**ALL OR NOTHING: MANDATING SELF-FUNDED EMPLOYEE SPONSORED HEALTH PLAN REPORTING TO STATE ALL-PAYER CLAIMS DATABASES**

## I. INTRODUCTION

Healthcare expenditures are increasing at an alarming rate in the United States—growing at about 5.4 percent per year and expecting to reach $6.2 trillion by 2028.[1] Healthcare stakeholders, including all levels of government, are continuously looking to control the rising cost of health care while still maintaining quality. State All Payer Claims Databases (APCDs) help create a comprehensive picture of the total cost of care, utilization, quality, and population health.[2] In the early 2000s, some states began collecting medical claims, pharmacy claims, dental claims, eligibility, and provider data from public and private health insurers to create state APCDs.[3] Today, twenty-one states created or are implementing APCDs, eleven states indicated a strong interest in implementing an APCD, and six states have them created voluntarily by healthcare stakeholders.[4]

States and researchers use APCDs to curb unnecessary healthcare spending, improve population health, and increase consumer transparency. The Minnesota Department of Health identified 1.3 million patient visits that resulted in almost $2 billion of potentially preventable

---

[1] Sean P. Keehan et al., *National Health Expenditure Projections, 2019–28: Expected Rebound in Prices Drives Rising Spending Growth*, 39(4) HEALTH AFFAIRS 704 (2020).
[2] *All-Payer Claims Databases*, AGENCY FOR HEALTHCARE RSCH & QUALITY, https://www.ahrq.gov/data/apcd/index.html (Feb. 2018).
[3] JO PORTER ET AL., THE BASICS OF ALL-PAYER CLAIMS DATABASES 1 (2014), https://www.apcdcouncil.org/publication/basics-all-payer-claims-databases-primer-states.
[4] *Interactive State Report Map*, APCD COUNCIL, https://www.apcdcouncil.org/state/map (last visited Mar. 29, 2021).

emergency department visits, hospital admissions, and hospital readmissions for a single year.[5] Using data from the APCD, Maine developed a predictive model to identify patients at risk for prescription opioid abuse.[6] New Hampshire sponsors a website that allows visitors to filter the cost of medical and dental procedures by payer.[7] The abundance of data from APCDs assist in the implementation and analysis of value-based payment reform initiatives to continue to support States' efforts to control spending and ensure quality.

Though the namesake contains the word "all," not all payers are required to submit data to the APCDs. Specifically, the 2016 Supreme Court decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), held that States cannot require self-funded employee sponsored health plans (ESPs) to report data to APCDs because the Employee Retirement Income Security Act (ERISA) reporting requirements preempt state law.[8] Self-funded ESPs cover 67 percent of covered employees in the United States,[9] leaving roughly 30 percent of the insured unaccounted for in states where self-funded ESPs do not voluntarily submit data to the APCD. This leaves a significant proportion of data missing, diminishing an APCD's effectiveness as a resource for cost containment and population health measures.

Recognizing the benefits of APCDs and the challenges with gathering information from all ESPs, Congress acted with the passage of The No Surprises Act within the Consolidated

---

[5] Press Release, Minn. Dep't of Health, Novel MDH Study Yields First Statewide Estimate of Potentially Preventable Health Care Events (Jul. 23, 2015), https://www.health.state.mn.us/news/pressrel/2015/hcevents.html.
[6] Alan G. White et al., *Analytic Models to Identify Patients at Risk for Prescription Opioid* Abuse, 15(12) AM. J. OF MANAGED CARE 897, 898 (2009).
[7] *Compare Health Costs & Quality of Care in New Hampshire*, NH HEALTHCOST, https://nhhealthcost.nh.gov/ (last visited Apr. 20, 2021).
[8] *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016).
[9] *2020 Employer Health Benefits Survey*, KAISER FAMILY FOUND. (Oct. 8, 2020), https://www.kff.org/report-section/ehbs-2020-summary-of-findings/.

Appropriations Act, 2021. Under Section 115 of The No Surprises Act, Congress established a grant program awarding $2.5 million dollars over three years to establish or improve an existing State APCDs.[10] Section 115 also amends ERISA to authorizes the Department of Labor (DOL) to establish a standardized reporting format for the *voluntary* reporting of claims, eligibility, and provider data by group health plans, including self-funded ESPs, to State APCDs.[11] Unfortunately, Section 115 does not go far enough. Specifically, the voluntary reporting is insufficient to ensure maximum participation by self-funded ESPs. States have already allowed the voluntary submission by self-funded ESPs, but the participation in each state is varied, and no state receives full participation by self-funded ESPs. Also, the National Association of Health Data Organizations (NAHDO) created a "Common Data Layout" to decrease the burden of reporting to APCDs. Still, no state has adopted this standard, and health plans are concerned with the efficacy.[12]

This paper analyzes policy options at the federal and state level, including the DOL promulgating a rule requiring participation, Congress requiring mandatory reporting by ERISA plans to State APCDs, and States regulating third-party administrators (TPAs) to encourage participation in APCDs. Finally, this paper argues that to ensure participation by self-funded ESPs Congress must amend Section 115 subsection (b) of the No Surprises Act to ensure that State ACPD participation is *mandatory* for all employee group health plans.

---

[10] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 2875-2879 (2020).

[11] *Id.*

[12] ANTHEM PUBLIC POLICY INST., ACHIEVING STATES' GOALS FOR ALL-PAYER CLAIMS DATABASES 11 (2018), https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mzq1/~edisp/pw_g345393.pdf.

## II. BACKGROUND

This section summarizes the current landscape of State APCDs. First, section 1 provides a brief overview of the history and purpose of APCDs. Section 2 summarizes the benefits data from APCDs provide state health departments, policymakers, and researchers. Section 3 identifies limitations of APCDs, including the lack of data from self-funded ESPs. Section 4 summarizes the recent provisions of the No Surprises Act as they relate to APCDs and how these provisions are insufficient to maximize self-funded ESP participation.

### 1. Overview of APCDs

An APCD is a data repository for healthcare claims, eligibility, and provider data for a geographic area.[13] Currently, all APCDs operate at the state level.[14] APCDs contain data from private and public payers.[15] State laws for APCDs require private health insurers and the State's Medicaid program to submit data to the APCD.[16] Self-funded ESP participation in APCDs is not mandatory due to the 2016 Supreme Court decision, *Gobeille v. Liberty Mutual Insurance Co*.[17] States also collect Medicare data from the Centers for Medicare and Medicaid Services (CMS). States can also request data from the federal government for Federal Employee Health Benefits, TRICARE, and the Veterans Administration.[18]

In 2003, Maine was the first state to implement an APCD.[19] Today, twenty-one states have created or are implementing APCDs, eleven states have indicated a strong interest in implementing

---

[13] PORTER, *supra* note 3.
[14] *Interactive State Report Map*, *supra* note 4.
[15] *All-Payer Claims Databases*, *supra* note 2.
[16] MATTHEW FIEDLER & CHRISTEN LINKE YOUNG, FEDERAL POLICY OPTIONS TO REALIZE THE POTENTIAL OF APCDS 2 (2020).
[17] *Gobeille*, *supra* note 8.
[18] PORTER, *supra* note 3, at 2.
[19] *Id.* at 1.

an APCD, and six states have APCDs created voluntarily by healthcare stakeholders, so these are not state-run.[20] APCDs typically include payment information (e.g., plan paid amount and member cost-sharing), revenue codes, procedure codes, diagnosis codes, drug codes, facility type, place of service, provider, service dates, patient demographics (e.g., age, gender, race/ethnicity), provider information (e.g., name, type, location).[21] Many states allow non-state agencies to request APCD de-identified data.[22]

### 2. Benefits of APCDs

Data from APCDs allow state health departments, policymakers, and researchers to understand healthcare spending and utilization, improve population health, and increase consumer transparency. For example, the Minnesota Department of Health identified 1.3 million patient visits that resulted in almost $2 billion of potentially preventable emergency department visits, hospital admissions, and hospital readmissions over for a single year.[23] Also, the Virginia Center for Health Innovation found an estimated $498 per member per month claims resulted from wasted healthcare services.[24] Using the Minnesota APCD, researchers analyzed telemedicine visits to assess utilization by coverage type, provider type, physician specialty, and geographic area.[25] The

---

[20] *Interactive State Report Map*, *supra* note 4.
[21] PORTER, *supra* note 3, at 2.
[22] RELEASING APCD DATA: HOW STATES BALANCE PRIVACY AND UTILITY, FREEDMAN HEALTHCARE 2 (2017), https://www.apcdcouncil.org/publication/releasing-apcd-data-how-states-balance-privacy-and-utility.
[23] Press Release, Minn. Dep't of Health, Novel MDH Study Yields First Statewide Estimate of Potentially Preventable Health Care Events (Jul. 23, 2015), https://www.health.state.mn.us/news/pressrel/2015/hcevents.html.
[24] Thomas Beaton, *All-Payer Claims Databases Offer Insights into Healthcare Spending* (Jan. 2, 2018), https://healthpayerintelligence.com/news/all-payer-claims-databases-offer-insights-into-healthcare-spending.
[25] Jiani Yu et al., *Population-Level Estimates of Telemedicine Service Provision Using an All-Payer Claims Database*, 37 HEALTH AFFAIRS 1931 (2018).

Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) evaluates healthcare expenditures, forecast drivers of cost and evaluates payment reform initiatives.[26]

ACPD data can aid in States' efforts to improve population health. Using data from the APCD, Maine developed a predictive model to identify patients at risk for prescription opioid abuse.[27] Researchers in Massachusetts are using the Massachusetts APCD data to perform a wide range of analytics, including creating a predictive model to understand population-level changes in emergency department use, analyzing maternal and infant characteristics associated with maternal opioid overdose, and developing a classification model of homelessness.[28]

Data collected by APCDs can provide a wealth of information to consumers. Some States create websites summarizing costs of procedures by payers or quality by provider to increase transparency. For example, New Hampshire sponsors a website, "NH HealthCost," that allows visitors to filter the cost of medical and dental procedures by payer.[29] The NH HealthCost website also providers quality metrics by provider.[30] Maine, Virginia, Maryland, and Minnesota have similar consumer-facing websites that are derived from data stored in APCDs.[31] Consumer price

---

[26] JENNIFER RICHARDS & LYNN BLEWETT, MAKING USE OF ALL-PAYER CLAIMS DATABASES FOR HEALTH CARE REFORM EVALUATION 25 (2014).

[27] Alan G. White et al., *Analytic Models to Identify Patients at Risk for Prescription Opioid* Abuse, 15(12) AM. J. OF MANAGED CARE 897, 898 (2009).

[28] *Resultant Research Using the MA APCD and CHIA's Case Mix Data*, CHIA, https://www.chiamass.gov/resultant-research-using-chia-data/ (last visited Apr. 20, 2021).

[29] *Compare Health Costs & Quality of Care in New Hampshire*, *supra* note 7.

[30] *Id.*

[31] *See Compare Costs of Healthcare Procedures and Quality of Care Across* Maine, COMPAREMAINE, comparemaine.org (last visited Apr. 20, 2021); *Healthcare Pricing Transparency*, VA. HEALTH INFO., http://www.vhi.org/healthcarepricing/ (last visited Apr. 20, 2021); MNHEALTHSCORES, mnhealthscores.org (last visited Apr. 20, 2021); *We Are the Cost*, MD. HEALTH CARE COMM'N, https://www.wearthecost.org/ (last visited Apr. 20, 2021).

and quality transparency can direct patients to lower cost and higher quality care, reducing the cost of health care over time.[32]

Outside of the standard claims, eligibility, and provider data, a few states collect data such as capitation payments, encounter data, quality bonuses, and other non-claims payment data to support analysis of value-based reimbursements.[33] California's APCD anticipates having a tiered approach to collecting and providing data to researchers.[34] The first tier includes "core" data typically available (e.g., claims, eligibility, provider), but tier two will expand the core data to include alternative payment models, pharmacy rebates, and pay for performance data. As states continue to collect and expand data available in State APCDs, policymakers, health departments, researchers, and other stakeholders can perform analyses of value-based payment reform initiatives in addition to the other analyses already performed.

**3. Limitations of APCDs**

As with any data collection initiative, APCDs face issues with data completeness, access, and quality. The Agency for Healthcare Research and Quality (AHRQ) performed a literature review and environmental scan of issues plaguing APCDs. AHRQ found that missing data elements, low-quality data, data standardization challenges, and difficulty with data linkage and

---

[32] *See How Price Transparency Can Control the Cost of Health Care*, ROBERT WOOD JOHNSON FOUND. (Mar. 1, 2016), https://www.rwjf.org/en/library/research/2016/03/how-price-transparency-controls-health-care-cost.html ("Most people in America want greater price transparency and would compare health care prices if given the option").
[33] Nat'l Ass'n of Health Data Orgs., *Discussion of Federal Grants for State APCD,* YOUTUBE (Jan. 15, 2021), https://www.youtube.com/watch?v=gpZMHPbhRyM.
[34] *Q&A: The What, When, Who and How of California's New APCD: The Health Care Payments Data System*, SOURCE ON HEALTHCARE PRICE & COMPETITION (Aug. 17, 2020), https://sourceonhealthcare.org/qa-the-what-when-who-and-how-of-californias-new-apcd-the-health-care-payments-data-system/#_ftn5.

aggregation were the most common issues.[35] These types of data challenges are incredibly common. APCDs try to mitigate these issues by sharing strategies, such as implementing data cleaning procedures, using national identification numbers, and creating recommended reporting structures.[36] The most significant limitation that APCDs face is a lack of participation across all types of health insurance plans.

Though the namesake contains the word "all," not all payers are required to submit data to the APCDs. Specifically, the 2016 Supreme Court decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), held that the states cannot require self-funded ESPs to report data to APCDs because ERISA reporting requirements preempt state law.[37] In *Gobeille*, Vermont law required health insurers, including self-funded ESPs, to report data to Vermont's APCD.[38] Respondent Liberty Mutual Insurance Company (Liberty Mutual) used a TPA to maintain its self-funded ESP for its employees.[39] Liberty Mutual claimed that ERISA preempted any reporting by its TPA to Vermont's APCD.[40] The Supreme Court agreed that ERISA's express preemption clause invalidated Vermont's statute as applied to ERISA plans.[41] The Supreme Court reasoned that the Vermont statute imposed duties on self-funded ESPs that were "inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the

---

[35] Inventory and Prioritization of Measures to Support the Growing Effort in Transparency Using All-Payer Claims Databases, Agency for Healthcare Research and Quality (Mar. 2017), https://www.ahrq.gov/data/apcd/backgroundrpt/review.html.
[36] *Data Quality Forum*, NAHDO, https://www.nahdo.org/node/1058 (last visited Apr. 20, 2021); *Inventory and Prioritization of Measures To Support the Growing Effort in Transparency Using All-Payer Claims Databases*, supra note 35.
[37] *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016).
[38] *Id.* at 940-941.
[39] *Id.* at 941.
[40] *Id.*
[41] *Id.*at 947.

administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements."[42]

The Supreme Court decision limited states' access to self-funded ESP data, creating an enormous void. Self-funded ESPs cover 67 percent of covered employees in the United States.[43] Therefore, roughly 30 percent of the insured population is unaccounted for in States where self-funded ESPs do not voluntarily submit data to the APCD.[44] This leaves a significant proportion of data missing, diminishing an APCD's effectiveness as a resource for healthcare cost containment, quality improvement, and population health efforts.

The magnitude of the consequences from *Gobeille* vary by state, but ultimately, the majority of self-funded ESPs are not reporting to APCDs. For example, Massachusetts compared participation by private insurers before and after *Gobeille* and found a 24 percent drop in enrollees and a 27 percent drop in medical claims volume.[45] Maryland's APCD contains only about 25 to 30 percent of the self-insured ESP.[46] Oregon estimates that in 2018 its APCD contained anywhere

---

[42] *Id.*
[43] *2020 Employer Health Benefits Survey*, *supra* note 9.
[44] *Id*.
[45] Sylvia D. Hobbs & Anne Medinus, *Demographic Differences in Massachusetts All Payer Claims Data (APCD) Before and After Gobeille*, CHIA (Aug. 2020), https://www.nahdo.org/sites/default/files/2020-08/Day%20Four%20Slides/402-70%20Sylvia%20Hobbs%20NAHDO_August2020_HOBBS_MEDINUS.pdf.
[46] *MCDB Data Release*, MARYLAND HEALTH CARE COMM'N, https://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_mcdb.aspx (last updated Mar. 1, 2021).

from 36 to 61 percent individuals covered by self-funded ESPs.[47] APCDs in Arkansas and Utah contain absolutely no self-funded ESP data.[48]

Spending and utilization by enrollees of self-funded ESPs may be higher than enrollees in other private health plans resulting in a larger than expected gap from data analyses. Massachusetts conducted an analysis reviewing data in its APCD before and after *Gobeille*. Massachusetts compared enrollment by self-funded ESPs to the rest of the private insurers and found that enrollees of self-funded ESP tend to be older, less healthy, and more female.[49] Also, more individuals in self-funded ESPs are enrolled in preferred provider organizations (PPOs).[50] PPOs provide individuals with more flexibility and tend to provide more robust healthcare options for enrollees leading to higher spending.[51] If self-funded ESPs are not reporting data to State APCDs, States are losing the opportunity to realize the true cost and utilization of health care as well as the health conditions that are found in this population.

#### 4. The No Surprises Act Brings *Some* Life to Self-Funded ESP APCD Participation

Recognizing the benefits of APCDs and the challenges with gathering information from all ESPs, Congress acted with the passage of The No Surprises Act within the Consolidated

[47] *All Payer All Claims Reporting Program*, Oregon, https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx (last visited Apr. 14, 2021).
[48] *2020 Data Attribute Supplement for Data Requests*, ARKANSAS APCD (Jan. 2020), https://www.arkansasapcd.net/Docs/282/; *Healthcare Affordability: Untangling Cost Drivers*, http://www.nrhi.org/uploads/benchmark_report_final_web.pdf
[49] *Meeting of the Market and Oversight and Transparency Committee*, MASS. HEALTH POLICY COMM'N (Jun. 13, 2018), https://www.mass.gov/files/documents/2018/06/13/20180613%20-%20MOAT%20-%20Presentation%20Posting.pdf.
[50] *Id.*
[51] *HMO vs. PPO: Which One is Right for You?*, HUMANA, https://www.humana.com/health-and-well-being/hmo-vs-ppo (last visited Apr. 14, 2021); *What is a PPO?*, HUMANA, https://www.humana.com/health-and-well-being/what-is-ppo (last visited Apr. 20, 2021).

Appropriations Act, 2021. Under Section 115 subsection (a) of the No Surprises Act, Congress established a grant program administered by the Department of Health and Human Services (HHS), awarding $2.5 million over three years to establish or improve an existing State APCDs.[52] To be eligible, the State must ensure the application includes information about how it will ensure (1) uniform data collection and (2) the privacy and security of such data.[53] Lastly, HHS will prioritize applications that demonstrate the State will work with other APCDs to create a single application across multiple states.[54] HHS will also prioritize applications that demonstrate the State will implement the reporting format for self-insured ESPs described in subsection (b).[55]

Section 115 subsection (b) amends ERISA to authorize the DOL to establish and periodically update a standardized reporting format for the voluntary reporting of claims, eligibility, and provider data by group health plans to State APCDs.[56] The DOL shall also provide guidance to States about how to collect data in the standardized format.[57]

To develop the standardizing reporting format, subsection (b) requires the DOL to convene an Advisory Committee consisting of 15 members from government agencies and members appointed by the DOL Secretary.[58] This committee includes individuals in health services research, health economics, health informatics, data privacy and security, APCD governance, patients, group health plan sponsors, health care providers, insurers, and TPAs.[59] In late March

---

[52] Consolidated Appropriations Act, *supra* note 10.
[53] *Id.* at 2875.
[54] *Id.* at 2876.
[55] *Id.*
[56] *Id.*at 2877-2879.
[57] *Id.* at 2877.
[58] *Id.* at 2877-2878.
[59] Nat'l Ass'n of Health Data Orgs., *supra* note 33.

2021, the State All Payer Claims Database Advisory Committee (SAPCDAC) was announced.[60] According to the DOL, the "SAPCDAC must submit a report that includes recommendations on the establishment of the format and guidance by June 25, 2021."[61]

States already can mandate group health plans that are fully insured participate in APCDs.[62] The challenge remains with self-funded ESP participation. States already allow voluntary submission by self-funded ESPs, but the participation is varied, and no state receives full participation by self-funded ESPs. A standardized reporting structure may incentivize participation by self-funded ESPs because of the decreased administrative burden. However, the voluntary reporting participation is not enough to ensure sufficient participation by self-funded ESPs.

Plans are concerned that the submission of raw claims data will lead to anti-competitive issues because the submission includes negotiated rates between plans and providers.[63] Therefore, self-funded ESPs are unlikely to participate in APCDs because they rather not disclose data. The non-standardized formatting requirements are unlikely to encourage participation either. Nearly 85 to 90 percent of the format requirements across State APCDs are the same, and self-funded ESPs still do not participate.[64] Finally, the NAHDO tried creating a "Common Data Layout" to

---

[60] Press Release, U.S. Gov't Acct. Off., GAO Makes Appointments to the State All Payer Claims Databases Advisory Committee (Mar. 29, 2021), https://www.gao.gov/press-release/gao-makes-appointments-state-all-payer-claims-databases-advisory-committee.
[61] Emp. Benefits Sec. Admin., *State All Payer Claims Databases Advisory Committee (SAPCDAC)*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/state-all-payer-claims-databases-advisory-committee (last visited Apr. 25, 2021).
[62] 29 U.S.C. § 1144.
[63] ANTHEM PUBLIC POLICY INST., *supra* note 12, at 10.
[64] *Id.*

decrease the burden for plans to report to APCDs. However, no state has adopted this standard, and health plans are concerned with the efficacy.[65]

## III. ANALYSIS

This section analyzes federal and state options to maximize participation by self-funded ESPs in APCDs. Part one identifies federal policy options and examines whether these are feasible given the enactment of the No Surprises Act by Congress in late 2020. Part two summarizes state policy options and assesses the feasibility of these too.

### 1. Federal Options to Increase Participation by Self-Funded ESP

#### *A. Department of Labor Promulgate a Rule*

The DOL could promulgate a rule requiring self-funded ESPs to report data necessary for State APCDs. The Supreme Court indicated that the DOL could authorize ERISA plans to submit data to fulfill APCD requests in the *Gobeille* majority and concurrent opinion. Specifically, the majority opinion states that

> [t]he Secretary of Labor, not the States, is authorized to administer the reporting requirements of plans governed by ERISA. He may exempt plans from ERISA reporting requirements altogether. And, he may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here.[66]

Further, Justice Breyer's concurrence indicates that States could request the DOL for approval to collect data necessary for State APCDs and that the DOL can authorize States to obtain the data

[65] *Id.* at 11.
[66] *Gobeille*, *supra* note 8, at 945 (citations omitted).

from self-funded ESPs.[67] Justice Breyer comments explicitly that he does not "see why the Department could not delegate to a particular State the authority to obtain data related to that State[.]"[68]

Though the DOL may have had the authority, little was done by the DOL after the *Gobeille* decision. In 2016, the DOL opened comments to its proposed rule that amends ERISA reporting regulations to enhance the Agency's ability to collect data in light of the *Gobeille* decision.[69] States and policy advocates submitted comments requesting the mandatory collection of health care claims and related data from self-funded ESPs to fulfill the data needs for APCDs.[70] States and policy advocates noted that the proposed reporting structure was too limited and that the DOL has broad authority to request more data with even more frequency.[71] These comments even support using a standard data layout to decrease the administrative burden on these health plans.[72] The

---

[67] *Id*. at 949-950 ("I would also emphasize that pre-emption does not necessarily prevent Vermont or other States from obtaining the self-insured, ERISA-based health-plan information that they need. States wishing to obtain information can ask the Federal Government for appropriate approval.").

[68] *Id.*

[69] Annual Reporting and Disclosure, 81 Fed. Reg. 47496 (proposed Jul. 21, 2016) ("The Department is specifically seeking public comments on those conforming amendments and the proposed annual reporting requirements for plans that provide group health benefits, including the new Schedule J, in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016)."); Proposed Revision of Annual Information Return/Reports, 81 Fed. Reg. 47534 (proposed Jul. 21, 2016).

[70] *See* Nat'l Acad. for State Health Policy, Comments on Department of Labor Notice of Proposed Rulemaking (Sept. 20, 2016), https://www.nashp.org/wp-content/uploads/2016/10/CA_-Final_-NASHP-Comments-and-Proposal-to-DOL.pdf; Commonwealth of Mass. Health Policy Comm'n, Comment Letter on Notice of Proposed Revision of Annual Information Return/Reports (Nov. 15, 2016).

[71] *Id.*

[72] *Id.*

proposed rule languished after the comment period and never became finalized.[73] Regrettably, this was a lost opportunity for state APCDs.

Even if DOL were to finalize the 2016 rule today and include mandatory reporting by self-funded ESPs, this option is no longer feasible. Opponents of a mandatory reporting requirement by self-funded EPSs can leverage Congress's use of the word "voluntary" in Section 115 to indicate that Congress did not intend for a mandatory APCD reporting requirement. However, opportunities to maximize voluntary participation by self-funded ESPs exist. As indicated by NAHDO, "there are multiple flavors of voluntary," meaning that DOL could create an "opt-out" definition of voluntary.[74] The additional step of opting out may result in more voluntary participation by self-funded EPSs.

### *B. Create a Federal APCD*

Congress can create legislation for a federally run APCD with mandatory participation by all payers, including self-funded ESPs. States could request data from the federal APCD to continue performing healthcare cost, utilization, and population health analyses. A centralized approach with a standard data reporting format also decreases the administrative burden for all health plans compared to submitting data individually to each State APCD. However, Congress has experienced challenges with setting up a federal APCD, so this is likely a remote solution.

In 2019, the Senate proposed a bill to develop a federal APCD, and in 2020, the House proposed a bill to establish one too.[75] Neither bill left committees, indicating that there is little

---

[73] Office of Info. & Regulatory Affairs, *View Rule*, U.S. GEN. SERVS. ADMIN. (2018), https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=1210-AB63 (last action by the DOL was an extension of the comment period on September 23, 2016).

[74] Nat'l Ass'n of Health Data Orgs., *supra* note 33.

[75] Federal All-Payer Claims Database of 2020, H.R. 8967, 116th Cong. (2020); Lower Health Care Costs Act, S. 1895, 116th Cong. (2019).

support for a federal APCD in Congress. Also, Congress seems to prefer States managing their own APCDs, as indicated by the passage of additional APCD funding in the No Surprises Act. Finally, a federal APCD would fail to capitalize on the investments already made by dozens of states over the last two decades.

*C. Congress Amends ERISA to Mandate Self-funded ESPs to Report to State APCDs*

Congress can amend ERISA to support State APCD data collection from self-funded ESPs. Since the *Gobeille* decision, Congress held various hearings related to healthcare transparency and reducing healthcare costs. At a few of these hearings, academics, researchers, and state officials addressed their concern that ERISA preemption's scheme made it so that self-funded ESPs were not required to participate in State APCDs and requested that Congress act.

The requests were to clarify or amend ERISA's preemption scheme to allow States to collect ACPD data from self-funded ESPs. For example, a professor from Harvard Medical School requested that Congress clarify "that ERISA's preemption of self-insured employer regulation does not extend to data collection by state-run APCDs."[76] A professor from Hastings College of Law asked Congress to amend ERISA's preemption scheme to "permit the states to experiment with a variety of health reform proposals," such as APCDs.[77] The passage of Section 115 from the No Surprises Act makes amending ERISA to narrow preemption less likely to occur because

[76] *How to Reduce Health Care Costs: Understanding the cost of Health Care in America Hearing of the Committee on Health, Education, Labor, and Pensions United States Senate*, 115th Cong. 21-22 (2018) (statement of Ashish Jha, M.D., M.P.H., Director, Harvard Global Health institute, K. T. Li Professor and Senior Associate Dean, Harvard T. H. Chan School of Public Health, and Professor of Medicine, Harvard Medical School)

[77] *Examining State Efforts to Improve Transparency of Healthcare Costs for Consumers Hearing Before the Subcommittee on Oversight and Investigation of the Committee on Energy and Commerce House of* Representative, 115th Cong. 53 (2018) (testimony of Jamie S. King, Professor of Law and the Bion M. Gregory Chair in Business Law at the University of California, Hastings College of Law).

Congress, even after hearing these requests, decided to only include voluntary APCD reporting indicating that Congress does not want to narrow ERISA preemption.

The best approach to ensuring participation of self-funded ESPs is for Congress to mandate participation. The State of Washington Insurance Commissioner stated that "[i]n the interests of transparency and payment reform, a bipartisan discussion on the possibility of mandating self-funded group health plans participation in State databases would be very welcome." [78] Therefore, to fulfill this request Congress can amend Section 115 subsection(b) of the No Surprises Act so that the standardized format created by the DOL is for *mandatory* reporting. Congress should fix the problem that they created.

**2. State Options to Maximize Participation by Self-Funded ESP**

Most self-funded ESPs use TPAs to administer their employee benefit plans.[79] The *Gobeille* case limited a States' ability to collect APCD data from TPAs on behalf of self-funded ESPs. However, two cases since the *Gobeille* decision provide States the opportunity to regulate TPAs to encourage them to report healthcare claims, eligibility, and provider data to APCDs: *Self-Insurance Institute of America, Inc. v. Snyder*, 827 F.3d 549 (6th Cir. 2019), and *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, 141 S. Ct. 474 (2020). The following summarizes these cases and outlines opportunities for states to regulate TPAs to encourage more participation in APCDs. One caveat to consider is that these cases occurred after the passage of Section 115. Therefore, any state regulation that leverages principals from these cases need to take

---

[78] *Stabilizing Premiums and Helping Individuals In the individual Insurance Market For 2018: State Insurance Commissioners Hearing of the Committee on Health, Education, Labor, and Pensions United States Senate*, 115th Cong. 88-89 (2017) (response by Mike Kreidler, State of Washington Insurance Commissioner to questions of Senator Whitehouse).
[79] *See Employer Self-funding of Employee Health Benefits*, Tex. Dep't. of Insurance., https://www.tdi.texas.gov/pubs/consumer/cb108.html (Feb. 9, 2021).

into account that Congress currently intends self-funded ESP participation in APCDs to be voluntary.

A. *Self-Insurance Institute of America, Inc. v. Snyder*

After the *Gobeille* decision, the Sixth Circuit held in *Self-Insurance Institute of America, Inc. v. Snyder* that ERISA did not preempt a Michigan law from levying a one-percent tax by all health insurers or TPAs for services rendered.[80] The law required insurers and TPAs to report quarterly returns and "keep accurate and complete records and pertinent documents" related to the tax.[81] Self-Insurance Institute of America filed a lawsuit against the Governor of Michigan seeking a declaratory judgement that the law was preempted by ERISA because it relates to the administration of employee benefit plans.[82] The Sixth Circuit reviewed whether the Michigan law had "an impermissible connection with an ERISA plans."[83]

In its analysis, the Sixth Circuit noted that *Gobeille's* preemption occurs only in the case of *direct* regulation of "reporting, disclosure, and recordkeeping."[84] The Sixth Circuit also noted that the Supreme Court observed that the analysis in *Gobeille* "may be different when applied to a state law, such as a tax on hospitals, the enforcement of which necessitates incidental reporting by ERISA plans."[85] The Sixth Circuit held that the Michigan law was not preempted and reasoned that the "thrust of the Act [was] to collect taxes" and that the reporting requirements were "peripheral requirements that do not warrant preemption."[86]

---

[80] *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549, 553 (6th Cir. 2016).
[81] *Id.* at 558.
[82] *Id.* at 553.
[83] *Id.* at 556.
[84] *Id.*
[85] *Id.* at 557 (citations omitted) (quoting *Gobeille*, 136 S. Ct. at 946, which was referencing *De Buono v. NYSA–ILA Med. & Clinical Servs. Fund*, 117 S. Ct. 1747 (1997)).
[86] *Id.* at 558.

B. *Rutledge v. Pharmaceutical Care Management Association (PCMA)*

In 2020, the Supreme Court held in *Rutledge v. Pharmaceutical Care Management Association (PCMA)* that an Arkansas law regulating PBMs' maximum allowable cost (MAC) lists was not preempted by ERISA.[87] The *Rutledge* case does not have a direct connection to reporting but instead is a case about cost regulation. However, *Rutledge* provides some daylight because it indicates that ERISA case law is evolving and provides States more flexibility for regulating ERISA plans.

The Supreme Court found that the Arkansas law did not have a "impermissible connection with nor reference to" an ERISA plan.[88] The Court used the *Gobeille* analysis to determine to review whether the law governs a central matter of plan administration or interferes with national uniform plan administration.[89] In its analysis, the Court stated that "state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage" are not preempted by ERISA."[90]

The Court held that the Arkansas law had no connection to an ERISA plan because it was "merely a form of cost regulation" and the cost would not dictate plan choices as it "applies equally to all PBMs and pharmacies in Arkansas."[91] For the "reference to" analysis, the Court held that the Arkansas law did not reference ERSIA because it did "not act immediately and exclusively on

---

[87] *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, 141 S. Ct. 474, 479-483 (2020).
[88] *Id.* at 478.
[89] *Id.* at 480.
[90] *Id.*
[91] *Id.* at 481.

ERISA plans" and "affects plans only insofar as PBMs may pass along higher pharmacy rate to plans with which they contract."[92]

*C. Regulate TPAs to Increase APCD Participation*

States can leverage concepts from *Self-Insurance Institute of America* and *Rutledge* to regulate TPAs and indirectly increase self-funded ESPs participation in its APCD. For example, States could tax TPAs for not submitting data to APCDs. TPAs then may pass the cost onto self-funded ESPs. Like the cost regulation in *Rutledge*, the cost of the tax would not dictate plan choices because the cost would apply to all TPAs. Therefore, if self-funded ESPs did not want to bear the cost burden, the plans may ask the TPA to opt-in to participate in the APCD. However, even though the tax would apply to all TPAs, the law may be considered to have a connection to ERISA because self-funded ESPs predominantly use TPAs.

As another option, States may regulate TPA reimbursements for services similar to the MAC pricing regulation in *Rutledge*. As part of the verification process, the State can require routine reporting like the "incidental reporting" required as part of in *Self-Funded Institute of America*. The reporting format could be like the one for APCD data submissions which the State agency collecting the report could share with the State APCD.

If the States regulate TPAs, this provides them with more flexibility. States each invest annually anywhere from $700 thousand to $4 million to maintain their APCDs, and thus, want to maximize the utility.[93] For instance, if the State relies on the DOL, it runs the risk that the DOL format may not match the State's APCD format requirements. The DOL format may not be comprehensive either and fail to include some key data fields, especially those used for value-

---

[92] *Id.*
[93] *Id.*

based payment analysis. Therefore, even if the State can convert the federal format, some key pieces of data may be missing because the DOL did not include it in its suggested format.

States will likely meet some legal challenges to its regulation. Unlike Michigan and Arkansas, States must deal with Section 115 of the No Surprises Act use of the word "voluntary" for reporting to APCDs by ERISA plans. Therefore, a self-funded ESP may claim that a tax on the TPA for not participating in an APCD is essentially mandating self-funded ESP to participate which is against the intent of Congress who made APCD participation voluntary. Also, depending on how the law is written, the State may meet legal challenges claiming that the regulation may be in "connection with" or "relate to" ERISA plans. However, only time can tell if States encounter legal challenges. Therefore, if a State prefers to maintain its APCD and not rely on the DOL, regulating TPAs may be its best option to increase self-funded ESP participation.

## IV. CONCLUSION

States and researchers use APCDs to curb unnecessary healthcare spending, improve population health, and increase consumer transparency. Many federal and state policy options exist to maximize the participation of self-funded ESPs. Though the States may be able to leverage *Rutledge* to regulate TPAs to participate in APCDs indirectly, these regulations will likely meet legal challenges, especially because *Rutledge* is about regulating cost rather than administrative reporting. The DOL may also have some leeway to maximize participation depending on how it defines "voluntary" participation. However, as shown by States' experience so far, most self-funded ESPs do not participate even though most of the data fields are similar across States. The optimal solution to ensuring maximum participation by self-funded ESPs is for Congress to mandate participation. Therefore, Congress must amend Section 115 subsection (b) of the No Surprises Act to require *mandatory* reporting by all employer group plans to APCDs.