12-4881

In the

United States Court of Appeals

for the

Second Circuit

Liberty Mutual Insurance Company,

Plaintiff – Appellant,

v.

Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration,

Defendants – Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

BRIEF OF AMICUS CURIAE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA IN SUPPORT OF REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, Amicus Curiae the Chamber of Commerce of the United States of America states that it has no parent corporation and no publicly held corporation owns 10% or more of its stock.

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INTEREST OF THE AMICUS[1]

The Chamber of Commerce of the United States of America (the "Chamber") is the world's largest business federation, representing 300,000 direct members and indirectly representing an underlying membership of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. The Chamber regularly advocates on issues of vital concern to the business community, and has frequently participated as *amicus curiae* before this Court and numerous others, including the United States Supreme Court. A majority of the Chamber's members provide health benefits for their employees.

As reflected in the vast health care reforms enacted as part of the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), the availability and cost of health care in this country is a matter of critical national importance. Some 149 million Americans receive their health benefits through their employment, which is the leading source of health benefits for nonelderly people. Over 60% of employers offer health benefits to their workers, and a majority of American workers receive these benefits from self-funded plans, the

[1] All parties have consented to the filing of this *amicus* brief. *See* Fed. R. App. P. 29(a). This brief was not authored in whole or in part by any party's counsel, and money was contributed to fund its preparation solely by the *amicus* and its members. *See* Fed. R. App. P. 29(c)(5); Loc. R. 29.1(b).

type of plan at issue in this case. As a consequence, employers have an enormous interest in the regulation of employee health benefits, and particularly those provided through self-funded plans.

This case involves an issue that is crucial to employers: whether a state can impose unique record-keeping and reporting obligations on self-employed plans, over and above those required by the Employee Retirement Income Security Act of 1974 ("ERISA"), the federal law that governs all employee benefit plans. The answer to this question will have far-reaching consequences for all sponsors of self-funded plans, including many members of this *amicus,* as well as their employees. The Chamber files this brief *amicus curiae* to aid the Court in its understanding of the nature of self-funded health benefit plans, the importance of the questions to be decided, and the deleterious impact that the district court's decision could have on employers that sponsor self-funded plans and their employees.

ARGUMENT[2]

I. Preservation of National Uniformity for Self-Funded Health Care Plans Is Crucial to Their Continued Viability.

There are two main kinds of plans that employers use to provide health benefits to their employees: insured plans and self-funded (or self-insured) plans. A company with an insured health plan ordinarily enters into a contract with a health insurance company for a fixed cost; the price of that coverage is paid by the employer, with the employees sometimes sharing the cost through premiums deducted from their pay. The insurance company then processes the employees' health care claims, using its own assets to pay claims covered by the plan, minus any annual deductibles and co-payments owed by the employees. The insurance company bears the ultimate risk that the magnitude of covered claims will exceed the fixed cost.

In self-insured plans, by contrast, the employer pays covered health care claims from its own assets.[3] As with insured plans, employees may share the cost, through premiums deducted from their pay, and the employer may impose

[2] The reasons why the district court's decision is incorrect are explained in detail in the Brief for Appellant. For the sake of efficiency and convenience, the relevant facts as laid out in that brief are incorporated here by reference. All defined terms used by Appellant are used in this brief with the same meanings.

[3] Some self-funded plans are only partially self-insured – the employer may limit its exposure by purchasing stop-loss or excess-loss insurance to protect the employer against very large claims.

deductibles and co-payments, but the employer, rather than an insurance company, bears the ultimate financial risk with regard to the health care claims incurred by its employees.

Employers with self-insured health plans often contract with third parties – called third-party administrators ("TPAs") – to perform various administrative duties for the plan, such as processing claims and keeping records. Some TPAs are also health insurance companies; others are solely in the business of serving as third party administrators. Occasionally, employers with self-funded plans perform the administrative duties themselves. Regardless of who administers the plan, a self-funded plan must be implemented and administered in accordance with the employer's policies and procedures, which may be very different from the policies and procedures a TPA that is an insurance company will use when administering an insured plan for which it provides the insurance.

Self-insured plans have been gaining in popularity. In 1999, 44% of covered workers were in self-funded plans; today, 60% of employees with health benefits are covered by self-funded plans. Kaiser Family Found., *2012 Annual Survey: Plan Funding*, at 161. The larger a company is, the more likely it is to use a self-funded plan to provide its employees with health benefits. *Id.* at 160, 161. In 2012, 78% of employees who worked for companies with more than 1,000 employees were covered by self-insured plans; that figure rose to 93% of

employees who worked for businesses with more than 5,000 employees. *Id.* Most of these large employers are national companies, with employees in many different states.

Employers provide health benefits to their employees through a self-funded plan rather than through an insured plan for a variety of reasons. Chief among these is that a self-funded plan offers an employer more control: more control over the cash flow needed to cover its workers' health costs, more control over its ability to design a health plan to address its own needs and the needs of its workforce, and more control over the plan's administration and overall cost. Employers are able to retain more control over the design and administration of self-funded plans for one principal reason – these plans, unlike insured plans, are not subject to regulation by the states. This dichotomy stems from the fact that, notwithstanding ERISA's broad preemption of state laws, the statute specifically allows states to regulate the business of insurance and, therefore, indirectly, permits the states to regulate insured plans. *See* 29 U.S.C. § 1144(b)(2)(A). This exception to preemption, however, does not apply to self-funded plans.

The uniformity that is available as a result of being free from state regulation is extremely important for large national companies that have employees spread across the country and could, therefore, be subject to unique, and often conflicting, regulations by numerous different states. Having to tailor employee health benefit

programs to comply with a patchwork of regulations on a state-by-state basis would be extremely burdensome and expensive. Faced with such burdensome and expensive regulatory requirements, many employers would decrease the benefits they provide to their employees. Others would increase the share of the cost that the employees themselves would bear, and yet others would eliminate employer-provided health care benefits altogether. Consequently, the preservation of the uniformity for self-funded health care plans is crucial to their continued viability.

II. The Statute and Regulations Are Preempted Because their Direct and Significant Effect on Self-Funded Plans Is Contrary to Core ERISA Objectives.

ERISA's broad preemption provision indicates Congress's intent to establish the regulation of employee welfare benefit plans, such as the plan at issue in this case, "as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). 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 . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). "The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *New*

York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).[4]

To that end, a state law is preempted, and cannot be applied to an ERISA-covered plan if, among other things, it "has an impermissible 'connection with' [such] a plan." *Boggs v. Boggs*, 520 U.S. 833, 841, 860 (1997) (citation omitted). Whether a particular state law has an impermissible connection with ERISA-covered plans is based, in turn, on "the objectives of the ERISA statute" and "the effect of the state law on ERISA plans." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quotation omitted); *see also Boggs*, 520 U.S. at 841 (holding preempted a state law that "operates to frustrate [ERISA's] objectives"); *Plumbing Indus. Bd. v. E.W. Howell Co, Inc.*, 126 F.3d 61, 67 (2d Cir. 1997) (noting that a state law is preempted if "there is something in the practical operation of the challenged statute to indicate that it is the type of law that Congress specifically aimed to have ERISA supersede") (citation omitted).

[4] "[A]lthough pre-emption stops short of 'any law of any State which regulates insurance' . . . [t]his exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not 'be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . .'" *Travelers*, 514 U.S. at 651(citations omitted). In other words, a self-funded welfare benefit plan may not be deemed an insurance company for purposes of this statutory exception to preemption.

A state law imposing direct, significant, and unique record-keeping and reporting obligations on self-funded plans, like the Statute and Regulations in this case, would frustrate several of ERISA's key, interrelated objectives.

First, the law is directly contrary to ERISA's central aim of having a nationally uniform system of administration for covered plans. It has long been recognized that one of Congress's principal goals in enacting ERISA was to establish one overall scheme to deal with covered plans "so that employers would not have to 'administer their plans differently in each State in which they have employees.'" *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (quoting *Shaw v, Delta Airlines, Inc.*, 463 U.S. 85, 105 (1983)); *see also Ingersoll-Rand*, 498 U.S. at 142. Requiring a large, national plan to prepare and file reports containing detailed and State-specific information, often several times a year, for the many different states in which it has employees would be extremely onerous. And that burden would extend to record-keeping tasks as well – collecting and storing that information – because in order to be in a position to comply with individual state reporting requirements, plans would have to create many different sets of record-keeping systems to correspond with the different states' reporting requirements. *See, e.g., Fort Halifax*, 482 U.S. at 8 (noting the requirement to "keep[] appropriate records in order to comply with applicable reporting requirements"); *Pharmaceutical Care Mgmt. Ass'n v. District of Columbia*, 613

F.3d 179, 185 (D.C. Cir. 2010) (same). These burdens would be especially onerous if reports had to be sent to numerous different states, in a specified format, and had to include the kind of comprehensive claims, eligibility, and provider information mandated by the Statute and Regulations in this case.

The administrative burden on plans would be tremendous. ***For each individual claim that it receives***, the TPA (or plan administrator) would have to: (1) identify which state the affected employee is from; (2) determine whether that state has reporting requirements; (3) identify the specific information that particular state requires it to report; (4) collect that information; (5) store the information in a way that would allow the TPA to compile it for reports to the state, along with the information for all the other claims in that state; and (6) prepare the reports, in whatever format the state requires. Clearly, allowing states to impose their own individual set of reporting requirements on self-insured plans runs directly counter to the ERISA-central concept of giving plans the benefit of "nationally uniform plan administration." *Egelhoff v. Egelhoff ex rel Breiner*, 532 U.S. 141, 148 (2001).

Imposing these significant administrative burdens on plans is also contrary to a second, related goal of ERISA: to keep plan administration efficient and cost-effective. "Requiring ERISA administrators to master the relevant laws of 50

States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators . . . . " *Egelhoff*, 532 U.S. at 149-50 (alterations in original) (citation omitted); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (noting that one goal of ERISA preemption is to avoid the inefficiencies stemming from "require[ing] plan providers to design their programs in an environment of differing state regulations"); *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2d Cir. 2006) (noting that ERISA preemption aimed to "minimize[] the administrative and financial burdens of complying with conflicting directives from the states").

Allowing individual states to impose unique record-keeping and reporting requirements on self-insured plans that operate in many different states would lead to obvious inefficiencies. Instead of having in place one record-keeping system to cover all claims, the administrator would have to set up various systems to collect and store the different data required to deal with the states' different requirements. All this additional work will cost additional money, to the detriment of employees.

Employers have a finite amount of money to cover employment costs. The increased expense of providing employee health benefits due to the additional cost of complying with different state reporting requirements will result in reductions in other employment costs, such as lower wages, reduced pension benefits, or, more likely, decreased health benefits. And some employers may decide not to offer

health benefits to its employees at all. This all flies in the face of ERISA's most basic goal: "to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries.'" *Gerosa v. Savasta & Co., Inc.*, 329 F.3d 317, 328 (2d Cir. 2003) (quoting 29 U.S.C § 1001(b)). In fact, the probability that a hodgepodge of state regulations on plans would cause a reduction in employee benefits in the long run was a main reason why Congress included ERISA's preemption provision in the first place:

> In enacting this [preemption] provision, Congress sought principally to address concerns that lack of uniformity and the administrative and financial burdens of compliance with conflicting state laws might work to the detriment of plan beneficiaries, and reduce the willingness of employer to adopt such plans, or lead to a reduction in the level of benefits furnished.

Plumbing Industry Board, 126 F.3d at 66; *see also Fort Halifax*, 482 U.S. at 11 (noting that subjecting a plan to regulation by the states "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them"); *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 8 (2d Cir. 1992) (same). In short, Congress intended to preempt state laws that would divert money now being used to cover employee benefits to pay for additional administrative costs necessary to comply with those laws.

CONCLUSION

Allowing states to impose their own unique reporting obligations on self-funded ERISA plans would lead to gross inefficiencies, increased costs, and reduced benefits for employees. These are the very results Congress sought to avoid when it included in the statute the broad preemption provision. The district court's decision should be reversed.

Dated: April 5, 2013

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify, pursuant to Fed. R. App. P. 32(a)(7)(C), that this Brief of Amicus Curiae Chamber of Commerce of the United States complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B)(i) because it contains 2,615 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

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CERTIFICATE OF SERVICE

On April 5, 2013, six copies of the foregoing Brief of Amicus Curiae Chamber of Commerce of the United States of America were sent via FedEx overnight delivery and one copy was transmitted via ECF to:

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