**Gobeille v. Liberty Mutual Insurance Co.: Just Another ERISA Preemption Decision—Or a Bellwether Decision for States and Providers Caught Up In Health Care Reform’s War of Attrition?**

**Introduction**

Some Supreme Court rulings decide comparatively isolated legal issues, such as whether religious figures can be placed on the front lawn of a county courthouse without violating the First Amendment. Other Supreme Court rulings decide legal issues which, while certainly important in their own right, have significant and far-reaching legal and/or public policy consequences. *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. ___ (March 1, 2016) (*Gobeille*), in which the Supreme Court held that Vermont’s claims data collection law was expressly preempted by the Employee Retirement Income Security Act (ERISA) when it comes to private sector employers’ self-insured group health plans, falls into this second category (41 PBD, 3/2/16). *Gobeille* is a significant ruling, with immediate and far-reaching consequences. For example, within a week of issuing its decision in *Gobeille*, the Supreme Court on March 7, 2016, vacated the Sixth Circuit’s holding in *Self-Insurance Institute of America v. Snyder*, 761 F.3d 631 (6th Cir. 2014); (45 PBD, 3/8/16), that Michigan’s health insurance tax law is not preempted by ERISA (as applied to self-insured group health plans) and sent that case back to the Sixth Circuit for further consideration in light of *Gobeille*.

How else to explain why seventeen states and the District of Columbia, led by New York state, filed an amicus brief in support of Vermont’s contention that it should be permitted to get a hold of the payer claims data being generated by Liberty Mutual’s own self-insured group health plan (and other employers’ self-insured group health plans)? How else to explain why the National Governors’ Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners joined the fray by filing a combined amicus brief, or why the American Hospital Association, the American Medical Association and the Solicitor of the United States each filed amicus briefs taking that same side? And why did they all urge the Supreme Court—unsuccessfully, as things turned out—to reverse the decision by a divided panel of the United States Second Circuit Court of Appeals, holding that Vermont did not have the authority to force private sector employers to directly or indirectly hand over their group health plan’s claims payment data because the Vermont law was preempted by ERISA? (*Liberty Mutual Ins. Co. v. Donegan*, 746 F.3d 497 (2nd Cir. 2014); the case was renamed on appeal when Vermont’s top official got replaced.)

To really find out what was going on in *Gobeille*, and why the case drew all that attention—particularly, from health care providers and state regulators—one has to dig into the decision. It is a worthwhile exercise. The decision changes the way that ERISA plan fiduciaries should look at their group health plan records and should change the conversation between plan fiduciaries and record keepers like Aetna, Anthem and United Healthcare. The decision also provides important insight into what health care providers, and states and state agencies, are doing to find out what approaches private sector employers are taking to deal with their health care costs—and, possibly, why they are doing it.

**What Was Decided in Gobeille**

It pays to start at the beginning, with what got decided in *Gobeille*. In a strong 6-2 ruling (Justices Breyer and Thomas joined the majority but filed separate concurring opinions, while Justices Ginsburg and Sotomayor filed...
a combined dissent), the Supreme Court held that Vermont’s health care information collection law is expressly preempted by ERISA, at least insofar as that law directly or indirectly applies to self-insured group health plans maintained by private sector employers and their claims payment data.

It all started when Vermont issued a subpoena in August 2011, ordering the claims administrator for the Liberty Mutual group health plan—Blue Cross and Blue Shield of Massachusetts (BC/BS Mass)—to transmit all its files on member eligibility, medical claims, and pharmacy claims on Vermont residents, and threatening BC/BS Mass with steep fines and the suspension of its license to operate in Vermont if it failed to comply. BC/BS Mass then put Liberty Mutual on notice of the Vermont demand and sought indemnification. That is when Liberty Mutual, concerned about its fiduciary duty under ERISA to its plan-covered participants and beneficiaries and acting out of a desire to protect the confidentiality of the plan’s records, brought suit to prevent Vermont from collecting from BC/BS Mass the claims and other payer data that related to Liberty Mutual’s self-insured group health plan. Four and a half years later, the Supreme Court decided that Vermont simply did not have that authority because Vermont’s data collection law is expressly preempted by ERISA.

**Immediate Takeaways**

There are two immediate takeaways from *Gobeille*. Both are relatively straightforward. First, *Gobeille* squarely holds that because the collection, compilation and maintenance of plan data (including participant and beneficiary records and their claims payment information) is a core function of ERISA, Vermont’s data collection law is expressly preempted. Notably, this was not a case where Vermont’s reporting scheme was found to have been preempted only because it “related” to Liberty Mutual’s ERISA plan. (Had that been the case, Vermont, and the other states that made an appearance in *Gobeille*, could easily circumvent preemption by artfully drafting their state statutes to avoid referring to self-insured plans or ERISA-regulated group health plans in particular.) As Justice Kennedy pointedly observed, writing for the majority:

> As all this makes plain, reporting, disclosure and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA. The Court, in fact, has noted often that these requirements are integral aspects of ERISA. [Citations to six Supreme Court decisions, dating from 1985, omitted.]

Vermont’s reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon a “central matter of plan administration” and “interferes with nationally uniform plan administration.” (quoting from *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001)). The State’s law and regulation govern plan reporting, disclosure and—by necessary implication—recordkeeping. These matters are fundamental components of ERISA’s regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability.

*Gobeille*, slip op. pp. 9-10.

The second takeaway has to do with the role that ERISA plan fiduciaries play—or should play—in the generation, protection and preservation of plan records. In *Gobeille*, the Supreme Court confirmed that a plan fiduciary (here, Liberty Mutual, which brought suit not as the plan’s sponsor, but as the plan’s administrator and thus as a plan fiduciary) has standing to protect the confidentiality of its participants’ and beneficiaries’ records from being disclosed to unauthorized third parties—even when a state or state agency makes the demand. Justice Kennedy noted that while the Second Circuit panel had been divided over the ERISA preemption question, the appellate panel had unanimously concluded that Liberty Mutual had standing—as a plan fiduciary and as its plan’s administrator—to challenge Vermont’s state law.

The importance of this second takeaway cannot be overstated. By holding that Liberty Mutual had the right as an ERISA plan fiduciary to fight Vermont’s attempt to obtain plan records, and that BC/BS Mass did the right thing as a plan record keeper to bring it to Liberty Mutual’s attention rather than simply turn over the records to Vermont, the Supreme Court made plain that a private sector plan fiduciary subject to ERISA has both the right, and the responsibility, to protect confidential participant and beneficiary information contained in those records.

While the medical records privacy provisions of Title II of the Health Insurance Portability and Accountability Act (HIPAA) and companion statutes (like the Health Information Technology for Economic and Clinical Health (HITECH) Act) impose their own standards, the Supreme Court’s decision in *Gobeille* casts that obligation in terms of ERISA’s fiduciary duty rules. And ERISA plan fiduciary violations (unlike HIPAA and HITECH breaches, which simply result in government-imposed penalties) are privately enforceable and are capable of being enforced by the U.S. Department of Labor (DOL).

Indeed, because Liberty Mutual was found to have standing under ERISA, as a plan fiduciary, to step in and protect the confidentiality of its participants’ and beneficiaries’ records in *Gobeille*, all ERISA group health plan fiduciaries presumably have that same right—and that same responsibility. Also, if BC/BS Mass apparently acted properly under its recordkeeping agreement when it alerted Liberty Mutual to Vermont’s demands rather than simply surrendering the records (because they constituted plan records, not just Blue Cross data), all claims administrators and recordkeepers arguably have that same duty—or, should have that duty contractually imposed upon them (as a matter of good fiduciary practice).

That duty can be significant and has potentially wide-ranging implications. For example, when Anthem’s massive data breach occurred in late 2014 or early 2015 (it was disclosed in January 2015), it became apparent that a large percentage of the 80 million individuals whose records were involved in the data breach were covered by self-insured group health plans. That obviously gave rise to the opportunity—and, as Gobeille appears to teach, the legal obligation—for the thousands of ERISA plan fiduciaries whose plan records Anthem had left unencrypted and vulnerable to cyberattack to make sure that Anthem did everything it could to protect their plan participants’ and beneficiaries’ interests, and would be held responsible if that effort failed.

I wrote about that fiduciary obligation at the time, in *Anthem Data Breach Focuses Attention on Role Benefit Plan Fiduciaries Play in Managing & Controlling Plan*.
Records, Bloomberg/BNA Health Ins. Rpt. (2.18.15); (33 PBD, 2/19/15). Gobeille simply reinforces this point. Many of the records and data that come into the custody of third parties like Anthem constitute plan records; accordingly, appropriate care needs to be taken by plan fiduciaries to protect plan participants’ and beneficiaries’ records from unwarranted and unwanted disclosure.

Anthem, at least, appears to have wholeheartedly embraced this view, judging from last year’s decision in Smilow v. Anthem Life & Disability Ins. Co. (In re Anthem Data Breach Litigation) (ND. CA. Nov. 24th); (228 PBD, 11/27/15). In Smilow, Anthem was able to defeat dozens of different state law-based claims brought against it in a nationwide (and consolidated) class action predicated on that data breach, by convincing the court that ERISA preempted substantially all those state law claims based on Aetna v. Davila, 542 U.S. 200, 210 (2004), because those claims could have been brought under ERISA (and by implication, against their respective ERISA plan’s fiduciaries, rather than against a mere recordkeeper like Anthem).

While these two takeaways are significant and explain (in part) why the case drew at least some of the attention it got from all the amicus briefs that got filed, they do not explain everything. A deeper dive into the ruling, and the arguments that Vermont and those supporting it made to the High Court, reveals that the decision has other, more far-reaching implications.

The Fight Over Who Collects the Information; What It May Mean

A review of the arguments made to the Supreme Court by Vermont and by the United States Solicitor (which supported Vermont’s position) reveals that the case was more than just a fight over whether states, and ultimately providers, can get access to the claims and other payment information generated by ERISA-regulated self-insured group health plans. Why? Because the arguments and the facts presented in Gobeille make clear that the states ultimately should be able to get access to all of the payer data that they have been trying to collect without having to resort to invoking state law.

Consider the following. Buried in a footnote, in the amicus brief that the United States Solicitor’s office filed May 19, 2015 (which, strangely, vigorously asserted that the case was wrongly decided by the Second Circuit panel but nevertheless urged the Supreme Court not to take up the case), the United States Solicitor’s Office disclosed that the DOL was considering adopting a rule requiring all health plans to provide more detailed information about benefits, claims, utilization and administrative expense. Brief for the United States as Amicus Curiae, filed May 19, 2015, at p. 3, n.1.

Understandably, Liberty Mutual seized upon this revelation and filed a Supplemental Brief virtually devoted to that revelation, while also urging the High Court to deny Vermont’s petition for a writ of certiorari:

The United States has disclosed that the Secretary of Labor (the Secretary), ‘in aid of his authority to ensure compliance with ERISA’s fiduciary standards and claims-processing rules,’ is ‘currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, utilization of medical services, and plan administration.’ U.S. Br. 3 n.1. Although the specifics of this potential rulemaking are unclear, as described by the United States, the rulemaking under consideration by the Secretary could impose on ERISA plans reporting requirements of the same type at issue in this case—reporting on the use of medical services by participants in ERISA plans.

Supplemental Brief for Respondent Liberty Mutual, filed June 3, 2015, at p. 3.

That revelation then took on a life of its own at oral argument (held December 2, 2015), when Justice Alito and then Justice Breyer brought up the DOL’s role, or potential role, to act as a common collector and disseminator of claims data. The following exchanges between the Justices and Vermont’s Solicitor General, from pages 7 and 8 of the Court’s official transcript from the Gobeille oral argument, are illustrative:

Justice Alito: [ ] Doesn’t the Affordable Care Act include in ERISA a section authorizing the Secretary to gather information from plans for the purpose of improving health outcomes?

Ms. Asay: Yes. The Affordable Care Act made a technical amendment to ERISA, which in turn incorporated the Act’s amendments to the Public Health Services Act. Those do not change the test for ERISA preemption. They’re not part of the plan’s annual reporting to the [DOL]. ... Part 7 of ERISA also, which has those amendments in it, is not part of ERISA as it was originally passed. That was added by HIPAA. And Part 7 itself has a provision that says it does not—

Justice Alito: But why does it matter—

Ms. Asay: —affect the—

Justice Alito: —why does it matter whether it was in ERISA as originally passed? It is in ERISA now . . . .

Justice Breyer then expanded the discussion, wondering aloud why the DOL could not simply streamline things by promulgating a single rule to eliminate the potentially crippling burden of having to comply with up to 50 potentially different state data collection laws (this, from pages 14-15 of the Court’s official transcript from the Gobeille oral argument):

Justice Breyer: But this is no problem for you. All you have to do is go to DOL or HHS. The State representative says, this is what we want to do, will you please promulgate a regulation—you can do it maybe in 90 days or 120 days—which says that this and similar things are fine. And in our opinion, it is not—it is not preempted . . . .

Those inquiries doubtlessly played a role in Justice Breyer’s decision to publish a concurrence in Gobeille (while voting with the majority) suggesting that the DOL can solve the states’ data collection problem. And Justice Kennedy’s majority opinion reflects and incorporates the sentiment set forth in more detail in Justice Breyer’s concurrence, by pointing out that:

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. [Citation omitted]. He may be authorized to require ERISA plans to report data similar to that which Vermont seeks, although 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 for the separate States.

Gobeille, slip opin. p. 10. (Emphasis added.)

So Gobeille may not be about consumer transparency, or at least not solely about consumer transparency, which is how the case has broadly been por-
trayed. According to the Supreme Court, based on what was disclosed by the United States Solicitor, the states and the health care providers are likely to be able to get at—eventually—the kind(s) of buyer/payer data that Vermont was claiming to be seeking under its state law. Those constituencies simply have to pressure the DOL to promulgate rules and implement them. This begs the question: why have the states been so insistent on being able to maintain their own rules and being able to control the information gathering process? None of those who unsuccessfully urged the Supreme Court to uphold Vermont’s data collection laws and limit ERISA’s preemptive reach has yet provided a cogent rationale (other than the desire to obtain the all-payer data more quickly without having to wait for the DOL to act). However, at least one rationale can be inferred: because each state, and perhaps each constituent group, has different reasons for collecting payer data, and envisions different uses for it. And transparency—at least at the consumer level—may have little to do with at least some of those contemplated uses.

**What Information Might Be There; Why Providers and States May Want to Know**

So what kinds of payer data might states and providers find within the claims payment and other records generated and held by self-insured group health plans pertaining to the 93 million lives such plans reportedly cover (which was the headcount provided to the Supreme Court as it considered *Gobeille*)? They likely would find a wide variety of information covering a range of activities, because self-insured group health plans are not homogenous. Simply, different plan sponsors and fiduciaries (ranging from employers and employer groups, to Taft-Hartley plan trustees and trustees of, e.g., the $60 billion UAW/Retiree VEBA) have taken different paths when tackling health care cost containment. And the sheer number of self-insured group health plans has been rising due to the increased use of that funding model by small and mid-sized employers and employer groups. In a trend that has drawn increased attention from state regulators (including the National Association of Insurance Commissioners), more and more mid-sized and small employers have directly or indirectly turned to self-insurance to help eliminate unnecessary cost and expense and avoid state benefit and coverage mandates.

While all sponsors and fiduciaries of self-insured group health plans face common challenges such as escalating benefits costs, they respond differently to those challenges. Responses likely include direct contracting with select providers to obtain “volume”-based pricing on select procedures, medical supplies and pharmaceuticals; financing private on-site clinics; maintaining pricing arrangements with centers of excellence; sending plan-covered individuals across state lines to have certain procedures or receive certain programs of treatment; providing cost- and outcomes-based performance incentives to providers; implementing reference pricing to combat out-of-network price gouging; aggressively promoting telemedicine; and facilitating the use of inter-state and/or international medical tourism to combat state-sanctioned anti-competitive arrangements.

Consider, alone, the recently-announced decision by 20 major corporations (including IBM, DuPont, Shell, Macy’s, Verizon and Marriott, to name just a few) to form an employer alliance to better manage and control the $14 billion that just those companies spend each year on the four million people covered by their self-insured plans. Actively managing such costs almost certainly won’t lead to blindly paying while covered individuals see their neighborhood physician(s) and visit their local hospitals and pharmacies. Rather, it will become far more likely that where a plan-covered individual resides will not be where that individual primarily obtains treatment, or where his or her medical supplies will come from. What use states and state agencies, and local providers, might have for *that* sort of data—and what relevance it might have for consumers functioning at the “retail” level (whether or not disclosed in the name of transparency)—is not yet known.

One possible reason why states, in particular, have wanted to do their own data gathering could have to do with the fact that some of those inquiries may have nothing to do with outcomes, utilization, or general pricing—or, the desire to promote pricing transparency at the consumer level. It is now both accomplished fact and common knowledge that health care providers have been consolidating, particularly after the Affordable Care Act (ACA) was signed into law in March 2010, and that the Federal Trade Commission (FTC) has been challenging some provider combinations as anti-competitive. The FTC’s most high-profile enforcement action, which challenged a hospital combination initiative in Albany, Georgia, led to the Supreme Court’s 2013 decision in *Federal Trade Commission v. Phoebe Putney Health System*, 568 U.S. ___, 133 S. Ct. 1003 (2013). In *Phoebe Putney*, the Supreme Court indicated that it is possible for a state to protect a consolidating health system from the federal anti-trust laws, but only if the state’s actions are sufficiently explicit and the state plays an active, supervisory role in the process.

The FTC continues to actively challenge health care provider consolidation efforts it considers anti-competitive, and has done or is doing so in Boise, Idaho, Toledo, Ohio and in Chicago, Illinois (to name a few). And some state legislatures have reacted to the Supreme Court’s decision in *Phoebe Putney* by enacting protectionist legislation designed to permit selected hospital systems to consolidate without fear of scrutiny or challenge under the federal anti-trust laws. The first state to do so was New York, which quickly adopted a post-*Phoebe Putney* anti-trust immunity statute in 2014 and applied it to a hospital combination in Nassau County. (Whether it was simply coincidence that New York State led the multi-state coalition that supported Vermont’s position in *Gobeille* may never be known.) Most recently, the West Virginia state legislature has been considering a bill designed to shield a Huntington, West Virginia hospital merger from a threatened FTC challenge.

Perhaps this is not why the states, and those who supported Vermont in its attempt to collect the “buyer” claims data directly, fought this particular battle. Perhaps the reason some states have wanted to directly collect private sector self-insured group health plan claims data is entirely innocuous. But a state that wants to collect and mine buyers’ claims payment data, to use it for purposes that the federal government might not look upon favorably, logically would want to do it directly and by itself.
Conclusion

Health care reform has spurred potentially profound changes across the entire health care delivery spectrum. In the end, it brings to mind a quote attributed to President Kennedy: “In a time of turbulence and change, it is more true than ever that knowledge is power.” No reasonable person will deny that this is a time of turbulence and change for health care providers, and for those that regulate them.

What does Gobeille teach? That ERISA’s preemption is broad (despite what one may have recently heard to the contrary). That ERISA plan fiduciaries need to pay closer attention to their participants’ and beneficiaries’ records. And that an awful lot of states and providers really, really want to know what private sector employers are up to when it comes to paying claims and making provider arrangements—and that they really would prefer doing it themselves, for as-yet undisclosed reasons. Stay tuned.