No. 14-181

In The Supreme Court of the United States

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

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF AMICUS CURIAE OF THE STATE OF NEW HAMPSHIRE IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

OTHER AUTHORITIES

TABLE OF AUTHORITIES – Continued

Page

NEW HAMPSHIRE'S INTEREST AS AMICUS CURIAE[1]

New Hampshire was the first state to use price transparency and market forces to foster competition and consumer choice in its health insurance markets through its comprehensive health claims database and website, both of which were created as an integral part of the state's system of insurance regulation. These efforts, which have helped to rein in health cost growth in New Hampshire, would be thwarted were this Court to affirm the ruling by the Second Circuit Court of Appeals that Vermont's health claims data reporting law, Vt. Stat. Ann. tit. 18, § 9410, is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. Chapter 18 ("ERISA").[2] New Hampshire submits this brief to support Vermont's position that its law is not preempted, and to bring to the Court's attention the serious implications of this case for states' continued ability to serve as the primary regulators of their health insurance markets.

In 2007, the New Hampshire Insurance Department ("NHID") launched NH HealthCost,[3] a

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[1] New Hampshire submits this brief pursuant to Supreme Court Rule 37.4.

[2] *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014).

[3] http://nhhealthcost.nh.gov/ As noted on the site's home page, NH HealthCost was developed by the NHID to improve the price transparency of health care services in New Hampshire. Through NH HealthCost, New Hampshire residents can compare prices from health care providers throughout the state

(Continued on following page)

consumer-friendly website that makes information derived from the state's all-payer claims database directly accessible to all members of the public – not only to researchers, legislators and health industry players, but also to consumers and employers, the individuals and organizations that purchase and use health insurance and health care services.[4] NH HealthCost users can easily compare the cost of having a medical procedure performed by different medical providers within the state, understand what their cost-sharing obligation would be for the procedure, and see what different insurance carriers have paid to different providers to perform the procedure. Making claims data public has helped consumers, who in New Hampshire as in the rest of the country face an increasing burden of cost-sharing in today's

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on more than two dozen medical procedures, including MRIs, CT scans, ultrasounds, and X-rays. The information on the site is derived from claims data collected from New Hampshire's health insurers and stored as a part of the Comprehensive Health Care Information System (NHCHIS). Data on the NH HealthCost website is updated quarterly.

[4] In 2015, New Hampshire was the only state to receive an "A" for Price Transparency from the Health Care Incentives Improvement Institute, which found that the NH HealthCost site is "a prime example of a price transparency website built with consumers in mind. The site accounts for both insured and uninsured patients and provides great details on the methodology in consumer-friendly terms." 2015 Report Card on State Price Transparency Laws, July 2015 at 1, Health Care Incentives Improvement Institute, http://www.hci3.org/sites/default/files/files/2015_Report_PriceTransLaws_06.pdf.

health insurance markets and are expected to act as prudent purchasers of health care services.[5]

The availability of data through NH HealthCost has also fostered competition in New Hampshire's markets. Use of the site enables insurance carriers to better understand the market price for health care services, encouraging competition including the development of health plan designs that create incentives for using lower-cost providers.[6] The transparency created by the NH HealthCost website has given New Hampshire employers, including those operating health plans governed by ERISA, access to statistics on market characteristics and the market shares of

[5] The NHID's most recent comprehensive report on health insurance markets found that between 2012 and 2013, "average deductibles grew $148 or by 10% overall. Over the same time period, the average for non-zero deductibles grew 8% overall." *Supplemental Report of the 2013 Health Insurance Market in New Hampshire*, January 14, 2015 ("2013 NH Market Report") at 17, http://www.nh.gov/insurance/lah/documents/2013_nhid_suprpt.pdf.

[6] A recent article described how New Hampshire's experience "suggests that publishing payment rates can have an impact on negotiations between insurers and providers," and noted that the initiative "also has encouraged new health plan benefit designs that are sending consumers to lower-cost care settings, and prompted hospitals to offer patients lower-cost care settings." Kutscher, Beth, "How New Hampshire Took the Guesswork Out of Health Costs," Modern Healthcare, July 16, 2015, http://www.modernhealthcare.com/article/20150716/NEWS/150719922.

insurance companies and third party administrators.[7] This information can help employers, including self-funded employers, understand how the benefits they offer compare with those offered by other employers in the state, and how they can lower the cost of providing coverage for their employees in New Hampshire.

The usefulness of the NH HealthCost website will be significantly diminished if the Insurance Department can no longer obtain claims data from state-regulated entities that administer plans on behalf of self-funded employers. More than half of New Hampshire residents with privately-funded health coverage receive coverage through a self-funded employer plan that is administered by an insurance company or other state-regulated entity, and these claims have always been part of New Hampshire's claims database.[8] Were a ruling in this

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[7] The "Health Costs for Employers" section of the NH HealthCost website includes a link to the NHID's 2013 NH Market Report, *supra* n.5, which includes summary market statistics on premiums, plan design and benefit richness, as well as information about the market share of insurance carriers, including those acting as third-party administrators.

[8] As of the spring of 2014, 531,844 New Hampshire residents had health coverage not from Medicaid/Medicare, and of these 291,388 were covered through self-funded plans. *See* Wakely Report on NH Health Insurance Markets, August 18, 2014, Table 3.1.1, http://www.nh.gov/insurance/reports/documents/wakely_ma_rpt_pr.pdf. The 2013 NH Market Report showed a similar distribution of fully-insured and self-insured membership. 2013 NH Market Report at 28, Table 26, *supra* n.5.

case to call into question the obligation of a New Hampshire insurance company, health maintenance organization ("HMO") or third-party administrator ("TPA") to report claims data associated with self-funded ERISA plans, or even potentially the data of an employer purchasing fully-insured coverage, the state would lose a valuable resource that has contributed to the development of private market solutions to the problem of rising health costs.

SUMMARY OF ARGUMENT

The Second Circuit's holding that Vermont's health claims reporting law is preempted because it implicates the core ERISA function of "reporting" is based on a fundamental misunderstanding of the nature of claims data reporting, the purposes of ERISA, and the character of ERISA preemption. The application of Vermont's health claims data reporting law to the health plan operated by Liberty Mutual Insurance Co. ("Liberty Mutual") is not preempted under ERISA, because the reporting obligation under the law arises only after the plan's claims have already been adjudicated and paid by Liberty Mutual's TPA, Blue Cross Blue Shield of Massachusetts ("Blue Cross").

Under this Court's reading of section 514 of ERISA, state laws are preempted if they "relate to" plan administration in a way that would interfere with an employer's ability to administer its employee

benefits uniformly across the country. Vermont's law does not mandate particular benefit structures or the coverage of particular services, nor does it impose any requirements with respect to the manner, timing or amount of claims payments. Rather, the reporting obligation arises after, and is entirely distinct from, administration of the plan. The reporting itself is performed by Blue Cross, an insurance-regulated entity that is independently responsible under Vermont law for submitting claims data for all the plans it administers for Vermont residents.

New Hampshire's claims data reporting laws, which like Vermont's law require the submission of claims data only after the claims have been adjudicated, represent a new form of insurance regulation – one that uses big data to stimulate market competition. New Hampshire has enacted extensive reporting requirements as part of its Insurance Code, for the express purpose of facilitating the functioning of insurance markets in the state and using market forces to contain costs. These laws are rooted squarely in the authority of the Insurance Commissioner and are binding only on insurance-regulated entities – insurance companies, HMOs, and TPAs. Yet this new effort, unlike states' traditional insurance regulation of solvency, covered benefits and claim processing, has no equivalent within ERISA. This Court's traditional analysis of insurance regulation under ERISA's savings and deemer clause is ill-suited to address the data-driven facilitation of markets in which New Hampshire is engaged. Rather, the standard that is

properly applicable to New Hampshire's law, and to Vermont's, is whether these laws "relate to" operation of an ERISA plan in the first instance.

Because the reporting obligation does not interfere with the administration of the employee benefit plan, either by Liberty Mutual or by Blue Cross, the claims data reporting law does not "relate to" an ERISA plan within the parameters of this Court's interpretation of ERISA. Vermont's claims data reporting law is not preempted, and the judgment of the Second Circuit should be reversed.

ARGUMENT

I. State Laws Are Not Preempted Under ERISA Unless They "Relate To" Core ERISA Plan Functions In A Way That Prevents National Uniformity In Plan Administration.

Congress enacted ERISA to protect employees by creating a uniform system of regulation for employer-sponsored benefit plans, including health plans. ERISA governs the plans' financial status and administration, creating standards of conduct and fiduciary obligations associated with the management of funds and the administration of claims, as well as reporting obligations and remedies designed to ensure financial solvency and fair treatment of plan participants. *See, e.g.*, 29 U.S.C. § 1001(b) (Congressional findings and declaration of purpose). Consistent with the law's purpose, ERISA's reporting requirements pertain to

the plan's financial status. 29 U.S.C. § 1021(b), (c) and (g) (filing of annual, terminal and supplementary reports with Secretary of Labor; reporting by multiple employer welfare arrangements); 29 U.S.C. § 1023 (details of annual reports).[9] In order to allow uniform plan administration for employers operating in multiple states, Congress included a provision specifying that ERISA preempts all state laws "insofar as they may now or hereafter relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a).

The broad reach of preemption under ERISA has been narrowed by this Court's rulings. In *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*., this Court observed that the expansive language of ERISA is still subject to "the starting presumption that Congress does not intend to supplant state law." 514 U.S. 645, 654 (1995) ("*Travelers*"). Acknowledging that a broad reading of the term "relate to" could result in more sweeping preemption than Congress intended, the Court looked to ERISA's central objective of eliminating the threat

[9] The other requirements under ERISA's Reporting and Disclosure Part relate to notices and disclosures, not to reporting. ERISA requires plan administrators to provide plan participants and beneficiaries with summary plan information, and with notice of a variety of financial circumstances and transactions. *See, e.g.*, 29 U.S.C. § 1023(a) (summary plan description); (d) (notice of failure to meet minimum funding standards); (e) (notice of transfer of excess pension assets to health benefits accounts) and (f) (defined benefit plan funding notices).

of conflicting and inconsistent state and local regulation of plans governed by ERISA. *Id.* at 657. Surveying the cases in which state laws had been found to be preempted, the *Travelers* Court noted that "[i]n each of these cases, ERISA pre-empted state laws *that mandated employee benefit structures or their administration*." *Id.* at 658 (emphasis added).[10] State laws providing alternative enforcement mechanisms are also preempted. *Id*.

In keeping with the traditional regulatory role of the states with respect to insurance, ERISA includes a "savings clause" for insurance laws, as well as a "deemer clause" that prevents states from treating self-funded employers themselves, as opposed to the insurance carriers with whom they contract, as being subject to state insurance regulation. 29 U.S.C. §§ 1144(b)(2)(A) and (B).[11] The insurance savings

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[10] This Court has ruled that state laws are also preempted if they contain a "reference to" an ERISA plan, *see Donegan*, 746 F.3d at 508, n.9; however, in this case there is no allegation of such a basis for preemption.

[11] The Eleventh Circuit has outlined the steps involved in an analysis of these clauses of ERISA:

> [I]n determining whether a challenged law is expressly preempted under Section 514 of ERISA, we first look to whether it 'relates to' employee benefit plans. If it does not, the law is not preempted. If it does 'relate to' employee benefit plans, we then turn to whether the law is 'saved' by the Savings Clause. If saved, we must determine whether the Deemer Clause applies. If the Deemer Clause applies, then the

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clause is relevant because of the implications of this case for insurance regulation in states like New Hampshire, where health claims information is gathered and used as part of the state's regulation of insurance. Examining the way this Court has approached cases involving the savings and deemer clauses is also necessary because Liberty Mutual relies on its status as a self-funded employer in arguing that Vermont's law is preempted as applied to its claims data.

Under this Court's rulings, an insurance law will escape preemption even in a case involving a self-funded ERISA plan so long as the law does not "relate to" administration of the plan, because the first step in the preemption analysis under section 514 of ERISA is always to look at whether the state law "relates to" the plan. Accordingly, this Court has read the deemer clause to preempt the direct application of state insurance laws to a self-funded ERISA plan only when the state regulation "relates to" the plan: "We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause. . . . [S]elf-funded ERISA plans are exempt from state regulation *insofar as that regulation 'relate[s] to' the plans*." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (emphasis added).

Savings Clause does not serve to protect the law from preemption.

America's Health Ins. Plans v. Hudgens, 742 F.3d 1319, 1330 (11th Cir. 2014).

Thus, nothing in the savings or deemer clauses alters this Court's fundamental approach to ERISA preemption: state laws, including insurance laws, are preempted when they "relate to" the administration of an employee benefit plan, but not when they have only an indirect effect on the plan's administration. *Travelers*, 514 U.S. at 658.

This Court's cases finding ERISA preemption with respect to self-funded ERISA plans have all involved state laws that relate *directly* to the operation or administration of the ERISA plan, including the remedies available to employees enrolled in the plan. In considering whether an HMO physician qualified as an ERISA fiduciary, the Court examined the meaning of the word "plan," noting that "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000). In its ERISA preemption cases, this Court has consistently interpreted section 514's "relate to an employee benefit plan" language as involving interference with the actual administration of benefits. *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (statute revoking spouse's plan beneficiary designation in the event of divorce preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status . . . this statute governs the payment of benefits, a central matter of plan administration"); *Cal. Div. of Labor Stds.*

Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 328 (1997) (noting that Court's cases finding preemption involved "state statutes that 'mandated employee benefit structures or their administration'"); *Holliday*, 498 U.S. 52, 60 (state law precluding ERISA plan from seeking reimbursement from claimant's tort recovery to offset medical payments preempted; requiring plan providers to comply with such laws in every state "would complicate the administration of nationwide plans"); *see also America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014) (Georgia prompt pay law preempted as to self-funded ERISA plans, because the law specifies the timeframes in which the plan must process and pay provider claims, or notify claimants of claim denials).

In sum, under this Court's rulings, the first step in determining whether Vermont's data reporting law is preempted under ERISA is to examine whether the law affects the core plan functions outlined in *Pegram*, such as definition of benefits, submission of claims, and resolution of disagreements over entitlement to services. This Court has made clear that state law requirements interfering in such functions with respect to self-funded ERISA plans are preempted under section 514 of ERISA, because they would undercut Congress's goal of allowing national uniformity in the way these plans are administered. Under the same logic, state laws that do not directly affect plan administration are not preempted, whether in the

context of insurance regulation or any other area of state jurisdiction.

II. In New Hampshire, Health Claims Data Reporting Laws Are Part Of The State's Regulation Of Insurance Markets, But Have No Direct Impact On Claim Or Plan Administration.

In the case under appeal, the Second Circuit's analysis rests almost entirely on the principle "that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 508 (2d Cir. 2014). The Second Circuit erred, however, in failing to consider the nature of the reporting required under the state law, or the entity on whom the burden of reporting fell. As noted by the dissent, Vermont's reporting requirement "differs in kind from the 'reporting' that is required by ERISA, and therefore was not the kind of state law Congress intended to preempt." *Id.* at 511 (Straub, J., dissenting in part and concurring in part).

Claims data reporting laws like those in Vermont and New Hampshire involve a type of reporting that falls outside the scope of both ERISA and traditional insurance regulation. The states' traditional regulation of insurance focuses on two main areas: ensuring that insurance companies are solvent and able to pay claims; and ensuring that benefits under the insurance policy are structured and paid in accordance

with any applicable legal requirements. Both of these regulatory areas have equivalents under ERISA, which concerns itself with the financial status of employer plans and preempts state laws governing the administration of plan benefits. In addition, ERISA provides remedies to employees for violations of the plan operator's fiduciary obligations; these preempt statutory and common law remedies that would otherwise be available in state court. *Aetna Health v. Davila*, 542 U.S. 200 (2004). For an ERISA plan, the selection of covered benefits and the processing of claims are governed by the ERISA plan documents and contracts, and are subject to state insurance law requirements only if the plan is fully insured – i.e., if an insurance-regulated entity bears the risk of paying claims under the plan.[12]

New Hampshire's health data claims reporting requirements are part of the state's regulation of insurance markets, but unlike typical insurance laws, they do not regulate the content or administration of insurance plans. New Hampshire's insurance rules contain detailed requirements applicable to claim adjudication for insurance policies issued by an entity

[12] *See, e.g.*, *Metropolitan Life Ins Co. v. Whaland*, 119 N.H. 894, 901-02, 410 A.2d 635, 639-40 (N.H. 1979) (ERISA does not preempt state insurance laws with respect to an insurance policy purchased by an employer; state law is saved under 29 U.S.C. § 1144(b)(2)(A) even though it relates to an employee benefit plan.).

regulated under state insurance law,[13] but these are separate from the rules governing the submission of claims data, and are not applicable to self-funded ERISA plans.

Claims data reporting in New Hampshire takes place only after a claim has been adjudicated – after the insurance company or TPA has made a determination about whether or not to pay the claim. The administrative rules provide that the data files to be submitted are "composed of service level remittance information *for all adjudicated claims* for each billed medical service provided to members." N.H. Admin. Rules, Ins 4002.01(q) (definition of "medical claims file") (emphasis added). Nothing in the claims reporting rules dictates that claims be adjudicated in any particular manner, only that the data be submitted once the claims have been adjudicated.

New Hampshire's data reporting laws are part of the Insurance Code, Title XXXVII of the state's Revised Statutes Annotated, and were placed by the legislature in N.H. Rev. Stat. Ann. chapter 420-G, which governs the Portability, Availability, and Renewability of Health Coverage. Under New Hampshire's

[13] *See, e.g.*, N.H. Admin. Rules, Ins chapter 400 (Filings for Life, Accident and Health Insurance); N.H. Admin. Rules, Ins Part 1001 (Claim Settlement for All Insurers, Except Property and Casualty); N.H. Admin. Rules, Ins chapter 1900 (Accident and Health Insurance); N.H. Admin. Rules, Ins chapter 2200 (Health Maintenance Organizations); N.H. Admin. Rules, Ins chapter 2700 (Managed Care).

statute, all health carriers and third-party administrators are required to provide their encrypted claims data electronically to the NHID and the New Hampshire Department of Health and Human Services. N.H. Rev. Stat. Ann. 420-G:11, II. The two agencies are charged with "collaborating in the development of a comprehensive health care information system," commonly referred to as the "CHIS database." N.H. Rev. Stat. Ann. 420-G:11-a, I. The information reported through the CHIS database is used, among other things, to populate the NH HealthCost website.

New Hampshire's claims data reporting law is part of a comprehensive statutory approach aimed at improving market competition through transparency, and rooted in the regulatory authority of the NHID commissioner. The state legislature created the CHIS database for the purpose of increasing transparency in order to enhance consumer choice, foster competition in health insurance markets, and inform public policy decisions. In addition to its placement in the heart of the Insurance Code, the provision's language expressly articulates an intention of using transparency to bring down costs:

> . . . the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to

> make informed and cost-effective health care choices.

N.H. Rev. Stat. Ann. 420-11-a, I. Under other sections of New Hampshire's Portability, Availability, and Renewability of Health Coverage law, the NHID has authority to require carriers to submit additional information about their coverage and product design, which the NHID uses to, among other things, hold an annual hearing and produce an annual report on health markets and premium rate trends. N.H. Rev. Stat. Ann. 420-G:14-a, I-III.

New Hampshire's use of the claims data is specifically focused on lowering health costs. By law, the NHID is obligated to compile and use data about New Hampshire's health markets in connection with an annual hearing "concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year." N.H. Rev. Stat. Ann. 420-G:14-a, V. Specifically, the NHID commissioner:

> shall identify variations in the price that health carriers pay for health care services and shall undertake further analysis to determine whether the observed price variations correlate to the sickness or the complexity of the population served, the relative proportion of patients on Medicare or Medicaid that are served by the health care provider, the cost to the health care provider of delivering the service, or the relative

> proportion of free or reduced care provided to the uninsured.

Id. The commissioner has authority to compel health carriers and third-party administrators to testify at the public hearing, and to "produce documents and information deemed necessary and relevant to evaluate the factors that contribute to cost growth in health care services, increased utilization of health care, and health insurance premium costs." *Id*. The commissioner is also responsible for preparing an annual report "which identifies and quantifies health care spending trends and the underlying factors that contributed to increases in health insurance premiums." N.H. Rev. Stat. Ann. 420-G:14-a, VI(a).

The comprehensive approach to market regulation laid out in the New Hampshire statutes can be successful only if the data being analyzed includes that of self-funded employers. New Hampshire's levels of employer-based coverage are the highest in the country, and self-funded employer plans are the source of coverage for more than half of those state residents whose health coverage is not publicly funded through Medicare or Medicaid.[14] Therefore, this case threatens not only the commissioner's ability to obtain data for NH HealthCost, but his ability to obtain necessary information from the

[14] NHID 2012 Annual Report on Cost Drivers, December 2013, at 9, http://www.nh.gov/insurance/reports/documents/nhid_ann_rrhrng_2013rpt.pdf.

entities he licenses in order to carry out his other responsibilities set forth in N.H. Rev. Stat. Ann. 420-G:14-a.

New Hampshire's law does not require the submission of claims data directly by a self-funded plan or a health care provider, but rather by the insurance-regulated entity that administers the plan's claims. The statute applies only to "health carriers, licensed third party administrators, and any entity required to be registered with the commissioner pursuant to RSA 402-H." N.H. Rev. Stat. Ann. 420-G:11, II.[15] Employers are excluded from New Hampshire's definition of third-party administrator. N.H. Rev. Stat. Ann. 402-H:1, I(a).[16] However, insurance-regulated entities involved in claims administration must include the claims data for self-funded employers whose claims they administer.[17] The NHID's

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[15] N.H. Rev. Stat. Ann. 402-H:11-a allows registration as an alternative to licensure for certain claims administrators.

[16] Similarly, the administrative rules governing the submission of claims data impose no reporting obligations on a "plan sponsor," a definition that includes employers, but only on a "carrier" or a "third party administrator." N.H. Admin. Rules, Ins 4005.01 (filing requirement); Ins 4002.01(e),(w) and (ad) (definitions), effective July 10, 2015.

[17] Because New Hampshire's claims reporting law is part of the state's system of insurance regulation, authority for enforcing it rests solely with the NHID commissioner. The chapter's penalties section provides that:

> [a]ny health carrier who. . . . shall in any way violate this chapter may . . . I. Be prohibited from marketing, selling, or otherwise administering to the individual

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administrative rules governing the submission of claims data have long made clear that carriers, including carriers acting as third party administrators, are responsible for submitting claims data for all New Hampshire residents whose claims they administer:

> Beginning on June 1, 2005, and continuing thereafter in accordance with the submission schedule set forth in Ins 4005.05, each carrier and each health care claims processor shall submit to the NHID and to the DHHS, or their designee, a completed health care claims data set for all residents of New Hampshire and for all members who receive services under a policy issued in New Hampshire. Data submission requirements apply to members that meet either criterion.

> or small employer market . . . II. Be subject to an administrative fine not to exceed $2,500 for each violation[; and/or] III. Have its certificate of authority indefinitely suspended or revoked at the discretion of the commissioner.

N.H. Rev. Stat. Ann. 420-G:16. When carriers have failed to submit data, the NHID has proceeded with enforcement action under the insurance laws to obtain compliance, and has issued at least one show cause order scheduling a hearing under N.H. Rev. Stat. Ann. 400-A:17 for such a violation. Order to Show Cause and Notice of Hearing, New Hampshire Insurance Department, In re: Celtic Insurance Company, Docket No. 12-041-EP, available at http://www.nh.gov/insurance/legal/enforcement/documents/12-041-ep.pdf.

Former N.H. Admin. Rules, Ins 4004.01(a); *see also* N.H. Admin. Rules, Ins 4005.01 (effective July 10, 2015).

While the claims data reporting requirements are detailed and technical, they are very familiar to insurance-regulated entities, which already maintain their data in a format compatible with state data reporting requirements. In 2013, out of 363,945 self-funded members in New Hampshire, 362,843 had their claims administered by Anthem, Cigna, Harvard Pilgrim or Aetna, each of which also wrote a substantial amount of fully-insured coverage in the state.[18] Thus, in New Hampshire, the vast majority of self-funded plans are administered by licensed insurance companies or HMOs, large entities which are already subject to New Hampshire's claims reporting requirement with respect to their fully-funded coverage, so data for self-funded members can be submitted via the same systems these companies are already using.

III. New Hampshire's Successful Transparency Efforts Could End If This Court Rules That Vermont's Law Is Preempted

A ruling that Vermont's law is preempted would have a devastating effect on New Hampshire's efforts to regulate its insurance markets using transparency.

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[18] 2013 NH Market Report at 28, Table 26, *supra* n.5.

Because New Hampshire's approach is a novel one outside the scope of traditional insurance regulation, the claims data submission requirement would likely fail this Court's current test for determining whether an insurance law is "saved" from ERISA preemption. Under *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003), a law is "saved" as regulating insurance under ERISA § 514(b)(2)(A) if it (1) is "specifically directed toward entities engaged in insurance," and (2) "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 341-42. Because it affects the risk pooling arrangement between insurer and insured through the facilitation of market forces and not through requirements addressing rates or benefits, it is unclear whether New Hampshire's data submission statute would pass the second prong of the *Miller* test, even as to fully-insured insurance policies purchased by an employer.

Halting New Hampshire's progress toward health cost transparency would be a huge step backwards for competitiveness in the state's insurance markets. New Hampshire's experience with the CHIS database, including its creation of the NH HealthCost website, has yielded results consistent with the statutory goal of using transparency to increase competition and allowing consumers and employers to make informed and cost-effective health care choices. The availability of data through NH HealthCost has enabled insurance carriers to better understand the market price for health care services,

encouraging competition in a historically non-competitive market.[19] Health insurance premiums are largely the result of the prices paid for health services. With no information available on the price of health care services, it is virtually impossible for a small carrier to evaluate its competitiveness in the market. Likewise, without transparency, health care providers are placed in the difficult position of attempting to maximize revenues while remaining competitive with other health care providers, something that is virtually impossible without data on the typical amounts paid for the services they offer.

Reports created and commissioned by the NHID using the claims data suggest that transparency has indeed facilitated competition among health insurance carriers and health care providers. As the CHIS data began to be available, the NHID outlined the potential usefulness of the data to the functioning of markets in the state.[20] Two reports issued two and a half years apart show the markets responding to the

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[19] *See* Tu, Ha and Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire's Health Care Price Transparency Experiment*, April 2014 (Robert Wood Johnson Foundation/ California Healthcare Foundation), http://www.mathematica-mpr.com/our-publications-and-findings/publications/moving-markets-lessons-from-new-hampshires-health-care-price-transparency-experiment.

[20] *NHCHIS and Population Based Risk Adjustment: Looking Beyond Health Cost*, March 20, 2008 (New Hampshire Insurance Department), http://www.nh.gov/insurance/reports/documents/nhchis.pdf.

availability of claims data; public release of information about the various discounts from charges carriers had negotiated with health care providers appears to have influenced carrier market share.[21] Other reports created using the CHIS data detailed particular market developments, such as the increases in member cost sharing over time, the cost of various health insurance mandates (or cost sharing mandates), hospital cost shifting and the impact on the private insurance market, the aging of the population in New Hampshire and its impact on health insurance costs, various cost drivers such as cesarean-section rates, ambulance payment levels, and the relative costs of various hospitals.[22] In addition, the NHID has worked to incorporate its use of the claims data into its evaluation of carriers' proposed premiums through the rate review process.[23] In late 2015,

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[21] *Payments to Providers Part II: Another Look at Carrier Discounts*, August 30, 2012 (New Hampshire Insurance Department) http://www.nh.gov/insurance/reports/documents/nhid_prov_disc_study_partII.pdf*; Payments to Providers: An Inside Look at Carrier Discounts*, January 28, 2010 (New Hampshire Insurance Department), http://www.nh.gov/insurance/reports/documents/pay_prov.pdf.

[22] The NHID website contains links to a variety of reports that were created by or on behalf of the NHID using the CHIS data and other data collected pursuant to N.H. Rev. Stat. Ann. chapter 420-G, including those cited in notes 5, 18-19, 21-22, and 24. A full list of these reports is available here: http://www.nh.gov/insurance/reports/index.htm.

[23] *Analysis of Data Sources to Support Rate Review*, January 2013 (Compass Health Analytics, on behalf of the New

(Continued on following page)

cost data on medical, dental, and prescription drug services will be available in the public domain, effectively improving the efficiency of the market for these services as well.

The usefulness of the NH HealthCost website will be virtually eliminated if the Insurance Department can no longer obtain claims data with respect to the plans offered by ERISA-regulated employers. Losing the claims data not only for self-funded employer plans, but also for fully-insured plans purchased by ERISA-regulated employers, would undercut the benefits the state has achieved through transparency regarding the charges billed for medical procedures performed on New Hampshire citizens, as a way to empower consumers and employers, increase competition in the state's health insurance markets, and encourage innovative health plan designs that incentivize the use of lower-cost providers. Moreover, employers themselves will lose the substantial benefits they have achieved from having access to the information on the NH HealthCost website, the benefit of the market analysis performed by and on behalf of the NHID using the claims data, and the development by insurance companies of innovative product designs, including designs available to self-funded ERISA plans for the administration of these employers' claims.

Hampshire Insurance Department) http://www.nh.gov/insurance/reports/documents/compass-haofda.pdf.

IV. Vermont's Data Reporting Law Is Similar To New Hampshire's From An Operational Perspective, In That Claims Data Reporting Occurs Only After Claim Adjudication.

In order to determine whether a state law is preempted under ERISA, it is important to understand with precision the manner in which the state law operates, and specifically how, if at all, the law affects the administration of ERISA plans. *See, e.g.*, *Travelers*, 514 U.S. 645 at 658-62 (detailed analysis of operation of state law and its connection with ERISA plans). Vermont's data collection law, like New Hampshire's, aims to create a resource for insurers, employers, providers and purchasers of health care. Vt. Stat. Ann. tit. 18, § 9410(h). It requires the filing of health insurance claims data, with provision for the protection of subscriber confidentiality. Vt. Stat. Ann. tit. 18, § 9410(a)(1), (c)-(d).[24]

Vermont's law, like New Hampshire's, is aimed at insurance industry participants; it imposes its reporting obligation on health insurers, as well as on state agencies. Vt. Stat. Ann. tit. 18, § 9410(h)(1)(A) and

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[24] Both the Vermont and New Hampshire claims data reporting laws require compliance with HIPAA, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg, 29 U.S.C. §§ 11181 *et seq.*, and 42 U.S.C. §§ 1320d *et seq*., and both shield personally identifiable information from public disclosure. Vt. Stat. Ann. tit. 18, § 9410(a)(1), (c)-(d); N.H. Rev. Stat. Ann. 420-11-a, I. This statutory language is consistent with regulations adopted under HIPAA, which allow disclosures of health information to the extent required by law. 45 CFR 164.512(a).

(C).[25] These entities already have full access to the claims data, as they are responsible for claims administration. As insurance-regulated entities, they are familiar with the form and timing requirements for claims data submission, so there is little additional burden associated with this reporting obligation. In this case, the reporting itself was to be performed by Blue Cross, an insurance-regulated entity that is independently responsible under Vermont law for submitting claims data for all the plans it administers for Vermont residents.

Most significantly, like New Hampshire's data reporting laws, Vermont's claims data reporting laws do not regulate operation of a self-funded ERISA plan itself, but rather impose an obligation to report claims data only *after* the plan's claims have been fully administered. The medical and pharmacy claims data that must be filed under the Vermont law consists of "service level remittance information from all non-denied *adjudicated claims*." Vt. Regulation H-2008-01 (emphasis added).

Vermont's state claims data reporting law, like New Hampshire's, does not mandate particular benefit structures or the coverage of particular services, nor does it impose any requirements with respect to the manner, timing or amount of claims

[25] The Vermont law also includes the reporting of federal employee claims data, but only "with the agreement of the federal government." Vt. Stat. Ann. tit. 18, § 9410(h)(1)(D).

payments. The claims data reporting does not interfere with any specific provision of ERISA; ERISA's reporting obligations are focused on plan solvency, while ERISA's health-plan-specific provisions concern issues of coverage and claim adjudication. 29 U.S.C. §§ 1021-1031 (Reporting and Disclosure Requirements); 29 U.S.C. §§ 1181-1191c (Group Health Plan Requirements). By contrast, the claims data reporting obligation arises after, and is entirely distinct from, administration of the plan.

V. Data Collection Laws Like Those In Vermont And New Hampshire Are Not Preempted Because They Do Not "Relate To" The Structure Or Administration Of An Employee Benefit Plan Under ERISA.

ERISA preempts state laws that regulate the terms, administration or benefits of an ERISA health plan; it does not preempt state laws that govern matters peripheral to plan operation, even if those laws may have a significant indirect effect, for example by increasing the cost to the employer of maintaining a plan or choosing a particular plan model. *Travelers*, 514 U.S. 645, 658 (1995). The New York law at issue in *Travelers* required hospitals to collect surcharges from patients covered by commercial insurance, but not from patients covered by a Blue Cross/Blue Shield Plan, with the effect of increasing the cost of commercial plans an employer might purchase. Despite this potential for increased cost, the Court found that the law was not preempted by

ERISA, because it did not "bind plan administrators to any particular choice and thus function as regulation of an ERISA plan itself." *Id.* at 659. The surcharge law's "indirect economic influence" did not relate to the plan's administration or benefit structure, the Court concluded; rather, it "simply bears on the costs of benefits and the relative costs of competing insurance to provide them." *Id.* at 659-60. Thus, the Court held that "the provisions for surcharges do not 'relate to' employee benefit plans within the meaning of ERISA's pre-emption provision, section 514(a), 29 U.S.C. section 1144(a), and accordingly suffer no preemption." *Id.* at 649.

This Court has held that under certain conditions, claims administrators qualify as ERISA fiduciaries, resulting in the preemption of state laws regulating their activities as they relate to ERISA plans. In *Aetna Health v. Davila*, 542 U.S. 200 (2004), the Court ruled that ERISA did preempt a Texas law imposing a heightened duty of care on insurance carriers in their handling of coverage decisions. In *Davila*, the insurance carriers were administering claims on behalf of self-funded employer health plans governed by ERISA. The Court ruled that plan enrollees could not bring a state-law action against the carriers, reasoning that carriers acting as TPAs had no independent duty to the enrollees, but rather were obligated to administer claims in strict accordance with the terms of the ERISA plan. *Davila*, 542 U.S. at 212-13. Thus, the enrollees' claims were inextricably tied to their employers' fiduciary duties under ERISA,

such that only ERISA remedies were available to the enrollees. *Davila*, 542 U.S. at 214.

Vermont and New Hampshire's claims data reporting requirements are very different from the Texas law that was challenged in *Davila*; that law governed the actual administration of the claim, not the submission of data after the claim had been administered. Similarly, in *Pharm. Care Mgt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005), *cert. denied*, 126 S. Ct. 2360 (2006), the First Circuit Court of Appeals considered whether ERISA preempted a Maine law requiring pharmacy benefit managers ("PBMs") to act as fiduciaries to their clients, including self-funded ERISA plans. Distinguishing *Davila*, the circuit court concluded that the law was not preempted, because the PBMs, which did not "exercise discretionary authority or control in the management or administration of the plan," were not fiduciaries under ERISA. *Rowe*, 429 F.3d at 301. Nor did the state law compel the administrators of the plan to structure their benefits in a particular manner:

> This is not an instance, such as that confronted by the Supreme Court in *Egelhoff*, where the plan administrators were *bound* to a particular choice of rules – rules mandated by the state for determining beneficiary status. The plan administrators here have a free hand to structure the plans as they wish in Maine.

Rowe, 429 F.3d at 303 (emphasis in original). Thus, the court concluded, the law did not "relate to" an ERISA plan and was not preempted. *Id*.

The Vermont and New Hampshire claims data reporting laws are far more similar to the law that was found not to be preempted in *Rowe* than the law that was held to be preempted in *Davila*. Vermont's law does not govern the administration of benefits or remedies of ERISA plans, including the benefits provided or the management of claims payments. As with the surcharge law in *Travelers*, the obligation to report claims data does not "relate to" the administration, benefits or remedies associated with a plan regulated under ERISA. Unlike the Texas law at issue in *Davila*, the reporting law does not conflict in any respect with the terms of the ERISA plan, because it imposes no requirements that relate to covered services or the administration of the plan, and provides no alternative remedy to plan enrollees. Ruling that these requirements are preempted would be inconsistent with this Court's interpretation of ERISA, because they bear no relation to the administration of benefits under an ERISA plan.

CONCLUSION

In enacting ERISA, Congress cannot have intended to eliminate state innovations like using transparency and market competition to control health costs, as New Hampshire has done through its

CHIS database and NH HealthCost website. New Hampshire's claims data reporting laws have no equivalent within ERISA; Congress enacted that law to govern plan solvency and benefit administration, not to regulate insurance markets, which is the traditional province of the states. New Hampshire's initiative has been beneficial to consumers and employers alike – but these gains will be lost if this Court finds that Vermont's law is preempted.

Both Vermont's and New Hampshire's claims data laws require submission of data only after the claims have been adjudicated, and do not impose requirements with respect to claims administration. Because Vermont's reporting law does not interfere in any way with administration of Liberty Mutual's employee benefit plan, it does not "relate to" an ERISA plan within the parameters of this Court's interpretation of ERISA. Vermont's claims data reporting law is not preempted, and the judgment of the Second Circuit should be reversed.

Respectfully submitted,

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