GOBEILLE v. LIBERTY MUTUAL

Impact on All-Payer Claims Databases

FEDERAL DATA SUBMISSION MANDATES

- **Medicaid Third Party Liability Data.**
  - DDA 2005 requires states to have laws to compel health insurers in the state to provide at least four data elements to identify TPL:
    - insured's name and group or member ID number
    - Address
    - periods of coverage
  - Health insurers are required to provide these files to the state Medicaid agency for purposes of identifying potential TPL, and mixed ability to obtain information from "third parties" (mainly group health plans)
  - States are pre-empted by the Employee Retirement Income Security Act of 1974 from regulating employer-sponsored health benefit plans that self-insure and cannot require that these plans submit files to the state for the purpose of identifying TPL

FEDERAL DATA SUBMISSION MANDATES

- **Medicare Secondary Payer Identification and Recovery.**
  - MMSEA Section 111 mandates **responsible reporting entities** (RRE) to report information on Medicare beneficiaries who:
    - have coverage under group health plan (GHP) arrangements (fully-insured or self-funded)
    - receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance.

FEDERAL DATA SUBMISSION MANDATES

- Purpose of these reporting mandates:
  - Reduce payments for Medicaid or Medicare by increasing recovery from third parties who were completely or somewhat responsible for medical payments by these governmental payers

ERISA PREEMPTION

ERISA PREEMPTION

- ERISA applies to all employee pension, health, and other benefits plans established by private sector employers (other than churches) or by employee organizations such as unions.
- If they meet certain requirements, employee plans are “ERISA plans” even if they offer benefits through state-licensed insurers.
- ERISA does not apply to plans administered by federal, state, or local governments. It does not apply to plans established solely to meet state workers’ compensation, unemployment compensation, or disability insurance laws.

ERISA PREEMPTION

- ERISA's preemption clause (ERISA § 514) makes void all state laws that "relate to" employer-sponsored health plans

  "the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...."

- Supreme Court has interpreted the preemption clause very broadly to preempt state laws that either refer explicitly to ERISA plans or have a substantial financial or administrative impact on them
  - Prohibits both state laws that directly regulate employer-sponsored health plans and some laws that only indirectly affect plans

ERISA PREEMPTION

- The “savings clause” allows states to regulate health insurance
- But “deemer clause” states are prohibited from regulating plans that self-insure by bearing the primary insurance risk, even though by bearing risk they appear to be acting like insurance companies
  - Supreme Court recognizes two classes of employer-sponsored health plans: Plans funding coverage through insurance are subject to state insurance regulation, while those that self-insure are completely beyond state jurisdiction.
  - Both types of plans are still ERISA plans, but only the former are subject to some types of state oversight.

ERISA PREEMPTION

- Congress has exercised more control over insurance and managed care, creating new models of federal-state jurisdiction (from benefit mandates to broader benefit issues such as HIPAA, COBRA and ACA)

ERISA PREEMPTION

- In Summary, the Supreme Court says that ERISA generally preempts two broad categories of state laws:
  - Those that refer to and purport to directly regulate ERISA plans
  - Those that are connected to “a central matter of plan administration” or would interfere with ERISA’s goal of fostering “nationally uniform plan administration” or cause “acute, albeit indirect, economic effects” on ERISA plan
  - Preemption is implied whenever a state law conflicts with a federal law, usually precludes private lawsuits seeking alternative remedies under state law, such as damages for pain and suffering, that are not available under the statute’s civil enforcement provisions.
  - Until 1995, Court interpreted “relate to” very broadly, essentially rendering any challenged state law invalid unless it regulated insurance, in which case it could be applied to fully insured employee benefit plans but not to self-insured arrangements.
  - Recent cases had been diminishing effect of ERISA § 514 Preemption on state regulation

THE CASE ITSELF

VERMONT STATUTE

- Adopted legislation similar to other states to create a mandatory All-Payer Claims Database
  - governing board to determine the types and formats of data from insurers, governmental payers, third parties who are mandated to provide the information
- Placed the requirement to submit information on health insurers, government program administrators and payers (but primarily through their third party administrators)

BACKGROUND

- Liberty Mutual (as an employer) challenged Vermont's 2015 statute creating and mandating employers provide information to the state's All-Payer Claim Database as being preempted by ERISA

ARGUMENTS

- Vermont: its All-Payer Claims Database law meets the *Traveler's* standard of "indirect" effect that was "not substantial" nor "unduly burdensome" with respect to benefit design or plan administration
  - It is a health care law, not a benefits or insurance law (which still couldn't be applied to self-insured plans)
  - Does not constrain Liberty Mutual's plan design or impose a substantial compliance burden
  - Does not conflict with ERISA because the Department of Labor has not issued regulations requiring plans to report clinical or claims data.

ARGUMENTS

- Liberty Mutual:
  - Vermont law depends on benefits administration for its effectiveness and therefore within scope of preemption
  - Reporting obligations are a core function of ERISA
  - Congress “clearly intended” to spare self-insured employers the potential burden of multiple, possibly inconsistent state mandates

FINDING

- Court concluded in a 6-2 decision that
  - ERISA preemption “is necessary to prevent States from imposing novel, inconsistent, and burdensome reporting requirements on plans.”
  - If multiple jurisdictions were to issue differing or parallel regulations, “could create wasteful administrative costs and threaten to subject plans to wide-ranging liability.”

CONCLUSION

- Main concerns about the decision:
  - Opinion is potentially influential not just because of its holding that insurance laws like Vermont's are expressly preempted, but because it could be basis for arguments that other state laws impacting benefits are similarly preempted
  - Court's decision in Gobeille is also significant because the recent trend of cases was to narrow ERISA preemption of state law.
    - ERISA's "central design" which is to "provide a single uniform national scheme for the administration of ERISA plans without interference from laws of several states..."

WHAT NOW?

ATTENTION SHIFTS TO USDOL

- “The Secretary of Labor, not the States, is authorized to administer the reporting requirements of plans governed by ERISA. He may exempt plans from ERISA reporting requirements altogether
- “…and, he may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here.
- “Either way, the uniform rule design of ERISA makes it clear that these decisions are for federal authorities, not the separate states”

NASHP LEADING EFFORT FROM STATES

- Working group of state officials and other interested parties to focus on USDOL and other regulators to spark action to permit APCDs to moved forward by the states

ESSENTIAL ELEMENTS

- Coalition of state All-Payer Claims Databases to create a single-state data field and format
- USDOL regulatory or Congressional action to permit states to adopt APCD statutes and to have those apply to third parties who are otherwise exempt under ERISA
- CMS adopt a EDI standard for data submission