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## State All-Payer Claims Databases and ERISA Preemption



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**T**he goals underlying State All-Payer Claims Database (APCD) initiatives are notable and worthy. However, these initiatives are not uniform and various states are taking different approaches to the purpose and implementation of APCDs. This presents thorny issues for those entities that are subject to the requirements of more than one APCD. In addition, the implementation of APCDs presents important issues concerning ERISA. Most state APCD statutes require the submission/reporting of data on self-insured ERISA health plans by health insurers (and others) acting as the third party administrators (TPAs) of these plans. These data submission requirements present important ERISA issues. If these ERISA issues are not addressed in the planning stages of APCD initiatives, they may prevent the initiatives from achieving these notable and

worthy goals, locally and nationally. The objective of the authors of this paper is not to prevent the collection of appropriate data by APCDs, but to ensure that there is full consideration given to these important issues.

In the view of the authors of this paper, the current, proposed and/or contemplated APCD data submission requirements imposed on the TPAs of self-insured ERISA health plans present significant ERISA preemption issues—both express and implied. Because TPAs only possess the data as a result of their activities on behalf of the self-insured plans and the information that the TPAs are or would be submitting to state APCDs pertain to the members of such plans and the functions the TPAs carry out for them, it is especially important that the employer sponsors of such plans are aware of these current, proposed or contemplated submission requirements and the ERISA preemption implications for the submission requirements. Even where states assert some police power authority to require TPAs to submit data to the state APCD, that does not overcome ERISA preemption or forestall the need to consider the ERISA preemption issues. TPA statutes have a limited purpose and cannot legally support requirements imposed on TPAs to submit any and all data—or for any purpose. Because of the significant ERISA preemption issues as-

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sociated with the required submission of claims and other data concerning self-insured ERISA health plans, states should work with TPAs, employer groups, and the Departments of Labor and Treasury/Internal Revenue Service, to reach a uniform consensus on the scope of ERISA pre-emption and, thus, on the permissible scope of APCD submission requirements.

## APCDs

According to the APCD Council, APCDs are “large-scale databases that systematically collect health care claims data from a variety of payer sources which include claims from most health care providers.”<sup>1</sup> The Council defines State APCDs as

Databases, typically created by a state mandate, that generally include data from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. In states without a legislative mandate, there may be voluntary reporting of APCD data.<sup>2</sup>

The purpose of an APCD varies across states. Similarly, the payers that are required to submit claims data for State APCDs vary from state to state. The payers can include insurance carriers, TPAs, pharmacy benefit managers, dental benefit administrators, Medicaid, Children’s Health Insurance Program, Medicare, Medicare Part D, Federal Employees Health Benefits Program, and TRICARE. The type of data required to be submitted/reported—and, thus, contained in a state APCD—similarly can vary from state to state, as can the format in which data is required to be submitted. APCD statutes typically require the submission of medical claims files or corresponding claims files for pharmacy and other health-care related claims. The medical claims files submitted to an APCD may include health care related data elements including diagnosis codes, types of care received (procedure and pharmacy codes), insurance product type (HMO, PPO, POS), facility type (hospital, office, clinic), cost amounts (charge, paid, member liabilities), eligibility, and provider information. But APCD statutes and/or implementing regulations may also require the reporting of the actuarial basis of the plan, plan designs or summary plan descriptions, broker payments, premium contribution levels for employees and employers, annual co-insurance totals, etc.

Approximately 14 states have enacted legislation or started to collect health care claims data in an effort to establish an APCD. They include Colorado, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Oregon, Rhode Island, Tennessee, Utah, and Vermont. Most of these state APCDs require the submission of claims data from TPAs, including with respect to self-insured employee welfare benefit plans. A sampling of mandatory reporting states<sup>3</sup>:

- **Colorado.** The Colorado legislature intends for the Colorado APCD to be “a resource to insurers, con-

sumers, employers, providers, purchasers of health care and state agencies to allow for continuous review of health care utilization, expenditures, and quality and safety performance in Colorado,” and to be presented in a manner “to allow for comparisons of geographic, demographic, and economic factors and institutional size.”<sup>4</sup> In contrast to other States, Colorado appears to have recognized the limits on its authority to require TPAs (and self-insured ERISA plans) to submit data to the Colorado APCD: Although Colorado’s proposed rule defined a “payer” who would be a data submitter<sup>5</sup> as “a private health care payer, a public health care payer and a **third party administrator of employer group health plans**”<sup>6</sup>, the final regulations omitted the reference to TPAs in the definition of “payer,” in recognition of the fact that Colorado had no way to enforce such a requirement.<sup>7</sup> The proposed definition of “private health care payer” was similarly revised to omit any reference to TPAs or to self-insured group health plans.<sup>8</sup> Payers are required to begin submitting, no later than June 30, 2011, “complete and accurate eligibility data files, medical and pharmacy claims data files, and provider files to the APCD pursuant to the submission guide.”<sup>9</sup>

- **Kansas.** The Kansas legislature’s purpose in creating the Kansas health care database was to be able “to provide health care consumers, third-party payers, providers, and health care planners with information regarding trends in use and cost of health care services . . . for improved decision-making.”<sup>10</sup> Providers of health care services and third-party payers, as identified in the statute, are required to submit information “necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services.”<sup>11</sup> Those required to submit health care data include licensed insurers, medical and hospital service corporations, health maintenance organizations (HMOs), and “fiscal intermediaries for government-funded programs and self-funded employee health plans.”<sup>12</sup>
- **Maine.** The primary use of the APCD is to provide analyses of cost, quality, system utilization, episodes, and geographical differences. Under the Maine statute, the reporting requirement applies to both providers and payors.<sup>13</sup> The latter term is defined to include both third party payers (defined

<sup>4</sup> Col. R.S. § 25.5-1-204(7)(a) & (c).

<sup>5</sup> Proposed 10 Colo. Con. R. 2505-5 § III (draft June 17, 2011).

<sup>6</sup> Proposed 10 Colo. Con. R. 2505-5 § II.H (draft June 17, 2011) (emphasis added).

<sup>7</sup> 10 Colo. Code Regs. § 2505-5.1.200.1 (Aug. 24, 2011).

<sup>8</sup> Compare Proposed 10 Colo. Con. R. 2505-5 § II.J (draft June 17, 2011) (“an insurance carrier as defined in C.R.S. § 10-16-102(8), third-party administrators, and self-insured group health plans.”) with 10 Colo. Code Regs. § 2505-5.1.200.1 (Aug. 24, 2011). (“an insurance carrier as defined in C.R.S. § 10-16-102(8), covering an aggregate of 1,000 enrolled lives in health coverage plans as defined in C.R.S. 10-16-102(22.5)”).

<sup>9</sup> 10 Colo. Code Regs. § 2505-5.1.200.2 (Aug. 24, 2011).

<sup>10</sup> Kan. Stat. Ann. § 65-6801(a) (2009).

<sup>11</sup> Ks. Stat. Ann. § 65-6801(b).

<sup>12</sup> Ks. Stat. Ann. § 65-6805.

<sup>13</sup> See, e.g., Me. Rev. Stat. Ann., Title 22, § 8701 (2011).

<sup>1</sup> APCD Council, All-Payer Claims Database (APCD) Fact Sheet at 1 (2010); Academy Health, All-Payer Claims Databases, An Overview for Policymakers at 1 (May 2010).

<sup>2</sup> *Id.*

<sup>3</sup> The summaries provided consist only of the provisions that seemed most relevant with respect to the issues of ERISA preemption and geographic limitations on state police power.

as “a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors,<sup>14</sup> nonprofit hospital, medical services organization or managed care organization licensed in the State”), third party administrators (defined as “any person who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on, residents of this State”), and pharmacy benefits managers (PBMs).<sup>15</sup> Under the implementing regulations, “health care claims processors” (which include third-party payers and third-party administrators) are required to submit to the agency operating Maine’s APCD a completed health care claims data set for all members who are Maine residents, including a member eligibility file, a medical claims file, a pharmacy claims file, and/or a dental claims file.<sup>16</sup> These files are to include capitated service claims, co-insurance/co-payment information, coordination of benefits claims, and any prepaid amounts.<sup>17</sup>

- **Massachusetts.** The primary use of the APCD is cost analysis and facilitation of administrative simplification by serving as the central repository of health care claims data for Massachusetts state government agencies, although it is apparently anticipated that the purpose may be expanded to permit studies of cost, patterns/episodes of care, global payments, modeling, behavioral health, comorbidity, leading indicators, and possibly quality and system utilization. Under its statute, the Massachusetts Division of Health Care Finance and Policy adopted regulations that require “health care payers”<sup>18</sup> (defined to include third-party administrators<sup>19</sup> and self-insured plans) to submit health plan information and health care claims data.<sup>20</sup> The health plan data to be reported includes information on premiums, the actuarial assumptions underlying plan premiums, summaries of plan designs, medical and administrative expenses, reserves and surpluses, and provider pay-

ment methods and levels.<sup>21</sup> The health care claims data that must be submitted under the regulations includes medical claims, pharmacy claims, dental claims, member eligibility files, provider files, and product files (including detailed information on covered services, group size, coverage levels, and copayments).<sup>22</sup> Payers are required to report “health care service paid claims and encounters” for “all Massachusetts resident members, and all members of a Massachusetts employer group including those who reside outside of Massachusetts” and must identify encounters corresponding to a capitation payment as well.<sup>23</sup>

- **Minnesota.** The primary use of the APCD is to provide analyses of cost, quality, system utilization, condition specific care, and geographic differences. Health plan companies or TPAs (defined in the statute as “a vendor of risk-management services or an entity administering a self-insurance or health insurance plan”) that have covered individuals and paid at least \$3 million in health care claims for covered individuals during the previous calendar year, or pharmacy benefit managers that have covered individuals and paid at least \$300,000 in claims for covered individuals during the previous calendar year, are required to submit data to the APCD.<sup>24</sup> For each covered individual, the data submitters are required to submit all enrollment data elements, encounter data elements and pricing data for all institutional and professional health care claims and pharmacy drug claims paid by the submitter.<sup>25</sup>
- **New Hampshire.** The primary uses of the APCD are to provide analyses of cost, HEDIS, system utilization, episode, and geographical differences, and to provide Medicaid payment rate benchmarking and competition within the commercial health market. Each health insurance carrier and health care claims processor (both of which terms are defined to include TPAs<sup>26</sup>) are required to submit “a complete health care claims data set for all residents of New Hampshire and for all members who receive services under a policy issued in New Hampshire.”<sup>27</sup> Such policies include any policy that provides coverage to employees of a New Hampshire employer that has a business location in the state – and New Hampshire branch loca-

<sup>14</sup> “Plan sponsor” is defined as “any person, other than an insurer, who establishes or maintains a plan covering residents of this State,” including employer plans and joint employer/employee organization plans. Me. Rev. Stat. Ann., Title 22, § 8702.8-A.

<sup>15</sup> Me. Rev. Stat. Ann., Title 22, § 8702.8, 8702.10-A, 8702.11.

<sup>16</sup> 90-590 Me Code R. § 243.2.

<sup>17</sup> *Id.*

<sup>18</sup> “Health Care Payer (‘Payer’)” is defined as “A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. A Health

Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third-Party Administrators, and self-insured plans.” 114.5 Mass. Code Regs. 21.02.

<sup>19</sup> “Third-Party Administrator” is defined as “Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.” 114.5 Mass. Code Regs. 21.02.

<sup>20</sup> 114.5 Mass. Code Regs. 21.03(1).

<sup>21</sup> 114.5 Mass. Code Regs. 21.03(2)(a).

<sup>22</sup> 114.5 Mass. Code Regs. 21.03(3)(a)(1), 21.03(3)(b)(6).

<sup>23</sup> 114.5 Mass. Code Regs. 21.03(3)(b)(1).

<sup>24</sup> Minn. R. §§ 4653.0200.A. & 4653.0100, Subp. 8, 18 (2009).

ERISA self-insured plans themselves are merely encouraged to comply with the reporting requirements. *See Boyle v. Anderson*, 68 F.3d 1093, 1100 (8th Cir. 1995).

<sup>25</sup> Minn. R. § 4653.0200.B.

<sup>26</sup> “Third-party administrator” is defined as “any person licensed by the department, that, on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on resident of the state.” N.H. Code Admin. R. Ann. [Ins.] § 4002(ao) (2011). A “plan sponsor” is defined, in turn, as “any persons, other than an insurer, who establishes or maintains a plan covering residents of the state of New Hampshire,” including employer plans and joint employer/employee organization plans. *Id.* § 4002(ab).

<sup>27</sup> N.H. Code Admin. R. Ann. [Ins.] § 4004.01(a).

tions of an out-of-state employer are considered a New Hampshire employer. Carriers are required to submit claims data sets for all members employed at such branch offices.<sup>28</sup>

- **Oregon.** Oregon anticipates mining its APCD for statistics and payment/purchasing strategies. Under administrative rules promulgated by the Oregon Health Authority, health insurance carriers and licensed TPAs with calculated mean total lives of 5,000, PBMs, and MCOs are mandatory reporters who are required to submit healthcare claims data files for all required lines of business, including Medicare, Medicaid, portability, individual, small employer health insurance, large group, associations and trusts, and self-insured plans (which is defined as “any plan, program, contract, or any other arrangement under which one or more employers, unions, or other organizations provide health care services or benefits to their employees or members in this state, either directly or indirectly through a trust or third-party administrator”).<sup>29</sup>
- **Tennessee.** Under Tennessee law, all group health plans (defined as employee welfare benefit plans or the administrators of such plans) and health insurance issuers (defined to include PBMs and TPAs) are required to provide “electronic health insurance claims data for state residents to the commissioner or a designated entity authorized by the commissioner.”<sup>30</sup>
- **Utah.** Utah uses its APCD primarily for planning capability to provide analyses of cost, efficiency, quality of care, system utilization, patterns of care, geographic differences, and physician-based reporting. Utah requires each carrier (defined to include a licensed TPA that collects premiums or settles claims of Utah residents, for health care insurance policies or health benefit plans) to submit enrollment, medical claims and pharmacy data “where Utah is the patient’s primary residence,” as well as such data “for services provided out of state” to Utah residents.<sup>31</sup>
- **Vermont.** The primary use of Vermont’s APCD is to generate analyses of cost, utilization, variations in quality, episodes, geographic differences, and risk adjustment. Under Vermont law, health insurers (which is defined to include “any third party administrator, any pharmacy benefit manager, . . . and any similar entity with claims data, eligibility data, provider files, and other information relating to [1] health care provided to Vermont resident[s], and [2] health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section”), health care providers, health care facilities and government agencies are required to file information, including health insurance claims and enrollment information used by health insurers, and any other information relating to health care costs, prices,

quality, utilization, or resources required to be filed by the commissioner.<sup>32</sup> The commissioner is given the authority to exempt from all or part of the filing requirements data reflecting utilization and costs for services provided in Vermont to non-residents.<sup>33</sup>

In addition to the current APCD data submission requirements, the APCD Council has recently suggested that, in the next APCD evolution, the types of data that insurers and TPAs are required to submit to APCDs should be significantly broadened.<sup>34</sup> The APCD Council has advised that APCDs should collect information concerning non-claim-based fiscal transactions between payers (or TPAs) and providers, such as pay-for-performance payments; per member per month medical home payments; capitation fees; contractual settlement debits or credits supporting risk contracts; and pharmacy benefit manager rebates.<sup>35</sup> In addition, the APCD Council has advised that State APCDs require plans and TPAs to submit information on premiums collected at the employee or employer level, including “premium equivalents” at the benefit tier level, and the submission of total premium amount, as well as a “premium equivalent” on each eligibility record.<sup>36</sup> Finally, the APCD Council advocates that State APCDs collect benefit information on enrollees, that is, information on the benefits offered to enrollees under their respective health plans. The benefits information that insurers and TPAs should be required to submit to State APCDs, according to the APCD Council, include co-payments, co-insurances, deductibles, out-of-pocket maximums, lifetime maximums, and detailed information concerning medical or pharmacy benefits (e.g., number of physical therapy visits covered or whether certain therapies are covered).<sup>37</sup>

## ERISA

### *Standards for Preemption*

“When Congress enacted the Employee Retirement Income Security Act (ERISA), it intended to “protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies.”<sup>38</sup> These national standards “include[] rules concerning reporting, disclosure, and fiduciary responsibility.”<sup>39</sup> Congress recognized that achieving this purpose “require[d] the avoidance of a ‘multiplicity of regulation’ and, concomitantly, the creation of a climate that ‘permit[s] the nationally uniform administration of employee benefit plans.’ ”<sup>40</sup> Accordingly, ERISA

<sup>32</sup> Vt. Stats. Ann., tit. 18, § 9410(c), (j)(1)(B) (2010).

<sup>33</sup> Vt. Stats. Ann., tit. 18, § 9410(h)(1)(A).

<sup>34</sup> See APCD Council, All-Payer Claims Databases 2.0: The Next Evolution, July 2011, accessed at [www.apcdouncil.org/issue-briefs-and-fact-sheets](http://www.apcdouncil.org/issue-briefs-and-fact-sheets).

<sup>35</sup> See All-Payer Claims Databases 2.0: The Next Evolution (APCD 2.0) at 7.

<sup>36</sup> *Id.* at 7-8.

<sup>37</sup> *Id.* at 9.

<sup>38</sup> 29 U.S.C. § 1001(b).

<sup>39</sup> *Retail Industry Leaders Assoc. v. Fielder*, 475 F.3d 180, 190 (4th Cir. 2007) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983)).

<sup>40</sup> *Carpenters Local Union No. 26 v. U.S. Fidelity & Guaranty Co.*, 215 F.3d 136, 140 (1st Cir. 2000) (quoting *New York*

<sup>28</sup> *Id.*

<sup>29</sup> Or. Admin. R. § 409-025-0100(5), (45), (83), (85), § 409-025-0110(1), (3)(a) (2011).

<sup>30</sup> Tenn. Code Ann. § 56-2-125(f), (a)(4) & (6) (2010).

<sup>31</sup> Utah Admin. Code R428-15-3(1), R428-15-2(a) (2011).

expressly “supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .”<sup>41</sup> The Supreme Court has found that, in adopting this preemption provision, Congress intended

to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.<sup>42</sup>

However, Congress did not want to affect state regulation of certain businesses, including insurance, so it adopted an ERISA provision that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”<sup>43</sup>

*Express Preemption.* A state law relates to an employee benefit plan, within the meaning of the ERISA preemption provision, “if it [1] has a connection with or [2] reference to such a plan.”<sup>44</sup> The courts determine whether such a connection exists by looking to the objectives of the ERISA statute and the effect of the state law on employee benefit plans.<sup>45</sup> ERISA was meant to protect employee benefit plan members by creating standards of conduct, responsibility, and obligation for ERISA plan fiduciaries.<sup>46</sup> This requires avoiding a multiplicity of regulation and creating a climate that permits the nationally uniform administration of benefit plans.<sup>47</sup> Courts, thus, “assess the effect of a state law on the ability of ERISA plans to be administered uniformly nationwide.”<sup>48</sup> There can be a meaningful nexus with ERISA, for example, when the state law interferes with the administration of covered employee benefit plans,

*State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 654, 657 (1995).

<sup>41</sup> 29 U.S.C. § 1144(a) (ERISA preemption provision).

<sup>42</sup> *Little v. UNUMProvident Corp.*, 196 F. Supp. 2d 659, 664 (S.D. Ohio 2002) (quoting *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656-57 (1995)).

<sup>43</sup> 29 U.S.C. § 1144(b)(1) (ERISA “savings clause”). Congress, however, further provided that neither an employee benefit plan, nor any trust established under such a plan “shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.” 29 U.S.C. § 1144(b)(2) (ERISA “deemer clause”). To the extent that state APCD statutes include self-insured ERISA plans in the definition of health insurance issuers required to report claims data, they would seem to run afoul of this deemer clause.

<sup>44</sup> *California Div. of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 324 (1997) (citations and internal quotation marks omitted).

<sup>45</sup> *Id.* at 325.

<sup>46</sup> *Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co.*, 215 F.3d 136, 141 (1st Cir. 2000) (citing 29 U.S.C. § 100(b)).

<sup>47</sup> *Id.* (citing *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657, 115 S.Ct. 1671 (1995)).

<sup>48</sup> *Retail Industry Leaders Association v. Fielder*, 475 F.3d 180, 194 (4th Cir. 2007).

purports to regulate plan benefits, or imposes additional reporting requirements.<sup>49</sup> Additionally, courts have held that there is an impermissible “connection with” an ERISA plan “if it directly regulates or effectively mandates some elements of the structure or administration of employers’ ERISA plans.”<sup>50</sup> In contrast, if the state law “has only a tenuous, remote, or peripheral connection” with ERISA plans – such as with many laws of general applicability – preemption would not occur.<sup>51</sup>

In addition, a state law references an ERISA plan, within the meaning of the ERISA preemption provision, if it acts immediately and exclusively upon ERISA plans, or if the existence of ERISA plans is essential to the law’s operation.<sup>52</sup> The Supreme Court has held that ERISA preempts a state statute on this basis where the state law “imposed requirements by reference to [ERISA] covered programs.”<sup>53</sup>

Whether a state statute relates to ERISA does not end the inquiry because of the savings clause. Under binding Supreme Court precedent, in order for a state statute to be saved from preemption by the ERISA savings clause, it must meet two requirements: (1) “the state law must be specifically directed toward entities engaged in insurance”; and (2) “the state law must substantially affect the risk pooling arrangement between the insurer and the insured.”<sup>54</sup>

*Implied Preemption.* The inquiry as to whether a state statute is preempted by ERISA does not end with consideration of the application of ERISA’s express preemption provision to the state statute at issue, because a state statute can also be subject to implied preemption. Under the doctrine of implied preemption, a state statute is preempted if it conflicts with ERISA provisions or if it operates to frustrate ERISA’s objectives. Indeed, the Supreme Court took this very approach to the issue of ERISA’s preemption of a state statute in *Boggs v. Boggs*, in which the Court held that certain of Louisiana’s community property laws were impliedly preempted by ERISA’s surviving spousal annuity and beneficiary designation requirements because “there is a conflict.”<sup>55</sup>

<sup>49</sup> *Carpenters Local Union No. 26*, 215 F.3d at 142.

<sup>50</sup> *Retail Indus. Leaders Assoc.*, 473 F.3d at 192-93.

<sup>51</sup> See *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992); *Little v. UnumProvident Corp.*, 196 F. Supp. 2d 659, 664 (S.D. Ohio 2002).

<sup>52</sup> *Dillingham*, 519 U.S. at 325.

<sup>53</sup> See *Dillingham*, 519 U.S. at 324 (citations and internal quotations omitted). Some courts have indicated that the reference must be patent before ERISA preemption looms. See *Carpenters Local Union No. 26*, 215 F.3d at 144.

<sup>54</sup> *Kentucky Assoc. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 334, 338, 341 (2003) (finding Kentucky any willing provider statute a statute that regulates insurance under 29 USC § 1144(b)(1)). See also *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 276 (5th Cir. 2005) (Texas statutory claims for violations of the state insurance code which provide remedies to insured injured by the bad faith of the insurer do not affect the scope of bargain between an insurer and insured and, consequently, do not affect their risk pooling arrangement; claims with respect to an ERISA welfare benefit plan not saved from preemption).

<sup>55</sup> 520 U.S. 833, 841 (1997) (“We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects. We hold that there is a conflict, which suffices to resolve the case. We need not inquire whether the statutory phrase “relate to”

## ERISA Preemption of APCD Laws

Where TPA statutes have been adopted and remain in effect,<sup>56</sup> the States may believe that they have the regulatory authority to require TPAs to submit some data with respect to the activities TPAs undertake on behalf of self-insured ERISA plans. But such a law does not surmount the effect of ERISA preemption, as discussed herein. The scope of the State's TPA licensing authority is limited to the purpose of overseeing the TPA functions; it does not encompass authority over all health issues within the State's borders. To the extent that TPA statutes impose regulatory requirements on TPAs, they are focused on ensuring that TPAs promptly and properly adjudicate and pay claims. As a consequence, the TPA statutes cannot provide the regulatory authority to require TPAs to submit information about self-insured plans when express or implied ERISA preemption applies. Thus, the actuarial basis of the product, plan designs or summary plan descriptions, broker payments, premium contribution levels for employees and employers, benefit information, and annual co-insurance totals are beyond the reach of a TPA statute due to express preemption, as is discussed below. Moreover, as to the submission of the claims transactions themselves, which may be subject to implied preemption under ERISA, the impacted parties need to reach agreement on the meaning and scope of ERISA preemption in the context of APCD enactment and implementation.

ERISA should preempt state APCD laws as to the requirement that TPAs of self-funded ERISA plans submit/report claims and other data to the APCD.<sup>57</sup> First, it is clear that state APCD statutes could not impose data reporting requirements directly on self-funded ERISA plans because they would interfere with the nationally uniform administration of such plans and/or undermine (or stand as an obstacle to) the uniform administration intended by federal law, and, thus, be preempted. Furthermore, there is no policy basis for distinguishing between directly imposing a reporting

provides further and additional support for the pre-emption claim. Nor need we consider the applicability of field preemption.”) (citations omitted); see also *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 217-18 (2004) (allowing state law lawsuits would “pose an obstacle to the purposes and objectives of Congress” such that “[u]nder ordinary principles of conflict preemption . . . even a state law that can arguably be characterized as regulating insurance will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA’s remedial scheme”).

<sup>56</sup> Several federal courts have held that TPA statutes are preempted by ERISA as applied to TPAs in their capacity as administrators of ERISA-governed insurance plans. See *NGS American, Inc. v. Barnes*, 998 F.2d, 296, 300 (5th Cir. 1993); see also *Self-Insurance Institute of America v. Gallagher*, 1989 WL 143288, \*8-10 (N.D. Fl. June 2, 1989), *aff’d*, 909 F.2d 1491 (11th Cir. 1990). But see *Benefax Corp. v. Wright*, 757 F. Supp. 800, 804 (W.D. Ky. 1990).

<sup>57</sup> The argument that state TPA licensing statutes provide authority to the state to require the submission of data by TPAs to an APCD is a red herring. Where such statutes have been adopted and remain in effect (see *supra* at \_\_ n.56), the reach of their legitimate authority to regulate—and, thus, to require the submission of data by TPAs with respect to the self-funded ERISA plans they serve—is bounded by the purpose of the licensing statute. The limit of such laws, thus, requires consideration of the ERISA preemption issues with respect to requiring TPAs to submit data to APCDs.

requirement on an ERISA plan and imposing such a requirement on an ERISA plan by requiring its TPA, which possesses that data solely because of the services it provides to the plan, to submit such data.<sup>58</sup>

*Express preemption.* Some state APCD laws require the submission of summary plan descriptions and other documents, data, or information that exist because their preparation and/or distribution are required by ERISA. For example, Massachusetts regulations require private “payers” to “submit data and information for all plan types, including self-insured plans,”<sup>59</sup> including information on premiums, the actuarial assumptions underlying plan premiums, summaries of plan designs, medical and administrative expenses, reserves and surpluses, and provider payment methods and levels. The APCD Council has also suggested that insurers and TPAs be required to submit premium and benefit information to State APCDs.<sup>60</sup> In fact, however, under ERISA, a plan is required to file with the federal government, or provide to plan participants and beneficiaries, Summary Plan Description, Plan Document, a self-insured plan’s actuarial basis, the premiums the plan collects, and information on many other features of self-insured plans.<sup>61</sup> For example, a plan is required to prepare and provide to participants and beneficiaries a summary plan description that includes, among other things:

- The plan’s requirements concerning eligibility for participation and for benefits, including conditions relating to benefit eligibility, a summary of the benefits (including where to obtain more information on covered benefits).
- A description of any cost-sharing provisions, including premiums, deductibles, co-insurance and copayment amounts, for which a participant would be responsible.

<sup>58</sup> See *American Med. Security, Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997) (affirming that ERISA preempted state statute which indirectly regulated self-funded ERISA plans by directly regulating plans’ stop-loss insurers).

<sup>59</sup> Private “payers” are required to submit “data and information for all plan types, including self-insured plans, including but not limited to the following:

1. individual and family plan premiums for a representative range of group sizes, and annual individual and family plan premiums for the lowest cost plan in each group size for every plan with at least 1,000 Massachusetts residents that meets the minimum standards and guidelines established by the Division of Insurance under section 8H of chapter 26, organized by product codes that also appear in the Member Eligibility File;
2. information supporting the actuarial assumptions that underlie the premiums for each plan;
3. summaries of the plan designs for each plan;
4. medical and administrative expenses by market sector, including medical loss ratios for each plan;
5. information regarding the payer’s current level of reserves and surpluses; and
6. information on provider payment methods and levels, including but not limited to total amounts and specific capitated payments, risk sharing arrangements and settlements, and any other provider payments made outside the automated or manual claims payment system.

114.5 CMR 21.03(2)(a).

<sup>60</sup> See APCD 2.0 at 7-9.

<sup>61</sup> See, e.g., 29 U.S.C. §§ 1021, 1022, 1023, 1024, 1026; 29 C.F.R. Part 2520 (rules and regulations for reporting and disclosure by ERISA plans).

- A description of any annual or lifetime caps or other limits on benefits.
- The extent to which various health care services, procedures, tests, drugs, or medical devices are covered.
- A description of provisions concerning networks, network providers, and use of out of network providers.
- A description of any provisions requiring preauthorization or utilization review.
- The sources of contributions to the plan and the method by which the amount of contribution is determined.<sup>62</sup>

ERISA employee welfare benefit plans (subject to an exemption for plans with fewer than 100 participants that are insured and/or funded from employer general assets) are also required to file annual reports with the U.S. Department of Labor on Form 5500, which are required to include, among other things:

- Separate financial statements and a report of an independent qualified public accountant on the financial statements, including statements of assets and liabilities, a statement of changes in fund balances and of changes in financial position, and notes to the financial statement that include a description of the plan (including any significant changes and the resulting impact on benefits) and any other matters necessary to fully and fairly present the financial statements of the plan.
- A statement from an insurance company, insurance service, or similar organization, if some or all benefits are purchased from and guaranteed by such organization, that includes
  - The premium rate or subscription charge and total premium or subscription charges paid to each organization and the number of persons covered by each class of such benefits.
  - Total amount of premiums received, the number of persons covered by each class of benefits, the total claims paid by the organization, dividends or retroactive rate adjustments, commissions, and administrative service or other fees or other specific acquisition costs paid from such organization, the remainder of such premiums, etc.<sup>63</sup>

The annual reports, statements, and other documents filed by ERISA with the Department of Labor are, for the most part, public documents and available for inspection through the Department's public document room.<sup>64</sup>

Because this information is required to be prepared, submitted, or disclosed under ERISA, a state's attempt to obtain this information from a TPA is expressly preempted. Such APCD reporting requirements would "re-

late to" an ERISA plan: the existence of ERISA plans required to prepare such documents is essential to the implementation of the APCD requirement. This express preemption also makes perfect sense given the Congressional desire to create uniform, national administration, reporting, disclosure, and oversight requirements for ERISA plans.<sup>65</sup>

State APCD laws also require TPAs for self-insured ERISA plans to collect, format, and produce claims and other data for APCDs in specific electronic formats, which may or may not be the formats contracted for by federally regulated ERISA plans to meet their federal requirements. In doing so, they impose reporting requirements over and above those already imposed by federal law with respect to the plans because the TPAs possess the required data only because they are administering the ERISA plans. Accordingly, they have a connection with the ERISA plans themselves. The state APCD laws, moreover, impose a significant administrative burden on the TPAs because they require the TPAs to report a significant volume of data on an ongoing basis. The required data (and the electronic formats in which the data is required to be submitted) vary from state to state, further burdening TPAs. The state APCD laws impose additional administrative burden on the TPAs because the TPAs are required to format the data according to state specifications, which may vary from how the data is maintained in the ordinary course of business.<sup>66</sup> And in some cases (such as where the APCD laws require submission of information concerning employee premium contributions), the TPAs may be required to submit data that they may not possess and could only obtain from the ERISA plan itself. This imposes further significant burdens on the TPAs of large, multistate ERISA plans – and, thus, on the self-funded plans themselves – by requiring them to submit different data in different formats to different states, undercutting the purpose of ERISA's provision for uniform national standards with respect to administration and reporting. This arguably constitutes "a patchwork of regulations" that would "inject 'considerable inefficiencies in benefit program operations.'" <sup>67</sup> In such cases, "the Supreme Court has applied the preemption clause to make certain that plans are governed by only a single set of regulations,"<sup>68</sup> namely the federal regulations, to the exclusion of any state regulations.

Furthermore, in most instances, the state APCD laws impose requirements by reference to ERISA plans (and, in particular, self-funded plans), or for which the existence of ERISA plans is essential to the operation of the laws. As catalogued above, most of the state APCD statutes define their requirements, at least in part, by reference to ERISA plans. Kansas, Maine, Minnesota, New

<sup>65</sup> See *supra* at \_\_\_\_.

<sup>66</sup> We recognize that the Accredited Standards Committee X12 (ASC X12) and the APCD Council have announced an initiative to develop a Uniform Medical Claims Payer Reporting Standard. If the initiative is successful in developing such a standard, if all State APCDs adopt the standard for the reporting of medical claims, and if State APCDs do not require any data in addition to the data required by such a standard, some of the burden associated with divergent state standards may be alleviated.

<sup>67</sup> See *Boyle v. Anderson*, 68 F.3d 1093, 1104-05 (8th Cir. 1995) (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987)).

<sup>68</sup> *Id.*

<sup>62</sup> 29 U.S.C. § 1021(a), 1022, 1024(b); 29 CFR §§ 2520.104b-2, 2520.102-3. Upon request, the plan administrator is required to submit any documents relating to the employee benefit plan, including the latest summary plan description, and the instrument under which the plan is established or operated, to the Department of Labor. 29 U.S.C. § 1024(a)(6).

<sup>63</sup> 29 U.S.C. § 1021(b), 1023, 1024(a); 29 C.F.R. §§ 2520.103-1, 2520.103-1, 2520.103, 2520.104a-1.

<sup>64</sup> 29 U.S.C. § 1026.

Hampshire, Tennessee, and Utah define the entities required to report data to the state APCD – and, in particular, the TPAs which are required to report data to the APCD – by reference to employee health plans (specifically self-funded employee health plans) and to plan sponsors of employer plans. Similarly, Oregon requires its mandatory reporters (which include TPAs) to report claims and other data on their particular lines of business, including large group and self-insured plans. As a result, it seems clear that most APCD statutes “impose[] requirements by reference to [ERISA] covered programs” and, thus, are preempted because they reference an ERISA plan. Furthermore, when the operation of the APCDs is considered, it is clear that data obtained with respect to ERISA plans is essential to the proper operation of the APCDs. The purpose of the APCDs is to gather claims and other data from all health care payers, in order to be able to properly analyze the state health care systems. Because a significant proportion of the population receives health care which is paid for through ERISA health plans, the claims data for such individuals can only be obtained through their health plans or the TPAs of the health plans.<sup>69</sup>

The issue of ERISA preemption of state APCD statutes appears to have been considered on the merits in one case, and only at the district court level.<sup>70</sup> In *Patient Advocates, LLC v. Prysunka*, Patient Advocates, a third party administrator, sued the Maine Health Data Organization (MHDO) under ERISA, seeking relief from state laws that required “providers” and “payors” (including licensed TPAs) to supply data for use in Maine’s APCD.<sup>71</sup> The case was referred to a magistrate judge who recommended granting summary judgment to MHDO, after holding that Patient Advocates was not an ERISA fiduciary and, therefore, had no preemption defense because the only ERISA provision Patient Advocates referenced was a requirement imposed on ERISA fiduciaries with respect to plan assets.<sup>72</sup> The magistrate judge – relying on case law that “[a] statute of general application that imposes ‘some burdens on the adminis-

tration of ERISA plans’ does not ‘relate to’ those plans within the meaning of ERISA” and, thus, is not preempted by ERISA – also found that the APCD laws do not “relate to” ERISA plans, as they apply to “large numbers of entities that have no specific linkage to ERISA plans,” and only impose “some” administrative burdens on the various entities.<sup>73</sup> He noted that the APCD laws might not even be “reporting requirements” under ERISA because they do not affect benefits disbursement.<sup>74</sup> The district court adopted the recommendation, but focused on the magistrate judge’s holding that claims data is not a “plan asset” which an ERISA fiduciary is required to manage prudently.<sup>75</sup> The court determined that summary judgment was appropriate because there was no evidence that the claims data had any value, or that Patient Advocates held the data in trust for the ERISA fiduciary, as required under ERISA.<sup>76</sup> The court was also “skeptical” that producing claims data in compliance with the APCD law would breach fiduciary duties concerning “plan asset” management.<sup>77</sup>

A good argument can be made that *Patient Advocates, LLC v. Prysunka* was wrongly decided. Focusing on the issue of plan assets, neither court appears to have adequately considered the two independent bases for finding ERISA preemption. The magistrate judge also erred in determining that the Maine APCD statute falls into the category of laws of general application that are not preempted by ERISA. This error can be seen by comparing the APCD statute to the state statutes at issue in the cases cited by the magistrate, *Carpenters Local Union No. 26 v. United States Fidelity & Guaranty Corporation* and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*. In *Carpenters Local Union No. 26*, the state statute of general applicability was a bond statute that requires a general contractor on a public works project to post a bond covering labor and material (including indebtedness incurred by subcontractors for wages and fringe benefits). Similarly, in *DeBuono*, the state statute imposed a tax on gross receipts for patient services at hospitals, residential health care facilities, and diagnostic and treatment centers. Neither statute appears to have contained an explicit reference to an ERISA plan. In contrast, while the state APCD statutes may apply to a slightly broader array of entities than applying exclusively to ERISA plans, some of the entities to which the APCD statutes are applicable are specifically defined by reference to ERISA plans. And another state APCD statute defines the data to be reported in part by reference to ERISA plans. Thus, case law that ERISA does not preempt laws of general applicability would seem inapposite here – where the state statutes clearly reference ERISA plans.<sup>78</sup> The magistrate judge similarly dismissed the

<sup>69</sup> [An argument could possibly even be made that ERISA preempts state APCD statutory requirements with respect to fully insured ERISA plans. The reason that states are permitted to regulate the insurance plans purchased by such plans, but not the plans themselves, is because they are issued by health insurance issuers – and the ERISA savings clause “saves” state regulation of the business of insurance from preemption. But here, the state APCD statutes may fail the second requirement of the savings clause: As a reporting requirement that is designed to enable states to aggregate data to analyze the healthcare system, the APCD statutes do not regulate the business of insurance because they do not “substantially affect the risk pooling arrangement between the insurer and the insured,” or enable the state to regulate insurance companies with respect to such risk pooling arrangements. Accordingly, it could be argued that ERISA preempts state APCD statutes even with respect to fully insured ERISA plans.]

<sup>70</sup> In *Boyle v. Anderson*, the Eighth Circuit dismissed the challenge of certain self-funded ERISA plans to the Minnesota APCD statute for lack of standing because, as self-funded plans, “plaintiffs ‘are not required to submit health care care [sic] revenue and expenditure data, but are merely ‘encouraged’ to do so.” See *Boyle*, 68 F.3d at 1100.

<sup>71</sup> *Patient Advocates, LLC v. Prysunka*, No. 03-118-P-H, 2004 WL 114980, \*5-6 (D. Me. Jan. 21, 2004) (magistrate’s recommendation), adopted at 316 F. Supp.2d 46 (D. Me. Mar. 24, 2004).

<sup>72</sup> *Patient Advocates*, 2004 WL 114980, \*5.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* at \*5, n.5.

<sup>75</sup> *Patient Advocates*, 316 F. Supp.2d at 48-49.

<sup>76</sup> *Id.*

<sup>77</sup> *Id.* at 49.

<sup>78</sup> Other cases holding that state laws were not preempted by ERISA as laws of general applicability involve states laws of similar generality to *Carpenters Local* and *DuBuono*. See, e.g., *Dillingham*, 519 U.S. 316 (application of California’s prevailing wage law to apprenticeship programs (some of which may be part of an ERISA plan) not preempted because a law of general applicability); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988) (application of Georgia’s general

idea that additional and varying state reporting requirements contained in Maine's APCD statute could cause it to be preempted by ERISA as undermining federal uniform administration largely because the magistrate saw the Maine APCD statute as a statute of general applicability.<sup>79</sup> However, the current variety of APCDs belies the concept that APCDs do not disturb uniform administration of ERISA plans. Finally, the very fact that states require the submission of claims and other data with respect to the beneficiaries covered by, and the claims paid by, ERISA plans would seem to demonstrate that the information has value, if only for analytic purposes.<sup>80</sup> And this data is clearly created and held by the TPA in the course of its responsibilities to, on behalf of, and for the benefit of, the ERISA plan.

In any event, imposing APCD data submission requirements on TPAs with respect to self-funded/self-insured ERISA plans will invite such TPAs or ERISA plans to file lawsuits challenging the statute and/or regulations that impose such requirements. Given the limited basis on which the district court made its decision, and the relative weakness of the analysis by both the district court and the magistrate judge, State APCDs and their supporters can take little comfort in the decisions.

*Implied preemption.* As noted above, when Congress enacted ERISA, it intended to protect the interests of participants in employee benefit plans by establishing nationally uniform standards of conduct, responsibility, and obligations for employee benefit plans and by providing for appropriate enforcement mechanisms. These

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garnishment procedures by ERISA welfare plan participants' judgment creditors not preempted, but finding preempted Georgia garnishment statute that provided protective treatment for ERISA welfare benefit plans).

<sup>79</sup> The magistrate also dismissed the First Circuit's reference to preemption based on additional reporting requirements as unsupported dicta. But there are several cases in which the imposition of additional reporting requirements that could impose significant administrative burdens has led to preemption. See, e.g., *Retail Industry Leaders Assoc. v. Fielder*, 475 F.3d 180, 194 (4th Cir. 2007) (Maryland statute which required employers to spend 8% of revenues on employee health care had a connection with the employers ERISA plans because it would require them to restructure not only their expenditures, but also their recordkeeping and reporting in order to comply with the statute).

<sup>80</sup> We note that, under the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, HHS will be using Medicare claims (and other) data to rank doctors and evaluate quality. See PPACA, Pub. L. 111148, § 3003, amending 42 U.S.C. § 1395w-4 (with respect to data CMS holds as a payer, not data it has collected from ERISA plans).

national standards include national rules on reporting, disclosure, and fiduciary responsibility.<sup>81</sup> Congress sought to create a climate of nationally uniform administration of employee benefit plans and to avoid the multiplicity of state regulations.<sup>82</sup> In such a situation, it would seem to frustrate Congress's objectives in adopting ERISA if states could impose additional data reporting requirements with respect to the day-to-day claims processing and payment activities associated with such plans, especially such self-funded plans. The requirement that the TPAs of such plan submit other data to State APCDs with respect to such plans would similarly frustrate Congress's objectives. As existing APCDs demonstrate, such requirements are state/local in nature, not national, and present a multiplicity of reporting/submitting requirements. Accordingly, APCD statutes that seek to impose requirements to report/submit claims and other data to state authorities would be subject to implied preemption under ERISA.

## CONCLUSION

State APCD initiatives can serve important public policy purposes. However, the adoption and implementation of APCDs present several thorny issues for those payer entities which are subject to the requirements of more than one APCD. The adoption and implementation of APCDs present significant legal and policy issues with respect to ERISA preemption of APCD requirements for health insurance issuers and third party administrators to submit claims and other data on self-insured ERISA plans. ERISA may very well preempt the states' ability to require TPAs to submit data with respect to the self-funded ERISA plans for which they provide administrative services. Such State APCD initiatives present a risk of costly litigation that would present a significant risk that important provisions of State APCD statutes or regulations that require submission of data regarding self-funded ERISA plans would be held preempted by ERISA. To avoid such risk, States should work with TPAs, employer groups and the Department of Labor and the Internal Revenue Service to reach a uniform, national understanding of the scope of ERISA preemption and of the State's ability to require the submission of data concerning such plans by TPAs in the context of APCD implementation. The failure to address such core issues prior to implementation of an APCD threatens to wreak havoc on the ability of APCDs to achieve their noble goals.

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<sup>81</sup> See, e.g., *Retail Industry Leaders Assoc.*, 475 F.3d at 190.

<sup>82</sup> See, e.g., *Carpenters Local Union No. 26*, 215 F.3d at 140.