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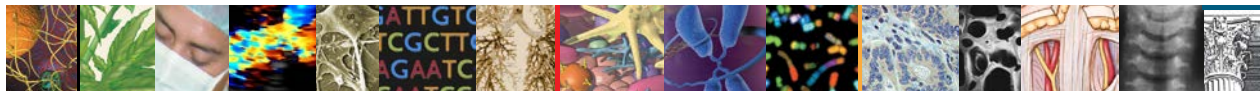


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Perspective

Transparency and the Supreme Court — Can Employers Refuse to Disclose How Much They Pay for Health Care?

Nicholas Bagley, J.D., and Christopher Koller, M.P.P.M., M.A.R.

For decades, the prices that hospitals and physicians charge private insurers have been treated as trade secrets. Even though inflated prices are an enormous reason why health care is so much more

expensive in the United States than in other countries, we have only a hazy picture of what those prices actually are.¹

Over the past decade, however, 18 states have embraced a new approach to revealing and clarifying the pricing practices of the health care industry. They have created “all-payer claims databases” in which they compile information on the prices that all insurers, public and private, pay for medical care. Although the databases vary in their particulars, they all share a market-oriented goal: greater transparency with regard to the prices that drive

health care spending. Depending on local policies, that transparency can serve any number of purposes. It can aid state regulators in fashioning new payment models, help researchers better understand the effects of payment and benefits policies, and enable people with high-deductible health plans to comparison shop.

An impending Supreme Court case, *Gobeille v. Liberty Mutual*, however, threatens to cripple these databases and other state initiatives that aim to improve the health care system. *Gobeille* involves the Employee Retirement Income Security Act (ERISA), a

complex federal statute that regulates employee benefit plans. Among other things, the statute sets minimum funding requirements for pension plans, obliges plan administrators to act in employees’ best interests, and requires employers to provide their employees with information about their benefits.

In exchange for imposing these rules, the statute exempts employers from state laws that “relate to” employee benefit plans. Because most Americans receive health insurance through their jobs, employers use ERISA as a shield to prevent the states from telling them how to structure their employees’ health plans. In the early 1980s, for example, New York told employers that they had to provide the same benefits to pregnant women as they did to

employees who face similar physical limitations on the job. When Delta Airlines sued under ERISA, the Supreme Court held that it could ignore New York's antidiscrimination law.²

In *Gobeille*, Liberty Mutual adopted Delta's approach. Under Vermont law, the details of what employers and insurers pay for health care must be reported to the state's all-payer claims database. In its role as an employer, Liberty Mutual objected, saying that the state reporting law relates to its employee benefit plan and is thus preempted.

A federal appeals court agreed with Liberty Mutual. As the court saw it, the Vermont law "related to" Liberty Mutual's health plan because it required employers to report certain information to the state. Particularly because Vermont's "burdensome, time-consuming, and risky" reporting provisions overlapped with ERISA rules governing disclosure, the Vermont law had to give way.

If the Supreme Court agrees with that analysis, employers nationwide that self-insure — in other words, pay directly for their employees' health care rather than buying insurance — will not have to report anything to the states. Because 63% of employees nationwide receive coverage through firms that self-insure and are unlikely to voluntarily assume the burden of self-reporting, ERISA would deprive these databases of much of the data that they need.³

Worse, the decision could interfere with other innovative efforts to reduce costs and improve quality. Take health information exchanges, for example. These exchanges enable the sharing of clinical information among health care providers so that, for in-

stance, emergency department personnel have access to a patient's medical records and claims history when the patient arrives in the department. Although some of these exchanges are private provider-to-provider efforts, others are organized under state auspices. These state-sponsored exchanges depend on the participation of all of the insurers and employers that pay for health care in the state — both to submit information and to help finance them. If self-insured employers can opt out, these new exchanges could founder.

Similarly, health departments in 15 states now take advantage of government discounts to purchase vaccines, in a program created in 1994. They then distribute those vaccines to primary care practitioners and bill their patients' insurers for the costs. Does this administrative practice — which includes patients enrolled in self-insured plans and makes us all safer — "relate to" an employer's health plan? If so, is it also preempted?

Finally, 17 states are attempting to align payment mechanisms across payers in an effort to create economic incentives for primary care practitioners to improve quality and reduce costs. All their patients and those who pay for the patients' care will eventually benefit from these improvements, but there are some up-front costs. If self-insured employers can refuse to cooperate, they can take a pass on contributing their fair share.

Fortunately, Liberty Mutual's argument appears weak. The Supreme Court has repeatedly emphasized that the scope of ERISA's "relate to" provision must be kept within reasonable bounds. Otherwise, ERISA could

undo nearly any state law, "since, as many a curbstone philosopher has observed, everything is related to everything else."⁴

No one thinks that ERISA preempts state tax laws, state property laws, or state health-and-safety laws. Although many such laws require employers to report information to the state, they do not tell employers what benefits to offer or how they must structure their benefit plans. They are instead laws of general application that leave employers free to offer (or not offer) whatever benefits they like on whatever terms they like. And as the Supreme Court has emphasized, "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."⁵

So, too, with Vermont's reporting requirement. It has nothing to do with structuring a health plan. It just asks employers — really, the third-party administrators who manage employer health plans — to share information about prices and utilization. If that modest requirement is unlawful, then most reporting requirements that touch on employee benefit plans will also be unlawful. Employers can operate day-care centers, for example. Does ERISA really prevent the states from requiring those centers to report information about staff qualifications and class size?

The Court will hear argument in *Gobeille* on December 2. If it sides with Liberty Mutual, its decision will not only thwart state efforts to shed some badly needed light on the byzantine way medical services are priced, but it will also circumscribe states' authority to experiment with new

approaches to overseeing their health care markets. In the wake of an adverse decision, individual states would be left to negotiate with national self-insured companies, most of whom would see no compelling reason to accommodate the states' varied requests when they can reap the benefits of any successful local efforts without participating.

The case's significance thus extends well beyond states' authority to regulate group health insurance. In the final estimation, improving population health de-

pends on collective, local efforts to help people stay healthy and get high-value, patient-centered care. Allowing large firms to exempt themselves will undermine those collective efforts at a time when they are sorely needed. Given the political dysfunction in Washington, now would be an especially inauspicious moment to sideline the states.

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