

Who Controls Health Cost Data?

Alfred Gobeille, Chair of the Green Mountain Care Board v. Liberty Mutual Insurance Company

By Lucy C. Hodder

“New Hampshire was the first state to use price transparency and market forces to foster competition and consumer choice in its health insurance markets through its comprehensive health claims database and website,” the State of New Hampshire claims in its *amicus* brief filed in *Gobeille v. Liberty Mutual Insurance Company*, which is pending before the United States Supreme Court.

These efforts to limit health cost growth “would be thwarted,” according to New Hampshire’s brief, were the Supreme Court to rule in favor of Liberty and affirm the 2nd Circuit’s decision that the Employee Retirement Income Security Act of 1974 (ERISA) preempts Vermont’s all-payer health claims data reporting law. Current and former solicitors general sparred over these issues during oral arguments in *Gobeille* on Dec. 2, 2015.

Vermont, like many states, currently maintains an “all-payer claims database” (APCD), an electronic system that aggregates paid health care claims data from public and private payers. States have developed APCDs in the face of increasing health costs to help policymakers identify and respond to cost and quality



trends across all payer settings and begin to make sense of mysterious and confusing health care pricing.

Vermont gathers the utilization and spending data from insurers and third-party administrators (TPAs); however, Liberty alleges that ERISA preempts Vermont’s reporting mandates insofar as they require the submission of data by TPAs

about claims paid under the terms of self-insured employer plans governed by ERISA. Consumer groups, provider organizations, researchers, and state insurance regulators have filed briefs supporting Vermont, claiming a decision for Liberty could have a far-reaching and negative impact on health reform and price transparency efforts in Vermont, New Hamp-

shire and across the country.

In New Hampshire, a health care consumer can use the NH Health Cost website (<http://nhhealthcost.nh.gov>) to find information on the actual price of different medical services. The information on the website is derived from claims data collected from New Hampshire’s Comprehensive Health Care Information System (NH’s APCD). New Hampshire contends that its cost website and analysis from otherwise guarded claims data shed light on price variations for services between providers, and began a series of policy changes and market movements towards consumer-driven care, new benefit designs and enhanced reporting on health cost drivers. The APCD also supports important transparency research, analysis and reporting on the costs, quality and accessibility of health care in New Hampshire.

Several years ago, Liberty prohibited its third-party administrator, Blue Cross Blue Shield of Massachusetts Inc., from submitting de-identified claims data to the Vermont APCD, claiming such reporting “related to” its ERISA health benefit plan and was thus preempted. Liberty’s health plan covers more than 30,000 employees

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nationwide, and Liberty claims in its response brief that “Vermont’s reporting requirements concern the core of what ERISA plans do” and “interfere with nationally uniform plan administration.”

ERISA establishes federal fiduciary standards for private pension plans. Congress passed ERISA in 1974 after a wave of investigations reported post-war generations of employees were enrolled in underfunded pension plans. Industry, however, was reluctant to agree to federal regulation unless free from state interference. Thus, ERISA includes a very broad “preemption” clause voiding all state laws to the extent that they “relate to” employer-sponsored benefit plans, whether they do so explicitly or have a substantial financial or administrative impact on benefit plans. See Section 514, 29 USC section 1144(a). Although ERISA focuses on pension plans, self-funded employee health benefit plans fall under ERISA’s jurisdiction, leaving states with little say in how self-funded plans are administered.

Liberty lost its original challenge in the district court, but the Second Circuit reversed, and Vermont appealed to the United States Supreme Court. Vermont was joined by the United States in arguing that its claims reporting requirement “enables it to populate a database that is designed as a tool to assess and improve healthcare outcomes for Vermont residents,” and the requirements do not have the requisite “connection” to ERISA plans

to warrant preemption.

“States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data,” the United States argues in its *amicus* brief. “If States are unable to acquire such data from self-insured ERISA healthcare plans, their databases will be significantly less comprehensive and thus not as useful in developing health policy at both the state and national levels.”

In one of the numerous *amicus* briefs filed in support of Vermont’s position, the National Association of Health Data Organizations (NAHDO) casts doubt on Liberty’s argument that APCD reporting is “onerous.” National and uniform standards under the Health Insurance Portability and Accountability Act (HIPAA) already govern data aggregation programs, and data submission is part of the routine course of business for insurers and third-party administrators, NAHDO argues. Further, NAHDO states, Liberty’s arguments fly in the face of “the longstanding consensus position of employers and business groups... that access to inde-

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– United States *amicus* brief
Gobeille v. Liberty Mutual Insurance Company

pendent sources of claims and eligibility data is critical for health care reform.”

If Liberty prevails, the impact on state data collection efforts will be substantial. More than 60 percent of employees who receive insurance through their employers are covered by self-funded insurance plans, and that percentage is growing. “Self-insured” means employers pay for each health claim as it is incurred, instead of paying a fixed premium to an insurance carrier. Self-insured employers typically hire a “third party administrator,” often an insurance company, to administer the plan and claims process. Employers who choose to “self-fund” offer health benefit plans regulated by ERISA and the US Department of Labor, not state insurance departments.

During the argument Dec. 2, the justices seemed universally concerned about the states’ interests in promoting health reform. However, Justices Samuel Alito and Antonin Scalia questioned why the Affordable Care Act amended ERISA by requiring additional health care claims reporting, but did not clarify whether state APCDs were “saved” from preemption. So too, many of the justices struggled with how each state could adopt a claims reporting statute, yet not cause “overly burdensome” regulation of self-insured benefit plans.

Justice Elena Kagan noted that there is value to states being able to consider their own health care needs, and “all the data that’s being requested is data that Blue Cross Blue Shield generates anyway.”

Justice Stephen Breyer asked whether perhaps the US Department of Labor could require ERISA plans to make such submissions to the states. When Liberty’s counsel suggested Vermont could simply collect the data directly from the clinics and hospitals, however, Justice Anthony Kennedy argued back, noting it would certainly be a lot easier to “ask” health insurers for the data than “15 doctors in one small town...” Dec. 2, 2015, US Supreme Court Oral Argument Transcript.

The case will be decided by June 2016. The State of New Hampshire pleads that in passing ERISA, “Congress cannot have intended to eliminate state innovations like using transparency and market competition to control health costs.” Health cost transparency is one of the few tools remaining to states, New Hampshire argued, “but these gains will be lost” if the Supreme Court finds that Vermont’s law is preempted.

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less the person regains decision-making capacity, the Circuit Court-Probate Division appoints a guardian of the person, or the patient is determined to be near death, in which case the surrogacy automatically extends.

Surrogacy may be extended for successive 90-day periods, if the physician or APRN documents the extension in the medical record. Notably, however, the Legislature did not intend for surrogacy to be a long-term, decision-making measure. Therefore, guardianship proceedings should be initiated if it appears that the patient is going to lack capacity long-term.

Best Practices for Health Care Providers

It is important to remember that, like intestate succession, surrogacy should serve as a last resort – a backstop if all else fails. As a result, providers should encourage competent adults to execute DPOA-H and living will documents while they have capacity to avoid utilization of the surrogacy system and the appointment of “long lost Aunt Ethel” as a decision-maker. The Foundation for Healthy Communities (FHC) website has a wealth of free information, including free DPOA-H and living will forms, in addition to helpful materials on the surrogacy decision-making law, including a form surrogacy policy. See <http://www.healthynh.com>.

Because most New Hampshire residents have not executed a DPOA-H or living will, providers and facilities should adopt a surrogacy policy and train physicians, APRNs, and staff on the operation of the policy and RSA 137-J:34-37. The existence of clear policies and procedures will serve to avoid any confusion if a surrogate must be appointed.

These policies and procedures should encourage health care facilities and providers to obtain biographical information upon admission or arrival at your hospital or practice, in order to know whom to contact and how to contact them should the need for surrogacy arise. These policies should also contain a detailed description of how to determine capacity and to ensure that a physician or APRN has actually declared the patient incapacitated before designating a surrogate.

The health care surrogacy decision-making law has helped many providers, facilities, and families to avoid the time-consuming and expensive guardianship process and to secure prompt and sound decision-making in times of emergency or the need for informed consent.

Although RSA 137-J:34-37 contains some ambiguities that need to be fixed, this surrogacy system beats the old system under which providers were stuck in limbo between running to court and incurring thousands of dollars in legal fees, or improperly relying on unauthorized family members.

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