themselves. *See FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (discussing "Congress' clear intent to exempt from direct state insurance regulation ERISA *em-*

III. ERISA §514(a) Preemption Should Be Clarified.

Despite this Court's statements since *Travelers*, the Second Circuit held that the Vermont statute "relate[s] to" employee benefit plans. This and similar holdings in the lower courts highlight the persistent lack of clarity concerning the scope of "relate to" preemption under ERISA §514(a). Preemption under §514(a) operates as field preemption, with the States ousted of all regulatory authority over matters that "relate to" ERISA plans. Section 514(a) preemption therefore potentially creates regulatory voids. This is not a problem where Congress intended to create a regulatory gap, such as leaving unregulated employer decisions whether to offer benefit plans. However, it is a problem when there is no indication that Congress intended to preclude States from regulating areas like health care and the practice of medicine. There is a strong need, therefore, to better define the scope of "relate to" preemption and thereby specify the boundary of the preempted field.

This Court has expressed concern that the boundaries of ERISA §514(a) "relate to" preemption are difficult to discern. *Travelers*, 514 U.S. at 655 ("we have to recognize that our prior attempt to construe the

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ployee benefit plans."). Insured plans, and TPAs for self-insured plans, remain "open to indirect regulation" by insurance regulations, because of the interplay between the savings clause and the deemer clause. *Metropolitan Life*, 471 U.S. at 747; *Rush Prudential*, 536 U.S. at 371 (nothing "stand[s] in the way of applying the savings clause ... [to] a contractor that provides only administrative services for a self-funded plan.").

phrase 'relate to' does not give us much help drawing the line here.") (internal citation omitted); *De Buono*, 520 U.S. at 813. It has also grappled repeatedly with how to derive substance from the limiting phrase "relate to" and thereby set meaningful boundaries to the scope of §514(a). *Travelers*, 514 U.S. at 655 ("[if] 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for 'really, universally, relations stop nowhere.'") (internal citation omitted); *Dillingham*, 519 U.S. at 329 ("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 pre-emptive reach, and the words 'relate to' would limit nothing.").

Amici therefore propose refining ERISA §514(a)'s preemption analysis to more clearly separate the areas occupied by ERISA's exclusive federal regulation from other areas of state regulation, like health care and the practice of medicine. The basics of this approach are straightforward. First, the scope of ERISA's regulatory domain should be identified based upon the structure and content of ERISA as a whole. Second, the scope of field preemption under ERISA §514(a) should be congruent with ERISA's regulatory domain. This approach gives meaningful content to §514(a)'s language. It preempts state laws where it makes substantive sense to do so. It also maintains the Court's traditional "starting presumption" that "Congress does not intend to supplant state law," particularly in areas of "traditional state regulation." *Travelers*, 514 U.S. at 654-55. Therefore, it

respects "the separate spheres of governmental authority preserved in our federalist system," *Fort Halifax*, 482 U.S. at 19, and avoids the "unsettling" possibility that ERISA §514(a) "results in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Dillingham*, 519 U.S. at 330.

A. ERISA Regulates Employee Benefit Plans And Relationships Between Plans And Other ERISA-Regulated Entities.

ERISA's core focus is upon the establishment, content and operation of the "employee benefit plan." An employee benefit plan is the formal mechanism through which a plan sponsor (usually the employer) provides benefits to employees and related plan beneficiaries. 29 U.S.C. §§1002(1)(A), 1002(3).

An ERISA plan is "established and maintained pursuant to a written instrument." *Id.*, §1102(a)(1). That instrument must identify at least one named fiduciary with authority to control and manage the plan's operation and administration, including the responsibility to deny benefit claims. *Id.,* §1102(a)(1), §1133(2). Every employee benefit plan must also establish procedures for funding and amending the plan, allocating responsibility for operating the plan, and specifying how payments are made to and from the plan. *Id.*, §1102(b).

A plan must provide a summary plan description ("SPD") to plan participants and beneficiaries, written in plain English, which summarizes the plan. *Id.*, §1122; 29 C.F.R. §2520.102-3 (SPD contents). An employee benefit plan must afford plan beneficiaries a process for reviewing benefit denials. 29 U.S.C.

§1133(2). It is also a distinct legal entity that "may sue or be sued" for plan benefits and other purposes. *Id.*, §1132(d)(1).

ERISA regulates the administration of employee benefit plans by imposing reporting and disclosure requirements regarding the plan's financial integrity, *id.*, §§1021-31 (except for exempted welfare benefit plans), participation and vesting requirements (except for welfare benefit plans), *id.*, §§1051-61, funding obligations (except for welfare benefit plans), *id.*, §§1081-86, and administrative provisions and civil and criminal enforcement provisions. *Id.*, §§1131-45.

ERISA regulates more than the plan itself. It also regulates the relationships between plans and other specified entities and individuals. Principally, these other entities and individuals are the "employer" or "plan sponsor," *id.*, §1002(5), §1002(16)(B), the plan "participant" or "beneficiary," *id.*, §1002(7) and (8), the plan "administrator," *id.*, §1002(16)(A), and plan "fiduciar[ies]." *Id.*, §1002(21)(A).

Some courts have called these entities the "traditional ERISA entities," *Bullock v. Equitable Life Assur. Soc. of U.S.,* 259 F.3d. 395, 399 (5th Cir. 2001), and limited ERISA preemption to addressing "the relationships among the core ERISA entities." *Donegan*, 746 F.3d at 507 (quoting *Stevenson v. Bank of N.Y. Co.*, 609 F.3d 56, 61 (2d Cir. 2010)); *Hattem v. Schwarzenegger*, 449 F.3d 423, 429-32 (2d Cir. 2006);

Gerosa v. Savasta & Co., 329 F.3d 317, 324 (2d Cir. 2003).[12]

ERISA imposes comprehensive decision-making duties on plan fiduciaries, 29 U.S.C. §1104, imposes liability to the plan for breaching those duties, *id.*, §§1105, 1109, and prohibits certain transactions between a plan and a plan fiduciary. *Id.*, §1106(b). ERISA imposes obligations on the employer or sponsor to fund the plan and maintain records, *id.*, §§1059, 1082, 1083, prohibits the employer from using plan assets for its own benefit, *id.*, §1103(c), and restricts the plan's ability to purchase the employer's securities. *Id.*, §1107. The plan administrator, who may be the plan sponsor, has various disclosure obligations, including the duty to file annual and other reports for the plan, *id.*, §§1021, 1023-24, along with notices of significant reductions in benefit accruals. *Id.*, §1054(h). Regarding plan participants and beneficiaries, ERISA prescribes the plan's obligations to participants for the accrual and payment of plan benefits, *id.*, §§1054, 1056, creates a private right of ac-

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[12] *See also Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376 (5th Cir. 2011), *reinstated en banc*, 698 F.3d 229 (5th Cir. 2012) ("whether the claims affect an aspect of a *relationship* that is comprehensively regulated by ERISA" determines preemption); *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692, 698 (6th Cir. 2005) (same); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1053 (9th Cir. 1999) (same); *Morstein v. National Insurance Services, Inc.*, 93 F.3d 715, 722 (11th Cir. 1996) ("when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such," no preemption); *Lordmann Enterp., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994) (same).

tion against the plan, *id.*, §1132(a), and provides a participant with a right to a notice of denial benefits claimed under the plan. *Id.*, §1133.

To a much lesser extent, ERISA addresses the relationship between plans and insurance companies. (Though insurer/TPAs often muddy this distinction to benefit from preemption, it should go without saying that the plan and the insurer or TPA are separate entities). ERISA acknowledges that plans may provide welfare benefits to plan participants "through the purchase of insurance or otherwise." *Id.*, §1002(1). ERISA obligates an insurer that provides plan benefits or holds plan assets to provide information to the plan administrator for the plan's annual report. *Id.*, §1023(a)(2)(A). It establishes requirements for ensuring the adequacy of an insurer's assets when an insurance policy has been purchased for the benefit of participants in an employee pension benefit plan. *Id.*, §1101(b), (c). However, ERISA does not presume that a relationship between an employee benefit plan and an insurer necessarily exists. Moreover, if that relationship exists, ERISA does not comprehensively regulate it. Rather, ERISA cedes to the states almost all the regulation of the insurer-plan relationship via the insurance savings provision. 29 U.S.C. §1144(b)(2)(A). Finally, ERISA does not directly regulate medical providers, or other third-party service providers (like TPAs), at all.

B. The Scope Of ERISA §514(a) "Relate To" Field Preemption Should Coincide With ERISA's Domain.

ERISA §514(a)'s "relate to" provision should preempt a field co-extensive with ERISA's regulatory

domain – that is, ERISA §514(a) should only preempt state laws that primarily regulate employee benefit plans (including their establishment, content, or administration) or the relationships between plans and other entities and individuals that ERISA regulates. This construction gives meaning to the statutory term "relate to," because the preempted field should encompass more than state laws regulating the plan itself. It also gives meaning to ERISA §514(a)'s preemption provision as a whole, because the result is field preemption (rather than merely conflict preemption based upon specific statutory provisions). *Cf. Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring) ("it accurately describes our current ERISA jurisprudence to say that we apply ordinary field preemption, and, of course, ordinary conflict preemption"); *Egelhoff*, 532 U.S. at 152-53 (Scalia, J., concurring); *id.* at 153-54 (Breyer, J., dissenting).

For example, ERISA does not require employers to have employee benefit plans or "mandate what kinds of benefits employers must provide if they choose to have [an employee benefit] plan." *Pegram*, 530 U.S. at 226-27. Nevertheless, because ERISA §514(a) preempts the field encompassed by ERISA's regulatory domain (which begins with the employee benefit plan itself), States may not mandate the benefits such plans must provide. *Dillingham*, 519 U.S. at 328. Similarly, because ERISA's domain encompasses the relationship between the plan and plan administrator, a state law that dictates aspects of that relationship "relate[s] to" the plan – regardless of whether ERISA addresses that aspect of the relationship. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 378-79 (1999) (state law making the "policyholder-employer the agent of the insurer.").

This reading of "relates to" reinforces ERISA's overarching statutory objectives. It preserves for exclusive federal regulation those areas that ERISA regulates but does not potentially create regulatory voids beyond ERISA's regulatory scope. This analysis also helps clarify the scope of ERISA §514(a)'s field preemption. The boundaries of the preempted field are delimited by ERISA's regulatory scope.

At the same time, statutes that regulate relationships between ERISA plans and parties not regulated by ERISA fall outside the scope of ERISA field preemption under *amici*'s proposed construction of §514(a). *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 833 (1988) ("lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted). Likewise, laws of general application that do not regulate employee benefit plans but may have some economic or other "effect" on them are not within the field preempted by §514(a). *See Travelers*, 514 U.S. at 659; *Dillingham*, 519 U.S. at 334; *De Buono*, 520 U.S. at 815-16. Areas that States historically regulate, like medicine, are even further afield from ERISA's regulatory domain and are not preempted, consistent with the Court's traditional presumption against preemption. *Pegram*, 530 U.S. at 236-37 (mixed eligibility and medical treatment decisions are outside ERISA's domain); *Travelers*, 514 U.S. at 654-55.

Focusing the ERISA §514(a) analysis, therefore, on whether the state law primarily regulates the establishment, content or administration of an employee benefit plan or its relationships with other ERISA-

regulated entities gives meaningful content to §514(a). It also defines the scope of ERISA field preemption in ways that coincide with the statute as a whole, while leaving States able to regulate within their traditional "separate sphere[] of governmental authority." *Fort Halifax*, 482 U.S. at 19. By more clearly defining the field preempted by §514(a)'s "relate to" provision, the areas of state law that lie outside the preempted field, including health care and the practice of medicine, are more easily identifiable.

C. State Laws Regulating Health Care Are Outside ERISA's Domain And So Outside The Field ERISA §514(a) Preempts.

Vermont's APCD statute is not preempted by ERISA §514(a) under the construction *amici* advocate. First, the APCD statute does not regulate employee benefit plans. As discussed in Part IA, *supra*, it regulates various actors that provide and pay for health care, including health care providers and insurers (including TPAs for self-insured plans). Second, it does not regulate the relationship between ERISA's "core," "principal," or "traditional" entities. Rather, it operates independently of any connection to an ERISA plan, is directed at entities ERISA does not directly regulate, and does not regulate ERISA relationships in any meaningful way.

For these reasons, the Vermont statute does not "relate to" employee benefit plans under ERISA §514(a). It directly and primarily regulates a sphere not governed by ERISA and entities not regulated by ERISA. The statute therefore does not relate to em-

ployee benefit plans and is not within the field preempted by ERISA §514(a).

CONCLUSION

Applying the Court's *Traveler*'s analysis, Vermont's APCD statute does not "relate to" employee benefit plans. It is simply "general health care regulation" reserved to the States and undisturbed by ERISA. This case also suggests that refocusing the ERISA §514(a) preemption analysis on the "employee benefit plan" and the plan's relationships with other ERISA-regulated entities will provide the Court with a more useful way to analyze "relate to" preemption. *Amici*'s proposed analysis adheres to the statutory text and the objectives of both ERISA's substantive provisions and preemption provision. Under this analysis, Vermont's APCD statute clearly is outside the field preempted by ERISA §514(a).

The judgment below should be reversed.

Respectfully submitted,

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September 4, 2015