No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,
Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Second Circuit

BRIEF OF *AMICI CURIAE* AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 individual members. The AHA educates its members on health care issues, and advocates to ensure that their perspectives are considered in formulating health care policy. AHA members are committed to improving the health of their communities, and to ensuring that health care is available and affordable for all Americans.

The Association of American Medical Colleges (AAMC) is a nonprofit educational association, whose members include all 144 accredited U.S. and 17 accredited Canadian medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians. The AAMC's mission is to serve and lead the academic medicine community, to improve the health of all.

Amici have a keen interest in the development and use of all-payer claims databases such as the one at issue in this case. Hospitals and other providers are assessed not only on the quality of the care that they

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[1] Counsel for both the petitioner and respondent have filed, with the Clerk of this Court, blanket consent to the filing of *amicus curiae* briefs. No counsel for any party authored this brief in whole or in part, and no person or entity other than *amici curiae* or their counsel made a monetary contribution to the preparation or submission of this brief.

provide, but on improvements in community health and reductions in the per capita cost of health care. Moreover, both private and public payers are increasingly moving away from volume-based reimbursement to value-based models.

Hospitals and health systems are therefore actively developing, reporting, and making use of data to improve care for patients, improve the health of their communities, and deliver services in the most cost-effective manner possible. The claims databases at the center of this case are essential for achieving those ends, and *amici* strongly support their further use and development. But, as detailed below, to be meaningful, the information in those databases must be *complete*—and that requires including claims data from self-insurers.

INTRODUCTION

The question in this case is whether patients, hospitals, physicians, and policymakers should have access to the kind of data that will enable them to improve the health of their communities while controlling the growth of health care costs. All parties in this case agree that the State of Vermont may lawfully collect health insurance claims data from the State's Medicaid program, and from health insurers operating within Vermont's borders. The only question is whether claims data from self-funding employers—that is, those who pay for their employees' medical expenses themselves, rather than purchasing insurance contracts to do so—should be treated differently.

The court of appeals concluded that employers who self-fund their health insurance plans should enjoy a special exemption from a generally applicable requirement to report claims data, in a confidential manner, to the State. Pet. App. 3–4. Inclusion of self-insurers' claims data is essential for the proper functioning of the databases at issue in this case, however, and federal law should not be read to preclude it.

Hospitals have been voluntarily leading efforts to gather and report data about cost and quality for more than a decade. That data is necessary to develop evidence-based medicine that can eliminate preventable infections and complications, and better manage chronic illness. Hospitals are using information technology to track the quality of the care they provide, to more deeply involve patients in their care, and to target care to populations in need. Patients and their families, moreover, deserve meaningful information about the price of their care, and America's hospitals are committed to providing it.

But hospitals only have data for the patients they treat. Information from across the spectrum of an individual's health care experience is needed to inform clinical, payment, and public health policy. Only health insurers have this broad range of data. Complete data across all payers (including self-insurers like Respondent) is required so that both health care providers and policymakers can understand the variations in the health care system, and address those that need to change. Access to the fullest possible range of data for the most providers and patients is central to achieving that goal, and will result in higher quality, more efficient care.

SUMMARY OF ARGUMENT

All-payer claims databases are vital and promising public policy tools, the development of which should be actively encouraged, as States are increasingly doing. Analysis of claims data is not new. But a comprehensive, longitudinal, multi-payer dataset—in other words, an all-payer database—can provide unprecedented research and policy opportunities for improving the health care delivery system. Federal law should not be interpreted to preclude the states' use of this tool to best improve the health of their communities.

For example, using the data from all-payer databases, States can develop targeted public health initiatives and interventions—such as evaluating whether patients with particular health conditions are typically receiving nationally recommended screening and procedures. States can evaluate the preventive-care behaviors of their healthy population, to improve care for the rest. They can study the effect of public-education campaigns—and much more. Moreover, all-payer databases can be used to test the effectiveness of pilot programs that offer alternatives to the traditional fee-for-service payment model. An all-payer database can reveal whether such pilots really do reduce costs, and (just as importantly) whether they result in the high quality care.

But for all-payer claims databases to be useful, they must contain *complete* claims data. And given the increasing popularity of self-insured plans, including their claims data is essential. Self-insured plans cover a large majority of the working population: in 2013, nearly 60% of workers with health insurance were enrolled in such plans, and that figure is growing. See Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996–2013*, 36 Emp. Benefit Research Inst. at 7 (2015). Some communities have even higher rates: in Illinois, for example, over 92% of employees at large firms are enrolled in self-insured plans. *Id.*, at 9. The self-insured population is also distinctive: excluding it will mean that the population in the database will be, on the whole, older, lower income, and less healthy (because the share of claims information from Medicaid and Medicare will grow). That, in turn, will present a misleading picture that will make it impossible for providers or policymakers to realize the potential benefits of these databases.

Including self-insured claims data, moreover, can be accomplished with little to no direct impact on self-insurers themselves. Most self-insurers, including Respondent, use a third-party insurance company to administer their claims, such as Blue Cross Blue Shield of Massachusetts. See JA 15. For such employers, their administrator maintains all of the information sought by the database. But because the administrators are insurance companies, they will already be in the business of turning over claims data to the state—so the added effort to include self-insurers' data is negligible. Moreover, States can collect claims data (as Vermont does) in nationally standardized formats, which will further reduce any impact on employers and their administrators.

ARGUMENT

I. BASIC FEATURES OF AN ALL-PAYER CLAIMS DATABASE

All-payer claims databases are a fast-growing public policy tool. "As of March 2014, 11 states had an [all-payer database] in place," and "five states were in [the] process of implementation." Paradis & Bartolini, *All Payer Claims Databases: Unlocking the Potential* at 1, Network for Excellence in Health Innovation (Dec. 2014). Many more States have expressed interest in creating such databases, and in total, "more than 30 states have, are implementing, or have strong interest in [all-payer databases.]" Porter, Love, Peters, Sachs & Costello, *The Basics of All-Payer Claims Databases: A Primer for States* 1, APCD Council and Robert Wood Johnson Foundation (Jan. 2014).

State legislation creating all-payer databases directs the periodic collection of claims data from commercial insurance carriers, the State's Medicaid agencies, and (increasingly) Medicare data.[2] The

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[2] See, *e.g.*, Ark. Code Ann. §23-61-901 ("Arkansas Healthcare Transparency Initiative Act of 2015"); Colo. Rev. Stat. §25.5-1-204 (creating advisory committee regarding "creation of all-payer health claims database"); Conn. Gen. Stat. Ann. §38a-1091 ("All-payer claims database program"); 22 Me. Rev. Stat. Ann. §8703 (establishing "Maine Health Data Organization"); Md. Code Health §19-133 ("Maryland medical care data base"); Mass. Gen. Law Ann. ch. 12C, §2 (establishing "center for health information and analysis"); Minn. Stat. Ann. §62U.04 ("Payment reform; health care costs; quality outcomes"); N.H. Rev. Stat. Ann. §420-G:11(II) (requiring insurers to provide "claims data … to the department of health and human services"); N.Y. Pub. Health Law §2816 ("Statewide planning

resulting database includes medical, pharmacy, and dental claims, combined with eligibility and provider files from private and public payers. Paradis & Bartolini, *supra*, at 1 (all-payer databases "regularly collect medical claims and pharmacy claims data, with some also collecting dental claims and eligibility data, from both private and public payers"). For example, the Vermont statute at issue in this case directs "[h]ealth insurers, health care providers, health care facilities, and governmental agencies" to file "health insurance claims and enrollment information used by health insurers," as well as "any other information relating to health care costs, prices, quality, utilization, or resources" that the responsible state agency directs. Vt. Stat. Ann. tit. 18, §9410(c). Similarly, Arkansas directs insurers to "submit health and dental claims data, unique identifiers, and geographic and demographic information," which shall be "treated as confidential." Ark. Code Ann. §23-61-906(a)–(b). See also R.I. Gen. Laws §23-17.17-10(a)–(b) (directing filing of "health insurance claims and enrollment information used by health insurers," not including "any data that contains direct personal identifiers").

(continued)

and research cooperative system"); Or. Rev. Stat. §442.466 ("Health care data reporting"); R.I. Gen. Laws §23-17.17-9 ("Health care quality and value database"); Tenn. Code Ann. §56-2-125 (establishing "[a]ll payer claims database"); Vt. Stat. Ann. tit. 18, §9410 ("Health care database"); Va. Code Ann. §32-.1-276.7:1 ("All-Payer Claims Database"); Wash. Rev. Code Ann. §43.371.020 ("Statewide all-payer health care claims database"); W. Va. Code §33-4A-1 ("All-payer claims database").

The claims data itself includes, among other things, privacy-protected basic demographic information (such as the patient's sex, age, and zip code); the date and time of the admission and discharge, as well as the status of the patient at discharge; the identity of the service provider; the location where the service was provided; procedures performed; the admitting diagnosis; and the price paid. See Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01 (Appendix A).

To safeguard patient privacy, the data is collected, handled, and released in a way that removes individual patient identifiers. Federal laws such as the Health Insurance Portability and Accountability Act (HIPAA) require as much. 42 U.S.C. §1320d-6 (prohibiting "disclos[ure]" of "individually identifiable health information to another person" except as permitted by that Act). See, *e.g.*, 10 Colo. Code Regs. §2505-5:1.200.4 (reports "shall protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information"); R.I. Gen. Laws §23-17.17-10(b) ("All data submitted to the director pursuant to this chapter shall be protected by the removal of all personal identifiers and the assignment by the insurer to each subscriber record of a unique identifier not linked to any personally identifiable information").

States collect this data for several reasons, but the declared purposes are broadly similar. The Vermont database at issue here, for example, exists to help the State in "determining the capacity and distribution of existing resources," "identifying health care needs and informing health care policy," "evaluating the effectiveness of intervention programs on improving patient outcomes," "comparing costs between various treatment settings and approaches," "providing information to consumers and purchasers of health care," and "improving the quality and affordability of patient health care and health care coverage." Vt. Stat. Ann. tit. 18, §9410.

Other states' statutes express similar goals.[3] Model legislation developed by the APCD Council (an independent group encouraging the adoption and development of these databases) states that such databases should be created to "make available timely and transparent information about health care quality, use, availability, and cost to consumers, researchers, communities, businesses, policy makers, providers, and payers so that they can make sound, economical, and medically appropriate decisions about health care coverage, benefits, and services in order to reduce the overall cost of health care to [the] state." Hodder, Porter, Love & Peters, *Model All-Payer Claims Database (APCD) Legislation* 3, APCD Council and West Health Policy Center (May 2015).

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[3] See, *e.g.*, Ark. Code Ann. §23-61-902(b) (purpose of database is to "[e]mpower Arkansans to drive, deliver, and seek out value in the healthcare system"); Colo. Rev. Stat. §25.5-1-204(a) (establishing a database for the purpose of "facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information" at all levels of health care); Or. Rev. Stat. §442.466(1) (purpose is "[e]valuating the effectiveness of intervention programs in improving health outcomes" and "[i]mproving the quality and affordability of health care and health care coverage").

II. ALL-PAYER CLAIMS DATABASES ARE AN IMPORTANT PUBLIC POLICY TOOL

Analysis of claims data is not new. But having a comprehensive, longitudinal, multi-payer dataset is now providing unprecedented research and policy opportunities for improving the health care delivery system. Federal law should not be interpreted in a way that would preclude states from using this tool to improve the health of their communities.

A. All-Payer Claims Databases Can Improve Public Health

Claims databases offer the opportunity to improve public health in major ways. First, all-payer claims data can be used to create benchmarks against which "payers and providers can … conduct performance analyses" and "improve clinical quality." Linda Green, Amy Lischko, and Tanya Bernstein, *Realizing the Potential of All-Payer Claims Databases* at 3, Robert Wood Johnson Foundation (Jan. 2014). This data can be used to improve treatment, strengthen quality measurements, and help develop tools to aid providers in better managing their patients. Claims data can reveal, for example, whether providers "followed nationally recommended medical protocols for treating patients diagnosed with diabetes." Christine Vestal, *Debating the Value of an All-Payer Claims Database*, MedCity News, June 19, 2014. How many diabetic patients in the state, in other words, received quarterly exams? How many received eye exams? How many were admitted to a hospital?

An all-payer database can provide reliable answers to questions like these. An individual provider's data cannot. A hospital cannot reliably document what happens to their patients once they leave the building. Even an individual insurer can only know how a patient is using care for as long as that patient remains in its network. But a complete set of statewide claims data can be used to analyze patient care and outcomes across *all* service providers and *all* insurers. That creates opportunities for research that simply would not be possible otherwise. In Utah, for example, researchers have used all-payer data about its *healthiest* citizens—such as how they access and use preventive care—in order to study potential improvements to the provision of preventive services to the whole population. See Utah Dep't of Health, *Making Cents of Utah's Healthy Population*, Utah Atlas of Health Care (Oct. 2010).

All-payer databases also can be used to evaluate the impact of public-education campaigns—such as "the impact of tobacco cessation programs" before and after a public-education effort. Green, Lischko, & Bernstein, *supra*, at 2. Because these databases provide a complete picture of a State's health spending, they can answer questions such as how many people are taking advantage of tobacco-cessation programs following a statewide campaign. *Ibid.* The answers, in turn, can be used to design more effective campaigns by better targeting efforts at those populations that are most in need.

Moreover, these databases can be used to support work on patient safety and preventable health care events. See Rexford, Andrews, & Shipley, *The Power of Data: Consumer Involvement and Accountability for Connecticut's All Payer Claim Database (APCD)* (March 2013). States such as "Massachusetts and Colorado are currently working on developing patient safety and quality reports," using all-payer databases to "identify patient safety problems and patterns to drive improved care." *Id.*, at 14. The Minnesota Department of Health used data from its all-payer database to study the volume and make-up of potentially preventable health care events, by analyzing emergency department visits, hospital admissions, and hospital readmissions. Minn. Dep't Health, *An Introductory Analysis of Potentially Preventable Health Care Events in Minnesota*. And in Colorado, researchers are using all-payer data to study patterns in opioid prescriptions following major surgery, in hopes of increasing "patient safety by finding avenues to optimize non-opioid based [prescription drugs] and to reduce the need for opioid [prescription drugs] for surgical patients following hospital discharge." See Colo. Med. Price Compare Data Showcase, *Identify Opportunities to Reduce Use of Potentially Harmful Medications During and Post Surgery*.

All-payer databases can even measure progress toward reducing "racial and ethnic disparities" in the health care system, by allowing researchers "to stratify analyses across health systems" and "provide evidence for public health and institutional interventions." Rexford, Andrews, & Shipley, *supra*, at 21. Such interventions may include, for example, targeted "outreach communications about preventive services" or comparisons of "the quality of care being provided by various entities serving similar populations." *Ibid.*

Finally, research suggests that patients who take a more active role in their health care decisions have improved health outcomes and experience a higher quality of care than their less-involved counterparts. See Hibbard, Stockard, Mahoney & Tusler, *Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers*, 39 Health Servs. Research 1005 (2004); Hibbard & Greene, *What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs*, 52 Health Affairs 207 (2013). As discussed below, all-payer databases make it possible to create (as some states have) consumer-facing websites that report information about price and outcomes at various health care providers. Through these websites, all-payer claims databases enable patients to engage more deeply in their care decisions, and experience improved outcomes.

B. All-Payer Claims Databases Provide Important Information for Individual Patients and Other Stakeholders

The United States is unique among developed nations, in that our health care market is structured by negotiations between employers, insurers, and health care providers, as to both the services that are covered and the prices that will be paid. See Christine Vestal, *Debating the Value of an All-Payer Claims Database*, MedCity News (June 19, 2014). That, in turn, can lead to significant price variations. *Ibid.* All-payer claims databases—because they contain detailed price information about who is paying what for which sorts of treatments, and under what circumstances—can reveal the causes of such price variation, as well as determine where it is reasonable and where it should be reduced.

Patients—especially those who personally bear a significant share of their health care costs—need reliable sources of information for determining how to spend their health care dollars. Some states, such as Colorado, have created websites that make aggregate all-payer data accessible to individual consumers, so that they can evaluate the range of prices for a given procedure. See *Colorado Medical Price Compare*, http://comedprice.org/. On a more systemic level, the aggregate price data benefits employers in designing benefits, understanding utilization patterns, and forecasting likely costs. The California Public Employees' Retirement System (CalPERS), for example, has used data from claims databases for years, describing it as an "invaluable" tool to assist benefit design and rate negotiation. Patrick Miller, *Why State All-Payer Claims Databases Matter to Employers,* Pension and Benefits Daily, at 3 (June 2012).

Indeed, since at least the 1990s, many "larger, self-funded employers" have been requiring their plan administrators and carriers "to deliver reports and data feeds to the employer or their broker for analysis," which those employers could then use to "drive decisionmaking" about benefit design and to better understand utilization. *Id.*, at 2. All-payer databases offer the same potential, but on a systemic level that goes well beyond a single employer or employer coalition. Information is necessary for any market to function well, and these databases are an essential source of information about health care costs.

C. All-Payer Claims Databases Are Essential as Payment for Health Care Moves from Volume to Value

The American health care system is in a transformative period. During the last century, providers were generally paid on the basis of the number of services they performed, under what is known as a fee-for-service model. As costs have increased and resources have decreased, the system has begun to focus on changing payment systems to reward quality (value) rather than amount (volume).

All-payer claims databases offer promising tools to support this effort. For instance, claims databases can be used to track the efficacy of alternatives to traditional fee-for-service models of providing care. Interest in such models is growing, and the Patient Protection and Affordable Care Act repeatedly makes provision for pilot programs designed to experiment with their efficacy. See, *e.g.*, 42 U.S.C. §1395b-1 ("Incentives for economy while maintaining or improving quality in provision of health services") (directing the creation of "experiments and demonstration projects" to "determine whether, and if so which, changes in methods of payment or reimbursement" could "have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services").

But such programs must be intelligently evaluated to ensure that they do not compromise the quality of care and that they do, in fact, result in decreased costs over the entire system. All-payer databases can be an essential tool for doing so. For example, many states "have implemented patient-centered medical home pilots." Porter, Love, Peters, Sachs, & Costello, *supra*, at 2. Those pilots have then been evaluated, in part, using all-payer claims data. See Evaluation Report: NH Multi-Stakeholder Medical Home Pilot (November 2013), at 3 ("The pilot included preliminary analysis of claims data using the … State's All-Payer Claims Database, to review site performance through claims data").

All-payer databases can be used to answer crucial questions about such pilot programs: Are their patients admitted to hospitals at higher or lower rates? If so, why? Do certain treatments make patients more or less likely to need high-cost interventions later? Is overall patient health maintained? Increased? In the New Hampshire medical home pilot, for example, "sites were able to see blinded comparisons" of cost, utilization, and other data between the pilot and "all other practices in the state." *Id.*, at 7. That sort of information can provide evidence about treatment changes that should be considered, and whether the pilot's model should be expanded to other populations or other disease categories.

III. INCLUDING CLAIMS DATA FROM SELF-INSURED HEALTH PLANS IS ESSENTIAL TO THE EFFECTIVENESS OF ALL-PAYER DATABASES

The public-policy benefits described above are substantial. It is, after all, a rare innovation that presents simultaneous opportunities to improve public health, reduce costs, and increase transparency. To realize those benefits, however, it is essential that claims from self-insured health plans be included in all-payer claims databases.

As to ordinary commercial insurance providers, there is no dispute that states have the authority to collect claims data as needed to make these databases function. ERISA expressly provides that it does not preempt state laws that "regulate[] insurance." 29 U.S.C. §1144. Therefore, employers who contract with insurers (like Blue Cross Blue Shield or Aetna) to provide traditional, fully-funded health insurance for their employees will automatically have their employees' claims data collected. And as to state-run programs like Medicaid, the State is itself the insurer, and therefore already has the claims data it needs.

Since the enactment of ERISA in 1974, however, it has also been possible for an employer to "self-insure"—that is, to "directly fund[] the health benefits for its covered enrollees." Michael Brien & Constantijn Panis, SELF-INSURED HEALTH BENEFIT PLANS 4 (2011). This option may offer potential advantages to employers, such as control "over the design of the benefits program," or "[i]mproved cash flow generated by keeping funds in-house until needed for payment of claims." *Id.*, at 6. An employer who elects to directly fund its enrolled members' health care expenses, however, will likely still find it convenient to use a third-party insurer to administer claims and payments, as Respondent here did. Liberty Mutual hired "claims administrators" to "process the claims and manage the health care provider networks," which administrators were (depending on the State the employee lived in)

"Aetna or Blue Cross Blue Shield of Massachusetts." JA 113 (excerpt from Summary Plan Description).

State all-payer databases "typically … collect data on all residents, for both fully insured and self-funded lines of business." Miller, *supra*, at 1. See, *e.g.*, 10 Colo. Code Regs. §2505-5:1.200.1 (including, in the definition of "private health care payer," "a self-insured employer-sponsored health plan"); Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01, §3(X) (defining "health insurer" to include "any administrator of an insured, self-insured, or publicly funded health care benefit plan"). That is essential for the long-term success of all-payer databases, for several reasons.

First, self-insured plans cover a large and growing share of the working population. In 1998, 40.9% of workers with health insurance were covered by self-insured plans. See Paul Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size, 1996–2013*, 36 Employee Benefit Research Institute at 7 (2015). By 2002, that number had grown to 50.2%. *Ibid.* By 2006, it had grown to 52.8%. And in 2013, 58.2% of workers with health insurance—nearly six in ten—were covered by self-insured plans. This trend is expected to continue for many reasons, not the least of which is that "that passage of the Patient Protection and Affordable Care Act of 2010" has made "self-insurance … a more attractive means to mitigate any expected regulatory cost increases." *Id.*, at 2.

Even those rather substantial figures do not tell the whole tale. Large employers are especially likely to be self-insurers: 83.9% of employers with more than 500 employees self-insure at least one of their health plans, up from 66.2% in 1999. *Id.*, at 4. And in some communities, these numbers are even higher. In Indiana and Nevada, for example, more than 70% of workers with health insurance are covered by self-insured plans. *Id.*, at 9. In Illinois, over 92% of workers at large firms (those with more than 1,000 employees) were enrolled in self-insured plans. *Ibid.* In Vermont, the comparable figure is 90.9%. *Ibid.* An all-payer database that excludes workers in self-insured plans is therefore excluding a majority of the working population, sometimes a supermajority, and is therefore substantially compromised in its capacity to realize the benefits to health, transparency, and cost control described above.

Moreover, different industries self-insure at different rates. Whereas only around 20% of employers in the construction industry and agriculture industry offer a self-insured plan, for example, over 55% of retail employers do. *Id.*, at 4. To the extent that construction workers have different health care needs than retail workers, excluding self-insured claims from these databases will skew the picture painted of the population, by over-counting workers in industries that tend not to self-insure and under-counting those that do. Excluding the self-insured population will also mean that the population in all-payer claims databases will be, on the whole, older, lower income, and less healthy—because it will cause the share of claims information provided from Medicaid and Medicare to grow. That, in turn, will skew the information in ways that will make the databases less useful: it is much harder to draw conclusions about public health or cost savings without data about the health and costs of most working people.

Including claims data from self-insured plans is not, however, burdensome to the employers. Indeed, it may be completely invisible to them. That is because self-insurers typically "do not manage the claims filed under their self-insured plan themselves; instead they enter into 'administrative services only' contracts with insurers or other claims managers to process claims, resolve disputes, negotiate payment rates, and contract with provider networks." Timothy Jost & Mark Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 NYU Annual Survey of American Law 539, 546 (2013). See also Brien & Panis, *supra*, at 4 (duties of a third-party administrator include "resolving disputes, negotiating payment rates, and performing other administrative duties"). That arrangement is common-sense enough: few employers are interested in getting into the business of directly handling their employees' health insurance claims or negotiating rates with providers. Even if the employer is ultimately *paying* the claims by self-insuring, it is often worthwhile to contract for those administrative functions with an outside insurer.

But as a consequence, the distinction "between fully-insured [plans] and self-insured [plans] is not a sharp one." *Ibid.* Indeed, to an employee, "the distinction between an insured plan and a self-insured plan administered by an insurer is invisible." Jost & Hall, *supra*, at 546. They file "their claims with an insurer that pays or denies their claims, sends them an explanation of benefits, and handles any appeals from claim denials." *Ibid.* Respondent here, for example, designated "Blue Cross Blue Shield of Massachusetts" as the "Plan's third party administrator," in which capacity it "administer[ed] the medical claims and associated confidential medical records of Plan participants and beneficiaries." JA 15.

This arrangement means that it is no burden on self-insurers at all to produce claims data, because their third-party administrator will simply produce it along with all other claims data. The subpoena at issue in this case was not even directed to Liberty Mutual—it was directed to Blue Cross Blue Shield of Massachusetts. JA 21–24. It is not, in other words, that Respondent does not want to assemble and produce the requested data. What it wants is to instruct Blue Cross Blue Shield of Massachusetts, an entity that already produces claims data regularly in its capacity as an ordinary insurance company, *not* to produce information that it already has on file regarding Respondent's employees. See JA 22 ("Liberty Mutual would continue to instruct [Blue Cross Blue Shield of Massachusetts] not to report the claims data").

Even if an employer did not use a third-party administrator for its self-funded plan, the use of nationally standardized codes and formats would make producing the claims data a minimal (or no) burden. Vermont, for example, uses standardized codes from the National Uniform Billing Data Element Specifications, Physicians' Current Procedural Terminology (CPT) Manual, Health Care Common Procedural Coding System, the Centers for

Medicare and Medicaid Services National Provider Identifiers, the National Association of Boards of Pharmacy Database and Listings, and other well-documented, standard data formats, which are in many cases likely to be the format in which claims data is already being generated. See Vermont Dep't of Banking, Insurance, Securities, and Health Care Administration, Regulation H-2008-01, Appendix A. Vermont's regulation also sets out in detail a standardized data format in which claims data is to be produced to the State, using those standardized codes, along with detailed explanations of how Vermont's submission format corresponds to the national standards. *Id.*, at Appendices B1–E2.

In recognizing the value of standardized coding for data submissions, Vermont is not alone. The APCD Council (an all-payer database advocacy group) has issued recommendations regarding standardization of data collection in all-payer claims databases, to encourage "states collecting the same data [to] do so in the same manner." Costello & Taylor, *Standardization of Data Collection in All-Payer Claims Databases*, APCD Council (Jan. 2011). The APCD Council has also promulgated a suggested core set of data elements along with suggested implementation guides. See APCD Medical Data Reporting: Proposed Core Set of Data Elements for Data Submission (Oct. 2011), available at http://www.apcdcouncil.org/sites/apcdcouncil.org/files/media/apcd_council_core_data_elements_5-10-12.pdf. The clear trend, in other words, is toward national standardization, such that the ease of data submission over time is likely to grow.

Self-insured plans cover a large, growing, and distinctive portion of the population. It is essential that they be included in all-payer databases if those databases are to realize their potential, and if America's hospitals are to realize their goal of improving community health and controlling costs while providing the high-quality care for which they are known. This Court should not interpret federal law in a way that would hamper that effort.

CONCLUSION

For the foregoing reasons, the judgment of the Second Circuit should be reversed.

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