Morgan Lewis

MEMORANDUM

TO:	James Gelfand The ERISA Industry Committee ("ERIC")
FROM:	John G. Ferreira Morgan, Lewis & Bockius LLP
DATE:	February 5, 2021
SUBJECT:	ERISA Preemption Analysis of the Proposed Amendments to Georgia All-Payer Claims Database Statute

I. INTRODUCTION

As requested, we conducted an analysis of arguments that could be made that amendments to the Georgia All-Payer Claims Database Statute proposed as Georgia SB 1 (2021) ("GAPCD Amendments" or the "Amendments") are preempted by Section 514 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1144, and the likely success of those arguments in light of existing precedent. As explained below, in our view, there is a significant likelihood that the GAPCD Amendments are preempted by ERISA.

II. SYNOPSIS OF ANALYSIS

The GAPCD Amendments would clearly be preempted by ERISA if they mandated participation in the Georgia All-Claims Payer Database ("GAPCD") by self-insured health plans and their sponsoring employers, because such a state mandate was specifically held by the Supreme Court to be preempted by ERISA in *Gobeille v. Liberty Mutual Insurance Company*, 136 S.Ct. 936 (2016). The only possible basis on which the Amendments could be upheld in the face of *Gobeille* is that the Amendments do not mandate participation in the GAPCD; rather, they allow employers that sponsor self-insured health plans the choice between participation in the GAPCD and forfeiting a variety of tax credits provided by Georgia to businesses that are headquartered in or otherwise do business in the state. However, as several courts have held, a state or local statute or ordinance that effectively coerces an employer to take an action that the state or municipality would not otherwise be permitted to mandate directly will also be deemed to be preempted by ERISA. The Amendments would impose a heavy financial burden on Georgia employers that have taken actions and incurred expenses in reliance on the ability to qualify for various tax credits provided by the state; that coercive effect makes the Amendments the functional equivalent of a mandate that they participate in the GAPCD, and that mandate, as noted, would clearly be preempted by ERISA, under *Gobeille*.

III. LEGAL BACKGROUND

A. Gobeille.

As noted, the Supreme Court in *Gobeille* was asked to rule on whether a Vermont statute that mandated participation by self-insured group health plans in a Vermont all-claims payer database was preempted by ERISA. In a 6-2 decision (Justices Ginsburg and Sotomayor dissenting), the Court held that the Vermont statute was preempted by ERISA. The Court noted that ERISA establishes a

comprehensive federal regime for employee benefit plans, including group medical plans, for reporting and disclosure, including extensive requirements administered by the Department of Labor ("DOL") for group medical plans to provide data and information regarding their claims administration to the DOL. As the majority opinion noted, one of the core objectives of ERISA's provisions preempting state laws that "relate to" employee benefits plans is to allow for uniform federal regulation of such plans, which often operate in multiple states, and to avoid a patchwork of potentially inconsistent and duplicative state regulation:

> Vermont's reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon "a central matter of plan administration" and "interferes with nationally uniform plan administration." *Egelhoff,* 532 U.S., at 148, 121 S.Ct. 1322. The State's law and regulation govern plan reporting, disclosure,and—by necessary implication—recordkeeping. These matters are fundamental components of ERISA's regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability. See, *e.g.,* 18 V.S.A. § 9410(g) (supplying penalties for violation of Vermont's reporting rules); CVR § 10 (same). Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.

Gobeille, 136 S.Ct. at 945. As the court noted, compliance with the Vermont statute was not voluntary on the part of self-insured medical plans; rather, employers and administrators of self-insured plans that did not comply were potentially subject to monetary penalties imposed by the state of Vermont. On that basis, the Court held that the Vermont statute was preempted by ERISA.

B. The GAPCD and the Proposed Amendments.

In August of 2020, Chapter 53 of Title 31 of the Official Code of Georgia Annotated, relating to the Office of Health Strategy and Coordination, was amended to add a new Article 3, which provided for the creation of a state all-claims payer database. The statute provides that the GAPCD would begin operating on January 1, 2023. Notably, in recognition of the preemptive effect of ERISA following the *Gobeille* decision, the statue provides for voluntary participation by self-insured group medical plans:

> Self-funded employer sponsored plans may **voluntarily** submit monthly claims data to the GAPCD when the employer has opted in writing to the submission of the data. The carrier or administrator shall notify the employer of the employer's option to authorize the submission of the data.

Title 31, Chapter 53, Article 3, Section 31-53-47(c) (emphasis added). By contrast, insurers and other "submitting entities" that are not self-insured plans may be subject to monetary penalties of up to $1000 a day for failure to comply with the APCD's requirements. Title 31, Chapter 53, Article 3, Section 31-53-50(a).

The Amendments would amend Title 31, Chapter 53, Article 3 to provide that employers that sponsor self-insured medical plans that do not agree to submit the requested data to the GAPCD will lose the benefit of a laundry list of tax credits provided to Georgia businesses effective January 1, 2022.[1]

[1] The credits that would be lost include: Georgia Agribusiness and Rural Jobs Act; tax credit for qualified low-income building; income tax credit for clean energy property; tax credits for certain business enterprises in less developed areas; tax credits for existing manufacturing and telecommunications facilities; tax credits for employers providing approved retraining programs; tax credits for employers providing child care; tax credit for qualified research expenses; alternative tax credits for base year port traffic increases; establishing or relocating quality jobs tax credit; tax credit for businesses headquartered in state; tax credits for existing business enterprises undergoing qualified business expansion; credit to

Depending on the specific circumstances, an employer that sponsors a self-insured medical plan could lose millions of dollars of tax credits annually if it does not elect to participate in the GAPCD – a financial burden that could be just as significant, or perhaps even much more significant, than any fines or penalties levied on submitting entities that are subject to a mandate to participate in the GAPCD. In many cases, a Georgia company that sponsors a self-insured group medical plan may have already incurred significant expenses in reliance on receiving these credits, e.g., to locate its headquarters in Georgia, or to locate facilities in Georgia that have created jobs for Georgia residents. Those employers will effectively be forced to participate in the GAPCD in order not to lose the tax credits on which they relied in incurring those expenses.

IV. ANALYSIS

As noted, the only basis on which the Amendments can escape ERISA preemption is that they make participation in the GAPCD "voluntary" – that is, that employers that sponsor self-insured group medical plans can simply decide not to participate and instead to forego the various tax credits listed in the Amendments. However, as a number of federal courts have recognized, where a state or local statute or ordinance that would otherwise be preempted by ERISA, but is alleged to be "voluntary," has a substantial coercive effect on an employer that sponsors an ERISA plan, that statute or ordinance will be treated as substantively no different than a direct mandate and will also be preempted.

The most notable example of such a case is *Air Transport Ass'n of America v. City and County of San Francisco*, 992 F. Supp. 1149 (N.D. Cal. 1998). This case involved a San Francisco ordinance that required employers that do business with the city and county of San Francisco to provide their employees' domestic partners with benefits comparable to those provided to spouses, including benefits under self-insured ERISA plans. The Air Transportation Association of America ("ATA") brought a challenge on behalf of its various airline company members to the application of the ordinance to self-insured ERISA plans. San Francisco argued that the ordinance was not preempted because it did not involve a mandate; rather, San Francisco was just exercising its right as a "market participant" to choose with whom it did business, and employers could simply choose not to do business with San Francisco if they were unwilling to comply. However, the ATA argued successfully that the inability of airlines to be able to fly into and out of San Francisco Airport was such a significant burden on their ability to maintain their passenger and cargo businesses in northern California that it amounted to a mandate. The District Court noted that the Supreme Court, in its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), had specifically stated that an statute or ordinance could be preempted by ERISA, even if not a direct mandate, if it had a sufficient coercive effect:

> [W]e do not hold today that ERISA preempts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted.

Travelers, 514 U.S. at 668 (citations omitted). The District Court held that since San Francisco effectively had a monopoly on airlines' access to the city and much of northern California, it was not

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business enterprises for leased motor vehicles and ridership; conditions for taking job tax credit by business enterprises; conditions for credit for business enterprises with existing manufacturing facilities; tax credit for film, gaming, video, or digital production in state; tax credit for postproduction expenditures; income tax credit for certain qualified investments; revitalization zone tax credits; tax credits for musical or theatrical performances; tax credit for Class III railroads; and credit for qualified employers.

acting merely as an ordinary consumer in requiring the provision of domestic partner benefits, but rather as a regulator, and therefore the ordinance was preempted as applied to ERISA plans:

> With respect to benefits that are covered by ERISA and provided through ERISA plans, such as family medical and bereavement leave paid from accumulated funds and health and pension benefits, the Ordinance is preempted as applied to ERISA plans if the City is exercising more economic power than an ordinary consumer could exercise. Because the City always exercises such power in its role as proprietor of the Airport, the Ordinance as applied to Airport contracts is entirely preempted insofar as it affects ERISA plans providing ERISA benefits.
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> *Air Transport Ass'n of America,* 992 F.Supp. at 1180.

The U.S. Court of Appeals for the Fourth Circuit applied a similar analysis in holding a Maryland statute to be preempted. Specifically, in *Retail Indus. Leaders Ass' v. Fielder*, 475 F.3d 180 (4th Cir. 2007), a Maryland law required employers to increase healthcare contributions for their employees or pay Maryland the difference between the required contribution and the employers' current contribution. Maryland argued that the statute was not preempted as applied to self-insured medical plans because it did not mandate that employers provide any particular level of benefits under the plan; rather, employers had a choice between increasing their contribution to their benefit plan or paying money to the state. However, the Fourth Circuit found that this presented employers with a false choice, because paying the State did not benefit the employees or employer; the only rational choice for an employer subject to the Maryland law would be to increase contributions to its ERISA plan. As such, the Fourth Circuit held that the Maryland law related to an employee benefit plan and was preempted by ERISA:

> At its heart, the Fair Share Act requires every employer of 10,000 or more Maryland employees to pay to the State an amount that equals the difference between what the employer spends on "health insurance costs" (which includes any costs "to provide health benefits") and 8% of its payroll. Md.Code Ann., Lab. & Empl. §§ 8.5-101, 8.5-104. As Wal-Mart noted by way of affidavit, it would not pay the State a sum of money that it could instead spend on its employees' healthcare. This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation. In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under Shaw's prohibition of state mandates on how employers structure their ERISA plans. See Shaw, 463 U.S. at 96-97, 103 S.Ct. 2890. Because the Fair Share Act effectively mandates that employers structure their employee healthcare plans to provide a certain level of benefits, the Act has an obvious "connection with" employee benefit plans and so is preempted by ERISA.

475 F. 3d at 193-194. The Amendments would have a similar effect. While ostensibly making participation in the GAPCD voluntary, the substantial financial penalty that employers would suffer from the loss of tax credits, with no concomitant benefit to the employer or its employees, would compel "any reasonable employer" to participate; thus, the Amendments would constitute a regulatory mandate clearly preempted by ERISA.

Incidentally, the Supreme Court's recent decision in *Rutledge v. Pharmaceutical Care Management Association*, No. 18-540 (slip op. December 10, 2020) does not detract in any way from the conclusions above. The Court held in that case that the Arkansas statute in question, which regulated the price at which pharmacy benefit managers reimburse pharmacies for the cost of drugs covered by prescription-drug plans, was not preempted by ERISA because it "has neither an impermissible connection with nor reference to ERISA." Slip op. at 1. The Court in that case did not suggest that it was overruling or limiting its holding in *Gobeille* in any way; to the contrary, it specifically cited *Gobeille* with approval:

> A state law may also be subject to pre-emption if "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." Gobeille, 577 U. S., at 320 (internal quotation marks omitted). As a shorthand for these considerations, this Court asks whether a state law "governs a central matter of plan administration or interferes with nationally uniform plan administration." Ibid. (internal quotation marks and ellipsis omitted). If it does, it is pre-empted.

Rutledge, slip op. at 5. The Court distinguished *Gobeille* and similar cases by holding that the Arkansas statute only indirectly affected the costs that ERISA plans pay for drugs and therefore did not have "an impermissible connection" to ERISA employee benefit plans. The Court also held that because the Arkansas statute only regulated the relationship between PBMs and pharmacies, it did not "refer to" ERISA, again citing *Gobeille* with approval: "A law refers to ERISA if it 'acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation.' Gobeille, 577 U. S., at 319–320 (quoting Dillingham, 519 U. S., at 325; ellipsis omitted)." By contrast, consistent with the Court's holding in *Gobeille*, the Amendments would directly impact self-funded ERISA plans' administration by imposing a state-mandated reporting scheme on them that is inconsistent with ERISA's regulations, and the Amendments act "immediately and exclusively on ERISA plans." Therefore, the Amendments are clearly distinguishable from the Arkansas statute at issue in *Rutledge*, and are just as clearly indistinguishable from the Vermont statute held to be preempted in *Gobeille*, which, as noted, remains good law after *Rutledge*.

V. CONCLUSION

As noted, there are strong arguments in favor of preemption of the Amendments as applied to self-insured ERISA plans. In particular, given that the original statute made participation voluntary, it is clear that the entire purpose of the Amendments is to change that aspect of the law and to compel participation by self-insured plans, and that would almost certainly be the effect of the Amendments if enacted. Rather than incur the significant risk of a successful court challenge of the Amendments if enacted, it would seemingly make much more sense for Georgia simply to wait until the Department of Labor implements a standardized national all-payer claims format, with access to claims data and information on that format being made available to all states.[2]

[2] See the Consolidated Appropriations Act of 2021, H.R. 133, Section 735 (providing that "not later than 1 year after the date of enactment of this section, the Secretary shall establish (and periodically update) a standardized reporting format for the voluntary reporting, by group health plans to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans in the standardized reporting format").