

12-4881-cv  
Liberty Mut. Ins. Co. v. Donegan

**UNITED STATES COURT OF APPEALS**  
**FOR THE SECOND CIRCUIT**

August Term, 2013

(Argued: November 18, 2013 Decided: February 4, 2014)

Docket No. 12-4881-cv

-----x

LIBERTY MUTUAL INSURANCE COMPANY,

Plaintiff-Appellant,

- v. -

SUSAN L. DONEGAN, IN HER CAPACITY AS THE COMMISSIONER OF THE  
VERMONT DEPARTMENT OF FINANCIAL REGULATION,

Defendant-Appellee.

-----x

Before: KEARSE, JACOBS, and STRAUB, Circuit Judges.

Liberty Mutual Insurance Co. appeals from a judgment entered in the  
United States District Court for the District of Vermont (Sessions, J.). The district  
court concluded that the Employee Retirement Income Security Act of 1974 does

1 not preempt a Vermont statute and regulation requiring self-insured employee  
2 health plans to report to the state, in specified format, claims data and “other  
3 information relating to health care.” For the following reasons, we reverse and  
4 remand with instructions to enter judgment for Liberty Mutual.

5 Judge STRAUB dissents in part and concurs in part in a separate opinion.

6 NANCY G. ROSS, McDermott Will &  
7 Emery LLP, Chicago, IL (John A. Litwinski,  
8 McDermott Will & Emery LLP, Chicago, IL;  
9 M. Miller Baker, McDermott Will & Emery  
10 LLP, Washington, DC, on the brief), for  
11 Appellant.

12  
13 BRIDGET C. ASAY, Assistant Attorney  
14 General, Office of the Attorney General,  
15 Montpelier, VT for William H. Sorrell,  
16 Attorney General, State of Vermont, for  
17 Appellee.

18  
19 KATHRYN COMERFORD TODD, National  
20 Chamber Litigation Center, Washington,  
21 DC (Jane E. Holman, National Chamber  
22 Litigation Center, Washington, DC; Carol  
23 Connor Cohen and Nancy S. Heermans,  
24 Arent Fox LLP, Washington, DC, on the  
25 brief), for amicus curiae Chamber of  
26 Commerce of the United States of America  
27 in support of Appellant.

28  
29 MELISSA MOORE, U.S. Department of  
30 Labor, Washington, DC (M. Patricia Smith,

1 Solicitor of Labor; Timothy D. Hauser,  
2 Associate Solicitor; Nathaniel I. Spiller,  
3 Counsel for Appellate and Special  
4 Litigation, on the brief), for amicus curiae  
5 Acting Secretary of the United States  
6 Department of Labor in support of  
7 Appellee.  
8

9 DENNIS JACOBS, Circuit Judge:

10 Liberty Mutual Insurance Co. operates a self-insured employee health  
11 plan. A Vermont statute requires all “health insurers” (including self-insured  
12 plans) to file with the State reports containing claims data and other  
13 “information relating to health care.” A State regulation specifies how such  
14 information must be recorded and transmitted.

15 When Vermont subpoenaed claims data from the Liberty Mutual plan’s  
16 third-party administrator, this suit was commenced in the United States District  
17 Court for the District of Vermont (Sessions, L). Liberty Mutual sought a  
18 declaration that the Employee Retirement Income Security Act of 1974 (“ERISA”)  
19 preempts the Vermont statute and regulation. The district court granted  
20 summary judgment in favor of Vermont.

21 The ERISA preemption clause is not self-reading and ERISA preemption  
22 doctrine is not static. The early judicial consensus, based on the broad wording

1 of the preemption clause (and legislative history), was to construe preemption  
2 broadly. More recent precedent has pulled back by setting a rebuttable  
3 presumption against preemption of state health care regulations. Two constants,  
4 however, remain: (1) recognition that ERISA’s preemption clause is intended to  
5 avoid a multiplicity of burdensome state requirements for ERISA plan  
6 administration; and (2) acknowledgment that “reporting” is a core ERISA  
7 administrative function. These two considerations lead us to conclude that the  
8 Vermont law, as applied to compel the reporting of Liberty Mutual plan data, is  
9 preempted. We therefore reverse and remand for entry of judgment in favor of  
10 Liberty Mutual.

11  
12 **BACKGROUND**

13 **I**

14 The Vermont statute establishes and provides for the maintenance of “a  
15 unified health care database.” Vt. Stat. Ann. tit. 18, § 9410(a)(1). The database  
16 “enable[s]” the State’s Department of Banking, Insurance, Securities and Health

1 Care Administration (“Department”)<sup>1</sup> “to carry out [its] duties . . . , including”:

- 2 (A) determining the capacity and distribution of existing resources;
- 3 (B) identifying health care needs and informing health care policy;
- 4 (C) evaluating the effectiveness of intervention programs on improving
- 5 patient outcomes;
- 6 (D) comparing costs between various treatment settings and approaches;
- 7 (E) providing information to consumers and purchasers of health care; and
- 8 (F) improving the quality and affordability of patient health care and
- 9 health care coverage.

10

11 Id.

12 To populate the database, the statute requires “[h]ealth insurers, health  
13 care providers, health care facilities, and governmental agencies” to “file reports,  
14 data, schedules, statistics, or other information,” as the Department deems  
15 necessary, at the time and place and in the manner the Department requires. Id.  
16 at § 9410(c)-(d). The statute authorizes the Department to require the filing of  
17 “health insurance claims and enrollment information used by health insurers”  
18 and “any other information relating to health care costs, prices, quality,  
19 utilization, or resources.” Id. at § 9410(c).

20

---

<sup>1</sup> The Department is now called the Department of Financial Regulation. Many of the Department’s health care database responsibilities were recently transferred to Vermont’s Green Mountain Care Board. See id. § 9410.

1           Knowing and willful failure to comply is punishable by penalty of not  
2 more than \$10,000 per violation. See id. at § 9410(g).

3           In 2008, the Department promulgated a regulation to implement the  
4 statute and create the Vermont Healthcare Claims Uniform Reporting and  
5 Evaluation System (the “Reporting System”). See Regulation H-2008-01, 21-040-  
6 021 Vt. Code R. § 1 (“Regulation H-2008-01”). The regulation requires reporting  
7 of myriad categories of claims data. See infra 26-29. “Health Insurers” are  
8 required to “regularly submit medical claims data, pharmacy claims data,  
9 member eligibility data, provider data, and other information relating to health  
10 care provided to Vermont residents and health care provided by Vermont health  
11 care providers and facilities to both Vermont residents and non-residents in  
12 specified electronic format to the Department for each health line of business . . .  
13 per the data submission requirements contained in” appendices to the  
14 regulation. Regulation H-2008-01 § 4(D).

15           A “[h]ealth insurer” is defined broadly to include “any health insurance  
16 company, . . . third party administrator, . . . and any entity conducting  
17 administrative services for business or possessing claims data, eligibility data,  
18 provider files, and other information relating to health care provided to Vermont

1 residents or by Vermont health care providers and facilities.” Id. § 3(X).

2 Begging the preemption question, the term “[h]ealth insurer” “may also  
3 include, *to the extent permitted under federal law*, any administrator of an insured,  
4 self-insured, or publicly funded health care benefit plan offered by public and  
5 private entities.” Id. (emphasis added). A health insurer with 200 or more  
6 enrolled or covered members in each month during a calendar year is designated  
7 a “Mandated Reporter.” Id. § 3(Ab). All other entities are “Voluntary  
8 Reporter[s].” Id. § 3(As).

9 The Department makes the collected data “available as a resource for  
10 insurers, employers, providers, purchasers of health care, and state agencies to  
11 continuously review health care utilization, expenditures, and performance in  
12 Vermont.” Vt. Stat. Ann. tit. 18, § 9410(h)(3)(B). The Department decides “the  
13 extent” of such disclosure “allowed by HIPAA,” the federal Health Insurance  
14 Portability and Accountability Act of 1996, id., and maintains the “confidentiality  
15 code” by which filed information “is handled in an ethical manner,” id. § 9410(f).  
16 “[D]irect personal identifiers,” such as name, address, and Social Security  
17 number, may not be publicly disclosed. Id. § 9410(h)(3)(D).

18

1 Sixteen other states collect health care data for their own health care claims  
2 databases. J.A. 368-74 (State Health Reporting Laws Summary Table). Data  
3 submission requirements vary. Some states provide only for voluntary  
4 reporting. See id. Some expressly exclude self-insured employee plan data from  
5 their database reporting laws. See id. The majority, however, follow Vermont in  
6 requiring such plans to report claims data. See id.

7

8

## II

9 Liberty Mutual Insurance Co. is the administrator and named fiduciary of  
10 a health plan (the “Plan”) that provides benefits to 137 individuals in Vermont  
11 and to over 80,000 individuals nationwide. The Plan is “self-insured” or “self-  
12 funded,” i.e., health care claims are paid from Liberty Mutual’s general assets.

13 Plan documents provide that the “Plan has been established for the  
14 exclusive benefit of Participants and except as otherwise provided . . . , all  
15 contributions under the Plan may be used only for such purpose.” J.A. 39. The  
16 documents also represent that medical records, such as those related to risk  
17 factor screening, are kept “strictly confidential.” J.A. 71-72. The Plan represents,  
18 however, that it “shall comply with all other state and federal law to the extent



1 not preempted by ERISA and to the extent such laws require compliance by the  
2 Plan.” J.A. 41.

3 Like many self-insured employer health plans, the Plan uses a third-party  
4 administrator (“TPA”). Blue Cross Blue Shield of Massachusetts, Inc. (“Blue  
5 Cross”), as the Plan’s TPA for Vermont participants, does claims-handling:  
6 processing, review, and payment. Under its contract with Liberty Mutual, any  
7 information transferred to Blue Cross must be used solely for the purpose of  
8 administering the Plan, and Blue Cross auditors must guard against  
9 unauthorized disclosure of health care information. See J.A. 57-58. Liberty  
10 Mutual itself is a Voluntary Reporter because it has fewer than 200 covered  
11 members in Vermont (and has presumably decided not to volunteer); but  
12 because Blue Cross qualifies as a Mandated Reporter and possesses the Plan’s  
13 claims data, the reporting of its data is mandatory.

14 In August 2011, Vermont issued a subpoena demanding that Blue Cross  
15 supply the Plan’s “[e]ligibility files,” “[m]edical claims files,” and “[p]harmacy  
16 claims files” and threatened that noncompliance might result in fines and a  
17 suspension of Blue Cross’s authority to do business. J.A. 24-25. Liberty Mutual  
18 instructed Blue Cross not to comply and filed this suit, seeking (1) a declaration

1 that ERISA preempts the Vermont statute and regulation; and (2) an injunction  
2 blocking enforcement of the subpoena. Vermont agreed to stay enforcement of  
3 the subpoena pending judicial resolution of the ERISA preemption question.

4 In dueling motions, Vermont sought to dismiss the complaint for lack of  
5 standing and for failure to state a claim, and Liberty Mutual moved for summary  
6 judgment. With the consent of the parties, the district court treated the motions  
7 as cross-motions for summary judgment. See Liberty Mut. Ins. Co. v. Kimbell,  
8 No. 2:11-cv-204, 2012 WL 5471225, at \*1 (D. Vt. Nov. 9, 2012).

9 The court concluded that Liberty Mutual had Article III standing but that  
10 ERISA did not preempt the Vermont statute and regulation and that Vermont  
11 was therefore entitled to summary judgment. See id.

## 13 DISCUSSION

### 14 I

15 We agree with the district court that Liberty Mutual has standing to  
16 challenge the subpoena issued to Blue Cross.<sup>2</sup> Liberty Mutual has demonstrated

---

<sup>2</sup> The parties have not briefed the standing issue on appeal, but Article III standing “is the threshold question in every federal case, determining the power

1 “the irreducible constitutional minimum of standing”: (1) “an invasion of a  
2 legally protected interest which is (a) concrete and particularized; and (b) actual  
3 or imminent, not conjectural or hypothetical”; (2) “a causal connection between  
4 the injury and the conduct complained of”; and (3) that the injury will likely be  
5 redressed by a favorable decision. Lujan v. Defenders of Wildlife, 504 U.S. 555,  
6 560-61 (1992) (footnote, citations, and internal quotation marks omitted).

7 It is of no moment that the subpoena was issued to Blue Cross and not  
8 directly to Liberty Mutual. The TPA agreement provides that Liberty Mutual  
9 will hold Blue Cross harmless for any financial charges “arising from or in  
10 connection with” the Plan. J.A. 54-55. Liberty Mutual therefore faces a choice  
11 between (1) allowing Blue Cross to turn over the Plan’s data in what Liberty  
12 Mutual considers a violation of its duties as Plan administrator and fiduciary; or  
13 (2) directing non-compliance, and indemnifying Blue Cross for the ensuing civil  
14 penalties. Either way, under Lujan, Liberty Mutual suffers a redressable injury-  
15 in-fact as a direct result of Vermont’s threatened, imminent action.

16

---

of the court to entertain the suit.” Warth v. Seldin, 422 U.S. 490, 498 (1975).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18

## II

We review de novo the grant of summary judgment on the preemption question. See, e.g., Wrobel v. Cnty. of Erie, 692 F.3d 22, 27 (2d Cir. 2012). Summary judgment is appropriate if the record shows “there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a). “[W]e may reverse the grant of summary judgment and order judgment for the non-moving party if we find undisputed support in the record entitling the non-moving party to judgment as a matter of law.” New England Health Care Emps. Union v. Mount Sinai Hosp., 65 F.3d 1024, 1030 (2d Cir. 1995).

### A

ERISA’s comprehensive regulatory scheme governs most employee benefit plans, including self-insured health plans. See 29 U.S.C. § 1003. ERISA requires plan administrators to file annually with the Department of Labor reports detailing financial and actuarial information. See id. §§ 1021-1024. The Department of Labor is authorized “to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans.” Id. § 1143. ERISA

1 broadly preempts “any and all State laws insofar as they may now or hereafter  
2 *relate to any employee benefit plan.*” Id. § 1144(a) (emphasis added). With  
3 remarkable consistency, the legislative history reflects that this broad wording  
4 was purposeful: it was intended to eliminate the threat of a multiplicity of  
5 conflicting or inconsistent state laws,<sup>3</sup> and to achieve broad preemptive effect in  
6 the areas of record-keeping, reporting, and disclosure.<sup>4</sup>

---

<sup>3</sup> See 120 Cong. Rec. 29197 (1974) (Statement of Rep. Dent) (“I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.”); id. at 29933 (Statement of Sen. Williams) (discussing “inten[t] to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans” and stating that “[t]his principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law”).

<sup>4</sup> See S. Rep. No. 93-127, at 35 (1973), reprinted in 1974 U.S.S.C.A.N. 4838, 4871 (“Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluating fiduciary conduct, and *for creating a single reporting and disclosure system in lieu of burdensome multiple reports.*” (emphasis added)); H.R. Rep. No. 93-533, at 17 (1973), reprinted in 1974 U.S.S.C.A.N. 4639, 4655 (virtually the same); see also 120 Cong. Rec. 29942 (1974) (Statement of Sen. Javits) (“In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans . . . will be superseded.”).

1 Vermont argues—and the district court agreed—that Congress could not  
2 have intended broad preemption of state reporting laws because the same  
3 Congress also passed the National Health Planning and Resources Development  
4 Act of 1974 (“NHPRDA”). The NHPRDA provided for the establishment of state  
5 health planning agencies and authorized these agencies to “assemble and  
6 analyze data concerning” health; health care delivery, resources, and use; and  
7 related environmental factors. See Pub. L. No. 93-641, 88 Stat. 2225, at § 1513(b)  
8 (1975). The Supreme Court consulted the NHPRDA to decide ERISA  
9 preemption in a case in which the NHPRDA expressly contemplated a state  
10 regulatory measure. See N.Y. State Conference of Blue Cross & Blue Shield Plans  
11 v. Travelers Ins. Co., 514 U.S. 645, 665-67 (1995). Here, however, the NHPRDA is  
12 not similarly indicative.<sup>5</sup> And if there were tension between NHPRDA and  
13 ERISA, it was relieved in 1986 when the NHPRDA was repealed.

---

<sup>5</sup> The NHPRDA’s encouragement of state data collection is not necessarily inconsistent with ERISA’s preemptive reach. A lot of data can be collected from health care providers, and from health care payers other than ERISA plans. Nothing in the NHPRDA compels the conclusion that, contrary to every indication in ERISA’s text and history, Congress intended to allow a multiplicity of state record-keeping and reporting requirements for self-insured employee plans.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15

**B**

The Supreme Court, and this Court, initially applied ERISA preemption as broadly as the statutory phrase (“relate to any employee benefit plan”) seemed to require.

As explained in Shaw v. Delta Air Lines, Inc., the “breadth of [ERISA’s] pre-emptive reach is apparent from that section’s language.” 463 U.S. 85, 96 (1983); see id. at 98 (“Congress used the words ‘relate to’ . . . in their broad sense.”).<sup>6</sup> Shaw formulated the modern ERISA preemption test: a state law is preempted if “it [1] *has a connection with* or [2] *reference to* [an ERISA] plan.” Id. at 96-97 (emphases added). The Court treated as obvious that ERISA preempted “state laws dealing with the subject matters covered by ERISA--*reporting, disclosure, fiduciary responsibility, and the like.*” Id. at 98 (emphases added). The open question was whether preemption went *beyond* these core areas, and the Court held it did. See id. at 96-97. The one note of caution in Shaw was consigned to a footnote:

---

<sup>6</sup> That interpretation was supported by ERISA’s exemption for generally applicable state criminal statutes, an exemption that would be unnecessary if preemption “applied only to state laws dealing specifically with ERISA plans.” Shaw, 463 U.S. at 98 (discussing 29 U.S.C. § 1144(b)(4)).

1 Some state actions may affect employee benefits plans in too tenuous,  
2 remote, or peripheral a manner to warrant a finding that the law “relates  
3 to” the plan. Cf. Am. Tel. & Tel. Co. v. Merry, 592 F.2d 118, 121 (CA2  
4 1979) (state garnishment of a spouse’s pension income to enforce alimony  
5 and support orders is not pre-empted). The present litigation plainly does  
6 not present a border-line question, and we express no views about where  
7 it would be appropriate to draw the line.

8  
9 Id. at 100 n.21.

10 For another decade, the Supreme Court and this Court followed Shaw and  
11 repeatedly emphasized the broad reach of ERISA preemption. See, e.g., FMC  
12 Corp. v. Holliday, 498 U.S. 52, 58 (1990) (“The pre-emption clause is conspicuous  
13 for its breadth.”); Gen. Elec. Co. v. N.Y. State Dep’t of Labor, 891 F.2d 25, 29 (2d  
14 Cir. 1989) (“ERISA was intended to have a ‘sweeping preemptive effect in the  
15 employee benefit plan field.’ Congress intended ERISA to occupy and regulate  
16 the field of employee benefit plans.” (citation omitted)). The threat of conflicting  
17 state and local regulation was consistently cited as a paramount reason for  
18 preemption: Preemption “was intended to ensure that plans and plan sponsors  
19 would be subject to a uniform body of benefits law; the goal was to minimize the  
20 administrative and financial burden of complying with conflicting directives  
21 among States or between States and the Federal Government.” Ingersoll-Rand  
22 Co. v. McClendon, 498 U.S. 133, 142 (1990); see Fort Halifax Packing Co. v.



1 Coyne, 482 U.S. 1, 10 (1987) (“We have not hesitated to enforce ERISA’s pre-  
2 emption provision where state law created the prospect that an employer’s  
3 administrative scheme would be subject to conflicting requirements. . . . Such a  
4 situation would produce considerable inefficiencies, which the employer might  
5 choose to offset by lowering benefit levels.”); Howard v. Gleason Corp., 901 F.2d  
6 1154, 1157 (2d Cir. 1990) (“[T]he express pre-emption provisions of ERISA are  
7 deliberately expansive, and designed to establish pension plan regulation as  
8 exclusively a federal concern in order to afford employers the advantages of a  
9 uniform set of administrative procedures governed by a single set of  
10 regulations.” (citations and internal quotation marks omitted)).

11 These cases specifically re-emphasized that “reporting” and “disclosure”  
12 are core ERISA functions subject to a uniform federal standard. See Ingersoll-  
13 Rand, 498 U.S. at 137 (“[ERISA] sets various uniform standards, including rules  
14 concerning reporting, disclosure, and fiduciary responsibility . . . .”); FMC Corp.,  
15 498 U.S. at 58 (listing “reporting” and “disclosure” as “subject matters covered  
16 by ERISA”).

17 The Supreme Court has explained the importance of having uniform  
18 federal record-keeping and reporting requirements:

1 [The legislative history] reflect[s] recognition of the administrative realities  
2 of employee benefit plans. An employer that makes a commitment  
3 systematically to pay certain benefits undertakes a host of obligations,  
4 such as determining the eligibility of claimants, calculating benefit levels,  
5 making disbursements, monitoring the availability of funds for benefit  
6 payments, and *keeping appropriate records in order to comply with applicable*  
7 *reporting requirements. The most efficient way to meet these responsibilities is to*  
8 *establish a uniform administrative scheme, which provides a set of standard*  
9 *procedures to guide processing of claims and disbursement of benefits.*  
10 Such a system is *difficult to achieve, however, if a benefit plan is subject to*  
11 *differing regulatory requirements in differing States. A plan would be required to*  
12 *keep certain records in some States but not in others; to make certain benefits*  
13 *available in some States but not in others; to process claims in a certain*  
14 *way in some States but not in others; and to comply with certain fiduciary*  
15 *standards in some States but not in others.*

16  
17 Fort Halifax, 482 U.S. at 9 (emphases added).

18 Liberty Mutual places great weight on the Supreme Court's summary  
19 affirmance of one of these early preemption cases, Standard Oil Co. v. Agsalud,  
20 633 F.2d 760, 763 (9th Cir. 1980). We need not rest our ruling on that case or on  
21 so perfunctory a disposition as summary affirmance.<sup>7</sup> At the same time, it is

---

<sup>7</sup> The district court in Agsalud held that a Hawaii law (1) requiring workers to be covered by a comprehensive prepaid health care plan and (2) imposing "certain reporting requirements which differ[ed] from those of ERISA," was preempted. 442 F. Supp. 695, 696, 706-07 (N.D. Cal. 1977). Though the ruling rested mainly on the state's comprehensive prepaid plan requirement, the court added that the ERISA preemption clause "was intended at the very least to preempt state laws regulating disclosure [and] reporting." Id. at 706 n.11. The Ninth Circuit agreed with the district court, 633 F.2d 760, 763 (9th Cir.

1 telling that when Congress amended ERISA in 1983 “to exempt from pre-  
2 emption certain provisions of the Hawaii Act,” it “did not exempt from pre-  
3 emption those portions of the law dealing with reporting, disclosure, and  
4 fiduciary requirements.” Fort Halifax, 482 U.S. at 13 n.7; see H.R. Rep. No. 97-  
5 984, at 18 (Dec. 21, 1982) (Conf. Rep.) (“The provision continues Federal  
6 preemption of State law with respect to matters governed by the reporting and  
7 disclosure and the fiduciary responsibility provisions of ERISA . . .”).

## 8 C

9 The Supreme Court’s 1995 decision in New York State Conference of Blue  
10 Cross & Blue Shield Plans v. Travelers Insurance Co. marked something of a  
11 pivot in ERISA preemption. See 514 U.S. 645 (1995). The Court began “with the  
12 starting presumption that Congress does not intend to supplant state law,”  
13 especially if the “state action [occurs] in fields of traditional state regulation,” like

---

1980), and the Supreme Court summarily affirmed, Agsalud v. Standard Oil Co.,  
454 U.S. 801 (1981). However, “the precedential effect of a summary affirmance  
extends no further than the precise issues presented and necessarily decided by  
those actions.” Anderson v. Celebrezze, 460 U.S. 780, 784 n.5 (1983) (internal  
quotation marks omitted).

1 health care.<sup>8</sup> Id. at 654-55. To preempt, a “clear and manifest purpose” by  
2 Congress is required. Id. at 655. Following on this presumption, the Court  
3 pulled back on its broad, literal reading of “relate to”: if the phrase “were taken  
4 to extend to the furthest stretch of its indeterminacy, then for all practical  
5 purposes pre-emption would never run its course.” Id.

6 Applying the two-part Shaw test in light of these new principles, the Court  
7 concluded that a state statute requiring hospitals to collect a surcharge from  
8 patients covered by commercial insurers was not preempted. See id. at 656. The  
9 Court explained that state law is preempted if it “mandate[s] employee benefit  
10 structures or their administration” or “provid[es] alternative enforcement

---

<sup>8</sup> The dissent relies on this presumption. See Dissenting Op. at 4-5. We acknowledge that the presumption applies when the state law “operates in a field that has been traditionally occupied by the States,” and that “the historic police powers of the State include the regulation of matters of health and safety.” De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 814 (1997) (internal quotation marks omitted). However, state health data collection laws do not regulate the safe and effective provision of health care services, which is among the states’ historic police powers. And collecting data can hardly be deemed “historic” --most such laws were enacted only within the last ten years. See J.A. 368-74. In any event, the Supreme Court has repeatedly found the presumption overcome if the state laws “upset[] the deliberate balance central to ERISA,” even if those laws “implement policies and values lying within the traditional domain of the States.” Boggs v. Boggs, 520 U.S. 833, 840, 854 (1997).

1 mechanisms.” Id. at 658. The state surcharge law withstood preemption in  
2 Travelers because it had no more than an “indirect economic influence” on  
3 ERISA plans, it did “not bind plan administrators to any particular choice and  
4 thus function as a regulation of an ERISA plan itself,” and it did not “preclude  
5 uniform administrative practice or the provision of a uniform interstate benefit  
6 package if a plan wishes to provide one.” Id. at 659-60.

7 The Court again recognized the central roles of reporting and disclosure:  
8 ERISA “controls the administration of benefit plans, as by imposing *reporting and*  
9 *disclosure mandates.*” Id. at 651 (emphasis added) (citation omitted). “Congress’s  
10 extension of pre-emption to all state laws relating to benefit plans was meant to  
11 sweep *more* broadly than state laws dealing with the subject matters covered by  
12 ERISA, *reporting, disclosure, fiduciary responsibility, and the like.*” Id. at 661  
13 (emphases added) (internal quotation marks and brackets omitted).

14 Applying Travelers, cases conclude that state laws having only an  
15 “indirect economic effect on ERISA plans” lack sufficient “connection with” or  
16 “reference to” an ERISA plan to “trigger ERISA preemption.” New England  
17 Health Care Emps. Union v. Mount Sinai Hosp., 65 F.3d 1024, 1030-33 (2d Cir.  
18 1995); see also De Buono v. NYSA-ILA Med. & Clinical Servs. Funds, 520 U.S.

1 806, 809 (1997) (state hospital tax not preempted); NYS Health Maint. Org.  
2 Conference v. Curiale, 64 F.3d 794, 801-03 (2d Cir. 1995) (“[O]nly link [state  
3 surcharge law] has with ERISA plans is its indirect effect on rate diversification  
4 among insurers.”). Nevertheless, the Supreme Court teaches that Travelers and  
5 its progeny do not disturb the long-standing principle that “state statutes that  
6 mandate[] employee benefit structures *or their administration*” have a “connection  
7 with” ERISA plans and are therefore preempted. Cal. Div. of Labor Standards  
8 Enforcement v. Dillingham Constr., 519 U.S. 316, 328 (1997) (emphasis added)  
9 (internal quotation marks omitted). Like Travelers itself, later cases reiterate that  
10 “ERISA is expressly concerned” with “reporting, disclosure, fiduciary  
11 responsibility, and the like.” Id. at 330 (internal quotation marks omitted); see  
12 also Boggs v. Boggs, 520 U.S. 833, 841 (1997); Plumbing Indus. Bd. v. E.W.  
13 Howell Co., 126 F.3d 61, 66 (2d Cir. 1997).

14 The use of preemption to avoid proliferation of state administrative  
15 regimes also remains a vital feature of the law. “[D]iffering state regulations  
16 affecting an ERISA plan’s system for *processing claims* and paying benefits impose  
17 precisely the burden that ERISA pre-emption was intended to avoid.” Egelhoff  
18 v. Egelhoff, 532 U.S. 141, 150 (2001) (emphasis added) (internal quotation marks

1 omitted)); see Romney v. Lin, 94 F.3d 74, 80 (2d Cir. 1996) (“basic purpose” of  
2 ERISA preemption is to “avoid a multiplicity of regulation in order to permit the  
3 nationally uniform administration of employee benefit plans”).

4 It is true that this Court’s three most recent cases focus primarily on “the  
5 relationships among the core ERISA entities,” and caution against preemption of  
6 generally applicable state laws. See Stevenson v. Bank of N.Y. Co., 609 F.3d 56,  
7 61 (2d Cir. 2010); Hattem v. Schwarzenegger, 449 F.3d 423, 429-31 (2d Cir. 2006);  
8 Gerosa v. Savasta & Co., 329 F.3d 317, 324 (2d Cir. 2003). But these cases involve  
9 either a state income tax with only indirect economic effects (the kind of law  
10 Travelers expressly permits), see Hattem, 449 F.3d at 425, or state law causes of  
11 action that have “little to do with the conduct of the plan,” Gerosa, 329 F.3d at  
12 328; see also Stevenson, 609 F.3d at 61 (noting that state law suit did not  
13 implicate “actual administration” of the plan). They do not purport to save state  
14 laws that subject plans to “sets of inconsistent state obligations” or that “tend to  
15 control or supersede central ERISA functions.” Gerosa, 329 F.3d at 324, 328.

16 When this Court has allowed a state reporting requirement to withstand  
17 preemption, as it has in two post-Travelers cases, the requirement:  
18

1 (1) imposed no “particular form” of record-keeping and created  
2 burdens “so slight” as to “create[] no impediment to an employer’s  
3 adoption of a uniform benefit administration scheme,” Burgio &  
4 Campofelice, Inc. v. NYS Dep’t of Labor, 107 F.3d 1000, 1009 (2d Cir. 1997)  
5 (internal quotation marks omitted); or

6 (2) “sought information readily obtainable from an employer”  
7 without specifying “a particular form of record-keeping,” HMI Mech. Sys.,  
8 Inc. v. McGowan, 266 F.3d 142, 150-51 (2d Cir. 2001).

9 In effect, these cases adhere to the intact pre-Travelers principle against  
10 preemption of laws “creat[ing] no impediment to an employer’s adoption of a  
11 uniform benefit administration scheme,” Fort Halifax, 482 U.S. at 14, and with  
12 “too tenuous, remote, or peripheral” an effect on employee benefit plans, Shaw,  
13 463 U.S. at 100 n.21. Thus HMI (which Vermont relies on heavily) cautioned that  
14 state subpoenas would indeed be “overbroad to the extent that they seek the  
15 amount of benefits that employees receive” or “examin[e] employer  
16 contributions on a benefit by benefit basis.” HMI, 266 F.3d at 151.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10**D**

We hold that the reporting requirements of the Vermont statute and regulation have a “connection with” ERISA plans (though no “reference to” them<sup>9</sup>) and are therefore preempted as applied. Our holding is supported by the principle (undisturbed in Travelers) that “reporting” is a core ERISA function shielded from potentially inconsistent and burdensome state regulation.<sup>10</sup>

ERISA preempts “state laws dealing with the subject matters covered by ERISA--*reporting, disclosure, fiduciary responsibility, and the like.*” Shaw, 436 U.S. at 98 (emphases added). “[R]eporting” is necessarily a function distinct from the disclosure that administrators provide beneficiaries; otherwise

---

<sup>9</sup> The Vermont statute and regulation lack “reference to” an ERISA plan because they apply to all health care payers and do not act “exclusively upon ERISA plans.” Dillingham, 519 U.S. at 325; Travelers, 514 U.S. at 656. A “connection with” an ERISA plan is sufficient, however, for preemption. Shaw, 463 U.S. at 96-97 (setting out disjunctive test).

<sup>10</sup> It is of no moment that the law is being applied to, and the subpoena targeted at, Liberty Mutual’s TPA rather than Liberty Mutual itself. See Pharm. Care Mgmt. Ass’n v. Dist. of Columbia, 613 F.3d 179, 182 (D.C. Cir. 2010) (holding ERISA preempts state law provisions “insofar as they apply to a pharmaceutical benefits manager . . . under contract with an employee benefit plan (EBP) because they ‘relate to’ an EBP”). We agree with the D.C. Circuit that “the objective of uniformity in plan administration” is not “for some reason inapplicable simply because a plan has contracted with a third party to provide administrative services.” Id. at 185.

1 “reporting” would be subsumed by “disclosure” and rendered superfluous.  
2 Rather, “reporting” entails what Vermont requires be done: plan record-keeping,  
3 and filing with a third-party.

4 But whatever the scope of plan “reporting,” Vermont cannot deny that  
5 that is what it is seeking. The relevant database is called the “Vermont  
6 Healthcare Claims Uniform *Reporting* and Evaluation System” and the operative  
7 section of the regulation is titled “*Reporting Requirements*.”<sup>11</sup> Regulation H-2008-  
8 01 §§ 3(Ar), 4 (emphases added).

9 Not every state law imposing a reporting requirement is preempted.  
10 Burgio and HMI allow a slight reporting burden to be laid on plans, consistent  
11 with the preemption rule tolerating laws that “create[] no impediment to an  
12 employer’s adoption of a uniform benefit administration scheme,” Fort Halifax,  
13 482 U.S. at 14, and with “too tenuous, remote, or peripheral” an effect on  
14 employee benefit plans, Shaw, 463 U.S. at 100 n.21.

---

<sup>11</sup> The dissent argues that the “reporting requirement imposed by the Vermont statute differs in kind from the ‘reporting’ that is required by ERISA and therefore was not the kind of state law Congress intended to preempt.” Dissenting Op. at 1. But the conclusion does not follow from the premise. To the contrary: A hodge-podge of state reporting laws, each *more* onerous than ERISA’s uniform federal reporting regime, and seeking different and additional data, is exactly the threat that motivates ERISA preemption.

1 But the reporting mandated by the Vermont statute and regulation is  
2 burdensome, time-consuming, and risky. Even considered alone, the Vermont  
3 scheme triggers preemption; considered as one of several or a score of  
4 uncoordinated state reporting regimes, it is obviously intolerable.

5 A quick overview of the Reporting System is telling:

6 ● Plans must periodically report:

- 7 (1) “medical claims data” “composed of service level remittance  
8 information for all non-denied adjudicated claims for each billed  
9 service including, but not limited to member demographics,  
10 provider information, charge/payment information, and clinical  
11 diagnosis and procedure codes, and . . . includ[ing] all claims related  
12 to behavioral or mental health”;
- 13 (2) “pharmacy claims data” “containing service level remittance  
14 information from all non-denied adjudicated claims for each  
15 prescription including, but not limited to: member demographics[,]  
16 provider information[,], charge/payment information[,], and national  
17 drug codes”;

18

1 (3) “member eligibility data” “containing demographic information  
2 for each individual member eligible for medical or pharmacy  
3 benefits for one or more days of coverage at any time during the  
4 reporting month”;

5 (4) and any “other information relating to health care provided to  
6 Vermont residents and health care provided by Vermont health care  
7 providers and facilities to both Vermont residents and non-residents  
8 . . . for each health line of business.” Regulation H-2008-01 §§ 3-4.

- 9 ● Plans must report their data frequently. Thus plans with 500 to  
10 1,999 covered members must report *quarterly* and plans with 2,000 or  
11 more covered members must report *monthly*. See id. § 6(I).

12 Compare this to ERISA, which requires a single report *annually*. See  
13 29 U.S.C. § 1021.

- 14 ● Data must be coded under the appropriate source code system. See  
15 Regulation H-2008-01 § 5(A)(5)(a). Sixteen source code systems are  
16 provided, including the “Admission Source Code” (“[a] variety of  
17 codes explaining who recommended admission to a medical  
18 facility”) and the “International Classification of Diseases, 9th

1 Revision, Clinical Modification” code (“describes the classification of  
2 morbidity and mortality information for statistical purposes and for  
3 the indexing of hospital records by disease and operations”). Id.

4 Appendix A.

- 5 ● “Individual data elements, data types, field lengths, field  
6 description/code assignments, and mapping locators” for each file  
7 must conform to specified requirements. Id. § 5(B). Fields include  
8 “Admission Hour” and “Discharge Hour,” thirteen “Diagnosis”  
9 fields, three “Procedure” fields, and the “Drug Name” and  
10 “Quantity Dispensed”. Id. Appendices C-1-E-2.

- 11 ● “[T]he social security number of the member/subscriber and the  
12 subscriber and member names” must be encrypted prior to  
13 submission by “utilizing a standard encryption methodology  
14 provided.” Id. § 5(A)(5)(b). (Encryption is not required for other  
15 data fields.)

16 And nothing prevents the Department from changing these myriad  
17 requirements from time to time, so long as the Department complies with the  
18 broad mandate of the statute.

1 The confidentiality provisions of the Vermont scheme are complex but  
2 loose, and impair or (at least) reassign the obligation in the Plan documents to  
3 keep medical records strictly confidential, as well as the undertaking by Blue  
4 Cross as TPA to use information solely for Plan administration purposes and to  
5 prevent unauthorized disclosure.<sup>12</sup> The regulation specifically contemplates  
6 “access to health care claims data sets and related information” by “persons  
7 other than the Department.” Id. § 8. Each data field is classified into one of  
8 three “use and release” categories:

9 (1) “Unavailable Data Elements”: not available for general use and  
10 release.

11 (2) “Restricted Data Elements”: only available for use and release as  
12 part of a “Limited Use Research Health Care Claims Data Set” approved  
13 by the Department. These elements, and information that can be derived  
14 from these elements, include the member’s city and zip code, the

---

<sup>12</sup> Whether disclosure to Vermont is authorized under the Plan documents may turn on whether Vermont law creates authorization, because the Plan undertakes to comply with state law; but compliance is allowed only “to the extent not preempted by ERISA,” a limitation that leaves the Plan and the TPA in a complex and expensive legal muddle.

1 admission and discharge dates and hours, and the service provider and  
2 pharmacy names.

3 (3) “Unrestricted Data Elements”: “available for general use and  
4 public release . . . . upon written request.” These publicly available  
5 elements, and information that can be derived from these elements,  
6 include the member’s gender, age, medical coverage, prescription drug  
7 coverage, and diagnosis; the type of procedure; the service provider’s  
8 speciality and zip code; and the name and price of any drugs prescribed.

9 Id. § 8 & Appendices J-1-J-14. Specific as these categories are, they may be  
10 illusory, because the Department can ease public release restrictions on data that  
11 is currently restricted or unavailable, so long as “direct” personal identifiers are  
12 not published and the data is (in the Department’s opinion) handled in an  
13 “ethical manner.” Vt. Stat. Ann. tit. 18, § 9410(e)-(f), (h)(3)(D).

14 Since other states can impose their own regimes for reporting—and many  
15 do—these burdens and risks must be multiplied.

16 The trend toward narrowing ERISA preemption does not allow one of  
17 ERISA’s core functions—reporting—to be laden with burdens, subjected to

1 incompatible, multiple and variable demands, and freighted with risk of fines,  
2 breach of duty, and legal expense.<sup>13</sup>

3

4

## CONCLUSION

5 For the foregoing reasons, we reverse and remand with instructions to  
6 enter judgment for Liberty Mutual.

---

<sup>13</sup> The dissent draws a “distinction between general administration and administration of plans, claims, and benefits” and concludes that ERISA preemption doctrine does not reach state reporting laws that implicate the former. Dissenting Op. at 14. Essentially, the dissent would preempt state reporting laws only if they require plans to submit financial statements. The dissent’s view of ERISA plan “administration” and “reporting” is unduly narrow.

The overview of requirements (set out above) makes clear that Vermont requires ERISA plans to record, in specified format, massive amounts of claims information and to report that information to third parties, creating significant (and obvious) privacy risks and financial burdens that will be passed from the TPA to the Plan and from the Plan to the beneficiaries. That is not a proper allocation of plan assets. See 29 U.S.C. § 1104(a)(1)(A) (“[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries; and . . . defraying reasonable expenses of administering the plan[.]”). Modest financial burdens may be tolerable when the state laws imposing them do not directly implicate an ERISA core administrative concern. But the statute and regulation here require reporting of health claims, pharmacy claims, etc., information about the essential functioning of employee health plans.



**United States Court of Appeals for the Second Circuit  
Thurgood Marshall U.S. Courthouse  
40 Foley Square  
New York, NY 10007**

**ROBERT A. KATZMANN**  
CHIEF JUDGE

**CATHERINE O'HAGAN WOLFE**  
CLERK OF COURT

Date: February 04, 2014  
Docket #: 12-4881cv  
Short Title: Liberty Mutual Insurance Compa v.  
Kimbell

DC Docket #: 11-cv-204  
DC Court: VT (BURLINGTON)  
DC Judge: Sessions

**BILL OF COSTS INSTRUCTIONS**

The requirements for filing a bill of costs are set forth in FRAP 39. A form for filing a bill of costs is on the Court's website.

The bill of costs must:

- \* be filed within 14 days after the entry of judgment;
- \* be verified;
- \* be served on all adversaries;
- \* not include charges for postage, delivery, service, overtime and the filers edits;
- \* identify the number of copies which comprise the printer's unit;
- \* include the printer's bills, which must state the minimum charge per printer's unit for a page, a cover, foot lines by the line, and an index and table of cases by the page;
- \* state only the number of necessary copies inserted in enclosed form;
- \* state actual costs at rates not higher than those generally charged for printing services in New York, New York; excessive charges are subject to reduction;
- \* be filed via CM/ECF or if counsel is exempted with the original and two copies.

**United States Court of Appeals for the Second Circuit  
Thurgood Marshall U.S. Courthouse  
40 Foley Square  
New York, NY 10007**

**ROBERT A. KATZMANN**  
CHIEF JUDGE

**CATHERINE O'HAGAN WOLFE**  
CLERK OF COURT

Date: February 04, 2014  
Docket #: 12-4881cv  
Short Title: Liberty Mutual Insurance Compa v.  
Kimbell

DC Docket #: 11-cv-204  
DC Court: VT (BURLINGTON)  
DC Judge: Sessions

**VERIFIED ITEMIZED BILL OF COSTS**

Counsel for

\_\_\_\_\_

respectfully submits, pursuant to FRAP 39 (c) the within bill of costs and requests the Clerk to prepare an itemized statement of costs taxed against the

\_\_\_\_\_

and in favor of

\_\_\_\_\_

for insertion in the mandate.

Docketing Fee \_\_\_\_\_

Costs of printing appendix (necessary copies \_\_\_\_\_ ) \_\_\_\_\_

Costs of printing brief (necessary copies \_\_\_\_\_ ) \_\_\_\_\_

Costs of printing reply brief (necessary copies \_\_\_\_\_ ) \_\_\_\_\_

**(VERIFICATION HERE)**

\_\_\_\_\_  
Signature

**United States Court of Appeals for the Second Circuit  
Thurgood Marshall U.S. Courthouse  
40 Foley Square  
New York, NY 10007**

**ROBERT A. KATZMANN**  
CHIEF JUDGE

**CATHERINE O'HAGAN WOLFE**  
CLERK OF COURT

Date: February 04, 2014  
Docket #: 12-4881cv  
Short Title: Liberty Mutual Insurance Compa v.  
Kimbell

DC Docket #: 11-cv-204  
DC Court: VT (BURLINGTON)  
DC Judge: Sessions

**NOTICE OF DECISION**

The court has issued a decision in the above-entitled case. It is available on the Court's website <http://www.ca2.uscourts.gov>.

Judgment was entered on February 4, 2014; and a mandate will later issue in accordance with FRAP 41.

If pursuant to FRAP Rule 39 (c) you are required to file an itemized and verified bill of costs you must do so, with proof of service, within 14 days after entry of judgment. The form, with instructions, is also available on Court's website.

Inquiries regarding this case may be directed to 212-857-8523.