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 FOR THE STATES OF NEW YORK, COLORADO, CONNECTICUT, HAWAI'I, ILLINOIS, KANSAS, MAINE, MARYLAND, MASSACHUSETTS, MINNESOTA, NEBRASKA, OREGON, RHODE ISLAND, TENNESSEE, TEXAS, UTAH, AND WASHINGTON, AND THE DISTRICT OF COLUMBIA, AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Many States require health care payers to report certain data about paid medical claims to state databases, which are used to develop and evaluate evidence-based health care policies. These state laws apply equally to traditional health insurance plans, self-funded plans, and government programs such as Medicare.

The question presented is:

> Whether ERISA preempts a state health care data collection law as applied to a self-funded ERISA benefit plan, even though the law does not implicate ERISA's objectives or interfere with its requirements.

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INTEREST OF THE *AMICI* STATES

All-payer claims databases (APCDs) are an important tool for States' efforts to develop and evaluate evidence-based health care policies. An APCD assembles anonymized statistical information about each medical claim paid in a State, permitting the State to analyze the safety, efficacy, availability, and cost of the medical services available to its residents. Eighteen States have enacted statutes that mandate reporting of claims data to their APCDs,[1] and at least twenty-two other States have demonstrated interest in creating similar databases.[2]

This amicus brief is filed on behalf of the States of New York, Colorado, Connecticut, Hawai'i, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Nebraska, Oregon, Rhode Island, Tennessee, Texas, Utah, and Washington, and the District of Columbia.

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[1] *Arkansas*: Ark. Code Ann. §§ 23-61-904, -906; *Colorado*: Colo. Rev. Stat. § 25.5-1-204; *Connecticut*: Conn. Gen. Stat. § 38a-1091; *Kansas*: Kan. Stat. Ann. § 65-6804; *Maine*: Me. Rev. Stat. Ann. tit. 22, §§ 8703, 8704; *Maryland*: Md. Code Ann., Health-Gen. § 19-133; *Massachusetts*: Mass. Gen. Laws Ann. ch. 12C, § 12; *Minnesota*: Minn. Stat. Ann. § 62U.04; *Nebraska*: Neb. Rev. Stat. § 71-9202; *New Hampshire*: N.H. Rev. Stat. Ann. § 420-G:11-a; *New York*: N.Y. Pub. Health L. §§ 206(18-a), 2816; *Oregon*: Or. Rev. Stat. § 442.466; *Rhode Island*: R.I. Gen. Laws § 23-17.17-10; *Tennessee*: Tenn. Code Ann. § 56-2-125; *Utah*: Utah Code Ann. § 26-33a-106.1; *Vermont*: Vt. Stat. Ann. tit. 18, § 9410; *Washington*: Wash. Rev. Code Ann. § 43.371.020; *West Virginia*: W. Va. Code § 33-4A-2.

[2] These States are Alaska, Arizona, California, Delaware, Florida, Hawai'i, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, Virginia, Wisconsin and Wyoming. See *infra* at 5.

This case affects every State that operates an APCD or may operate one in the future, because the usefulness of an APCD depends on its comprehensiveness. APCD statutes require health care payers to disclose certain information about every paid claim, typically including the patient's diagnosis, the service provided, the fee paid, the identity of the service provider, and demographic information about the patient (e.g., age, sex and ZIP code). States use this information to improve access to health care, control health care costs, identify unnecessary and potentially dangerous procedures, and regulate health insurance markets. But in order for policymakers and health officials to be able to draw correct statistical inferences from the data, an APCD must include all patient experiences.

Amici States accordingly urge this Court to reverse the decision below, which erroneously held that the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA) exempts self-funded insurance plans from APCD reporting requirements.[3] Employees covered by self-funded plans constitute about sixty percent of privately insured Americans, and are on average younger and healthier than people with other kinds of coverage. *See* Emp. Benefit Research Inst., *Self-Insured Health Plans: State Variation and Recent Trends By Firm Size*, Notes, Nov. 2012, at 1; Robert Pear, *Employers With Healthy Workers Could Opt Out of Insurance Market, Raising Others' Costs*, N.Y. Times, Feb. 18,

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[3] A self-funded plan is one in which an employer assumes the cost and risk of paying for its employees' health care instead of contracting that risk to an outside health insurance company.

2013, at A9. If self-funded plans are exempt from reporting their claims data to APCDs, the information in the resulting databases will be limited to Americans covered by traditional commercial insurance, Medicare, and Medicaid. That will skew the data in the APCDs toward the experiences of demographic groups more heavily represented by those forms of coverage. Furthermore, because Americans are likely to change insurance plans several times over the course of their lives, the omission of data from self-funded plans will make it difficult to track treatments and disease progressions over time.

Amici States also share an interest in protecting the States' broad authority over health care regulation, which ERISA did not displace. As this Court has made clear, Congress enacted ERISA for the benefit of employees, not to shield plans from state laws of general applicability that are unrelated to ERISA's objectives and do not interfere with ERISA duties. APCD laws do not implicate the administration of ERISA plan benefits or intrude on the federal government's fiscal oversight of plans. Rather, APCD laws occupy a wholly different sphere from ERISA. There is no tension between the two warranting preemption.

STATEMENT OF THE CASE

1. Congress enacted ERISA in 1974 to guarantee "the continued well-being and security of millions of employees and their dependents." 29 U.S.C. § 1001(a). ERISA "establish[es] standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." *Id.* § 1001(b). To make it more

practical for employers and plan administrators to comply with those requirements, ERISA's provisions "supersede any and all State laws insofar as they . . . relate to any employee benefit plan." *Id.* § 1144(a).

For more than two decades, this Court has resolved ERISA preemption challenges by considering the "objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). ERISA preemption does not reach "traditionally state-regulated substantive law in those areas where ERISA has nothing to say." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997).

2. States have used health data collection to help develop evidence-based public health policies since the earliest days of the Republic. State data collection initiatives have included mandatory reporting of infectious diseases, statewide cancer registries, and collection of hospital discharge data. Building on these past efforts, many States have in more recent decades enacted laws requiring data about paid health care claims to be reported to a state-run all-payer claims database.

Maine created the Nation's first APCD in 2003, and since that year has collected claims data from all private payers (including self-funded plans), Medicaid, Medicare, and pharmacy managers. *See* Me. Health Data Org., *The All Payer Claims Database*. Over the next two years, Kansas and New Hampshire established similar databases. *See* APCD Council, *Interactive State Report Map* (links to listed States) ("*Interactive Map*"). As of September 2015, mandatory

APCDs are fully operational in a total of thirteen States,[4] and five more States with mandatory-reporting statutes are in the process of implementing their databases.[5] Three States collect limited claims data on a voluntary basis,[6] and nineteen States that do not yet have APCD statutes have demonstrated an interest in creating databases by conducting feasibility studies, introducing proposed legislation, or obtaining funding grants.[7]

Creation of an APCD is an expensive undertaking requiring several years of work. After a State enacts an APCD statute, policymakers must coordinate with payers, providers, employers and health insurance exchanges to ensure efficient data collection. *See* APCD Council, *The Basics of All-Payer Claims Databases* 3-5 (Jan. 2014). For example, New York began collecting data from insurers on its state-run health insurance exchange in early 2015, but is still working to phase in data from Medicaid plans and non-exchange private payers. *See* N.Y. Dep't of

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[4] Mandatory APCDs are operational in Arkansas, Colorado, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Rhode Island, Tennessee, Utah, and Vermont. *See* APCD Council, *Interactive Map*, *supra*.

[5] Mandatory APCDs are at the implementation phase in Connecticut, Nebraska, New York, Washington and West Virginia. *See* APCD Council, *Interactive Map*, *supra*.

[6] Data is collected voluntarily in California, Virginia, and Wisconsin. *See* APCD Council, *Interactive Map*, *supra*.

[7] Interest in APCDs has been shown by Alaska, Arizona, Delaware, Florida, Hawai'i, Idaho, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New Jersey, New Mexico, Ohio, Pennsylvania, South Carolina, Texas, and Wyoming. *See* APCD Council, *Interactive Map*, *supra*.

Health, *All Payer Database*. As of September 2015, at least ten States collect data from self-funded plans,[8] and others are preparing to do so in the future.

3. The actual task of collecting and reporting data from self-funded plans falls on the third-party administrators (TPAs) who process claims on their behalf. Blue Cross Blue Shield of Massachusetts (BCBSMA) is the TPA for the Liberty Mutual Medical Plan, a self-funded plan created to benefit employees and retirees of respondent Liberty Mutual Insurance Company. Pet. App. 50. In August 2011, when Liberty Mutual filed this declaratory judgment action asserting that ERISA preempts Vermont's APCD law, it ordered BCBSMA to stop reporting claims data for the 137 Vermonters on its plan. Pet. App. 56. BCBSMA now strips that data from reports submitted to Vermont's APCD, but complies with APCD reporting requirements in every other instance. Pet. App. 56, 72 & n.5; *see also* BCBSMA, *Third Party Administration* (2010).

The district court entered summary judgment in favor of Vermont, holding that because States have traditional authority over "the health care field," APCD statutes are entitled to a presumption against preemption even if they "do[] not directly regulate health care providers or services." Pet. App. 65-66 (citing *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-15 (1997)). The court also found the reporting of APCD data to be "peripheral to

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[8] The States that collect self-funded data include at least Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, and West Virginia. *See* APCD Council, *Interactive Map*, *supra*.

the core ERISA functions" and any administrative burden minimal. Pet. App. 78-79.

In reversing, the Second Circuit held that Vermont cannot compel self-funded plans to report data to the State's APCD because ERISA already requires such plans to report other, different kinds of data. Pet. App. 23-29. Notwithstanding *De Buono*'s presumption against preemption of state laws operating in the *field* of health care, the court below assumed that the presumption applies only to state laws that *directly regulate* health care services. Pet. App. 18 n.8. And notwithstanding *Travelers*' instruction that ERISA's objectives dictate the scope of ERISA preemption, the court assumed that the categorical differences between the reporting requirements of ERISA and Vermont's APCD law were a reason why the latter *should* be preempted. Pet. App. 24 n.11. A dissenting opinion criticized both of these assumptions, adding that Liberty Mutual had made no effort to show it was burdened by sharing data that it and its TPA already collect. Pet. App. 31-34, 39 (Straub, J., dissenting).

SUMMARY OF THE ARGUMENT

The central purpose of APCD laws is to promote the safe and effective provision of health care through more informed policymaking. This Court's precedents foreclose any argument that the presumption against preemption applies only to laws that *directly* regulate health care services. Furthermore, contrary to the assumption of the court below, APCD statutes are part of a long tradition of state health data collection, and thus fall comfortably

within the scope of the States' historic oversight of health care.

In any event, ERISA preempts only state laws that intrude on its objectives or directly conflict with its requirements. APCD laws do not attempt to regulate the relationships that ERISA regulates (i.e., among plans, participants, administrators, employers, and trustees) and thus do not implicate ERISA's core purposes. And because APCD laws do not interfere with the choices that ERISA plans must make when administering or paying plan benefits, they do not conflict with ERISA's requirements. In holding that ERISA preempts all state laws that mandate any form of "reporting" by self-funded plans—however unrelated to ERISA's reporting requirements—the court below erroneously approached ERISA preemption with the "'uncritical literalism'" that this Court has repeatedly rejected. *Dillingham*, 519 U.S. at 325 (quoting *Travelers*, 514 U.S. at 656).

ARGUMENT

I. APCDs Are Entitled to a Strong Presumption Against Preemption Because States Use Them to Regulate Health Care, a Traditional Responsibility of State Government.

It is well-settled that the ERISA preemption analysis should begin with a presumption against preemption, *see De Buono*, 520 U.S. at 813, particularly in "fields of traditional state regulation," *Travelers*, 514 U.S. at 655. ERISA thus should not be held to preempt state laws in the historically state-regulated field of health care "unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655; *accord De Buono*, 520 U.S. at 813

n.8. This strong presumption applies to any law that operates in the health care field, and not merely to laws that directly regulate how services are provided. *See De Buono*, 520 U.S. at 814.

The Second Circuit declined to apply that presumption here, on the grounds that APCD laws "do not regulate the safe and effective provision of health care services." Pet. App. 18 n.5. But APCD laws were enacted to provide States with the data needed to pursue evidence-based health care policies, and thus are an important tool in States' exercise of their historic police power over health care.

A. All-Payer Claims Database Laws Provide States With Crucial Evidence to Improve Health Care Policy.

APCD laws require health care payers to report certain data about paid medical claims to a statewide database. That data includes the diagnosed condition, the procedure performed, the identity of the provider, the amount paid for the service, demographic information about the patient (e.g., age, sex, and ZIP code), and the patient's type of insurance coverage (e.g., Medicare, Medicaid, or private insurance). *See* APCD Council, *The Basics*, *supra*, at 2.

The Vermont program at issue here is representative. *See* Vt. Stat. Ann. tit. 18, § 9410 (*reproduced at* Pet. App. 92-99). It requires "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to report all "health insurance claims" to a statewide database. *Id.* § 9410(c)(1) (*reproduced at* Pet. App. 94). "Health insurers" are defined to include the TPAs who process claims on behalf of self-insured employers.

Code Vt. R. 21-040-021 H-2008-01 § 3(X) (*reproduced at* Pet. App. 112-13). Health insurers must provide the database with the data from each paid medical claim, *id.* § 4(D). Once collected, the data is "available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance." Vt. Stat. Ann. tit. 18, § 9410(h)(3)(B). The APCD laws of other States take a similar approach.[9] States either require payers to purge personal identifying information about patients from their reports, *see, e.g.,* Code Vt. R. 21-040-21 H-2008-01 § 7(A)(5), or require that such data be released only in encrypted form to prevent identification of individual patients, *see, e.g.,* 90-590 Me. Code R. Ch. 120, § 9(A).

The principal reason States create APCDs is to provide policymakers with information they can use to develop programs that improve the quality of health care while controlling costs. *See* Nat'l Conf. of

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[9] *See, e.g.,* Md. Code Ann., Health-Gen. § 19-133(c) (requiring reporting, "for each type of patient encounter with a health care practitioner," of "(i) [t]he demographic characteristics of the patient; (ii) [t]he principal diagnosis; (iii) [t]he procedure performed; (iv) [t]he date and location where the procedure was performed; (v) [t]he charge for the procedure" and other claim-specific data); *see also* Ark. Code Ann. § 23-61-904; Colo. Code Regs. § 2505-5:1.200.2; Conn. Gen. Stat. § 38a-1091(a)(1); 90-590 Me. Code R. ch. 243, § 2; Mass. Gen. Laws Ann. ch. 12C, § 8(a); Minn. Stat. Ann. § 62U.04, subd. 4; Neb. Rev. Stat. § 71-9204(1)(a); N.H. Code Admin. R. Ins. 4004.01(a); N.Y. Pub. Health L. § 2816(2)(a)(v); Or. Rev. Stat. § 442.466(2)(b)(A); R.I. Gen. Laws § 23-17.17-10(a)(1); Tenn. Code Ann. § 56-2-125(f)(1)(A); Utah Admin. Code R. R428-15-3(1); Wash. Rev. Code Ann. § 43.371.020(1); W. Va. Code R. § 114A-1-5.

State Legislatures, *Collecting Health Data: All-Payer Claims Databases*, Health Cost Containment & Efficiencies 1 (May 2010). Most APCD statutes contain express statements of this purpose. For example, Vermont's statute specifies that regulators should use the database for "identifying health care needs and informing health care policy, . . . evaluating the effectiveness of intervention programs on improving patient outcomes, . . . [and] comparing costs between various treatment settings and approaches." § 9410(a)(1). Several other States, including Tennessee, Nebraska, and Oregon, describe the purposes of their databases using statutory language nearly identical to Vermont's. *See* Tenn. Code Ann. § 56-2-125(b)(1); Neb. Rev. Stat. § 71-9202; Or. Rev. Stat. § 442.466(1). Utah's APCD is intended to "assist the Legislature . . . by reporting on geographic variances in medical care and costs . . . [and] rate and price increases by health care providers." Utah Code Ann. § 26-33a-106.1(1)(c). Kansas has directed that its data be used "to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services."[10] Kan. Stat. Ann. § 65-6801(c).

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[10] Similarly, Massachusetts' APCD statute directs agencies to use the database for "lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, administrative or planning purposes." Mass. Gen. Laws Ann. ch. 12C, § 12(b). Minnesota uses its data to "reduce avoidable [hospital] readmissions . . . [and] analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations." Minn. Stat. Ann. § 62U.04(11), subds. 2-3. Rhode Island's APCD promotes "new and improved public sector approaches to measuring, evaluating and improving quality." R.I. Gen. Laws § 23-17.17-

(*continues on next page*)

States use APCDs to improve health care in a variety of ways, as the following examples illustrate.

1. States use APCDs to control health care costs.

Nationally, as much as thirty percent of health care spending is wasted. *See* Nat'l Conf. of State Legislatures, *Collecting Health Data*, *supra*, at 1. APCDs help States to make sure that unnecessary procedures are avoided, and that necessary care occurs in the most cost-effective setting.

Minnesota has used its APCD to address the problem of readily preventable emergency room visits and hospital admissions. *See* Minn. Dep't of Health, *Potentially Preventable Health Care Events in Minnesota* (July 2015). By studying its APCD data, Minnesota has determined that two out of three emergency room visits in Minnesota were for conditions that could be treated as effectively in an outpatient setting, and that as many as fifty thousand Minnesotans had four or more preventable ER visits in 2012. *Id.* at 3. Minnesota estimates that, in a typical year, about $2 billion of the $40 billion spent on health care in the State is spent on preventable events. *Id.* at 1-2. Identifying the conditions that typically lead to unnecessary hospital admissions—for example, upper-respiratory tract

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1(3). Virginia's database was "created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system." Va. Code Ann. § 32.1-276.7:1(A).

infections, back pain, and pneumonia—enables Minnesota to redirect treatment of those conditions to lower-cost outpatient settings. *Id.* at 3.

New York's APCD will soon be used to identify "health care services that are unnecessary, increase costs, and may even endanger [patients'] health." N.Y. Dep't of Health, *New York State All Payer Database Use Cases* 8 (Oct. 2011). A pilot study based on limited data has shown that one in six hysterectomies may be medically inappropriate. *Id.* at 9. Regulators in New York also plan to study expenditures for chronic diseases. For example, a study of fifteen different care coordination programs revealed that two had noticeably fewer hospitalizations. *Id.* Further study revealed that, as compared with patients in programs that reported more patient hospitalizations, patients from those two programs received a greater number of substantial in-person contacts and achieved equivalent health outcomes, but at a much lower cost. *Id.* at 9-10.

2. States use APCDs to regulate local insurance markets.

Federal law establishes a state-federal partnership to ensure that increases in premiums for health insurance are reasonable. *See* 42 U.S.C. § 300gg-94. Insurers who wish to participate in state-run health insurance exchanges must provide justifications for premium increases, and States have primary responsibility for preventing excessive and unjustified premium increases. *Id.* § 18031(e)(2). The U.S. Department of Health and Human Services has strongly encouraged States to use APCDs to perform this rate review function. At least eleven States with mandatory APCD statutes—Arkansas, Kansas,

Maryland, Massachusetts, Minnesota, New York, Oregon, Rhode Island, Utah, Vermont, and Washington—have received approval for HHS grants totaling approximately $ 36 million to develop APCDs for use in rate review. *See* Ctr. for Medicare & Medicaid Servs., *Rate Review Grants*. Two States that do not yet have APCD statutes, California and Hawai'i, have received HHS grants to create such databases in the future. *See id.*

Even before the recent federal reforms, about half the States already had laws giving their insurance commissioners the power to approve or disapprove changes in the premiums that insurers charge for coverage. *See* Nat'l Conf. of State Legislatures, *State Approval of Health Insurance Rate Increases* (Aug. 2015). New York, for example, requires that certain insurers obtain prior state approval before increasing or decreasing a premium rate, and permits regulators to reject unjustified, unreasonable, or excessive changes. *See* N.Y. Ins. Law §§ 3231(e), 4308(b)-(c). New York intends to use its APCD to complement and verify the data that insurers supply to regulators. The APCD data will allow regulators to determine the costs that drive premium increases, both on a statewide and region-by-region basis, and thus confirm that there is a practical justification for a proposed increase. *See* N.Y. Dep't of Health, *New York State All Payer Database*, *supra*, at 17-18.

3. States use APCDs to investigate whether their health care policies are working.

The agency overseeing Maryland's APCD generates two annual reports on health care costs and payment rates, as well as special reports at the

legislature's request. For example, in 2010, Maryland enacted a law that limits a patient's financial liability for treatment received at a hospital from a doctor who is not a preferred provider under the patient's insurance plan, while ensuring that the doctor receives a statutory minimum payment from the patient's insurer. *See* Md. Code Ann., Ins. § 14-205.2. After the statute took effect, the legislature directed regulators to study cost data from the State's APCD to see if the law was having its intended effect. The study found that the law had been largely successful, producing more predictable bills for patients while protecting doctors' payment levels. Md. Health Care Comm'n, *Impact of the Assignment of Benefits Legislation* (2015).

APCD studies can also reveal when legislative goals have not yet been attained. After Maryland required non-radiologist physicians to divest themselves of ownership interests in radiology services and prohibited self-referral of patients to such services, the General Assembly ordered regulators to use the APCD to determine whether the law actually reduced referrals. Md. Health Care Comm'n, *Assessment of Changes in Advanced Imaging Referrals by Orthopedists 2010-2012* (2014). The report concluded that prior to divestment, physicians with a financial stake in imaging services did have higher referral rates than other physicians who did not have ownership interests, but that divestiture did not immediately drive a decrease in those rates. *Id.* at 2.

4. States use APCDs to identify and promote specific prevention and treatment measures.

Utah has used its APCD to improve preventive medicine by studying the preventive and screening care received by its healthiest citizens in each age bracket. Utah Dep't of Health, *Making* Cents *of Utah's Healthy Population*. Utah Atlas of Health Care 3 (Oct. 2010). Colorado—in an effort to confront the nationwide problem of death from opioid overdoses—is using its APCD to study the extent to which lawful prescriptions of opioid analgesics lead to dependence. Focusing on patients with no past exposure to opioids who receive prescriptions for opioid analgesics after major surgeries, researchers are studying the rates at which those patients continue to seek opioid prescriptions at thirty-, ninety-, and 180-day intervals after their discharge from hospitals following major surgery. The goal of the study is to identify classes of patients who would be better served by non-opioid analgesics. Ctr. for Improving Value in Health Care, Project: Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery.

Massachusetts is pursuing a number of research initiatives with its APCD data. Like most States, Massachusetts maintains a cancer registry,[11] which contains detailed information about the histology, stage, and date of diagnosis for each tumor diagnosed in the State. But similar to other cancer registries,

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[11] *See infra* at 21 (discussing cancer registries in forty-five States).

the Massachusetts registry generally does not contain information about the medical procedures used in treatment and the costs that those procedures incur. This kind of information is contained in the Massachusetts APCD, however. And by linking its APCD to its cancer registry, Massachusetts can study how the quality, costs and outcomes of care vary across providers, particularly for patients with potentially curable lung, colorectal, breast, and prostate cancer (the four most common causes of cancer-related death). *See* Nat'l Cancer Inst., Project: Linking State Registry and All Payer Claims Data to Study Cancer Care. New York similarly intends to link its APCD to its State Cancer Registry. *See* N.Y. Dep't of Health, *New York State All Payer Database*, *supra*, at 12. In another project, the Massachusetts Department of Public Health is using APCD data to study tobacco cessation methods across demographic and socioeconomic groups, with the goal of determining which methods of quitting smoking are most effective and efficient. *See* Mass. Div. of Health Care Fin. & Policy (now the Massachusetts Center for Health Information and Analysis), Project: Utilization of Tobacco Treatment in Massachusetts to Quit Smoking.

These kinds of studies are effective precisely because they identify the differences in outcomes across demographic groups, income levels, and types of insurance coverage. When researchers identify patients with a given medical need who have better or more cost-effective outcomes than other patients with the same need, they can propose better and more efficient approaches for all patients.

B. APCD Laws Also Improve the Quality and Efficiency of Health Care by Creating Transparency for Consumers and Providers.

Although APCDs originated as a tool for policy-makers, many States make the anonymized claims data they collect available to other stakeholders in the health care industry, including consumers and providers. In almost every sector of the economy, Americans regard data-driven comparison-shopping as a fact of life. Today's consumer has access to tools for comparing the quality and cost of prospective homes, automobiles, and kitchen appliances. But health care, despite accounting for a fifth of the Nation's spending, largely remains an exception. By making APCD data available to consumers themselves, States are in a unique position to fill this information gap.

Colorado, New Hampshire, and Maine have already adapted their APCDs for this purpose. Each State has used its APCD data to create a public website that enables its residents to compare the cost of health care services across providers within the State. *See* Ctr. for Improving Value in Health Care, *CO Medical Price Compare–Research Entity*; N.H. Ins. Dep't, *NH HealthCost*; Me. Health Data Org., *HealthCost*. Several other States, including New York and Maryland, intend to create similar websites. *See* Ctr. for Medicare & Medicaid Servs., *Maryland Rate Review Grants Award*.

A patient visiting the Colorado website can compare costs by selecting a particular kind of health care service, a geographical area, and the kind of insurance to be billed. For example, a patient could

specify that she needs a hip replacement, would prefer a hospital within twenty-five miles of Denver, and expects to bill private insurance. The website would then display the median price of a hip replacement at each hospital within the specified radius for patients using private insurance.[12] The New Hampshire website functions similarly.[13] The Maine website allows consumers to browse the costs of a large number of outpatient and office-visit procedures across providers, and also to see how often each provider performs the chosen procedure in the course of a year. Each of these websites rates providers on the complexity of the procedures they typically perform, enabling patients to understand that in some cases higher prices may reflect a hospital's acceptance of higher-risk procedures.

Similarly, providers can use APCDs to assess the rates that different payers are actually paying for services, and to identify market opportunities that are underserved. The State of Washington encourages providers to use its forthcoming APCD to identify the procedures that residents of rural parts of the State travel long distances to obtain, in order to enhance competition to provide services in the rural areas

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[12] As of August 28, 2015, performing this illustrative search returns median prices as low as $20,797 and as high as $36,446.

[13] New Hampshire, in a separate amicus brief supporting Vermont, describes how NH HealthCost also promotes competition in its insurance markets. *See* Br. for New Hampshire at 3-5, 22-25. By providing insurers with better information about the market price for health care services, New Hampshire promotes competition, "including the development of health plan designs that create incentives for using lower-cost providers." *Id.* at 3.

themselves. *See* Wash., Office of the Gov., *Gov. Inslee Continues Push for Health Care Cost Transparency* (Jan. 29, 2015). The Arkansas database is specifically intended "to promote competition based on value" by promoting price transparency. Ark. Ctr. for Health Improvement, *Arkansas All-Payer Claims Database*.

C. APCD Laws Promote Public Health in a Manner That Fully Qualifies for a Strong Presumption against Preemption.

The court below wrongly assumed that APCD laws are ineligible for a presumption against preemption because they do not *directly regulate* how health care services are provided. *See* Pet. App. 18 n.8. *De Buono* expressly forecloses this gloss on the presumption. Like the New York tax on hospital receipts at issue in *De Buono*, an APCD statute is entitled to a strong presumption against preemption because it "*operates in a field* that has been traditionally occupied by the States." 520 U.S. at 814 (emphasis added) (quotation marks omitted). What matters is the field of operation, not the manner of regulation. *See id.* (applying presumption even though the state law at issue was "a revenue raising measure, rather than a regulation of hospitals"). And in any event, the manner of regulation here more strongly warrants a presumption against preemption than the law at issue in *De Buono*. Whereas the hospital tax found eligible for a strong presumption in *De Buono* raised revenue for New York's general treasury, *see id.* at 809-10, APCDs promote better health care directly, by allowing evidence-based policymaking, increasing competition, and promoting cost transparency.

The court below also wrongly assumed that the States have not historically collected health care data when it concluded that APCD laws fall outside "the states' historic police power." Pet. App. 18 n.8. In fact, APCDs are an effort to achieve on a comprehensive scale the kind of health data collection that States have long pursued, dating back to the Colonial Era. In 1743, the Rhode Island colony created the first government-mandated disease registry, requiring the reporting of all instances of smallpox, yellow fever, and cholera. Bernard C.K. Choi, *The Past, Present, and Future of Public Health Surveillance*, 2012 Scientifica ID 875253, at 2.2. In 1850, a state legislator in Massachusetts proposed a regular census of the State's health data by age and sex; his bill became the template for laws creating health registries in the twentieth century. *Id.* For example, in 1935, Connecticut created the nation's first cancer registry, which contains a record of every tumor diagnosed in the State since that year. *See* Conn. Dep't of Pub. Health, *Connecticut Tumor Registry*. Forty-five States now have similar registries, half of them dating back to the 1960s and 1970s. *See* Nat'l Cancer Inst., *National and State Cancer Registries*.

In the past thirty years, forty-eight States have introduced requirements that hospitals report discharge data from inpatient hospitalizations,[14] and

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[14] *See, e.g.,* 10 N.Y.C.R.R. § 400.18 (previously § 405.30) (creating Statewide Planning and Research Cooperative System reporting of hospitalization data since 1979); N.H. Code Admin. R. ch. He-C 1500 (requiring reporting of hospital discharge data since 1986).

thirty states have extended those requirements to emergency room visits. *See* Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health-Care Transparency* 3 (The Commw. Fund Issue Brief Sept. 2010). These hospital discharge databases (HDDs) are an important precursor to APCDs, and establish that States indeed have a long-standing and historic practice of collecting health care data.

HDDs, however, have significant limitations as guides to state health care policy. In particular, HDDs lack the capacity of APCDs to reveal the true cost of health care. What a provider initially charges for a health care service upon a patient's discharge is often much higher than the rate negotiated by health care payers. APCDs, because they are based on data from *paid* claims, disclose the real-world prices paid for health care services. *See* Denise Love & Claudia Steiner, *Key State Health Care Databases for Improving Health Care Delivery* (Feb. 2011).

APCDs thus continue and improve a long-standing state practice of using health data collection to supervise public health. Moreover, as the United States has noted, there is no federal APCD, making States "uniquely positioned" to serve this function. Br. for the United States as *Amicus Curiae* on Cert. at 22.

II. The Presumption Against Preemption Is Not Overcome Here Because APCD Laws Do Not Implicate ERISA's Objectives or Interfere with Its Requirements.

ERISA manifests no congressional intent to preempt state laws collecting health care data, as is evident from "'the objectives of the ERISA statute'" and the "'nature of the effect of'" APCD laws on ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). APCD laws require reporting of data about individual, paid medical claims. See *supra* Part I.A. They do not affect the benefits that plans must offer, require the reporting of data about plans' fiscal stability, or otherwise intrude on ERISA's regulation of benefit plans, sponsors, trustees, fiduciaries, and participants. They thus do not "implicate[] an area of core ERISA concern." *Id.*

APCD laws are instead "general health care regulation[s]," *Travelers*, 514 U.S. at 661, and are among the many "generally applicable laws regulating 'areas where ERISA has nothing to say,'" *Egelhoff*, 532 U.S. at 147-48 (quoting *Dillingham*, 519 U.S. at 330). In holding that ERISA preempts APCD statutes because both involve "reporting" in the broadest sense, the court below ignored the practical approach to ERISA preemption that this Court has followed for more than two decades, and interpreted 29 U.S.C. § 1144(a) with the "uncritical literalism" that the Court has rejected. *See Travelers*, 514 U.S. at 656.

A. ERISA Preempts Only State Laws That Implicate Its Core Functions or Conflict with Its Requirements.

Congress enacted ERISA for the benefit of working Americans, as a response to the twin problems of pension fund looting and pension fund underfunding. *See Dillingham*, 519 U.S. at 326-27 (ERISA was enacted to prevent "mismanagement of funds" or "failure to pay employees benefits from accumulated funds" (quotation marks omitted)).[15] The statute's express purpose is to ensure that employees actually receive the benefits they earn over the course of their working lives. 29 U.S.C. § 1001(a).

ERISA was never intended to shield employers from the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans" but do not impede employers from complying with ERISA's own requirements. *De Buono*, 520 U.S. at 815 (quoting *Travelers*, 514 U.S. at 668). To the extent that ERISA confers a benefit on employers by preempting certain state laws, *see* 29 U.S.C. § 1144(a) (superseding state laws that

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[15] *See also* Sen. Jacob K. Javits, Address at the Briefing Conference on Pension and Employee Benefits (Sept. 19, 1974) (stating that ERISA's purpose was "to safeguard workers against loss of their earned or anticipated benefits, . . . which, over the years, had led to widespread frustration and bitterness"), *quoted in* Michael S. Gordon, *Overview: Why Was ERISA Enacted?*, Staff of Senate Special Comm. on Aging, 98th Cong., *The Employee Retirement Income Security Act of 1974: The First Decade* 25 (Comm. print 1984).

"relate to any employee benefit plan"), it does that to make compliance with ERISA itself feasible. For example, ERISA guarantees employers "'a set of standard procedures *to guide processing of claims and disbursement of benefits*,'" *Egelhoff*, 532 U.S. at 148 (emphasis added) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)), but does not contain any broader promise of general administrative uniformity. As one court of appeals has noted, an "effect on uniform plan administration would assuredly arise from the apprentice wage law in *Dillingham* and the state tax at issue in *De Buono*, but the Supreme Court found no ground for preemption in those cases." *Willmar Elec. Serv., Inc. v. Cooke*, 212 F.3d 533, 539 (10th Cir. 2000).

This Court "look[s] . . . to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," rather than attempting to parse the meaning of the words "relate to" in § 1144(a). *See Travelers*, 514 U.S. at 656. This is because, "as many a curbstone philosopher has observed, everything is related to everything else." *Dillingham*, 519 U.S. at 335 (Scalia, J., joined by Ginsburg, J., concurring).

Since *Travelers*, this Court has invalidated only three state laws on the grounds that they improperly "relate to" ERISA plans within the meaning of § 1144(a). Two of those laws would have affected to whom plan benefits should be paid, and thus conflicted with ERISA's own rules for payment of benefits. *See Egelhoff*, 532 U.S. at 147-48 (state law automatically revoking spouse's interest in benefit plan upon divorce); *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (state law allowing nonparticipant spouse to convey an interest in plan via her will). The third law

would have required an employee's claim for benefits to be treated as timely even if the employee incorrectly gave notice of the claim to the employer instead of the insurer, thus changing the benefits that a plan must offer. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 377-79 (1999). Over the same time period, this Court has rejected ERISA preemption challenges to state laws occupying fields that ERISA does not touch, even where those laws have had some effect on ERISA plans. *See, e.g., De Buono*, 520 U.S. at 816 (taxes on hospitals); *Dillingham*, 519 U.S. at 330 (prevailing wage and apprenticeship laws); *Travelers*, 514 U.S. at 662 (regulation of the actual cost charged for medical services).

As these cases demonstrate, the Court has "discern[ed] no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis."[16]

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[16] Courts and commentators frequently cite *Travelers* as the starting point for this Court's current approach to ERISA preemption because of its explicit instruction that courts should focus on ERISA's purposes in judging the scope of preemption. *See, e.g.,* John H. Langbein et al., *Pension and Employee Benefit Law* 842 (5th ed. 2010) (describing *Travelers* as a "sea change" in ERISA preemption). But as Justice Scalia pointed out in his *Dillingham* concurrence, Justice Ginsburg first announced the current standard in her *Harris Trust* majority opinion two years earlier. 519 U.S. at 336 (Scalia, J., joined by Ginsburg, J., concurring) (citing *Harris Trust*, 510 U.S. at 99). Clarity in the applicable legal framework is important to guide lower courts past potentially vexing questions, and the Court has previously chosen to "make a clean break" with statements in prior § 1144 opinions when appropriate to ensure analytic clarity. *See Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341 (2003)

John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 510 U.S. 86, 99 (1993). *see also Dillingham*, 519 U.S. at 336 (Scalia, J., joined by Ginsburg, J., concurring) ("[I]t accurately describes [the Court's] current ERISA jurisprudence to say that [the Court] appl[ies] ordinary field pre-emption, and, of course, ordinary conflict preemption.").

In sum, ERISA preempts regulation of the relationships among the "core ERISA entities" whose interactions are already regulated by ERISA—namely, the "beneficiaries, participants, administrators, employers, trustees and other fiduciaries, and the plan itself." *Gerosa v. Savasta & Co.*, 329 F.3d 317, 324 (2d Cir. 2003). Every circuit that has considered the question agrees.[17] State laws that do

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[17] Nine circuits have resolved the proper scope of § 1144(a) by adopting a test assessing whether a state law interferes with ERISA's regulation of the relationship among the core ERISA entities. *See Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co.*, 215 F.3d 136, 141 (1st Cir. 2000); *Gerosa*, 329 F.3d at 324 (2d Cir.); *LeBlanc v. Cahill,* 153 F.3d 134, 147 (4th Cir. 1998); *Sommers Drug Stores Co. Emp. Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986); *Self-Insurance Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 635-36 (6th Cir. 2014); *Wilson v. Zoellner*, 114 F.3d 713, 720-21 (8th Cir. 1997); *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1082 (9th Cir. 2009); *Woodworker's Supply, Inc. v. Principal Mut. Life Ins. Co.*, 170 F.3d 985, 990 (10th Cir. 1999); *Morstein v. Nat'l Ins. Servs., Inc.*, 93 F.3d 715, 722-723 (11th Cir. 1996) (en banc). That test accurately and simply reflects congressional intent and reconciles all of this Court's rulings on preemption under § 1144(a). *See generally Gen. Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1522 (9th Cir. 1993) (analyzing the law at length and concluding that preemption of a state law under ERISA requires a court to "look at whether it encroaches on the relationships regulated by ERISA").

not affect the relationships among these groups operate in a field separate from ERISA. Accordingly, they are not preempted unless they would necessarily alter how benefits are paid, or to whom. *See, e.g., Gerosa*, 329 F.3d at 324.

B. The Reporting Requirements of APCD Laws Are So Unrelated to the Reporting Requirements of ERISA That They Neither Intrude on ERISA's Field nor Conflict with It.

The reporting requirements in ERISA do not preempt the reporting requirements of state APCD laws because they are so utterly different in both character and purpose. As relevant here, ERISA requires reports from plan sponsors to plan participants and to the Secretary of Labor, for purposes of fiscal oversight.[18] State APCD laws, by comparison, require health payers to report data about paid medical claims for purposes of improving substantive health care policy. See *supra* Part I.A.

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[18] The Affordable Care Act amended Part 7 of ERISA's regulatory provisions to add certain reporting requirements with respect to minimum levels of quality care. *See* 29 U.S.C. § 1185d(a); 42 U.S.C. § 300gg-17(a). However, those requirements are not relevant here, because ERISA expressly states that nothing in Part 7 should be construed to expand ERISA's preemptive scope. *See* 29 U.S.C. § 1191(a)(2).

1. The field ERISA preempts is the reporting of data about plan finances to enable oversight of their fiscal stability, and that field is not implicated by APCD laws.

ERISA requires plan sponsors to report plan details and finances, *see* 29 U.S.C. §§ 1021-1030, so that plan participants and the Secretary of Labor can assess whether the plans are financially stable and responsibly managed, *see Fort Halifax*, 482 U.S. at 15. In particular, ERISA requires self-funded plans to file an annual report with the Secretary. *See* 29 U.S.C. § 1023. That report must disclose the plan's assets and liabilities; its receipts and disbursements; the identities of the plan's fiduciaries, trustees, and administrators; and statements from independent accountants and actuaries confirming that the plan has kept its books in accordance with accepted principles. *See id.* These reports enable participants, their designated beneficiaries, or the Secretary to bring a civil enforcement action when it appears a plan has fallen below ERISA's standards. *See id.* § 1132. Thus, supervision of the fiscal stability and ethical management of ERISA plans, and any enforcement proceedings arising from that supervision, are the "exclusive" provinces of federal law. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Elsewhere, separate from its reporting requirements, ERISA creates a nationwide set of rules for plan administrators to follow in deciding how plans are to be funded, *see* 29 U.S.C. § 1082, and to whom, when, and how benefits are to be paid, *see id.* §§ 1002(8), 1102(b)(4).

State APCD statutes collect different data for an entirely different purpose: the improvement of state

health care policy. As Vermont correctly points out, APCD laws do not even apply to "ERISA plans as *plans*." Pet. Br. 38. Instead, they require all health care *payers*—a group that happens to include self-funded health benefit plans—to report medical data to databases, usually run by state health departments. Indeed, Liberty Mutual expressly conceded below (*see* Pet. App. 38 (Straub, J., dissenting)) that there is no overlap between the data reported under ERISA and the data that APCD laws require. That concession should have resolved this case.

A state law's operation in an area completely separate from ERISA's objectives is a strong indication that such a law is *not* preempted. The court below lost sight of this principle when it concluded that because ERISA imposes certain reporting requirements, States may not require plans to report information unrelated to the fiscal stability and funding of plans. By defining "reporting" more broadly than the function it serves in ERISA's scheme, the court below failed to follow this Court's repeated instructions to "look to . . . the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Dillingham*, 519 U.S. at 325 (quotation marks omitted); *see also De Buono*, 520 U.S. at 813-14 (same); *Travelers*, 514 U.S. at 656 (same). Following those instructions forecloses any argument that "reporting" is a field that ERISA preempts: ERISA's objective is to make sure that the Secretary and plan participants have access to the information they need to scrutinize a plan's fiscal stability; the reporting of certain specific types of data is merely a means of attaining that objective. State laws that require reporting of categorically distinct data, as do APCD

laws, do not encroach on the federal role. Moreover, APCD laws do not regulate the relationships among ERISA's core entities; they would at most affect "merely the plan's bookkeeping obligations." *UNUM*, 526 U.S. at 378.

2. APCD laws do not conflict with ERISA even if they impose some economic burden on self-funded plans.

Under this Court's precedents, APCD laws do not conflict with ERISA simply because they seek "different and additional" data from the information sought by ERISA, Pet. App. 24 n.11, thereby imposing some cost or administrative burden on self-funded plans. As this Court has recognized, it would do "grave violence" to the presumption against preemption to "hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation" as financial cost. *Dillingham*, 519 U.S. at 334. Congress simply did not intend for ERISA to preempt "all laws with indirect economic effects on ERISA plans." *Travelers*, 514 U.S. at 664-65. Indeed, this Court has made clear that even a state *tax* that "increases the cost of providing benefits" to employees covered by a self-funded plan is not preempted when the tax applies generally to the health care industry. *See De Buono*, 520 U.S. at 811, 816. Similarly, in *Travelers*, this Court recognized that the hospital surcharges at issue would cost ERISA plans some profits, but it upheld them because that cost did not dictate any choices that the plans faced *as ERISA plans*. 514 U.S. at 659. APCD laws merely require the mandatory transmission of claims data already collected by a plan's TPA in the ordinary course of business, and

any costs the laws may impose are even more indirect than the state laws sustained by this Court in *De Buono* and *Travelers*.

Moreover, the record in this case contains no evidence that complying with Vermont's APCD requirements will result in any net cost or administrative burden. Nor is there any basis to conclude that Vermont's APCD law would have such "acute . . . economic effects" on self-funded plans as to force an alteration in the benefits they could provide, *see Travelers*, 514 U.S. at 668; Br. for the United States as *Amicus Curiae* on Cert. 12-13 (noting that "the record before the court of appeals" is insufficient to find more than an "incidental effect" on respondent). This Court's cases demand far more evidence of effect than Liberty Mutual's conclusory assertion that "all regulations have their costs." Br. for Liberty Mutual 28 (2d Cir. No. 12-4881, ECF No. 50).

Compliance with APCD laws may impose little to no administrative burden on health care payers. When a plan or third-party administrator transmits data about a claim to an APCD, it can generally do so using procedure and cost codes already widely used in health care billing. *See* Nat'l Ass'n of Health Data Orgs., *All-Payer Claims Databases*. These codes, which will usually be included with the required patient demographic data on the claim itself, provide most of the information APCDs require.

On the other hand, excluding data from self-funded plans will likely increase administrative costs for health care payers. Like many third party administrators, BCBSMA—Liberty Mutual's third party administrator—is also an issuer of traditional

commercial health insurance in its own right. There is no dispute that in that role BCBSMA must comply with state APCD laws, and it already provides APCD reports covering thousands of Vermonters, carving out only the 137 individuals Liberty Mutual has asked it to omit. *Compare* App. 204-05, *with* Pet. App. 50. Under Liberty Mutual's proposed regime, BCBSMA and other TPAs would be required to undertake the additional effort of sorting through their claims data to identify and exclude claims paid by self-funded plans, before they could transmit their reports to a state APCD.

For more than twenty years, this Court has rejected "uncritical literalism" in interpreting ERISA's preemption clause. *Dillingham*, 519 U.S. at 325 (quoting *Travelers*, 514 U.S. at 656); *see also De Buono*, 520 U.S. at 812-13 (criticizing Second Circuit for "failing to give proper weight to *Travelers*' rejection of a strictly literal reading of [29 U.S.C. § 1144(a)]"); *Self-Insurance Inst. of Am., Inc. v. Snyder*, 761 F.3d 631, 635-36 (6th Cir. 2014) (declining to follow the Second Circuit's "literal approach to preemption" in this case), *pet. for cert. filed*, No. 14-741 (U.S. Dec. 23, 2014). And there are sound reasons for its approach.

The revival of literalism in ERISA preemption analysis would threaten a broad array of state laws that have no connection to ERISA's functions or purposes, and that Congress never intended to preempt. For example, Michigan has imposed a one-percent tax on all paid claims in order to fund its Medicaid obligations, and has imposed on all insurers (including self-funded plans) the ministerial duties of recording and reporting the tax payments. *See Self-Insurance Inst.*, 761 F.3d at 633. Because the compu-

tation of taxes is "a function entirely divorced from plan administration," *id.* at 636, and falls within an area of traditional state authority, *see id.* at 635 (describing taxation as "an important 'attribute of state sovereignty'"), the Sixth Circuit correctly rejected a preemption challenge. Yet under the theory propounded by the court below, the Michigan law would be related to ERISA plans because it requires reporting in the broadest sense, at some unspecified cost to plans. That cannot be correct, for the only effect of Michigan's law is to "cut the plans' profits" in exactly the same manner as "the surcharges upheld in *Travelers* and *De Buono*," and "to create work independent of the core functions of ERISA." *Id.* at 636. Further, accepting the Second Circuit's broad theory about reporting obligations would have a dramatic effect: under that court's logic, "states would not be able to require ERISA-covered entities to submit any paperwork or preserve any records in any circumstances," and, "[a]s a result, ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records," *id.* at 638.

In sum, the effect of the lower court's approach to ERISA preemption in this case is to curtail States' authority to regulate not only here but also in many areas of traditional state interest, including health and safety, taxation, and licensing. See Pet. 32-33. Congress did not contemplate that outcome when enacting ERISA.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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