No. 16-

IN THE

Supreme Court of the United States

SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Petitioner,

v.

RICK SNYDER, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE STATE OF MICHIGAN; R. KEVIN CLINTON, IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE OFFICE OF FINANCIAL AND INSURANCE REGULATION OF THE STATE OF MICHIGAN; AND ANDREW DILLON, IN HIS OFFICIAL CAPACITY AS TREASURER OF THE STATE OF MICHIGAN

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." A 2011 Michigan Act imposes a tax on ERISA Plan Administrators equal to a percentage of payments they make for healthcare services rendered to the covered Michigan residents in Michigan. To administer this tax, Michigan imposes a bevy of recordkeeping and reporting requirements on ERISA plans. Petitioner's challenge to the constitutionality of this tax regime under the express preemption provisions of ERISA § 514(a) was rejected initially by the Sixth Circuit in 2014. In the Circuit Court's view, the Michigan tax did not "relate to any [ERISA] benefit plan" because it did not directly regulate plan administration and imposed on ERISA plans only reporting and recordkeeping obligations "ancillary" or "incidental" to the State's taxation scheme. Petitioner sought *certiorari* in this Court. After its decision in *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) ("*Gobeille*"), the Court granted Petitioner's petition, vacated the decision below and remanded for further consideration in light of *Gobeille*. On remand, the Sixth Circuit essentially reinstated its vacated opinion by relying on a strong presumption against preemption of state tax laws and limiting § 514(a) preemption to state interference with the "*administration of employee benefit plans*" (emphasis in original). It distinguished *Gobeille* as addressing "only direct regulations of fundamental [plan] functions" and relied on this Court's passing mention in *Gobeille* of *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997) ("*De Buono*") to uphold

what it deemed to be Michigan's "incidental reporting and record keeping" demands on ERISA plans. The questions now presented are:

1. Whether the Sixth Circuit's determination that the Michigan tax, including its reporting and recordkeeping obligations, does not "relate to" employee benefit plans and is not preempted by ERISA § 514(a) conflicts with *Gobeille* and other decisions of this Court; and

2. Whether the Sixth Circuit's constricted reading of *Gobeille* and the increasing tendency of States to impose onerous new financial and administrative requirements on ERISA plans requires this Court to further elaborate *Gobeille's* teaching.

PARTIES TO THE PROCEEDING

Petitioner Self-Insurance Institute of America, Inc. was the plaintiff-appellant in the court of appeals. Respondents Rick Snyder, in his official capacity as Governor of the State of Michigan; R. Kevin Clinton, in his official capacity as Director of the Office of Financial and Insurance Regulation of the State of Michigan; and Andrew Dillon, in his official capacity as Treasurer of the State of Michigan, were the defendants-appellees in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

Self-Insurance Institute of America, Inc. is a not-for-profit trade association that is organized as a corporation under the laws of California. SIIA has no parent and no publicly held company owns more than 10% of its stock.

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Petitioner Self-Insurance Institute of America, Inc. ("SIIA") respectfully submits this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit (App. 1a–18a) is reported at 827 F.3d 549 (6th Cir. 2016). The order of the Supreme Court granting a writ of certiorari, vacating the judgment and remanding the case to the Sixth Circuit is reported at 136 S. Ct. 1355 (2016). The original opinion of the Sixth Circuit (App. 19a–38a) is reported at 761 F.3d 631 (6th Cir. 2014). The decision of the United States District Court for the Eastern District of Michigan (App. 39a–62a) is not reported, but is available at No. 11-15602, 2012 WL 3888212 (E.D. Mich. Sept. 7, 2012).

JURISDICTION

The judgment of the court of appeals was entered on July 1, 2016. App. 18a. Petitioner's application to extend the time to file the petition for certiorari to and including October 29, 2016 was granted by Justice Kagan on September 13, 2016. Order, No. 16A260 (U.S. Sept. 13, 2016). This Court has jurisdiction under 28 U.S.C. § 1254(1). The jurisdiction of the district court was invoked under 28 U.S.C. § 1331.

PERTINENT CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS

The Supremacy Clause provides in relevant part: "[T]he laws of the United States . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. art. VI, cl. 2.

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), provides in part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Pertinent provisions of the Michigan Health Insurance Claims Assessment Act, Mich. Comp. Laws §§ 550.1731 *et seq.* (the "Michigan Act" or the "Act") and its implementing regulations, Mich. Admin. Code r. 550.402–550.404, are reproduced at App. 63a–80a.

STATEMENT OF THE CASE

I. Background

ERISA comprehensively regulates employee benefit plans nationwide, encouraging employers to establish

pension and welfare benefit plans voluntarily. ERISA streamlines and economizes plan administration and preempts state regulatory incursions to avoid the conflicts and expense that would result if ERISA plans were subject to burdens under a multiplicity of state laws. *See, e.g.*, *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656–57 (1995) ("Travelers"); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). The preemption of "relate[d]" state laws is not confined to state laws that directly regulate ERISA plans. Instead, Section 514(a) broadly applies whenever "the effect of the state law on ERISA plans" is incompatible with the federally protected sphere, *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (internal citations omitted). As this Court has observed, a fundamental goal of ERISA is "nationally uniform plan administration," and "[u]niformity is impossible . . . if plans are subject to different legal obligations in different states." *Id.* at 148.

ERISA requires all welfare benefit plans, including health plans that provide medical, dental and vision coverage, to designate a plan administrator. *See* 29 U.S.C. § 1102; 29 C.F.R. § 2509.75-8 (plans must "have at least one named fiduciary who serves as plan administrator"). For self-insured plans that require the payment of benefits by employers or employees, the administrator may be an in-house entity that handles claim-processing, payment and recordkeeping functions or a third party contracted for that purpose. *See* 29 C.F.R. § 2510.3-16. In either case, the duties federally imposed on the designated administrator are comprehensively set forth in ERISA. *See, e.g.*, 29 U.S.C. § 1021 (requiring plan administrators to provide plan descriptions to participants and file annual, terminal and supplementary reports with the Secretary

of Labor); *id.* § 1023 (requiring plan administrators to file detailed financial and actuarial statements, opinions prepared by independent accountants and actuaries, and additional information pertaining to covered plans). In the performance of their responsibilities, ERISA administrators necessarily collect large quantities of data relating to healthcare claims and direct substantial payment streams using plan assets. The performance of these federally mandated functions make ERISA administrators inviting targets for states seeking to obtain claims information for their own purposes or, as here, to tap payment streams as a means of taxing healthcare payments efficiently.[1]

1. Nationwide, 63% of employees with health benefits provided through their employer or union are enrolled in self-insured plans covered by ERISA. Kaiser Family Found. & Health Research & Educational Trust, *2015 Annual Survey: Plan Funding*, at 174, *available at* http://files.kff.org/attachment/report-2015-employer-health-benefits-survey. This figure is even greater for large companies which often have employees in multiple states. Thus, in 2015, 82% of the employees who worked for companies with more than 1,000 but less than 5,000 employees, and 94% of the employees who worked for companies with more than 5,000 employees, were enrolled in self-insured plans. *Id.* Consistent with these figures, the dollar value of the claim payment streams that pass through self-insured healthcare plans is substantial, totaling more than $48 billion annually. *See* Thomas E. Perez, Sec'y, U.S. Dep't. of Labor, Report to Congress: Annual Report on Self-Insured Group Health Plans 3 (2014) (reporting 2011 estimates) *available at* http://www.dol.gov/ebsa/pdf/ACAReportToCongress2014.pdf.

II. The Michigan Health Insurance Claims Assessment Act

In 2011, the State of Michigan feared that the federal government would disapprove its reliance upon a 6% use tax imposed directly on Medicaid-contracted and specialty prepaid health plans to fund the State's expanded Medicaid obligations. In response, the State abandoned the use tax and enacted the Health Insurance Claims Assessment Act, Public Act 142, Mich. Comp. Laws §§ 550.1731 *et seq.* (the "Michigan Act" or the "Act").[2] Instead of imposing the tax directly on healthcare providers, the Michigan Act imposes a tax (originally 1%, now .75%[3]) on the value of paid claims for healthcare services rendered in Michigan to Michigan residents, coupled with extensive reporting and recordkeeping requirements. The regime is designed to generate $400 million in annual revenues for use in funding Michigan's

2. According to a legislative analysis of the Michigan Act, the new law was occasioned by "an anticipated action by the federal Centers for Medicare and Medicaid offices to disallow the Use Tax as a means to generate State revenue to be used as a match for federal Medicaid funds. The health insurance paid claims tax is a broad-based tax which should satisfy the federal government as a replacement for the current Use Tax model." Mary Ann Cleary, Dir., House Fiscal Agency, Legislative Analysis: Health Insurance Claims Assessment 1 (Mich. 2011), *available at* http://www.legislature.mi.gov/documents/2011-2012/billanalysis/house/pdf/2011-HLA-0347-3.PDF (last visited Oct. 18, 2016). A similar Oklahoma law that was passed in 2010, *see* 36 Okla. Stat. §§ 7201-7204, 7301, was subsequently invalidated on state constitutional grounds in *Holland v. State ex rel. Oklahoma Health Care Authority,* 240 P.3d 665 (Okla. 2010).

3. *See id.* § 550.1733(3)(1).

share of its Medicaid program. *Id.* § 550.1733(6).[4] The Act requires ERISA plan administrators and insurance carriers to calculate the value of claims paid to Michigan providers on behalf of Michigan residents pursuant to the State's tabulation rules, remit the tax, file quarterly and annual returns that are subject to audit by the State, and determine in turn how (if at all) to seek reimbursement of the tax from others. *Id.* § 550.1733(1); *see also id.* § 550.1732(s) (definition of "paid claims"); Form 4930, Quarterly Worksheet for Michigan Health Insurance Claims Assessment, App. 81a. (foldout).[5]

The Sixth Circuit adopted a narrow purpose-based view of ERISA preemption and concluded that, because the core purpose of the Act is to "generate the revenue necessary to fund Michigan's obligations under Medicaid," the Act's effect on ERISA plans is only "peripheral." App. 13a. However, the Act is hardly an incidental, *de minimis*

4. As of July 2014, with the exception of Alaska, every state and the District of Columbia impose a Medicaid-related provider tax or fee. *See Health Provider & Industry State Taxes & Fees*, National Conference of State Legislatures (July 10, 2014) (describing the entities that state laws target for taxation), *available at* http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx.

5. If an ERISA plan "uses the services of a third party administrator or excess loss or stop loss insurer," the Act provides that the tax must be paid and the return must be filed by the administrator or insurer that paid the claim that gave rise to the assessment. Mich. Comp. Laws § 550.1733(3); *see also id.* § 550.1734(1). For purposes of an ERISA preemption analysis, it makes no difference whether the challenged state law affects covered plans, their third party administrators, or both. *See, e.g.*, *Travelers,* 514 U.S. at 659.

burden on the responsibilities of ERISA administrators. For example, the Act requires plans and administrators to:

- determine whether plan beneficiaries are Michigan residents under Michigan law, Mich. Comp. Laws § 550.1732(s)(iv);

- determine whether the medical provider to whom payment was made rendered the services "out of state," *id.*;

- "develop and implement a[n unspecified] methodology" to collect the tax "from an individual, employer, or group health plan" subject to criteria set forth in the Act, *id.* § 550.1733a(2), including criteria that exempt certain types of claim payments from the tax, *id.* § 550.1732(s)(i)–(ix);

- file quarterly tax returns and "an annual reconciliation return," *id.* § 550.1734(1); *Taxes: Frequently Asked Questions,* Michigan Dep't of Treasury (2014), http://www.michigan.gov/taxes/0,4676,7-238-43519_43542-389419--,00.html (last visited Oct. 27, 2016);

- make payments to the State together with the quarterly returns regardless of whether, in the ordinary course, the reporting entity maintains its own bank account or source of funds, Mich. Comp. Laws § 550.1734(1);

- maintain detailed records for at least four years after the tax is due, *id.* § 550.1735(1); and

- submit to audits at the State's discretion, *id.* § 550.1735(2); Mich. Admin. Code R. 550.403.

See generally App. 63a–80a. Compliance with the foregoing mandates imposes substantial costs on plan sponsors and raises a host of administrative burdens that, as exemplified below, are clear on the face of the Act and the implementing guidance that has been promulgated by the Michigan Department of Revenue.[6]

1. Michigan requires an ERISA plan administrator to "develop and implement a methodology by which it will collect the assessment levied under this act from an individual, employer, or group health plan." Mich. Comp. Laws § 550.1733a(2). To comply with this mandate, administrators must determine how to calculate the tax consistent with the Act's terms and exclusions.

2. The Act defines "paid claims" as "actual payments, net of recoveries,[7] made to a health and medical services

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6. The Court can take judicial notice of state laws, regulations, and related official guidance published on official state websites. *See*, *e.g.*, *Harris v. Quinn*, 134 S. Ct. 2618, 2635 n.9 (2014) (relying on state website to buttress conclusion certain persons are not public employees under state law); *Ariz. Free Enter. Club's Freedom Club PAC v. Bennett*, 131 S. Ct. 2806, 2825 n.10 (2011) (relying on state website's description of statutory purpose to ascertain voter intent in state referendum); *Crawford v. Marion Cty. Election Bd.*, 553 U.S. 181, 199 n.18 (2008) (plurality opinion) ("Frequently Asked Questions" page on state website contained "facts of which we may take judicial notice").

7. The term "recoveries" is not specifically defined. *See* Form 4930, Quarterly Worksheet for Michigan Health Insurance Claims Assessment, App. 83a, line 3 instructions ("'[r]ecoveries' includes

provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier," *id.* § 550.1732(s), and forces administrators to collect and analyze detailed claims information that ERISA does not require fiduciaries to maintain.[8] The requirement that administrators calculate "paid claims" to the State's satisfaction ignores that it may take much longer than 90 days for an administrator to reconcile the true cost of "paid claims" where, for example, services are billed on the basis of estimates or payments are subject to recoupment.

In addition, to determine whether a "paid claim" is subject to assessment, a plan administrator must determine whether the service was rendered in Michigan. *Id*. When the billing information provided to the administrator does not specify the place of service, the administrator is required to obtain and analyze "additional information," because "it is the burden of the entity claiming a right to an exclusion or exemption . . . to prove its entitlement to that exclusion or exemption," and a "third party administrator must be able to prove upon audit that the services associated with . . . [excluded] claims were, in fact, not performed in Michigan." *Taxes: Frequently Asked Questions,* Michigan Dep't of Treasury (2014), *available at* http://www.michigan.gov/taxes/0,4676,7-23843519_43542-389419--,00.html -

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any amounts received by the payer that are applied against a claim (and that actually affect the amount of actual payment made to the provider)").

8. In contrast to the Michigan Act, ERISA does not impose detailed reporting requirements regarding individual claims, the domicile of a plan's beneficiaries, or the state in which specific services were rendered. *See, e.g.*, 29 U.S.C. § 1023.

(last visited Oct. 27, 2016). In short, the Act directs plan administrators either to engage in onerous information-gathering to calculate the tax with the necessary precision, or to overpay on the assumption that the service was rendered in-state. *See id.*

3. The Act also requires plan administrators to determine the residency of beneficiaries. *See* Mich. Comp. Laws § 550.1732(s)(iv). The court of appeals acknowledged that, if an ERISA-covered entity were required to "ask a beneficiary which state she considers 'her fixed, permanent and principal home . . .' to comply with the Act. . . . we might be inclined to agree that the residency requirement alters the ERISA-covered entities' relationships in form, if not substance." App. 15a. However, the court dismissed this concern on the ground that, under the implementing regulations, there is a "rebuttable presumption" that an individual's home address is the same as their domicile. *Id.* at 15a-16a (citing Mich. Admin. Code r. 550.404(3)). But putting aside that beneficiaries might use a post office box or work address or maintain multiple residences such that a plan administrator can comply with ERISA without knowing a beneficiary's "home address," the presumption is rebuttable, not conclusive, and there is nothing to prevent a state auditor from second-guessing and demanding changes to the recordkeeping procedures that the administrator relies upon in the ordinary course of business pursuant to ERISA. *See, e.g.*, *id.* Rule 550.403.

In addition to data collection and tabulation duties, the Act imposes payment obligations on ERISA plan administrators regardless of whether they have direct access to the funds necessary to pay an assessment. Specifically, "third party administrators are required

to pay the HICA Act assessment on covered claims that they pay or process, even if the claims are not paid from the assets or bank account of the third party administrator, and instead are funded directly by the third party administrator's client." *Taxes: Frequently Asked Questions,* Michigan Dep't of Treasury (2014), *available at* http://www.michigan.gov/taxes/0,4676,7-238-43519_43542-389419--,00.html (last visited Oct. 27, 2016). Thus, ERISA fiduciaries must collect the tax (somehow) for the State's benefit, a mandate that requires at least some administrators to alter their relationships with plan sponsors or beneficiaries, forces changes on plan design and implementation, and is likely to result in increased costs for beneficiaries. *See, e.g.*, 29 U.S.C. §§ 1102(b)(2)–(4) (plans must "describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan . . . and specify the basis on which payments are made to and from the plan").

4. Further, the matrix of recordkeeping, reporting, disclosure and audit requirements set forth in the Michigan Act grafts substantial additional burdens on a plan administrator's ERISA duties. The Michigan Treasury Department rules promulgated pursuant to the Act starkly illustrate the extent to which the Act's requirements shadow a plan administrator's discharge of its responsibilities under ERISA, because they require the preservation of (i) "suitable and adequate records" to avoid a determination of "willful noncompliance with a tax law;" (ii) "quarterly worksheets as well as all source documents," including "documents and records maintained in the ordinary course of business" in the discharge of an administrator's responsibilities pursuant to federal law

and the plan; and (iii) "all documents and records used to determine eligibility for, and the amount of, each of the exclusions from the assessment." Mich. Admin. Code R. 550.403(4). ERISA fiduciaries that are covered by the Act are subject to comprehensive audits under the Michigan Revenue Act. *See* Mich. Comp. Laws § 205.3; *see generally* PowerPoint, Michigan Dep't of Treasury, Health Insurance Claims Assessment, at 31-42 (Feb. 2012) (detailing audit and appeal procedures), *available at* http://michigan.gov/documents/taxes/HICA_Info_Seminars_370417_7.ppt. The Act thus invites intrusive inquiries into the manner in which an administrator is discharging its responsibilities pursuant to federal law and the plan.[9]

In sum, the Sixth Circuit's conclusion that the Act does not "'function[] as a regulation of an ERISA plan itself,'" App. 8a, but merely imposes "incidental reporting" requirements "[i]n order to facilitate collection of the tax," App. 13a, improperly ignores that but for the responsibility of ERISA fiduciaries to "process[] claims" and oversee large numbers of "paid claim" disbursements, *see* Mich. Comp. Laws § 550.1733(1), there would be no impetus at all for the Act to target plan administrators.

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9. Specifically, the Act requires administrators to "notify the commissioner of the methodology used for the collection of the assessment," Mich. Comp. Laws § 550.1733a(2)(f), "keep accurate and complete records and pertinent documents . . . for a period of 4 years after the assessment . . . to which the records apply is due," *id.* § 550.1735(1), respond to requests for additional information by the State, *id.* § 550.1735(2), and file quarterly and annual returns. *Id.* § 550.1734; *see also Taxes: Frequently Asked Questions,* Michigan Dep't of Treasury (2014), *available at* http://www.michigan.gov/taxes/0,4676,7-238-43519_43542-389419--,00.html (last visited Oct. 27, 2016).

III. Michigan Is Not Alone In Targeting ERISA Fiduciaries For Regulation Based On Their Exercise Of ERISA Functions

Michigan is not alone in adopting laws that regulate ERISA plans to exploit the responsibilities that the plans discharge in their federally protected role, but purport not to meddle in the execution of those responsibilities or alter the plans' terms. *See generally* C. Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 Yale J. Health Pol'y Law & Ethics 197, 200 (2010) (noting that "states continue to experiment with . . . schemes designed to avoid ERISA preemption") .

The Sixth Circuit correctly acknowledged that other states might adopt tax laws similar to the Michigan Act. App. 16a n.3. For example, in 2013, Vermont enacted a 0.999% annual tax that is imposed on "all health insurance claims paid by [a] health insurer for its Vermont members." Vt. Stat. Ann. Tit. 32, § 10402(a). The Vermont statute implicitly acknowledges the risk of ERISA preemption, because it further provides that, "[i]n the event that the tax is found not to be enforceable as applied to third party administrators or other entities, the tax owed by all other health insurers shall remain at the existing level and the General Assembly shall consider alternative funding mechanisms that would be enforceable as to all health insurers." *Id.* § 10402(d).[10] Furthermore, in contrast to

10. An Oklahoma law similar to the Michigan Act, *see* 36 Okla. Stat. §§ 7201-7204, 7301, was invalidated on state constitutional grounds. *See* discussion *supra* note 2. From 2011 to 2013, Maine imposed an "access payment" on "all health insurance carriers, 3rd-party administrators and employee benefit excess insurance

the Michigan Act, the Vermont tax is not limited to health services that are provided to "Vermont members" in-state, so differentiating its reporting and recordkeeping obligations from those in Michigan.[11] States have also passed or considered passing laws that tax ERISA plan administrators to fund vaccine programs. *See* N.H. Rev. Stat. Ann. ch. 126-Q; Conn. Substitute Sen. Bill No. 21 § 25(b)(2)(b) (2014), *available at* http://www.cga.ct.gov/2014/FC/2014SB-00021-R000601-FC.htm.

In addition, as demonstrated two Terms ago when six states filed amicus briefs supporting Vermont's now-defunct regulatory scheme, states are seeking broadly to support impositions on independent ERISA fiduciaries. *See* Petition for a Writ of Certiorari, No. 14-181 (U.S. Aug. 13, 2014), at 26–27, 30 (collecting authorities; internal quotations omitted).

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carriers" that ranged from 1.14% to 2.14% of the value of all paid claims. Me. Rev. Stat. tit. 24-A, § 6917. Georgia's attempt to apply a "Prompt Pay" law to ERISA plans that would have imposed a high annual interest rate on proceeds or benefits due if a claim was not paid within 15 days of receipt was held preempted by the Eleventh Circuit. *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324, 1334 (11th Cir. 2014).

11. *See also* K. Gregg, *Healthsource RI seeks $14.5 million from state to keep exchange alive*, Providence Journal (Nov. 19, 2014) (noting that "Rhode Island's state-run Obamacare program faces an uncertain future unless it can scrounge up at least $14.5 million in non-federal dollars," and that funding proposals include imposing an assessment across all payers, including self-insured employers), *available at* http://www.providencejournal.com/article/20141119/News/311199994.

IV. Proceedings Below

1. Petitioner SIIA is a nationwide, non-profit organization with nearly 1,000 members including plan sponsors, multi-employer Taft-Hartley plans, independent third party service organizations, insurers, and a host of additional service providers dedicated to the advancement and protection of the self-insurance industry, which serves tens of millions of ERISA health plan beneficiaries nationwide. SIIA's membership includes self-insured entities such as employer plan sponsors and service providers such as third party administrators, many of whom are responsible for managing multi-state plans.

2. On December 22, 2011, SIIA filed a complaint seeking a declaration that the Michigan Act is preempted by Section 514(a) of ERISA and an injunction preventing defendants from giving effect to the Act. The district court granted the State's motion to dismiss the complaint, holding that the Act was not preempted because it is a law of general application and the tax is imposed only after benefit payments have been calculated. App. 54a–56a, 60a.

3. SIIA appealed and, in the Sixth Circuit, both SIIA and the State were supported by numerous amici curiae.[12]

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12. SIIA was supported by amici Iron Workers Health Fund of Eastern Michigan, Plumbers Local No. 98 Insurance Fund, Roofers Local No. 149 Security Benefit Trust Fund, Pipefitters Local No. 636 Insurance Fund, Pipefitters Local 636 Retiree Insurance Fund, Detroit and Vicinity Trowel Trades Health and Welfare Fund, Electrical Workers' Insurance Fund, and Sheet Metal Workers' Local Union No. 80 Insurance Trust Fund. The State was supported by the Michigan Association of Health Plans, Michigan Health & Hospital Association, Michigan State Medical

The court of appeals described ERISA preemption as a "quagmire," App. 20a, but affirmed the district court. The court invoked with "special force" a presumption against federal preemption because tax laws are a traditional attribute of state sovereignty. App. 25a. Adopting a narrow construction of the zone of activity that is protected by Section 514(a), the court gave short shrift to SIIA's contentions that the Act impermissibly interferes with plan administration and burdens fiduciaries with a host of vaguely defined reporting, disclosure, recordkeeping and audit requirements that directly "relate[] to" the discharge of their federally protected responsibilities. App. 26a–34a. The court also expressly rejected the Second Circuit's broader conception of ERISA preemption in *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497, 508 (2d Cir. 2014) and its reliance on "the principle . . . that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation," cited the *Donegan* dissent with approval, and held that ERISA preemption is limited only to state laws that impact an ERISA fiduciary's "*administration of benefits to beneficiaries* . . . ." App. 34a–35a (emphasis in original).

SIIA filed a petition for a writ of certiorari on December 18, 2014. On March 7, 2016, this Court granted the petition, vacated the judgment, and remanded the case for further consideration in light of its decision upholding preemption in *Gobeille. Self-Ins. Inst. of Am., Inc. v. Snyder*, 136 S. Ct. 1355 (2016) (mem.).

Society, Michigan Osteopathic Association, Small Business Association of Michigan, Michigan League for Public Policy, Aging Services of Michigan, Michigan County Health Plan Association, Health Care Association of Michigan, and Michigan Association of Community Mental Health Boards.

On July 1, 2016, the Sixth Circuit issued a decision which reaffirmed and largely tracked its original determination that the Michigan tax required only incidental record-keeping, not a burdensome amassing of data not required by ERISA. The Sixth Circuit read *Gobeille* as involving a "direct regulation of a fundamental ERISA function," App. 11a, despite the fact that the state reporting requirement in *Gobeille* had equally no direct impact on a plan's federal responsibilities. The court below seized upon *Gobeille's* reference to *De Buono* as indicating that *Gobeille* did not apply to obligations imposed on ERISA plans by state tax laws whose incidental burdens were to be evaluated under *De Buono* and the Court's earlier decision in *Travelers*. Finding the administrative obligations imposed by Michigan to be "peripheral" to its revenue generation purpose and its financial burdens to be tangential, the court again rejected Petitioner's § 514(a) claim.

The court concluded its analysis by observing that because the principal purpose of the Act is to "facilitate collection of the tax," this case "falls in the *De Buono* and *Travelers* category of state laws that necessitate incidental reporting and recordkeeping and thus are not preempted—as opposed to the *Gobeille* category of state laws preempted by ERISA because they directly regulate ERISA's essential reporting and recordkeeping functions." App. 13a.

This petition for certiorari followed.

REASONS FOR GRANTING THE PETITION

Certiorari Should Be Granted To Eliminate The Direct Conflict Between The Decision Below And The Decisions Of This Court, Including *Gobeille*

This Court vacated the prior judgment in this case and remanded it to the court of appeals for reconsideration in light of its opinion in *Gobeille*. The Sixth Circuit, however, did not meaningfully apply the *Gobeille* analysis in the decision. Instead, the court paid only lip service to this Court's precedent and distinguished this case from *Gobeille* on the basis that, unlike the Vermont law, the Michigan Act was not a "direct regulation of a fundamental ERISA function," App. 11a, because its core purpose was tax collection, not data reporting. But a faithful application of the *Gobeille* analysis in this case leads to the inexorable conclusion that the Sixth Circuit's opinion on remand is in conflict with this Court's precedent and must be reversed. Tax collection is no more sacrosanct than "the State's traditional power to regulate in the area of public health," *see Gobeille*, 136 S. Ct. at 946, which this Court held could "not suffice to avoid federal pre-emption," *id.* Accordingly, the Sixth Circuit's reliance upon this Court's decisions in *Travelers* and *De Buono* as creating a blanket exemption for state tax regulation even when it invades the federally regulated domain of core ERISA functions is misplaced and cannot withstand scrutiny.

The Michigan Health Insurance Act imposes financial and administrative burdens on the core, health claims payment function of ERISA plans in Michigan. Claims paid by the plans on behalf of beneficiaries are directly taxed and Michigan dictates new reporting and record-

keeping requirements in connection with claim payments. These requirements do not arise indirectly from State programs aimed at the business community in general such as garnishment assistance or minimum wage policies. *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (holding that the application of a general state garnishment statute to ERISA fiduciaries was not preempted merely because responding to a garnishment order might affect plan costs). Rather, ERISA plans are a principal target of Michigan's law because of their core activity—making payments to providers on behalf of plan beneficiaries.

By any reasonable construction of § 514(a)'s language, Michigan's law "relate[s] to" an employee benefit plan and should be preempted under ERISA § 514(a) and the precedents of this Court. Indeed, the Court's most recent interpretation of § 514(a) in *Gobeille* should have made this an *a fortiori* case for preemption particularly when this Court vacated and remanded the prior decision below immediately after deciding *Gobeille*. Nevertheless, the court below reaffirmed its prior rejection of § 514(a) preemption by continuing to apply an inappropriate presumption against preemption. It also misinterpreted and expanded the line of cases involving only an indirect impact on ERISA plans from State impositions on service providers to the plan. This sleight of hand was designed to fashion a narrowing of § 514(a) preemption to State mandates that govern the administration of ERISA plans in conflict with federal requirements. That constrained, anti-textual reading of § 514(a)—following the *Gobeille* dissent rather than the Court's opinion, *Gobeille*, 136 S. Ct. at 952–53,—cannot be allowed to stand.

A. The Strong Presumption Against Section 514 Preemption Of State Tax Laws Invoked By The Sixth Circuit Is Unwarranted And Inconsistent With *Gobeille*.

The Sixth Circuit impermissibly tipped the § 514 scale by invoking a strong presumption against § 514(a) preemption of state tax laws. Specifically, the court held that "the presumption that Congress does not intend to preempt state laws applies with special force in this case." App. 7a. Such a myopic reading of § 514(a), despite Congress's deliberate choice of preemptive language whose breadth has been repeatedly emphasized by this Court and Congress's express recognition that ERISA can and does preempt state tax laws, is plainly inconsistent with *Gobeille*.

In *Gobeille*, the State of Vermont required health insurers and providers, among other organizations, to report any information related to healthcare costs, prices, quality and use for the state to build an all-inclusive healthcare database. This Court held that the Vermont law, "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.'" *Gobeille*, 136 S. Ct. at 945 (citation omitted). As a result, this Court held that "[p]re-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans." *Id.*

This Court also carefully explained that Vermont's law could not "be saved by invoking the State's traditional power to regulate in the area of public health." *Id.* at 946.

"ERISA pre-empts a state law that regulates a key facet of plan administration even if the state law exercises a traditional state power." *Id.* Because "reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA," *id.* at 945, Vermont's ordering ERISA plans "to report detailed information about the administration of benefits" constituted "a direct regulation of a fundamental ERISA function," *id.* at 946. A state's noble objectives, "do[] not transform this direct regulation of a 'central matter of plan administration' into an innocuous and peripheral set of additional rules." *Id.*

The Sixth Circuit ruling here also must be overturned because its talismanic incantation of a "special force" that cabins the express preemption clause of § 514(a) has no basis in this Court's jurisprudence. The Sixth Circuit ruling attempted to distinguish the Michigan Act from the Vermont law based on its fallacious conclusion that "only direct regulations of fundamental functions are preempted," App. 12a, and the Michigan Act, unlike the Vermont law, does not directly regulate any integral aspects of ERISA. The court held that at its core, the purpose of the Act is "to generate the revenue necessary to fund Michigan's obligations under Medicaid," App. 13a, and that its reporting and record-keeping requirements are merely peripheral. The court concluded that because state laws imposing only incidental reporting and record-keeping burdens are not preempted, the Michigan Act is not preempted. App. 13a.

These arguments are not new and mirror those which were soundly rejected by this Court in *Gobeille*. Although generally there is a starting presumption that

Congress does not intend to supplant state law, this "general" rule of engagement must give way where, as here, ERISA expressly and most "'certainly contemplated the preemption of substantial areas of traditional state regulation.'" *Gobeille*, 136 S. Ct. at 946 (quoting *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 330 (1997)). Thus, "[a]ny presumption against pre-emption, whatever its [special] force in other [general] instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does." *Id.*

Gobeille confirms this result, regardless of whether the traditional state interest asserted is taxation as opposed to public health. Indeed, the motive of the State, whether enhancement of its healthcare database or its tax collection, is not an appropriate basis for limiting the effect of §514(a). The guiding principle of statutory preemption analysis is that the intent of Congress must prevail. That principle is firmly established in *Gobeille*, consistent with a long line of statutory preemption cases. *Id.* The Sixth Circuit's holding to the contrary is in direct opposition to *Gobeille*, and certiorari should be granted to resolve this clear conflict.

B. A So-Called Presumption Against Preemption Cannot Rescue A Newly Minted State Law Like The Michigan Act.

The decision below independently warrants review because the Sixth Circuit's reliance on an implied presumption against preemption arising from Michigan's traditional exercise of taxing authority is seriously

mistaken. Contrary to the court's premise below, the Michigan Act is not entitled to any tradition-based presumption against preemption because, like the Vermont scheme, it is a newly minted state law that specifically targets ERISA fiduciaries in name and substance.

ERISA preemption precedents occasionally have referred to an implied presumption against preemption.[13] But whatever the validity of that presumption in situations where Congress has not expressly adopted preemption language, it does not survive analysis here for several reasons. First, similar to Vermont's decision to "mandate[] reporting to build a healthcare database," App. 34a, the Michigan Act was adopted in 2011, almost 40 years *after* ERISA was enacted, and expressly targets ERISA-covered entities by name, so it makes no sense to extend the Act special protection from an express federal preemption provision and place a thumb on Michigan's side of the scale based on purported fidelity to traditional principles of federalism. *See Donegan*, 746 F.3d at 506 n.8 ("[C]ollecting [health] data can hardly be deemed 'historic'—most such laws were enacted only within the last ten years."), *aff'd*, 136 S. Ct. 936 (2016).

13. *See, e.g.*, *De Buono*, 520 U.S. at 813 (reiterating that the Court must go beyond the text of ERISA "to evaluate whether the normal presumption against pre-emption has been overcome in a particular case"); *Dillingham*, 519 U.S. at 332 (applying the "presumption that ERISA did not intend to supplant" the state law); *Travelers*, 514 U.S. at 654 ("[W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.").

Second, ERISA itself was expressly intended to preempt state tax laws. *See* 29 U.S.C. § 1144(b)(5)(B)(i) ("Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section . . . any State tax law relating to employee benefit plans."). As one court of appeals has observed, "Congress intended that the same preemption analysis should apply to state tax laws as to other state laws." *Ret. Fund Tr. of Plumbing v. Franchise Tax Bd.*, 909 F.2d 1266, 1276 (9th Cir. 1990). In adopting ERISA, Congress specifically rejected a proposal to include an exception that would have allowed states expressly "to prescribe the rules and regulations governing the tax qualifications and taxation of . . . employee benefit plan[s]." *Id.* at 1277. And when Congress amended ERISA in 1982 to save a Hawaii tax law from preemption, it reiterated that "[p]reemption is continued with respect to . . . any State tax law relating to employee benefit plans." *Id.* at 1278 (citing H.R. Conf. Rep. No. 97–984, 97th Cong., 2d Sess. 18 (1982), *reprinted in* 1982 U.S.C.C.A.N. 4598, 4603). Accordingly, the Sixth Circuit's solicitude for the Michigan Act is unwarranted. There is similarly no support for that court's suggestion that the obvious potential for conflicting state reporting and recordkeeping requirements arising from potentially differing concepts of covered beneficiaries and payments is immune from scrutiny unless and until an unspecified number of Michigan's sister states adopt and impose similar tax laws with conflicting administrative requirements.[14]

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14. Contrary to the court of appeals' reasoning, App. 16a n.3, a preemption analysis cannot turn on whether *multiple* states have adopted similarly intrusive, conflicting legislation, because among other things that mode of analysis would permit the adoption of state laws that violate the federal mandate and invite arbitrary

Third, this Court has repeatedly rejected the notion that the implied presumption against preemption has any real force where, as here, a state law targets ERISA fiduciaries for regulation and runs afoul of ERISA's preemptive mandate. As the Court noted in *Dillingham*, 519 U.S. at 330, "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Accord Egelhoff*, 532 U.S. at 151 ("[W]e have not hesitated to find state family law pre-empted when it conflicts with ERISA or relates to ERISA plans."); *Boggs v. Boggs*, 520 U.S. 833, 840–41 (1997) (holding that "there [wa]s a conflict [between the state law and ERISA], which suffice[d] to resolve the case" even though the state law "implement[ed] policies and values lying within the traditional domain of the States"). Nothing in this Court's precedents permits a state to avoid an express federal preemptive mandate by insisting that it is merely exercising "an 'important attribute of state sovereignty.'" App. 7a.

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determinations as to whether the accretion of such laws has reached a magical tipping point. *Gobeille*, 136 S. Ct. at 945 ("A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs."). Instead, the proper inquiry is whether multiple state regulation of a similar type *could result* in a patchwork of potentially conflicting state regulation that the federal statute was enacted to eliminate or avoid. *See, e.g.*, *Rowe v. N.H. Motor Transp. Ass'n*, 552 U.S. 364, 373, 375 (2008) (holding that federal carrier legislation preempted Maine tobacco law because "allow[ing] Maine directly to regulate carrier services would permit other States to do the same. . . . [which] could easily lead to a patchwork of state [requirements]"); *see also Memphis Bank & Tr. Co. v. Garner*, 459 U.S. 392, 398 & n.8 (1983) (rejecting argument that impact of state tax was *de minimis* when all 50 states might adopt comparable provisions).

C. The Decision Below Wrongly Invoked *De Buono* And *Travelers* To Constrain Section 514(a) Preemption Of State Enactments Addressing Core ERISA Plan Functions.

The Sixth Circuit's reliance on *De Buono* and *Travelers* for the proposition that the traditional state power of taxation creates a blanket exemption from ERISA preemption, or a more restrictive impact analysis for assessing the Act's relation to ERISA, is misplaced. In reaching its holding, the Sixth Circuit improperly focused on this Court's dicta that "[t]he analysis 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." *Gobeille*, 136 S. Ct. at 946 (citing *De Buono,* 520 U.S. 806). But as is evident from the language quoted above, *Gobeille* carefully noted that *De Buono* arose from a "tax on hospitals" where ERISA preemption was sought because certain plans were their own service providers subject to tax in that capacity. Thus, the effect on ERISA's core functions was indirect—an increase in cost—and indistinguishable from other cost change in services procured by ERISA plans.

Mistakenly, the court of appeals relied upon this Court's approval of state levies in *De Buono* and *Travelers* to conclude that the Michigan Act is not preempted. It reasoned that the Act has only incidental effects on ERISA plans and administrators, and it left undisturbed the district court's conclusion that the Act is a law of "general applicability." App. 7a. But the Michigan tax is readily distinguishable and triggers ERISA preemption because it imposes administrative burdens on core ERISA functions that were not present in the state tax statutes upheld in *De Buono* and *Travelers*.

In *De Buono*, the plan was not being taxed in connection with core plan administration. Instead, the tax at issue was on the business income of a hospital that just happened to be owned by an ERISA plan. 520 U.S. at 810. Similarly, the reporting related to hospital administration, not plan administration itself. *Id.* Nor did the New York statute subject ERISA plans to state sanctions if the ERISA plan did not properly report facts relating to plan administration and the calculation of state taxes arising out of ERISA claim administration. This Court concluded, based on these facts, that a direct hospital tax would not be preempted because "the indirect impact [of the tax] on the fund's [plan administration] decisions would be in all relevant respects identical to" the impact of taxing the fund directly. *Id.* at 816.

In *Travelers*, 514 U.S. at 656, the Court rejected an ERISA preemption challenge to a New York law that regulated hospital rates throughout the State and encouraged participation in Blue Cross/Blue Shield plans by requiring hospitals—including hospitals owned by ERISA-covered entities—to collect surcharges from patients whose hospital bills were paid by certain commercial, non-Blue Cross/Blue Shield insurers. There, the Court pointed out that New York was addressing ERISA entities as hospital owners and modifying the cost of hospital services not regulated by ERISA.

Thus, in both *De Buono* and *Travelers*, the Court rejected ERISA preemption challenges to state statutes that were generally applicable to employers and health service providers without regard to their ERISA capacity. In other words, there was no "but-for" nexus between ERISA plan operations and the state's regulation of

plan fiduciaries. Because the state laws at issue were directed at ERISA entities in their capacity as employers or consumers, or in some other capacity unrelated to the performance of ERISA responsibilities, the Court determined that the laws were not preempted by Section 514(a), at least absent a demonstrated substantial impact on plan administration.

According to the decision below, the Act's "potential effects are to cut the plans' profits—as did the surcharges upheld in *Travelers* and *De Buono*—and to create work independent of the core functions of ERISA." App. 14a. The court's characterization misses the forest for the trees, however, because in contrast to the state laws that were upheld in *Travelers*, *De Buono*, and other recent decisions, the Act does not impact ERISA fiduciaries incidentally in furtherance of a general state purpose that has nothing to do with the performance of their federally protected functions. Instead, the Act deliberately targets fiduciaries for regulation *precisely because they handle large payment streams for healthcare services on behalf of beneficiaries* and saddles them with burdensome compliance, payment and reporting requirements for the State's convenience. Specifically, the Act (i) focuses on entities that direct payments to healthcare providers, *see* Mich. Comp. Laws § 550.1732(s) (definition of "paid claims"); (ii) targets ERISA-covered, self-insured group health plans by name, *see id.* § 550.1732(h) (definition of "group health plan");[15] (iii) and zeroes in on several

15. SIIA does not contend that the Michigan Act is preempted merely because it references ERISA-covered entities by name, but because in conception, purpose and effect the Act targets ERISA-covered entities for burdensome regulation based solely on their exercise of federally protected functions.

essential "core functions" of ERISA welfare benefit plans: the processing and disbursement of payments for healthcare services on behalf of plan beneficiaries and the reporting duties attendant to those functions. *Id.* § 550.1732(s) (definition of "paid claims").

A generally applicable law is one that regulates "areas where ERISA has nothing to say," *Egelhoff*, 532 U.S. at 148 (quoting *Dillingham*, 519 U.S. at 330), not one that seeks to leverage plan operations for a state's benefit. None of this Court's precedents holds or suggests that a state law does not relate to "the subject matters covered by ERISA," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983), merely because it purports to advance a different goal like revenue collection. *See, e.g., Gade v. Nat'l Solid Wastes Mgmt. Ass'n,* 505 U.S. 88, 107 (1992) ("Whatever the purpose or purposes of the state law, pre-emption analysis cannot ignore the effect of the challenged state action on the pre-empted field."). The court of appeals expressed concern that, under SIIA's view, "ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records." App. 14a. That concern does not survive scrutiny, however, because such laws have no but-for relationship to ERISA functions, and preempting the Michigan Act would have no impact on the types of generally applicable state laws that this Court has previously sustained against ERISA preemption challenges.

Furthermore, the Act necessarily impacts plan design and the arrangements between and among ERISA sponsors, administrators and beneficiaries. Plan administrators must remit to the State on a continuing

quarterly basis and bear the administrative costs of compliance, but the Act delegates no taxing authority to them and merely invites them to seek reimbursement from "individual[s], employer[s] and group health plan[s]." *Id.* § 550.1733a(2). The almost inevitable consequence of the State's imposition is that administrators will seek to amend ERISA plan documents to require advance payments from sponsors or plan beneficiaries subject to retroactive adjustment and credit as the new tax liability is trued up to the calculation of actual payments made to service providers. There is, therefore, nothing "tenuous, remote, or peripheral" about the Michigan Act, *Shaw*, 463 U.S. at 100 n.21, because it deliberately overlays an ERISA plan's responsibility to "process[] claims and disburse[] benefits" to serve the State's interest in tax collection, grafts additional, state-specific burdens on administrators, undermines ERISA's goal of national uniformity, and opens the plan's procedures and reports up to audit and second-guessing in furtherance of the State's revenue goals.

At bottom, the Michigan Act is preempted because it "*relate[s] to* . . . employee benefit plans" within the ordinary meaning of that term and regulates plan administrators on the basis of the functions they perform in the discharge of their federally protected fiduciary obligations. Indeed, the Act would not target ERISA fiduciaries for regulation but for those functions.

D. The Sixth Circuit's Conclusion That Section 514(a) Is Limited To State Laws That Directly Regulate Administration Of ERISA Plans Rewrites *Gobeille* And Must Be Reversed.

The Sixth Circuit wrongly concluded that § 514(a) should preempt only when State law necessarily modified the administration of ERISA plans. App. 9a. For example, the court rejected SIIA's argument that the Act's admonition that plans make arrangements to recoup their tax payment from beneficiaries would *force* changes in ERISA plans because recoupment itself was not mandated. App. 16a–17a. Such reasoning is contrary to *Gobeille* on both effect and necessity.

Gobeille teaches that it is the area of plan function to which State law relates, rather than its impact on ERISA compliance, that governs § 514(a). *Gobeille*, 136 S. Ct. at 945 (finding Vermont law preempted because it related to an area of plan function that is an "intergral aspect of ERISA"—"reporting, disclosure, and recordkeeping"). While the Vermont statute in *Gobeille* did not modify federal reporting requirements nor foreclose Liberty Mutual from complying with them, its impact on the core reporting functions clearly was sufficient to invoke § 514(a). *Id.*

Similarly, the Court below put aside concerns about plan modification because Michigan did not prevent administrators from absorbing the full burden of the tax. But this Court has made clear that where a likely and foreseeable impact on plan administration exists, there is no precedential support for the proposition that the possibility that plans might avoid it by acting to their

detriment precludes preemption. *See Mut. Pharm. Co. v. Bartlett*, 133 S. Ct. 2466, 2477–78 (2013).

Letting the decision below stand on the Sixth Circuit's rationale would undercut *Gobeille* and put the lower courts back into the very "quagmire" *Gobeille* sought to dry up. This Court recently has emphatically reaffirmed the fundamental principle that adherence to its decisions by inferior courts is mandatory. *Bosse v. Oklahoma*, 580 U.S. ___, No. 15-9173, 2016 WL 5888333, at *1 (Oct. 11, 2016) (per curiam); *see also DIRECTV, Inc. v. Imburgia*, 136 S. Ct. 463, 468 (2015). The Sixth Circuit's attempt to evade that responsibility should not be countenanced.

E. The Court's Attempt To Bring Clarity To The Field Of ERISA Preemption Stands At Risk Of Erosion By Overzealous States And Misguided Lower Courts.

Despite this Court's holding in *Gobeille*, which was intended to bring much needed clarity to the area of ERISA preemption, the Sixth Circuit commenced its analysis on remand, lamenting the fact that it was "once again" required to "navigate the quagmire that is preemption." App. 2a. This could not have been the result the Court envisioned. In issuing its decision in *Gobeille*, the Court provided guidance that should have enabled the lower courts to function consistently and uniformly in the area of ERISA preemption. Indeed, if this case could have been resolved pre-*Gobeille*, there would have been no reason to vacate and remand the prior decision to the Sixth Circuit. But the Sixth Circuit refused to get the message. Instead of faithfully applying this Court's precedent, the Sixth Circuit's decision adds to the quagmire and invites

lower courts to act as if *Gobeille* does not mean what it says.

Incongruous decisions like that of the Sixth Circuit have led numerous commentators to note that the ERISA preemption field remains "at least as muddled as it was before the [*Gobeille*] decision."[16] To be sure, this sentiment is not merely academic, as other courts have begun to follow the Sixth Circuit's lead in refusing to engage in thoughtful analysis and application of *Gobeille*.[17] This result is particularly troubling given that, prior to granting certiorari in *Gobeille*, the Court was implored to more broadly address and define when state laws are preempted by ERISA.[18] Unless the Court clearly reaffirms

16. Stephen Rosenberg, *The Centre Barely Holds: ERISA Preemption After Gobeille v. Liberty Mutual Insurance Company*, 44 Tax Mgmt. Compensation Plan. J. 166, 172 (Aug. 5, 2016). *See also* Patrick C. DiCarlo, Elizabeth Wilson Vaughan, *The High Court's Preemption Tango And The Future Of ERISA*, LAW360 (April 4, 2016) available at http://www.alston.com/publications/high-courts-preemption-tango/ (last visited September 27, 2016) (describing the preemption analysis as an "elaborate dance").

17. *See, e.g.*, *In re Anthem, Inc. Data Breach Litig.*, No. 15-MD-02617-LHK, 2016 WL 3029783, at **48–50 (N.D. Cal. May 27, 2016) (refusing to give *Gobeille* determinative weight); *Ctr. for Restorative Breast Surgery, L.L.C. v. Blue Cross Blue Shield of Louisiana*, No. CV 11-806, 2016 WL 4208479, at *6 & n.54 (E.D. La. Aug. 10, 2016) (same); *Thomas v. Aetna Life Ins. Co.*, No. 2:15-CV-01112-JAM-KJN, 2016 WL 4368110, at **5–7 (E.D. Cal. Aug. 15, 2016) (same); *Vasquez v. Dillard's, Inc.*, Case No. 114810, 2016 WL 4804078, at **11–14 (Okla. Sept. 13, 2016) (same).

18. Amicus Brief of Professor Edward A. Zelinsky as Amicus Curiae in Support of Neither Party, No. 14-181 (U.S. Sept. 1, 2015); *See also* Edward A. Zelinsky, *Gobeille v. Liberty Mutual*: *An Opportunity to Correct the Problems of ERISA Preemption,* 100 Cornell L. Rev. Online 24 (2015).

Gobeille's core function analysis, § 514(a) challenges will continue to arise and be wrongly decided, putting ERISA plans in jeopardy and doing great violence to congressional intent under § 514(a).

In addition to the unabated morass of judicial decisions attempting to navigate ERISA preemption, the decision below requires immediate correction because it encourages the proliferation of similar state laws that target ERISA fiduciaries for burdensome regulation.

As this Court has observed, "[t]he basic thrust of the [ERISA] pre-emption clause . . . [i]s to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657; *see also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1897)(noting that an employer takes on a heavy burden when it decides to offer benefits plans to its employees, and that "[t]he most efficient way to meet th[is burden] is to establish a uniform administrative scheme," which is "difficult to achieve . . . if a benefit plan is subject to differing regulatory requirements in differing States"). If the decision below is not reversed, ERISA plan administrators (including ERISA administrators that operate plans in multiple states) will be threatened with a proliferation of conflicting state laws that, similar to the Michigan Act, improperly target ERISA plans with burdensome and potentially conflicting state regulation to further state interests and threaten plans with sharply increasing compliance costs. *See, e.g.*, *Buckman Co. v. Pls.' Legal Comm.*, 531 U.S. 341, 350 (2001) (noting that "complying with [a federal] regulatory regime in the shadow of 50 states' . . . regimes will dramatically increase the burdens facing [those attempting to comply]"); *cf.*

North Dakota v. United States, 495 U.S. 423, 458 (1990) (Brennan, J., concurring in the judgment and dissenting in part) (noting that the difficulties imposed by state regulation can increase "exponentially if additional States adopt equivalent rules"). Indeed, the vigorous opposition that seven states—including states outside of the Second Circuit—previously expressed on certiorari to the decision in *Donegan* confirms that states will continue to target ERISA fiduciaries with regulations that exploit their federally regulated plan responsibilities unless and until this Court clarifies its existing precedents and supplies a bright-line, but-for rule that implements the broad mandate of § 514(a) and puts an end to such intrusions.

CONCLUSION

For the foregoing reasons, the Court should grant SIIA's petition for a writ of certiorari.

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