US Supreme Court Invalidates State All-Payer Health Claims Databases

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Over the last decade, 21 states (including New York and California) have created health claims databases and have imposed substantial and costly health care data reporting requirements upon public and private employers, health care plans, health care insurers, and third-party administrators that provide or pay for health care services. In recent years, 18 more states have moved towards creating such databases (including Michigan, Illinois, and Ohio).

On March 1, 2016, the US Supreme Court brought that accelerating trend to a halt. In one of the first decisions issued after the sudden death of Justice Scalia just two weeks earlier, six justices agreed that the Employee Retirement Income Security Act ("ERISA") expressly preempts state "all-payer claims database" ("APCD") statutes, even if those statutes impose requirements consistent with ERISA. *Gobeille v. Liberty Mutual Ins. Co. ("Gobeille").*

Before the Supreme Court's March 1st decision, state APCD statutes had imposed significant monetary and other penalties for non-compliance with reporting requirements, had required extensive health claims data reporting in prescribed formats, and had permitted the disclosure of reported information to insurers, employers, health care providers and others to facilitate review of utilization, cost and quality of care provided.

The Proliferation of State APCD Statutes:

In an era of health care reform, various state agencies and some nonprofit organizations working on health care access, quality, and cost issues have advocated for the use of these databases as a tool to improve health care delivery and help understand utilization and to focus attention on data-driven and evidence-based practices. The movement to an APCD is designed to bring together commercial and employer plan

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data, along with publicly paid (Medicare and Medicaid) claims data.

By way of example, a December 8, 2014 feasibility study commissioned by the Michigan Legislature recommended that "the Legislature pursue a staged approach for establishment of a PCD with the following capabilities: (1) perform analytics during rate review; (2) measure health outcomes and utilization; (3) evaluate health care reform initiatives and new payment models; and (4) enable cost and quality transparency."

The Invalidated Vermont APCD:

The Vermont APDC statute broadly required health insurers, health care providers, health care facilities and governmental agencies to report any "information relating to health care costs, prices, quality, utilization, or resources required" by the state, including data relating to health insurance claims and enrollment, and claims data on members, subscribers and policy-holders.

Vermont required "health insurers" to submit "medical claims data, pharmacy claims data, member eligibility data, provider data, and other information" relating to health care provided to Vermont residents or by Vermont health care providers and facilities in prescribed formats with codes and other requirements. The ACPD statute even permitted the collection of data on denied claims.

The statute defined "health insurer" to include:

- self-insured plans
- health insurance companies
- nonprofit hospital and medical service corporations
- managed care organizations
- third party administrators
- pharmacy benefit managers
- any entities conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information.

The Dispute and Threatened Penalties:

Liberty Mutual, which challenged the Vermont statute, fell within its definition of "health insurer," as did its third-party administrator ("TPA"), Blue Cross and Blue Shield of Massachusetts ("BCBS MA").

At Liberty Mutual's instruction (an instruction it gave out of concern that the disclosures Vermont sought to compel by subpoena might violate its ERISA fiduciary duties), BCBS MA did not comply with the subpoena, at least as to Liberty Mutual's participants. The subpoena ordered BCBS MA to submit all files on member eligibility, medical claims and pharmacy claims for Vermont members.

Vermont threatened to impose penalties of up to $2000 per day for non-compliance. It also threatened to revoke BCBS MA's authorization to operate in Vermont for as long as 6 months.

Liberty Mutual then sued, claiming federal preemption of the state law.

The Supreme Court's Decision:

The impact of these statutes on employers with employees in several states concerned the the Supreme Court in *Gobeille*. As an employer and plan sponsor, Liberty Mutual maintains a national "self-insured and self-funded" plan with about 80,000 participants. As the amicus ("friend of the court") brief of the American Benefits Council (of which Butzel Long is a member) apprised the Court, self-insured ERISA-governed plans now predominate in the health care market and supply health care benefits to 93 million Americans.

The Supreme Court agreed with Liberty Mutual that ERISA expressly preempts the diverse state health claims reporting statutes as applied to ERISA plans. The Court invalidated the Vermont ACPD statute because the statute "imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from the laws of the several States even when those laws, to a large extent, impose parallel requirements."

Writing for the majority, Justice Kennedy recognized that ERISA authorizes the federal Secretary of Labor (and not the states) to administer the reporting requirements applicable to ERISA-governed plans. The Court understood that, under ERISA, the Secretary might exempt self-insured plans from certain reporting requirements or might "require ERISA plans to report data similar to what which Vermont seeks." In either event, "the uniform rule design of ERISA makes it clear that these decisions are for federal authorities, not for the states."

Possible Ramifications of the Decision:

Gobeille means that health care plans, plan sponsors, plan administrators and third-party administrators do not have to face a patchwork quilt of diverse state reporting regulations under APCD statutes. The decision clearly contemplates that the US Department of Labor may develop national health care data reporting requirements under ERISA. Such reporting requirements, however, would be uniform, without unnecessarily creating costly conflicts for ERISA plans.

As a bellweather decision, *Gobeille* may also signal that courts should be willing to strike down state laws as having an impermissible "connection with" ERISA plans where the laws interfere with the uniformity of plan administration. Underscoring the importance of Gobeille, less than a week later, the Supreme Court vacated a 2014 federal Court of Appeals decision from the Sixth Circuit (governing Michigan, Ohio, Kentucky, and Tennessee) holding that Michigan's health insurance tax law survived ERISA preemption, *Self-Insurance Institute of America v. Snyder*. The Supreme Court remanded that case back to the Sixth Circuit for reconsideration in light of *Gobeille*.

Read broadly, *Gobeille* could open the door to challenges to state attempts to eliminate deferential review of claims denials by self-insured plans, or to impose additional state reporting requirements for breaches of HIPAA and HITECH privacy and security standards for protecting health information.

As with any Supreme Court decision, the impact of *Gobeille* will only become clear over time. For now, plans, plan administrators, TPAs and other service providers tasked with compiling health plan data to comply with various state APCD statutes should review with benefits or health care counsel whether to cease compiling such data and whether to seek a return of any fines or penalties imposed by a state for non-compliance.

If you have questions regarding APCDs, other employer health plan issues or other health care law matters generally, please contact your regular Butzel Long attorney, the authors of this alert, or any member of Butzel Long's Employee Benefits or Health Care Industry Groups.

Diane M. Soubly
734.213.3625
soubly@butzel.com

Mark R. Lezotte
313.225.7058
lezotte@butzel.com