No. 14-

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,

Respondents.

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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December 18, 2014

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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." Acknowledging "the quagmire that is [ERISA] preemption," the court of appeals upheld Michigan's imposition of a tax on ERISA plan administrators with burdensome attendant reporting, recordkeeping and audit requirements notwithstanding that the Michigan law targets administrators precisely because they perform claims-handling functions pursuant to ERISA. The circuit court invoked a strong presumption against the preemption of state taxing powers to read Section 514(a) narrowly 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. The decision below expressly conflicts with the Second Circuit's contemporaneous decision in *Liberty Mutual Insurance Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014), *cert. pending*, No. 14-181 (U.S. Aug. 13, 2014), *Solicitor General invited to file a brief expressing the views of the United States* (Order (U.S. Dec. 15, 2014)), and opens the door to the proliferation of state laws that target ERISA administrators with burdensome and potentially conflicting state law duties relating to the performance of their federally protected fiduciary responsibilities.

With a growing number of states saddling ERISA plans with costly regulatory responsibilities that impinge on the relationships between plan administrators, sponsors and beneficiaries, the questions below require urgent resolution:

Whether a state law that imposes new reporting, payment, recordkeeping, and audit requirements on ERISA plan administrators that arise directly from their processing of welfare benefit claims pursuant to ERISA "relate[s] to" ERISA benefit plans and is therefore preempted under Section 514(a); and

Whether the broad preemption language in Section 514(a) can be judicially narrowed to accommodate a presumption against preemption of newly minted state laws that seek to exploit the core functions of ERISA plan administrators.

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 10% or more of its stock.

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CASES

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Egelhoff v. Egelhoff,
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Mackey v. Lanier Collection Agency & Service, Inc.,
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CONSTITUTIONAL PROVISIONS

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36 Okla. Stat. §§ 7201-7204. . . . . .5, 13

36 Okla. Stat. § 7301 . . . . .5, 13

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Vt. Stat. Ann. Tit. 32, § 10402(a) 13

Vt. Stat. Ann. Tit. 32, § 10402(d) 13

OTHER AUTHORITIES

C. Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 Yale J. Health Policy & Ethics 197 (2010). 12

Connecticut Substitute Senate Bill No. 21 § 25(b)(2)(b) (2014), *available at* http://www.cga.ct.gov/2014/FC/2014SB-00021-R000601-FC.htm 14

Health Provider & Industry State Taxes & Fees, National Conference of State Legislatures (July 10, 2014), *available at* http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx 5

K. Gregg, *Healthsource RI Seeks $14.5 Million from State to Keep Exchange Alive*, Providence Journal (Nov. 19, 2014), *available at* http://www.providencejournal.com/breaking-news/content/20141119-healthsource-ri-seeks-14.5-million-from-state-to-keep-exchange-alive.ece. 13-14

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Kaiser Family Found. & Health Research & Educational Trust, *2013 Annual Survey: Plan Funding*, *available at* http://kff.org/private-insurance/report/2013- 4

Mary Ann Cleary, Director, House Fiscal Agency, Legislative Analysis: Health Insurance Claims Assessment (Mich. 2011), *available at* http://www.legislature.mi.gov/documents/2011-2012/billanalysis/house/pdf/2011-HLA-0347-3.PDF (last visited Dec. 12, 2014). 5

Powerpoint, Michigan Department of Treasury, Health Insurance Claims Assessment (Feb. 2012), *available at* http://michigan.gov/documents/taxes/HICA_Info_Seminars_370417_7.ppt 11

Taxes: Frequently Asked Questions, Michigan Department of Treasury (2014), *available at* http://www.michigan.gov/taxes/0,4676,7-238-60726---F,00.html 7, 9, 10, 12

Thomas E. Perez, Secretary, U.S. Department of Labor, Report to Congress: Annual Report on Self-Insured Group Health Plans (2014), *available at* http://www.dol.gov/ebsa/pdf/ACAReportToCongress2014.pdf 4

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U.S. Department of Labor Employee Benefits Secretary Administration, *Understanding Your Fiduciary Responsibilities Under a Group Health Plan* (2013), *available at* http://www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html 26

1982 U.S. Code Congressional & Administrative News 4598. 32

PETITION FOR A WRIT OF CERTIORARI

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 court of appeals (App. 1a-20a) is reported at 761 F.3d 631. The decision of the district court (App. 21a-44a) is not reported, but is available at 2012 WL 3888212.

JURISDICTION

The judgment of the court of appeals was entered on August 4, 2014. App. 1a. Petitioner's application to extend the time to file the petition for certiorari to and including December 18, 2014 was granted by Justice Kagan on October 7, 2014. Order, No. 14A373 (U.S. Oct. 7, 2014). 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. 45a -62a.

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 prohibits 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); *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 collect large quantities of data relating to health care 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 health care payments efficiently.[1]

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

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1. Nationwide, 61% 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, *2013 Annual Survey: Plan Funding*, at 176, *available at* http://kff.org/private-insurance/report/2013-employer-health-benefits/. This figure is even greater for large companies which often have employees in multiple states. Thus, in 2013, 79% 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.* at 181. Consistent with these figures, the dollar value of the claim payment streams that pass through self-insured health care 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.

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 directly on health care providers, the Michigan Act imposes a tax (originally 1%, now .75%[3]) on the value of paid claims for health care services rendered in Michigan to Michigan residents, and is designed to generate $400 million in annual revenues for use in funding Michigan's 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.*

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 Dec. 12, 2014). 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. For dates of service on or after July 1, 2014, the tax is reduced from 1% to .75%. *Id.* § 550.1733(1).

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.

§ 550.1732(s) (definition of "paid claims"); Form 4930, Quarterly Worksheet for Michigan Health Insurance Claims Assessment, App. 63a (foldout).[5]

The Sixth Circuit adopted a narrow conflict-based view of ERISA preemption and concluded that, because the Act does not regulate claims processing *per se* but instead imposes a tax on the value of paid claims, "the Act does not require a plan administrator to change how it administers the plan at all." App. 8a. However, the Act is hardly an incidental, *de minimis* 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

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.

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), *available at* http://www.michigan.gov/taxes/0,4676,7-238-60726_60726-291166—F,00.html (last visited Dec. 12, 2014);

- 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. 45a-62a. Compliance with the foregoing mandates imposes substantial costs on plan sponsors and raises a host of administrative burdens that, s 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]

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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

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 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

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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 Cnty. 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. 65a, line 3 instructions ("'[r]ecoveries' includes 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. § 1032.

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* https://www.michigan.gov/taxes/0,4676,7-238-60726-274645—F,00.html (last visited Dec. 12, 2014). In short, the Act directs plan administrators either to engage in onerous information-gathering to calculate the tax with the necessary precision, or to pay 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. 17a. 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 17a-18a (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.* r. 550.403.

4. 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/0,4676,7-238-60726-274626—F,00.html (last visited Dec. 12, 2014) (emphasis added). 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").

5. Further, the matrix of recordkeeping, reporting 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. 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 (Feb. 2012) at 31-42 (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]

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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

In sum, the Sixth Circuit's conclusion that the Act does not "'function[] as a regulation of an ERISA plan itself,'" App. 7a, but merely "create[s] additional administrative work *unrelated to the processing of . . . claims*," App. 16a (emphasis added), 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 to target plan administrators for regulation.

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 & 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.

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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/0,4676,7-238-60726_60726-291166—F,00.html (last visited Dec. 12, 2014).

App. 18a n.2 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 the Michigan Act, the Vermont tax is not limited to health services that are provided to "Vermont members" in-state, so it could result in double taxation where Vermont members receive services in sister states that tax health care providers.[11] States have also passed or considered

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 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, 1335 (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-

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, states are seeking to impose data collection burdens on ERISA fiduciaries. The State of Vermont, with the *amicus* support of six other states, is currently seeking review in this Court of the Second Circuit's divided panel decision in *Donegan*, 746 F.3d 497, *cert. pending*, No. 14-181; earlier this week, the Court invited the Solicitor General to file a brief expressing the views of the United States in that case. Order, No. 14-181 (U.S. Dec. 15, 2014). *Donegan* held that ERISA preempted a Vermont regulatory scheme that required "'all health insurers [including self-insured plans] [to] file with the State reports containing claims data and other 'information related to health care,'" reasoning that "[t]he use of preemption to avoid proliferation of state administrative regimes . . . remains a vital feature of [ERISA]" and "'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." 746 F.3d at 499, 507-08. In its petition, Vermont acknowledges that it targets self-insured ERISA plans because they "provide coverage to millions of Americans" and argues that the Second Circuit's ruling "threatens to undermine efforts by at least sixteen states" to create health care claims databases by "leav[ing] a large hole in the data collection the state has fashioned. . . ."

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insured employers), *available at* http://www.providencejournal.com/breaking-news/content/20141119-healthsource-ri-seeks-14.5-million-from-state-to-keep-exchange-alive.ece.

Petition for a Writ of Certiorari, No. 14-181 (U.S. Aug. 13, 2014), at 26-27, 30 (collecting authorities; internal quotations omitted).

IV. Proceedings Below

1. Petitioner SIIA is a 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. 36a-38a, 42a.

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

The court of appeals described ERISA preemption as a "quagmire," App. 2a, 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. 7a. 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, recordkeeping and audit requirements that directly "relate[] to" the discharge of their federally protected responsibilities. App. 8a-16a. The court also expressly rejected the Second Circuit's broader conception of ERISA preemption in *Donegan* 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. 15a-16a (emphasis in original).

This petition for certiorari followed.

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 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.

REASONS FOR GRANTING THE PETITION

This case presents important questions about the application of this Court's ERISA preemption precedents to recently enacted and burgeoning state laws that (i) expressly or impliedly burden ERISA plans to capitalize on the responsibilities that ERISA plan administrators discharge pursuant to federal law; but (ii) do not directly regulate primary plan functions. The tax regime established by the Michigan Act and the Vermont data collection scheme addressed in *Donegan* represent a category of state regulation that has not been squarely addressed by this Court. The state laws that this Court has previously examined have either been deemed preempted because they impermissibly have "a connection with" or "refer[] to" the operations of an ERISA plan such as the administration of benefits, or not preempted because, in conception, purpose and effect, their impact on ERISA plan operations is "tenuous, remote, or peripheral." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 100 n.21 (1983).

The court of appeals rejected SIIA's ERISA preemption challenge invoking a strong presumption against preemption and holding that the Act does not meddle with an ERISA fiduciary's threshold evaluation and payment of submitted claims. The court's crabbed conception of state laws that "relate to" ERISA plans is wrong, because Section 514(a) creates a federally protected zone to ensure that plan administrators can perform their federally mandated functions free of targeted state interference regardless of the state's purpose, and regardless of whether federal and state law squarely conflict. Moreover, the court improperly

attributed no significance to the facts that the Michigan Act (i) is a newly minted, post-ERISA enactment that targets ERISA plan fiduciaries by name for the State's taxing convenience; and (ii) acts on ERISA fiduciaries by subjecting them to substantial regulatory burdens that directly "relate[] to" the discharge of their federally protected plan responsibilities. Put another way, the court failed to acknowledge that, by design, the Act pulls revenue *from the very payment streams that ERISA safeguards and that administrators handle for plan beneficiaries*, and grafts burdensome regulations onto the operations of ERISA health care plans without regard to existing plan requirements and procedures or the additional work and expense that the Act creates.

By ignoring the substantial, targeted burdens that are clear on the face of the Act, the Sixth Circuit misapplied this Court's recent ERISA preemption precedents and rejected the Second Circuit's analysis in *Donegan*, opening the door to proliferation of similarly burdensome and potentially overlapping and conflicting state requirements that target ERISA fiduciaries based on their performance of ERISA responsibilities. Accordingly, there is an urgent need for this Court to resolve the circuit split and clarify the application of its ERISA preemption precedents to state laws that exploit ERISA plans to serve state interests.

I. The Court Should Clarify That Michigan And Other States Are Prohibited From Targeting ERISA Fiduciaries For Burdensome Regulation That Would Not Be Imposed But For Their Fulfillment Of ERISA Responsibilities

A. The Michigan Act Does Not Fall Within The Limited Exception To ERISA Preemption For State Laws That Have Purely Incidental Or Trivial Impacts On ERISA Plan Administration

This Court has repeatedly recognized that while parsing the broadly framed "relate[d] to" standard may be "unhelpful" in isolation to the preemption analysis, the ERISA preemption clause is "clearly expansive." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997). Thus, in *Ingersoll-Rand*, the Court described the broad preemptive sweep of ERISA in terms that should have governed this case:

> Where . . . Congress has expressly included a broadly worded preemption provision in a comprehensive statute such as ERISA, our task of discerning congressional intent is considerably simplified.
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> "The [ERISA § 514(a)] pre-emption clause is conspicuous for its breadth." *FMC Corp., supra* 498 U.S., at 58. Its "deliberately expansive" language was "designed to *establish pension plan regulation as exclusively a federal concern.*" *Pilot Life, supra,* 481 U.S.,

> at 46 *(quoting Alessi v. Raybestos-Manhattan, Inc.,* 451 U. S. 504, 451 U. S. 523 (1981)). The key to § 514(a) is found in the words "relate to." Congress used those words in their broad sense, rejecting more limited preemption language that would have made the clause "applicable only to state laws relating to the specific subjects covered by ERISA." *Shaw, supra,* 463 U.S., at 98.
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> "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw, supra,* at 96-97. Under this "broad common sense meaning," a state law may "relate to" a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect. *Pilot Life, supra,* 481 U.S., at 47. . . . Pre-emption is also not precluded simply because a state law is consistent with ERISA's substantive requirements. *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739 (1985).

Id., 498 U.S. at 138-39 (emphasis added).

In reaching a contrary conclusion, the court of appeals relied upon a series of cases decided between 1988 and 1997 in which this Court recognized certain narrow limitations to ERISA's express preemption mandate. The state laws that were upheld in those cases, however, are readily distinguishable from the Michigan Act. In *Mackey*

v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988), the Court held 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. Similarly, 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. And in two cases decided in 1997, the Court also rejected ERISA preemption challenges to state statutes that were generally applicable to employers and health service providers without regard to their ERISA capacity. *Dillingham,* 519 U.S. 316 (upholding state prevailing wage law that had only incidental effects on ERISA fiduciaries); *DeBuono v. NYSA Med. & Clinical Servs. Fund*, 520 U.S. 806, 820 (1997) (upholding state gross receipts tax that was imposed on income earned on patient services provided at hospitals, residential health care facilities, and diagnostic and treatment centers).

In all of the foregoing cases, 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).

B. The Michigan Act Is Not A Law Of "General Application," But One That Was Specifically Designed To Tap The Substantial Payment Streams Administered By ERISA Fiduciaries

The court of appeals relied upon this Court's approval of state levies in *Travelers* and *DeBuono* to conclude that the Michigan Act is not preempted, reasoning that the Act has only incidental effects on ERISA plans and administrators and leaving the district court's conclusion that the Act is a law of "general applicability" undisturbed. App. 6a. According to the decision below, "[t]he Act's only potential effects are to cut the plans' profits—as did the surcharges upheld in *Travelers* and *DeBuono*—and to create work independent of the core functions of ERISA." App. 10a; *see also* App. 13a (ERISA does not "bar states from imposing additional administrative burdens unrelated to the plans' core functions"). The court's characterization misses the forest for the trees, however, because in contrast to the state laws that were upheld in *Travelers*, *DeBuono*, 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 health care 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 health care 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");[13] (iii) and zeroes in on several essential "core functions" of ERISA welfare benefit plans: the processing and disbursement of payments for health care 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*, 463 U.S. at 98, 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.

13. 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.

As this Court has previously held, preemption will be found where a state law "mandate[s] employee benefits structures *or their administration*" or "acts immediately and exclusively upon ERISA plans . . . *or . . . the existence of ERISA plans is essential to the law's operation.*" *Dillingham*, 519 U.S. at 325, 328 (emphasis added).[14] Here, as the Second Circuit observed, the decisions that have recognized limited exceptions to ERISA preemption "do[] not allow . . . ERISA's core functions . . . to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense." *Donegan*, 746 F.3d at 510.

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14. In determining whether a state law improperly makes "reference to" an ERISA plan, this Court has stated that a state law is preempted if it acts "exclusively" upon ERISA plans. *See, e.g., Boggs v. Boggs*, 520 U.S. 833, 859 (1997) (considering whether a state law "act[ed] exclusively on, or rel[ied] on the existence of, ERISA plans"); *Dillingham*, 519 U.S. at 325 (a state law will be preempted if it "acts immediately and exclusively upon ERISA plans"). Exclusivity is not a prerequisite for ERISA preemption, however, because (i) the Court has repeatedly stricken down state laws that were not exclusively limited to ERISA plans; and (ii) logically, exclusivity is only one possible indicator of whether a state law unduly impinges on the protected sphere that Congress established by adopting the broad language in Section 514(a). *See, e.g., Shaw*, 463 U.S. at 98 (preempting state human rights law and noting that "[t]o interpret § 514(a) to preempt only state laws specifically designed to affect employee benefits plans would be to ignore the remainder of § 514").

C. The Decision Below Permits Imposition Of A Host Of Administrative Burdens On ERISA Plan Sponsors And Administrators That Directly Relate To Their Federally Protected, Fiduciary Responsibilities

The court of appeals concluded that, for ERISA preemption purposes, the burdens imposed by the Michigan Act are not "inappropriate" because they "just create additional administrative work *unrelated to the processing of the claims*" and the "reporting and record-keeping requirements come into play only when the . . . [administrator] compute[s] the tax." App. 9a, 16a (emphasis added); *see also* App. 11a (the Act "has no impact upon plan administration, as the [Supreme] Court has defined [it]"). The court's unduly restrictive conception of what constitutes protected plan administration is incorrect, because the administration of pension and welfare plans encompasses a host of responsibilities—including investing, recordkeeping, reporting and the standards of care attendant to those functions—that do not concern claims processing.

For that reason, this Court has repeatedly recognized that one of ERISA's principal goals is to shield plans and administrators from the expense of complying with conflicting or redundant state laws that shadow the discharge of the plans' responsibilities under federal law or would otherwise "produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels" or "refrain[ing] from adopting" plans altogether. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1,10-11 (1987); *accord Egelhoff*, 532 U.S. at 149-50 ("Requiring ERISA administrators to master the relevant laws of 50

States and to contend with litigation would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators - burdens ultimately borne by beneficiaries.'" (citation omitted));[15] *Travelers*, 514 U.S. at 656-57 ("the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction"). "Plan administration" is plainly not limited to the "processing of claims," because ERISA regulates a host of fiduciary responsibilities and actions regardless of whether they concern claim analysis and payment. *See* U.S. Dep't of Labor Emp. Benefits Sec. Admin., *Understanding Your Fiduciary Responsibilities Under a Group Health Plan* 2, 4–5, 9–11 (2013), *available at* http://www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html (fiduciary responsibilities of plan administrators include controlling plan assets, managing employee contributions, hiring and monitoring a service provider, furnishing plan information to participants and beneficiaries, and submitting reports to government agencies). Under the Michigan Act, a plan administrator's performance of its claim processing obligations consistent with ERISA and the procedures established by the plan, *including the data collected*

15. The Sixth Circuit's assertion that *Egelhoff* stands for the proposition that ERISA-preempted plan administration is limited to the "processing of claims and disbursement of benefits," App. 10a, fails to acknowledge both the broader language in that decision and the fact that *Egelhoff* itself concerned a dispute over a state law that required "ERISA plans to disburse benefits according to state law, rather than federal law." *Id.*

(or not collected) pursuant thereto, are essential to the administrator's calculation of "paid claims" and the state tax. *See, e.g.,* Mich. Comp. Laws § 550.1732(h) (defining "group health plan" as an ERISA "employee welfare benefit plan . . . to the extent that the plan provides medical care, including items and services paid for as medical care . . . as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.").

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.

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.

II. Review Is Needed To Resolve The Fundamental Disagreement Between The Second And Sixth Circuits Over The Proper Application Of This Court's ERISA Preemption Precedents To State Statutes That Have An Indisputable But-For Relationship To ERISA Plan Operations

A. The Recent Decisions Of The Second And Sixth Circuits Squarely Conflict

In *Donegan*, after performing a detailed review of this Court's ERISA preemption precedents, the Second Circuit struck down a Vermont regulatory scheme that required ERISA plan administrators to "report[] myriad categories of claims data." 746 F.3d at 500. The central objective of the Vermont scheme was data collection, not tax collection, but similar to the Michigan Act it required ERISA plan administrators to report to the State on a quarterly (or monthly) basis and imposed specific disclosure requirements that did not overtly regulate plan operations. The Second Circuit reasoned that, while "'[s]ome state actions may affect employee benefits plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan," *id*. at 504 (quoting *Shaw*, 463 U.S. at 100 n.21), a "paramount reason" for the preemption effected by ERISA "'was to minimize

the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government.'" *Id.* at 504-05 (quoting *Ingersoll-Rand*, 498 U.S. at 142). In contrast to the Sixth Circuit, the Second Circuit squarely held that state recordkeeping and reporting requirements related to benefits administration are preempted. *Donegan*, 746 F.3d at 508. The Second Circuit also rejected reliance on the presumption against preemption, noting that Vermont's data collection law was not an example of a historically exercised police power that pre-dated ERISA, but a recent enactment. *Id.* at 506 n.8 (if state laws "'[u]pset[] the deliberate balance central to ERISA,'" the presumption against preemption is overcome "even if those laws 'implement policies and values lying within the traditional domain of the States'" (quoting *Boggs*, 520 U.S. at 840, 854).

Supporting their pending certiorari petition in *Donegan*, Vermont and its six supporting state amici agree that the Second Circuit's decision conflicts with the Sixth Circuit's decision below. Petition for Certiorari, No. 14-181 (U.S. Aug. 13, 2014), at 14, 35 (noting that the circuit split "may generate another 'avalanche' of ERISA litigation"); Amicus Curiae Brief in Support of Petitioner, No. 14-181 (U.S. Sept. 15, 2014), at 3 (noting "circuit split on the fundamental character of ERISA preemption"). Moreover, if the ERISA preemption principles endorsed in *Donegan* were faithfully applied to the Michigan Act, the Act would be preempted on the grounds that (i) it acts directly, not incidentally, on ERISA fiduciaries to enlist them in the State's tax collection scheme; (ii) it imposes data collection, tabulation, reporting, audit and related obligations on ERISA fiduciaries that are burdensome and potentially inconsistent with the functions that fiduciaries discharge

consistent with federal law; and (iii) it is not entitled to any deference in the preemption analysis because it is a newly minted effort to require ERISA fiduciaries to do precisely what ERISA's express preemption provision forbids.

The Court has requested the views of the Solicitor General in *Donegan*, Order, No. 14-181 (U.S. Dec. 15, 2014), and it is timely and important for this Court to eliminate the ERISA preemption "quagmire" that underlies the current circuit court conflict and deter further state intrusions by making clear that state laws that impose significant burdens on ERISA plans and have a "but-for" nexus with plan operations "relate to" those plans under Section 514(a) and are federally preempted. *See Dillingham*, 519 U.S. at 335-36 (Scalia, J., concurring) ("Today's opinion is no more likely than our earlier ones . . . to bring clarity to this field . . . . [T]he 'relate to' clause of the [ERISA] pre-emption provision is meant, not to set forth a *test* for preemption, but rather to identify the field in which ordinary *field pre-emption* applies . . . ." (emphasis in original)). By adopting a straightforward "but-for" test, this Court can demarcate the boundaries of the field.

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

The decision below warrants review for the independent reason that the Sixth Circuit's reliance on an implied presumption against preemption to tilt the analysis in the Michigan's favor was improper. Contrary to the court's analysis below, the Michigan Act is not entitled to any 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 have referred to an implied presumption against preemption,[16] but whatever the validity of that presumption where Congress has expressly adopted preemption language, it does not survive analysis in this case for several reasons. First, similar to Vermont's decision to "mandate[] reporting to build a healthcare database," App. 16a, 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.").

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

16. *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.").

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 Trust 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, and there is similarly no support for that court's suggestion that the Act is immune from scrutiny unless and until an unspecified number of Michigan's sister states adopt similar tax laws with conflicting requirements.[17]

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17. Contrary to the court of appeals' reasoning, App. 18a & n.2, 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 determinations as to whether the accretion of such laws has reached a magical tipping point. 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, 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

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. at151 ("[W]e have not hesitated to find state family law pre-empted when it conflicts with ERISA or relates to ERISA plans."); *Boggs*, 520 U.S. at 840–41 (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 States"). Nothing in this Court's precedents permits a state to evade an express federal preemptive mandate by insisting that it is merely exercising "an 'important attribute of state sovereignty.'" App. 7a.

III. 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*, 482 U.S. at 9 (noting that an employer takes on a heavy burden when it decides to offer benefits plans to its employees, and that "[t]he

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to a patchwork of state [requirements]"); *see also Memphis Bank & Trust 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).

most efficient was 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—have 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 Section 514(a) and puts an end to such intrusions.[18]

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18. Given the importance of the issues presented and the conflict between the circuits, the Court should consider granting certiorari in both this case and *Donegan* and addressing the cases together.

CONCLUSION

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

Respectfully submitted,

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December 18, 2014

Appendix

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT, FILED AUGUST 4, 2014

UNITED STATES COURT OF APPEALS,
SIXTH CIRCUIT

No. 12-2264

SELF-INSURANCE INSTITUTE
OF AMERICA, INC.,

Plaintiff-Appellant,

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; ANDREW DILLON, in this official capacity as Treasurer of the State of Michigan,

Defendants-Appellees.

January 31, 2014, Argued
August 4, 2014, Decided
August 4, 2014, Filed

Before: BOGGS and MOORE, Circuit Judges; BARRETT, District Judge.*

* The Honorable Michael R. Barrett, United States District Judge for the Southern District of Ohio, sitting by designation.

OPINION

KAREN NELSON MOORE, Circuit Judge.

This case requires us, once again, to navigate the quagmire that is preemption. Plaintiff-Appellant, Self-Insurance Institute of America, Inc. ("SIIA"), represents various sponsors and administrators of self-funded ERISA benefit plans, which it claims are affected by Michigan's Health Insurance Claims Assessment Act. SIIA argues that federal law—the Supremacy Clause, U.S. Const. art. VI, § 2, and ERISA's express-preemption provision, 29 U.S.C. § 1144(a)—prohibits the application of the Act to ERISA-covered entities. The Michigan statute, however, escapes the preemptive reach of federal law, and we AFFIRM the district court's dismissal of SIIA's suit.

I. BACKGROUND

In 2011, Michigan passed the Health Insurance Claims Assessment Act ("the Act"), 2011 Mich. Pub. Acts 142, codified at Mich. Comp. Laws §§ 550.1731-1741, to generate the revenue necessary to fund Michigan's obligations under Medicaid. The Act functions by imposing a one-percent tax on all "paid claims" by "carriers" or "third party administrators" to healthcare providers for services rendered in Michigan for Michigan residents. §§ 550.1732(s), 550.1733(1). "Carriers" include sponsors of "group health plan[s]" set up under the strictures of the Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. No. 93-406, codified at 29 U.S.C. §§ 1002-1461. Mich. Comp. Laws § 550.1732(a), (h). On top

of the tax, every carrier and third-party administrator paying the tax must submit quarterly returns with the Michigan Department of the Treasury and "keep accurate and complete records and pertinent documents as required by the department." §§ 550.1734(1), 550.1735(1). Every carrier and third-party administrator must also "develop and implement a methodology by which it will collect the [tax]" subject to several conditions. § 550.1733a(2).

In district court, SIIA filed suit against Rick Snyder, the Governor of Michigan; R. Kevin Clinton, the Director of the Michigan Office of Financial and Insurance Regulation ("OFIR"); and Andrew Dillon, Treasurer of Michigan. R. 1 at 1 (Compl.) (Page ID #1). SIIA sought a declaratory judgment, which would state that ERISA preempted the Act, and an injunction, which would prevent implementation and enforcement of the Act against the ERISA-covered entities. *Id.* The defendants filed a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a valid claim. R. 14 at 1 (Mot. to Dismiss) (Page ID #33). The district court granted this motion after concluding that the Act did not offend ERISA's express-preemption clause because the Act did not "'relate to'" an ERISA-governed benefit plan. R. 41 at 9 (Am. D. Ct. Order) (Page ID #480) (quoting 29 U.S.C. § 1144(a)). SIIA now appeals.

II. STANDARD OF REVIEW

We review de novo a district court's dismissal of a claim pursuant to Rule 12(b)(6). *Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.* ("*PONI*"), 399 F.3d

692, 697 (6th Cir. 2005). Whether ERISA preempts a state law is a question of federal law that we also review de novo. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988).

III. ANALYSIS

"Congress enacted ERISA to 'protect . . . the interests of participants in employee benefit plans and their beneficiaries' by setting out substantive regulatory requirements for employee benefit plans and to 'provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts.'" *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004) (quoting 29 U.S.C. § 1001(b)) (alteration and ellipses in original). Accordingly, ERISA makes plan administrators fiduciaries, *see* 29 U.S.C. § 1104; imposes liabilities on plan administrators, *see* § 1109; requires plan administrators to disclose specific information and to file reports with the Secretary of Labor, *see* § 1021(a), (b); mandates that plan administrators retain records for substantial periods of time, *see* § 1027; and creates an exclusive enforcement mechanism, *see* § 1132. Along with these burdens, however, the statute also seeks "to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208; *see also Conkright v. Frommert*, 559 U.S. 506, 130 S. Ct. 1640, 1649, 176 L. Ed. 2d 469 (2010). Thus, ERISA contains a broad preemption provision that "supersede[s] any and all State laws insofar as they . . . relate to any employee benefit plan" that falls under the regulation of the comprehensive federal scheme. 29 U.S.C. § 1144(a).

The Supreme Court has called ERISA's express-preemption provision "broadly worded" and "deliberately expansive." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 324, 117 S. Ct. 832, 136 L. Ed. 2d 791 (1997) (internal quotation marks omitted). The Court, however, has found providing useful guidance in this area to be difficult and defining "relates to" to be a "frustrating" task. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995). We readily concur. The statutory text is simply "unhelpful" because "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.'" *Id.* at 655-56 (1995) (quoting Henry James, *Roderick Hudson* xli (New York ed., World's Classics 1980)); *see also Dillingham*, 519 U.S. at 335 (Scalia, J., concurring) ("[A]pplying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else."). The best guidance that the Court has been able to give us is to say that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983).

SIIA contends that ERISA preempts the Act because the Act has an impermissible connection with employee benefit plans, namely that it (1) interferes with the administration of the plans; (2) imposes administrative

burdens in addition to those prescribed by ERISA; and (3) interferes with the relationships between ERISA-covered entities. In their amicus briefs, the Iron Workers Health Fund of Eastern Michigan ("Iron Workers Fund") and the Detroit and Vicinity Trowel Trades Health and Welfare Fund ("Trowel Trades Fund") argue that the Act inappropriately references ERISA plans. The district court rejected both arguments. We agree and **AFFIRM** the dismissal of SIIA's claims.

A. "Connection With"

We begin with SIIA's allegations that the Act has an impermissible connection with ERISA plans. The district court rejected this argument in its entirety, finding that the Act was a law of "'general applicability,'" R. 41 at 18 (D. Ct. Am. Order) (Page ID #489) (quoting *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 820, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997)), that "does not mandate any particular benefit structure or bind administrators to certain benefits choices," *id.* at 16 (Page ID #487). On appeal, SIIA makes several, slightly different arguments as to different sections of the statute, and we address each in turn.

1. Legal Standard

In determining whether a state law has an impermissible connection with ERISA plans, we start with the presumption that Congress did not intend to preempt state laws, particularly in areas of traditional state concern. *Travelers*, 514 U.S. at 654; *Associated*

Builders & Contractors v. Michigan Dep't of Labor & Economic Growth, 543 F.3d 275, 280 (6th Cir. 2008) (citing *Dillingham*, 519 U.S. at 332). In this case, we are concerned with a state tax and its ancillary requirements, a type of law long recognized as an important "attribute of state sovereignty." *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 555 (6th Cir. 1987) (citing *County of Lane v. Oregon*, 74 U.S. (7 Wall.) 71, 76-77, 19 L. Ed. 101 (1869)); *see also Thiokol Corp. v. Roberts*, 76 F.3d 751, 755 (6th Cir. 1996) (citing *Fair Assessment in Real Estate Ass'n, Inc. v. McNary*, 454 U.S. 100, 103, 102 S. Ct. 177, 70 L. Ed. 2d 271 (1981)). Therefore, the presumption applies with special force in this case, and overcoming it "requires two showings . . . : (1) the law at issue must mandate (or effectively mandate) something, and (2) that mandate must fall within the area that Congress intended ERISA to control exclusively." *Associated Builders*, 543 F.3d at 281.

All agree that "[t]he purpose of ERISA preemption was to avoid conflicting federal and state regulation and to create a nationally uniform administration of employee benefit plans." *PONI*, 399 F.3d at 698. In line with this congressional intent, we have held that "ERISA preempts state laws that (1) mandate employee benefit structures or their administration; (2) provide alternate enforcement mechanisms; or (3) bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself." *Id.* (internal quotation marks omitted). "Congress did not intend, however, for ERISA 'to preempt traditional state-based laws of general applicability that do not implicate the relations among the traditional ERISA

plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries.'" *Id.* (quoting *LeBlanc v. Cahill*, 153 F.3d 134, 147 (4th Cir. 1998)). In short, ERISA does not "create a state-law-free zone around everything that affects an ERISA plan . . . ." *Associated Builders*, 543 F.3d at 284. Therefore, SIIA must show that the Act (1) "mandates an aspect of law with which ERISA is concerned," such as the administration of the plan itself, *id.* at 280, or (2) interferes with the relationship between ERISA-covered entities, *PONI*, 399 F.3d at 698.

2. The Act Does Not Interfere with Plan Administration

SIIA first claims that the Act interferes with uniform plan administration. This argument takes two forms. One, SIIA focuses upon the Act's definition of "paid claims" and argues that the state law's definition of a claim may conflict with a plan's definition of a claim. Appellant Br. at 35-36; *see also* Mich. Comp. Laws § 550.1732(s) (defining "Paid claims"). Two, SIIA argues that the Act's reporting and record-keeping requirements jeopardize "uniform administrative practice." Appellant Br. at 29; *see also* Mich. Comp. Laws §§ 550.1734, 550.1735. However, for all of the pages that SIIA devotes to documenting ERISA's concern with uniformity, SIIA never actually explains how the Act changes or interferes with plan administration. In reality, the Act does not require a plan administrator to change how it administers the plan at all, and thus, this argument fails.

To start, SIIA fails to grasp that ERISA guarantees uniformity only with regard to the "administration *of employee benefit plans*." *PONI*, 399 F.3d at 698 (emphasis added). Neither the Act's definition of "paid claims" nor its reporting and record-keeping requirements conflict with the administrator's "standard procedures to guide processing of claims and disbursement of benefits."[1] *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9, 107 S. Ct. 2211, 96 L. Ed. 2d 1 (1987); *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir. 1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."). The state's definition of "paid claims" applies, and the state's reporting and record-keeping requirements come into play, only when the carriers compute the tax—a function entirely divorced from plan administration. The Act's provisions simply do

1. For that matter, the Act does not mandate that a plan provide certain kinds of benefits either. *See De Buono v. NYSA-ILA Medical & Clinical Servs. Fund*, 520 U.S. 806, 815 n.13, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997) (citing *Shaw*, 463 U.S. 85, 103 S. Ct. 2890, 77 L. Ed. 2d 490). Nor does the Act force a plan to provide a certain level of benefits. *See Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007). Nor does it require an administrator to pay benefits to someone not specified by the plan, *see Egelhoff v. Egelhoff*, 532 U.S. 141, 150, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001), to calculate benefits in a certain manner, *see Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524-25, 101 S. Ct. 1895, 68 L. Ed. 2d 402 (1981), or to act as a beneficiary's agent, *see UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379, 119 S. Ct. 1380, 143 L. Ed. 2d 462 (1999).

not conflict with the plan or impact its administration. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985) (noting that ERISA "displace[s] all state laws that *fall within its sphere*" (emphasis added)). The Act's only 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—as do permissible state property and employment laws. *See Thiokol*, 76 F.3d at 755 ("[T]he Supreme Court does not require that state laws have absolutely zero effect on ERISA plans, for this likely would be impossible as a matter of logic or practicality. State property, contract, and tort law all surely have some effect on ERISA plans, but they are not pre-empted."); *Firestone*, 810 F.2d at 555.

At oral argument and in its briefing, SIIA relied heavily upon *Egelhoff v. Egelhoff*, 532 U.S. 141, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001), in support of its view. But that case ultimately cuts against SIIA. In *Egelhoff*, the Supreme Court did state that "[o]ne of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme," but, importantly, it defined that scheme as the "set of standard procedures *to guide processing of claims and disbursement of benefits*." *Id.* at 148 (internal quotation marks omitted) (emphasis added). The state law at issue in *Egelhoff* directed ERISA plans to disburse benefits according to state law, rather than the plan documents. *Id.* at 147. The Court struck down this statute because it "directly conflict[ed] with ERISA's requirements that *plans be administered*, and *benefits be paid*, in accordance with plan documents." *Id.* at 150

(emphasis added). If the Act involved here altered which benefits were offered, how they were calculated, or to whom they were dispersed, under *Egelhoff*, it would be preempted. It does none of these things; it has no impact upon plan administration, as the Court has defined that concept. Thus, *Egelhoff* does not compel us to hold the Act preempted for interfering with plan administration.

3. The Act Does Not Create Inappropriate Administrative Burdens

Next, SIIA argues that ERISA preempts §§ 550.1734 and 550.1735 of the Act, which require carriers and third-party administrators to file reports and to keep certain records, because they allegedly add to ERISA's administrative requirements. There is no doubt that Congress intended for plan administrators to file various reports and to maintain the records that serve as the basis for those reports. *See* 29 U.S.C. §§ 1021, 1027. The question is whether Congress intended these ERISA provisions to preclude states from enacting laws imposing administrative burdens—of any kind—upon plan administrators and sponsors unrelated to the administration of the plans. *See Travelers*, 514 U.S. at 655; *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248-49, 104 S. Ct. 615, 78 L. Ed. 2d 443 (1984). Logic and case law require us to answer that question in the negative.

Here, principles of field preemption guide our inquiry into congressional intent. *See Dillingham*, 519 U.S. at 336 (Scalia, J., concurring). Under this doctrine,

> Congress' intent to supersede state law altogether may be inferred because "[t]he scheme of federal regulation may be so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it," because "the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject," or because "the object sought to be obtained by federal law and the character of obligations imposed by it may reveal the same purpose."

Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta, 458 U.S. 141, 153, 102 S. Ct. 3014, 73 L. Ed. 2d 664 (1982) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S. Ct. 1146, 91 L. Ed. 1447 (1947)) (alteration in original).

In this case, it is clear that Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans. The Supreme Court has recognized that "ERISA is designed to ensure the proper administration of pension and welfare plans, both during the years of the employee's active service and in his or her retirement years." *Boggs v. Boggs*, 520 U.S. 833, 839, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997). In other words, "ERISA is principally concerned with protecting the financial security of plan participants and beneficiaries." *National Sec. Sys., Inc. v. Iola*, 700 F.3d 65, 81 (3d Cir. 2012) (citing *Boggs*, 520 U.S. at 845; *Shaw*, 463 U.S. at 90); *see also Hamilton v. Washington State*

Plumbing & Pipefitting Indus. Pension Plan, 433 F.3d 1091, 1095 (9th Cir. 2006). "To this end, the statute sets forth detailed disclosure and reporting obligations for plans and imposes various participation, vesting, and funding requirements." *Iola*, 700 F.3d at 81 (referencing, *inter alia*, 29 U.S.C. §§ 1021, 1027). In the language of *Fidelity Federal*, this scheme is "pervasive," and therefore, we conclude that Congress intended to ERISA to preempt state laws requiring ERISA entities to file reports related to the plans' financial stability.

This basic conclusion, however, does not mean that Congress intended federal law to bar states from imposing additional administrative burdens unrelated to the plans' core functions. In fact, several cases indicate to us that the opposite is true. First, in *Travelers*, the Supreme Court upheld a New York law that required ERISA-covered hospitals to collect surcharges from certain patients. 514 U.S. at 649. That law also required the hospitals to "furnish to the [state tax] department such reports and information as may be required by the commissioner to assess the cost, quality and health system needs for medical education provided." N.Y. Pub. Health Law § 2807-c(25)(b) (McKinney 1993). Second, in *De Buono*, the Supreme Court upheld another New York law that "impos[ed] a gross receipts tax on the income of medical centers operated by ERISA funds." 520 U.S. at 809. That law required "[e]very hospital [to] submit reports on a cash basis of actual gross receipts received from all patient care services . . . ." N.Y. Pub. Health Law § 2807-d(7)(a) (McKinney 1993). Admittedly, neither *Travelers* nor *De Buono* explicitly concerned reporting requirements

regarding the taxes, but those requirements were essential parts of the tax schemes and drew no comment. While we are generally slow to infer approval through silence, in this case we think it merited given that the Supreme Court had previously refused to find a Georgia statute preempted merely because it imposed "substantial administrative burdens." *Mackey*, 486 U.S. at 831.

Finally, under SIIA's logic, states would not be able to require ERISA-covered entities to submit any paperwork or preserve any records in any circumstances. As a result, ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records. We have said, time and again, that ERISA does not reach so far. *See, e.g., Thiokol*, 76 F.3d at 755; *Firestone*, 810 F.2d at 555-56; *see also De Buono*, 520 U.S. at 816 ("Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute."). We see no reason to change course now.

SIIA's arguments to the contrary are unpersuasive. To start, it points us toward *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993), in which the Fifth Circuit held that ERISA preempted Article 21.07-6 of the Texas Insurance Code. *Id*. at 299. The scope and substance of Article 21.07-6, however, are a far cry from the requirements of the Act involved here. Article 21.07-6 mandated the inclusion of certain terms in the plan, Tex. Ins. Code Ann. art. 21.07-6, §§ 11, 16 (West 1993); it set a

timeframe for adjudicating claims, *id*. at § 17; and it gave the state access to information for the purpose of judging the plan's financial soundness, *id*. at § 8. Each of these requirements plainly offends a core aspect of ERISA. In particular, Article 21.07-6 requires reporting related to the plan's financial solvency, a requirement clearly within ERISA's sphere. The Act here requires none of this. To the extent that the Act requires reporting and record-keeping, it is only to guarantee that the carriers pay the correct amount of tax. *See* Mich. Comp. Laws §§ 550.1734(1), 550.1735(1)-(3). As noted above, such recordkeeping requirements accompany all taxes and remain in force despite ERISA. Accordingly, we find *Barnes* to be factually distinct from the situation here.

SIIA also cites *Liberty Mutual Insurance Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014). In *Liberty Mutual*, a divided panel of the Second Circuit held that ERISA preempted a Vermont statute that requires "all health insurers (including self-insured plans) to file with the State reports containing claims data and other information relating to health care." *Id*. at 499 (referencing Vt. Stat. Ann. tit. 18, § 9410) (internal quotation marks omitted). This data included highly sensitive and extensive information on the types of services provided, the demographics of the beneficiaries, and the patients' diagnoses—all of which had to be collected, coded, and reported in a particular manner. *Id*. at 509. The Second Circuit based its holding on "the principle (undisturbed by *Travelers*) that 'reporting' is a core ERISA function shielded from potentially inconsistent and burdensome state regulation." *Id*. at 508. For the reasons explained above, we disagree

with this literal approach to preemption. And as Judge Straub stated in dissent, "the majority's argument misses the nuance of what 'reporting' means in the context of ERISA, and ignores the case law's focus on whether the *administration of benefits to beneficiaries* is impacted, an issue on which there is no showing." *Id*. at 512 (Straub, J., dissenting).

In addition, *Liberty Mutual* can be distinguished on two other grounds. One, here the Act's reporting requirements are intimately related to a state tax—a traditional area of state concern that we presume Congress left untouched. In contrast, the Vermont statute mandates reporting to build a healthcare database, a purpose not entitled to the presumption. Two, according to the Second Circuit, the Vermont statute effectively gave the ERISA plan a choice: (1) allow its third-party administrator to turn over the data in violation of its plan document, which protected beneficiaries' privacy; or (2) direct the third-party administrator not to comply with the law and then indemnify it according to their contract. *Id*. at 502; *see also id*. at 502 n.4 (relying upon floor statements of individual members of Congress). Under our conception of the ERISA preemption provision, state laws cannot put this choice to the ERISA-covered entities. The Vermont scheme actually affects the administration of the plans; it does not just create additional administrative work unrelated to the processing of the claims, as the Act involved here does. For these reasons, we do not find *Liberty Mutual* persuasive or helpful. As a result, we are not persuaded by SIIA's counterarguments, and we hold that ERISA does not preempt §§ 550.1734 and 550.1735 of the Act.

4. The Act's Residency Requirement Does Not Interfere with the Relationships Between ERISA-Covered Entities

SIIA's next claim is that the Act's limitation of the tax to claims paid on behalf of Michigan residents effectively alters the relationship between plan administrators and plan beneficiaries because the requirement forces the administrators to collect additional information from beneficiaries. We disagree.

Under Michigan law, an individual is a Michigan resident if the individual considers the state her domicile. Mich. Admin. Code § 550.404(1). Domicile, perhaps problematically, is a subjective determination. § 550.404(2). SIIA fears that administrators will need to ask a beneficiary which state she considers "her fixed, permanent and principal home . . ." to comply with the Act, a change in their relationship and potentially burdensome in the aggregate. *Id*. If this were an accurate recitation of the current state of the law, we might be inclined to agree that the residency requirement alters the ERISA-covered entities' relationships in form, if not substance. But the same regulation that problematically defines residency also obviates the need for a carrier to communicate with the beneficiaries. Section 550.404(3) of the Michigan Administrative Code states in full:

> A rebuttable presumption shall exist that an individual's home address, as maintained in the ordinary business records of a carrier or third-party administrator, indicates the domicile of

> that individual under this definition. Example: An individual who is domiciled in Michigan, but attends college in another state, is a Michigan resident for purposes of the Act. If that individual obtains health services in Michigan while home between semesters, a "paid claim" for the performance of those services will be subject to the assessment under the Act.

By defining residency by reference to the administrators' already-existing business records, Michigan leaves the relationship between ERISA-covered entities untouched. As a result, we do not believe Congress intended ERISA to preempt the Act's residency requirement.[2]

5. Section 550.1733a Does Not Interfere with the Relationships Between ERISA-Covered Entities

SIIA finally argues that Michigan Compiled Laws § 550.1733a(2) requires carriers and third-party

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2. We recognize that each of the fifty states might enact similar taxes and that multiple states could potentially claim an individual, perhaps a student, as a resident. This scenario could be burdensome to ERISA-covered entities. This state of affairs, however, is hypothetical and not before us at this point. We prefer to rule based on concrete facts rather than a blind appraisal of future events, but we note in passing that each of the fifty states has its own property, income-tax, and employment laws that act upon ERISA-covered entities and are not preempted. It is unclear whether these residency requirements would be any different.

administrators to alter their relationship with ERISA-covered entities by mandating that carriers and third-party administrators collect the tax from them. We disagree. Section 550.1733a(2) states: "[a] carrier or third party administrator shall develop and implement a methodology by which it will collect the assessment levied under [the Act] from an individual, employer, or group health plan, subject to [certain conditions]." Importantly, Michigan has interpreted this section of its statute to say "the collection of the assessment from these parties by carriers and third-party administrators is permissive." Mich. Admin. Code § 550.402(1). Under this interpretation, § 550.1733a(2) does not force carriers and third-party administrators to change their plan documents. Therefore, there is no ERISA-preemption issue.

B. "Refers To"

The Iron Workers Fund and the Trowel Trades Fund ask us to hold that the Act makes an inappropriate reference to ERISA-regulated employee benefit plans, triggering the operation of § 1144(a). Regardless of the merits of this contention, there is a procedural problem: SIIA has explicitly waived this argument. Amici cannot revive it.

In its opening brief, SIIA forthrightly states that "[it] does not appeal the District Court's conclusion that the Act does not have a 'reference to' ERISA plans." Appellant Br. at 28. By conceding this issue, SIIA has waived it, and this waiver generally precludes us from considering the issue. *See, e.g., Demyanovich v. Cadon*

Plating & Coatings, LLC, 747 F.3d 419, 434 n.6 (6th Cir. 2014); *Bickel v. Korean Air Lines Co.*, 96 F.3d 151, 153 (6th Cir. 1996). Furthermore, we have stated that "[w]hile an amicus may offer assistance in resolving issues properly before a court, it may not raise additional issues or arguments not raised by the parties. To the extent that the amicus raises issues or makes arguments that exceed those properly raised by the parties, we may not consider such issues." *Cellnet Commc'ns, Inc. v. FCC*, 149 F.3d 429, 443 (6th Cir. 1998); *see also New Jersey v. New York*, 523 U.S. 767, 781 n.3, 118 S. Ct. 1726, 140 L. Ed. 2d 993 (1998) (stating that courts "must pass over" arguments of amici that the named party to the case "has in effect renounced"); 16AA Charles Alan Wright et al., *Federal Practice & Procedure* § 3975.1 (4th ed. 2008) ("In ordinary circumstances, an amicus will not be permitted to raise issues not argued by the parties."). Otherwise, outside parties could hijack litigation quite easily. Therefore, to avoid this result, we hold that SIIA has waived this issue and, therefore, decline to consider its validity.

IV. CONCLUSION

For the above-stated reasons, we **AFFIRM** the district court's dismissal of SIIA's claims.

APPENDIX B — AMENDED ORDER OF THE UNITED STATES DISTRICT COURT, EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION, FILED AUGUST 31, 2012

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case number 11-15602

SELF-INSURANCE INSTITUTE
OF AMERICA, INC.,

Plaintiff,

v.

RICK SNYDER *et al.*,

Defendants.

August 31, 2012, Decided
August 31, 2012, Filed

AMENDED ORDER

JULIAN ABELE COOK, JR., District Judge.

In this case, the Plaintiff, the Self-Insurance Institute of America, Inc. ("SIIA"), seeks to obtain a declaration from the Court that the Michigan Health Insurance Claims Assessment Act ("Act"), P.A. 142 of 2011, Mich. Comp. Laws § 550.1731 *et seq.*, (1) is preempted by the

Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, and (2) violates the Supremacy Clause of the United States Constitution. SIIA has also filed a petition to obtain an injunction which, if granted, would preclude the enforcement of the Act. Currently before the Court is the Defendants'[1] motion to dismiss the complaint for failure to state a claim upon which relief can be granted pursuant to Fed. R. Civ. P. 12(b)(6).

The Court has previously granted two motions by the following non-parties for leave to file briefs as *amici curiae*: (1) the Michigan Health & Hospital Association, the Michigan State Medical Society, the Michigan Osteopathic Association, and the Small Business Association of Michigan ("joint *amici*") and (2) the Michigan Association of Health Plans ("MAHP"). As explained in more detail in that order, the *amici* are associations whose members are directly affected by the Act.

I.

The Act imposes an assessment of 1% on the value of all claims paid by every carrier or third party administrator for medical services that are rendered in Michigan to a resident of Michigan. Act § 3(1), Mich. Comp. Laws § 550.1733(1). The proceeds from these assessments will be used to finance Michigan's portion of Medicaid program

1. The Defendants—all of whom were named in their official capacities only—are Rick Snyder, the Governor of the State of Michigan; R. Kevin Clinton, the Director of the Office of Financial and Insurance Regulation; and Andy Dillon, the Treasurer of the State of Michigan.

expenditures.[2] As defined in the Act, the word "carrier" includes, *inter alia*, certain "group health plan sponsor[s]." Act § 2(a)(v), Mich. Comp. Laws § 550.1732(a)(v). A "group health plan," in turn, is defined as "an employee welfare benefit plan as defined in [ERISA], to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise." Act § 2(h), Mich. Comp. Laws § 550.1732(h). SIIA contends that, as it applies to self-funded ERISA plans, the Act is preempted by ERISA.

II.

When considering a motion to dismiss under Rule 12(b)(6) of the Federal Rules of Civil Procedure, the Court accepts the plaintiff's well-pleaded allegations as true and construes each of them in a light that is most favorable to it. *Bennett v. MIS Corp.*, 607 F.3d 1076, 1091 (6th Cir. 2010). However, this assumption of truth does not extend to the plaintiff's legal conclusions because "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009). The complaint "must contain either direct or inferential allegations respecting all material elements to

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2. The Act was enacted in response to concerns that had been expressed by the Centers for Medicare & Medicaid Services that the previous funding mechanism—namely, a 6% tax on Medicaid managed-care organizations - was invalid, thus potentially jeopardizing federal reimbursements for Medicaid expenditures.

sustain a recovery under some viable legal theory." *Bishop v. Lucent Techs., Inc.*, 520 F.3d 516, 519 (6th Cir. 2008) (citation and internal quotation marks omitted).

In order to survive an application for dismissal, the complaint must allege "enough facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007). To meet this standard, the "plaintiff [must] plead[ ] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678. In essence, "[a] pleading that states a claim for relief must contain . . . a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2).

In considering a 12(b)(6) motion, "documents attached to the pleadings become part of the pleading and may be considered." *Commercial Money Ctr., Inc. v. Ill. Union Ins. Co.*, 508 F.3d 327, 335 (6th Cir. 2007) (citing Fed. R. Civ. P. 10(c)). "In determining whether to grant a Rule 12(b)(6) motion, the court primarily considers the allegations in the complaint, although matters of public record, orders, items appearing in the record of the case, and exhibits attached to the complaint, also may be taken into account." *Amini v. Oberlin Coll.*, 259 F.3d 493, 502 (6th Cir. 2001) (emphasis omitted)). Moreover, "documents that a defendant attaches to a motion to dismiss are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to [the plaintiff's] claim." *Weiner, D.P.M. v. Klais & Co.*, 108 F.3d 86, 88 n.3 (6th Cir. 1997); *see also Bassett v. NCAA*, 528 F.3d 426,

430 (6th Cir. 2008). Supplemental documents attached to the motion to dismiss do not convert the pleading into one for summary judgment where the documents do not "rebut, challenge, or contradict anything in the plaintiff's complaint." *Song v. City of Elyria*, 985 F.2d 840, 842 (6th Cir. 1993) (citing *Watters v. Pelican Int'l, Inc.*, 706 F. Supp. 1452, 1457 n.1 (D. Colo. 1989)).

III.

A. *Jurisdiction and Associational Standing*

The SIIA has invoked the federal question jurisdiction of this Court, 28 U.S.C. § 1331, pointing to the Supremacy Clause of the United States Constitution and § 502 of ERISA, 29 U.S.C. § 1132(a) ("A civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan . . . ."). The action is also brought pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, which grants authority to the federal courts to "declare the rights and other legal relations of any interested party seeking such declaration" so long as there exists "a case of actual controversy within [the federal courts'] jurisdiction."

There is a split among the circuit courts with respect to whether the Tax Injunction Act ("TIA"), 28 U.S.C. § 1341 ("The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State."), nevertheless bars

federal court review of ERISA-based challenges to state tax laws. *Compare Hattem v. Schwarzenegger*, 449 F.3d 423 (2d Cir. 2006) (TIA does not bar federal court review of claim that state tax law is preempted by ERISA because exclusive federal jurisdiction provision of ERISA means that there is no "plain, speedy and efficient" remedy in state court), *Thiokol Corp. v. Dep't of Treasury*, 987 F.2d 376 (6th Cir. 1993) (same), *and E-Sys., Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991) (same), *with Darne v. Department of Revenue*, 137 F.3d 484 (7th Cir. 1998) (TIA bars claim because state tax practice provides "plain, speedy and efficient" remedy), *and Chase Manhattan Bank, N.A. v. City & Cnty. of San Francisco*, 121 F.3d 557 (9th Cir. 1997) (TIA precludes claim because ERISA's grant of exclusive federal jurisdiction not intended to create exception to TIA); *see also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund.*, 520 U.S. 806, 817, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997) (Scalia, J., dissenting) (noting split among circuits, and expressing "uncertain[ty about] the federal courts' jurisdiction" over ERISA-based challenges to state tax laws). However, because the Sixth Circuit has held that the TIA does not bar federal court review under these circumstances, *Thiokol*, 987 F.2d at 380-81, the Court concludes that—regardless of whether the Act is a tax or an insurance law, *see infra* Section III.B—it is authorized to adjudicate this matter.

SIIA is a trade association that represents companies which sponsor and administer self-funded ERISA welfare plans, including plan sponsors, plan administrators, and third-party administrators. It has commenced this litigation on behalf of its members, who, it claims, are

directly and adversely affected by the Act. An "association has standing to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 343, 97 S. Ct. 2434, 53 L. Ed. 2d 383 (1977) (citing *Warth v. Seldin*, 422 U.S. 490, 95 S. Ct. 2197, 45 L. Ed. 2d 343 (1975)). When assessing standing, a court "must accept as true all material allegations of the complaint, and must construe the complaint in favor of the complaining party." *Warth*, 422 U.S. at 501. Although it is also within the reviewing court's "power to allow or to require the plaintiff to supply, by amendment to the complaint or by affidavits, further particularized allegations of fact deemed supportive of plaintiff's standing," *id.*, such a showing does not appear necessary here. The Court is satisfied that the three elements of the associational standing test have been met.

First, SIIA alleges that its "members include employers, plan sponsors, plan administrators and third party administrators who will be assessed and regulated by the Act, including members who function as ERISA fiduciaries with respect to the processing and payment of medical claims." (Compl. ¶ 20). The fiduciary-members would be empowered to initiate this civil action "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3)(A). Moreover, the employers, sponsors,

and administrators will be affected by the Act insofar as they will be required to pay the claims assessment and undertake the associated administrative burdens. (Compl. ¶¶ 17-19). This lawsuit was initiated only ten days before the effective date of the Act, so the alleged injury was sufficiently imminent at the time of filing. *See Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298, 99 S. Ct. 2301, 60 L. Ed. 2d 895 (1979) ("[O]ne does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough." (citation and internal quotation marks omitted)). SIIA has properly alleged that the Act would cause its members to suffer a cognizable injury, and that the relief it seeks would redress that injury, within the meaning of *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 112 S. Ct. 2130, 119 L. Ed. 2d 351 (1992). Thus, the members of SIIA would have standing to sue in their own right. *See also Self-Ins. Inst. of Am., Inc. v. Korioth*, 993 F.2d 479 (5th Cir. 1993) (SIIA had prudential standing to challenge Texas law imposing tax on contract administrators on behalf of its members, because (1) at least some members were fiduciaries, and (2) all members (a) would be affected by the law, and (b) provide services to ERISA plans and were therefore within ERISA's zone of interest (citing *Ass'n of Data Processing Serv. Orgs. v. Camp*, 397 U.S. 150, 153, 90 S. Ct. 827, 25 L. Ed. 2d 184 (1975))); *Self-Ins. Inst. of Am., Inc. v. Gallagher*, No. TCA 867308 WS, 1989 U.S. Dist. LEXIS 13942, 1989 WL 143288, at *7 (N.D. Fla. June 2, 1989) (SIIA had standing to challenge Florida statutes governing its members' business activities because "SIIA employer/plan sponsors and contract administrators, by those activities with

respect to self-funded ERISA employee benefit plans, are clearly subjected to the regulatory effects of the challenged Florida statutes").

The second and third prongs of the *Warth*test are plainly satisfied. The SIIA's organizational purpose is to represent the interests of companies that sponsor and administer self-funded ERISA plans—interests that are implicated by the challenged Act. Finally, because the claim asserted and relief requested would affect the membership as a whole, the members' individual participation is not necessary. Therefore, because all three elements of the *Warth* test for associational standing are satisfied, SIIA may properly represent its members in this litigation.

B. *Parties' and Amici's Arguments*

SIIA argues that the Act—as it applies to its members—is preempted under ERISA § 514(a) because it relates to an ERISA plan. *See* ERISA 514(a), 29 U.S.C. § 1144(a) (ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA). It advances two main arguments in favor of a finding of preemption. First, the Act refers to ERISA and ERISA plans in its text. Second, the Act has an impermissible connection with an ERISA plan because it interferes with the uniform nationwide administration of ERISA plans and it imposes impermissible burdens and fees on those plans.

The Defendants argue that the Act does not fall within the scope of ERISA preemption because it is a generally applicable tax that has only an indirect economic influence on any ERISA plan's choices; it does not bind plan administrators to any particular choice about plan benefits, structure, or administration or otherwise preclude uniform administration of the plan. In the alternative, it argues that, if the Act is preempted by ERISA § 514(a), it is saved by ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), as a law that regulates insurance.

Amicus MAHP adopts the Defendants' arguments as outlined above, and advances, as an independent reason to dismiss the complaint, the argument that state laws which further the objectives of federal laws—here, the Medicaid Act—are not preempted by ERISA. *See* ERISA § 514(d), 29 U.S.C. § 1144(d) ("Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law."); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983). The joint *amici* adopt and amplify the Defendants' argument that the Act does not "relate to" ERISA plans, and thus does not fall within the preemptive scope of § 514(a).

C. *The Act Does Not "Relate to" ERISA Plans*

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions . . . which are intended to ensure that employee benefit plan

regulation would be exclusively a federal concern." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 208, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004) (citations and internal quotation marks omitted). The preemption provision provides that ERISA "supersedes any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA. 29 U.S.C. § 1144(a).

The Supreme Court has held that a state law will "relate to" an ERISA plan if it makes reference to or has a connection with the plan. *Shaw*, 463 U.S. at 96-97. Although earlier cases operated from the premise that "relate to" should be construed in extremely broad terms, in 1995, the Supreme Court noted that, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for [r]eally, universally, relations stop nowhere." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995) (citation and internal quotation marks omitted); *see also Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp.*, 399 F.3d 692, 697 (6th Cir. 2005) ["*PONI*"] (describing evolution of doctrine). But such a result would be inconsistent with the general starting presumption against preemption and the clear Congressional intent that the words "insofar as they . . . relate" impose at least some degree of limitation on the scope of the preemption provision. *Travelers*, 514 U.S. at 655; *see also De Buono*, 520 U.S. at 814 n.8 ("Where federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the assumption that the historic police powers of the States were not to be

superseded by the Federal Act unless that was the clear and manifest purpose of Congress." (citations and internal quotation marks omitted); *id.* at 814 ("[T]he historic police powers of the State include the regulation of matters of health and safety."); *Thiokol Corp. v. Roberts*, 76 F.3d 751, 755 (6th Cir. 1996) ("Although . . . a state law's status as a tax is not dispositive on the issue of whether the law escapes pre-emption, we are mindful that federal courts must give due respect to the fundamental principle of comity between federal courts and state governments that is essential to 'Our Federalism,' particularly in the area of state taxation." (citations and internal quotation marks omitted)).

In *Travelers*, after noting that the text of the ERISA preemption provision failed to offer much guidance as to the outer limits of its preemptive scope, the Supreme Court held that courts "simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656; *see also De Buono*, 520 U.S. at 813-14. The ERISA preemption provision was intended "'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" *Travelers*, 514 U.S. at 656-67

(quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990)). Thus, the "basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657; *see also PONI*, 399 F.3d at 698 ("The purpose of ERISA preemption was to avoid conflicting federal and state regulation and to create a nationally uniform administration of employee benefit plans. Thus, ERISA preempts state laws that (1) mandate employee benefit structures or their administration; (2) provide alternate enforcement mechanisms; or (3) bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as a regulation of an ERISA plan itself." (citation and internal quotation marks omitted)). This uniform regime "provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001) (citation and internal quotation marks omitted). However, "Congress did not intend . . . for ERISA to preempt traditional state-based laws of general applicability that do not implicate the relations among the traditional ERISA plan entities, including the principals, the employer, the plan, the plan fiduciaries, and the beneficiaries." *PONI*, 399 F.3d at 698 (citation and internal quotation marks omitted).

SIIA's analysis largely depends upon cases that (1) predate *Travelers* and apply the since-rejected expansive understanding of "relate to" and/or (2) address state laws that mandated particular benefit structures. The

Defendants, on the other hand, rely primarily on cases that are factually distinguishable, insofar as the taxes and assessments challenged in those cases were levied against providers, and were thus only indirectly passed on to the ERISA plans. However, in light of the holding by the Supreme Court that "the supposed difference between direct and indirect impact . . . cannot withstand scrutiny," *De Buono*, 520 U.S. at 816, it appears that the direct/indirect distinction is a distinction without a difference.

In *De Buono*, the plaintiff challenged a state tax that applied to all health care facilities—including those facilities that were directly owned and operated by ERISA plans. The Court held that the law was simply "one of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *Id.* at 815 (citation and internal quotation marks omitted). The challenged tax was levied against hospitals, and the plaintiff fund could have opted to purchase hospital services at independent hospitals rather than operating its own. The Court noted that, in the former case, the tax would have an indirect impact on the fund and, in the latter case, the tax would have a direct impact, but determined that, regardless of whether the tax was assessed directly or indirectly, "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *Id.* at 816. By analogy, it would appear that the fact that the claims tax at issue here

is imposed at the point of claim payment—and thus affects insurers and ERISA plans directly, as opposed to being imposed at the point of care—thus affecting insurers and ERISA plans indirectly, does not mean that it has an impermissible effect on ERISA plans. By analogy to *De Buono*, ERISA plans can choose to purchase insurance coverage for their beneficiaries' medical services, or, as the SIIA members have chosen, to self-insure.

In *Thiokol*, the Sixth Circuit stated that the "reference to" and "connection with" prongs "are not analytically distinct; rather, they are two related methods of determining the fundamental question in ERISA analysis: whether the state law has an impermissible effect on a covered plan." 76 F.3d at 758. However, the Supreme Court and subsequent Sixth Circuit opinions have treated the two prongs separately. *E.g., Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324, 117 S. Ct. 832, 136 L. Ed. 2d 791 (1997); *Associated Builders & Contractors v. Mich. Dep't of Labor & Econ. Growth*, 543 F.3d 275 (6th Cir. 2008). Thus, the Court will now examine each prong in turn.

SIIA at times appears to argue that the fact that the Act "repeatedly references ERISA plans" (Pl.'s Resp. to Defs.' Mot. to Dismiss at 10) is, standing alone, sufficient to mandate a finding of preemption under the "reference to" prong of preemption analysis.[3] However, the Supreme

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3. However, elsewhere in its briefing and during oral argument, SIIA conceded that a reference to ERISA, without any showing of an effect on an ERISA plan, is insufficient to trigger preemption.

Court has retreated from its earlier approach premised on such "uncritical literalism," *Travelers*, 514 U.S. at 656, and this argument has been expressly rejected by the Sixth Circuit. In *Thiokol*, 76 F.3d at 759, for example, the Sixth Circuit held that, regardless of whether the challenged law "referred to" an ERISA plan, it would only be preempted if it had an impermissible, burdensome effect on that plan. "[S]ome statutes that refer to covered plans do not have an effect on covered plans, and others have only a tenuous, remote, or peripheral effect. Both of these types of state laws fall outside the scope of ERISA pre-emption. Other statutes do not refer to ERISA but nonetheless have an effect on a covered plan; these are pre-empted because they have more than a tenuous, remote, or peripheral effect." *Id.* at 759. Thus, the relevant inquiry is the nature of the effect, if any, that the law has on ERISA plans. *See Associated Builders*, 543 F.3d 275 (challenged rules did not "refer to" ERISA plan because they "do not 'act[ ] immediately and exclusively upon ERISA plans' and thus do not depend on 'the existence of ERISA plans [for their] . . . operation'" (quoting *Dillingham*, 519 U.S. at 325); *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 360 (6th Cir. 2000), *aff'd sub nom. Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S. Ct. 1471, 155 L. Ed. 2d 468 (2003) ("While a mere reference to an ERISA plan, without more, may not be enough to cause preemption, Supreme Court precedent shows that if such a reference is combined with some effect on those plans, such as singling them out for different treatment, preemption will result.").

The Act does not act exclusively on ERISA plans or single them out for different treatment, but rather

treats them the same as other entities that make "actual payments, net of recoveries . . . , to a health and medical services provider . . . ." Act § 2(s), Mich. Comp. Laws § 550.1732(s) (defining "paid claims"); *see also* Act § 3(1) (levying tax on any carrier or third-party administrator for all paid claims); Act § 2(a), Mich. Comp. Laws § 550.1732(a) (defining "carrier" to include, *inter alia*, commercial insurers and health maintenance organizations, nonprofit health care corporations, speciality prepaid health plans, and ERISA plans). Although SIIA suggests that the Act specifically targets ERISA plans, it is clear that the Act is aimed not at ERISA plans per se, but rather at a broad array of entities—including ERISA plans—that pay claims on behalf of a Michigan resident for medical services provided in Michigan. Thus, while the Act would surely bring in less revenue if self-insured ERISA plans were exempted, it does not depend on the existence of these plans for its operation. *See Dillingham*, 519 U.S. 327-28 (state prevailing wage statute did not "refer to" ERISA plan where statute treated all apprenticeship programs—irrespective of whether they were ERISA-funded or not—alike and thus "function[ed] irrespective of . . . the existence of an ERISA plan"); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 838 n.12, 108 S. Ct. 2182, 100 L. Ed. 2d 836 (1988) ("*[A]ny* state law which singles out ERISA plans, by express reference, *for special treatment* is pre-empted. It is this 'singling out' that pre-empts the [state statute exempting ERISA welfare benefit plans from general garnishment statute]." (second emphasis added)). Indeed, elsewhere in its briefing, SIIA highlights the breadth of the entities that fall within Act's reach. (*See* Pl.'s Resp.

Br. at 3 (claims tax applies to "'**every** carrier and third party administrator' which pays a 'claim' on behalf of a Michigan resident for services provided to that resident in Michigan" (emphasis in original) (footnote omitted); *id.* at 4 ("The Act applies to 'any entity' wherever located which processes claims for services rendered to a Michigan resident in Michigan.")).

Thus, even though the Act "refers to" ERISA plans in the "uncritical[ly] literal[]" sense, *Travelers*, 514 U.S. at 656, it does not have the sort of impermissible "reference to plus effect on" ERISA plans that ERISA preemption analysis forbids. Therefore, the Court concludes that the Act does not "refer to" an ERISA plan within the meaning of preemption doctrine.

SIIA also argues that the Act has an impermissible "connection with" ERISA plans, insofar as it imposes certain administrative burdens that, it contends, conflict with the burdens imposed by ERISA and undermine ERISA's interest in uniform administration of benefits plans. The Defendants and joint amici vigorously dispute this claim, arguing that any additional administrative burdens, beyond those already mandated by ERISA, are minimal. SIIA, pointing to the standard of review that applies to a motion to dismiss under Rule 12(b)(6), contends that the Court must, for present purposes, accept as true its well-pleaded factual allegations and cannot consider its adversaries' contrary factual allegations. To the extent that they have offered factual—as opposed to legal—allegations that (1) are not properly subject to judicial notice and (2) contradict those actually pleaded

in the complaint, the Court agrees. However, as will be seen, even accepting SIIA's factual assertions as true, the Act does not have an impermissible "connection with" ERISA plans.

The Sixth Circuit, after examining the history of Supreme Court preemption cases, determined that the "'connection with' inquiry . . . requires two showings to preempt a state law: (1) the law at issue must mandate (or effectively mandate) something, and (2) that mandate must fall within the area that Congress intended ERISA to control exclusively." *Associated Builders*, 543 F.3d at 280-81. It is obvious that the claims tax mandates something—to wit, the payment of a 1% tax on all paid claims. With respect to the second prong, the court noted that the "key distinction is between a statute that mandates or effectively mandates an aspect of law with which ERISA is concerned—*i.e.*, a statute that mandates employee benefit structures or their administration—and a statute that does not." *Id.* at 280 (citations and internal quotation marks omitted); *see also Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir. 1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit.").

The Act does not mandate any particular benefit structure or bind administrators to certain benefits choices. *See PONI*, 399 F.3d at 698. Elsewhere in its briefing, SIIA appears to concede as much. (S*ee* Pl.'s Resp.

Br. at 19 (contrasting Act with "statutes which mandate benefits or directly regulate the scope of permissible bargains between insurers and insureds")). Thus, the claims tax is not like the statute found preempted in *Eglehoff*, which provided for the automatic revocation of a plan participants's designation of a spouse as a beneficiary in the event that the participant and beneficiary-spouse divorced. 532 U.S. 141, 121 S. Ct. 1322, 149 L. Ed. 2d 264 Because the challenged "statute governs the payment of benefits, a central matter of plan administration," it was preempted by ERISA. *Id.* at 148; *see also District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 113 S. Ct. 580, 121 L. Ed. 2d 513 (1992) (law required employers who provide health insurance to provide equivalent coverage for injured employees eligible for workers' compensation); *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990) (statute prohibited "plans from being structured in a manner requiring reimbursement [from a beneficiary] in the event of recovery from a third party"); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985) (law required benefit plans to include certain mental health benefits); *Shaw*, 463 U.S. 85, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (law required plans to include pregnancy benefits); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S. Ct. 1895, 68 L. Ed. 2d 402 (1981) (statute eliminated particular method of calculating pension benefits that was permitted under federal law); *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 193 (4th Cir. 2007) (challenged law "effectively mandate[d] that employers structure their employee healthcare plans to provide a certain level of benefits").

In contrast, courts have found that laws that do not mandate particular structures for or decisions about the "processing of claims and disbursement of benefits," *Egelhoff*, 532 U.S. at 148, are not preempted, even if they may "impose some burdens on the administration of ERISA plans . . . [or] increase[ ] the cost of providing benefits to covered employees," *De Buono*, 519 U.S. at 816-17. Thus, in *Mackey*, the Supreme Court held that a state's general garnishment procedures were not preempted as they applied to ERISA plans even though they imposed substantial administrative burdens on ERISA plans and trustees.[4] 486 U.S. at 831-32. Indeed, a separate provision of the garnishment statute which expressly exempted ERISA plans from having to bear those administrative burdens was found preempted under the "refers to" prong because it singled out ERISA plans for differential—even if preferential—treatment. *Id.* at 829-30. In *De Buono*, the Supreme Court noted that a general tax assessed on hospitals was not preempted as it applied to hospitals owned and operated by ERISA plans because it was "one

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4. According to the plan trustees, "when an employee welfare benefit plan is garnished under Georgia law by a creditor of a participant, plan trustees are served with a garnishment summons, become parties to a suit, and must respond and deposit the demanded funds due the beneficiary-debtor - funds that otherwise they are required to hold and pay out to those beneficiaries. At the very least, petitioners contend, benefit plans subjected to garnishment will incur substantial administrative burdens and costs." *Mackey*, 486 U.S. at 831. The Court nevertheless rejected their claim that, "[b]ecause garnishment will involve and affect the plan and its trustees in these ways . . . , the Georgia garnishment law necessarily 'relates to' such ERISA welfare benefit plans and is therefore pre-empted by § 514(a)." *Id.*

of myriad state laws of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." 520 U.S. at 815 (citation and internal quotation marks omitted). The Court noted that "there might be a state law whose economic effects, intentionally or otherwise, were so acute as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers and such a state law might indeed be pre-empted under § 514," but determined that the general tax on hospitals was not such a law. *Id.* at 806 and n.16 (citation and internal quotation marks omitted).

Indeed, here, the claims tax is implicated and assessed only *after* a coverage decision has been made and a claim has been paid. *See Union Sec. Ins. Co. v. Alexander*, No. 11-10858, 2011 WL 5199918, at *5 (E.D. Mich. Nov. 2, 2011) ("Once the administrator processes the claim and disburses the benefits, however, the federal interest in administrative uniformity is achieved.").

Thus, even assuming the Act results in some lack of uniformity in post-benefit-decision plan administration, this effect is unrelated to ERISA's concern of establishing "standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff*, 532 U.S. at 148.

For these reasons, the Court concludes that the Act does not have an impermissible "connection with" an ERISA plan. Because the Court has already concluded that the Act does not impermissibly "refer to" an ERISA

plan, it does not "relate to" ERISA under either prong of the preemption analysis and is therefore not preempted under § 514(a).[5]

D. *The "Deemer Clause" Is Not Implicated Where the Act Does Not "Relate to" ERISA Plans*

The Court notes that SIIA also argues that the Act runs afoul of ERISA's "deemer clause," which, in relevant part, prohibits any state law from deeming an ERISA plan to be an insurer. *See* ERISA § 514(b)(2), 29 U.S.C. § 1144(b)(2). However, the deemer clause has no place in the initial determination of whether a state law "relates to" an ERISA plan. On the contrary, this clause only comes into effect to prevent an otherwise preempted law from being "saved" as a law that regulates insurance. Here, where the Court has already determined that the Act does not impermissibly "relate to" an ERISA plan, the deemer clause is not triggered. The same, of course, is true of the Defendants' argument in the alternative that the Act is saved by the "saving clause" as a law regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).[6]

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5. For these same reasons, the Court rejects SIIA's argument that the Act violates the Supremacy Clause.

6. In light of the Court's disposition of this matter, it need not consider the alternative—and broader—argument advanced by *amicus* MAHP that the Act is not preempted because it furthers the objectives of the Medicaid Act.

IV.

For the reasons that have been set forth above, the Defendants' motion to dismiss (ECF 14) is granted.

IT IS SO ORDERED.

Date: August 31, 2012

/s/________________________
JULIAN ABELE COOK, JR.
U.S. District Judge

APPENDIX C — SELECTED PROVISIONS OF THE MICHIGAN HEALTH INSURANCE CLAIMS ASSESSMENT ACT

SELECTED PROVISIONS OF
THE MICHIGAN HEALTH INSURANCE
CLAIMS ASSESSMENT ACT,
Mich. Comp. Laws §§ 550.1731 *et seq.*

AN ACT to impose an assessment on certain health care claims; to impose certain duties and obligations on certain insurance or health coverage providers; to impose certain duties on certain state departments, agencies, and officials; to create certain funds; to authorize certain expenditures; to impose certain remedies and penalties; to provide for an appropriation; and to repeal acts and parts of acts.

* * *

550.1732 Definitions.

Sec. 2. As used in this act:

(a) "Carrier" means any of the following:

(*i*) An insurer or health maintenance organization regulated under the insurance code of 1956, 1956 PA218, MCL 500.100 to 500.8302.

(*ii*) A health care corporation regulated under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(*iii*) A nonprofit dental care corporation subject to 1963 PA 125, MCL 550.351 to 550.373.

(*iv*) A specialty prepaid health plan.

(*v*) A group health plan sponsor including, but not limited to, 1 or more of the following:

(A) An employer if a group health plan is established or maintained by a single employer.

(B) An employee organization if a plan is established or maintained by an employee organization.

(C) If a plan is established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan.

(b) "Claims-related expenses" means all of the following:

(*i*) Cost containment expenses including, but not limited to, payments for utilization review, care or case management, disease management, medication review management, risk assessment, and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping those covered individuals maintain or improve their health.

(*ii*) Payments that are made to or by an organized group of health and medical service providers in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals.

(*iii*) General administrative expenses.

(c) "Commissioner" means the commissioner of the office of financial and insurance regulation or his or her designee.

(d) "Department" means the department of treasury.

(e) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a stated level for a group as a whole or protection against a high-dollar claim on any 1 individual.

(f) "Federal employee health benefit program" means the program of health benefits plans, as defined in 5 USC 8901, available to federal employees under 5 USC 8901 to 8914.

(g) "Fund" means the health insurance claims assessment fund created in section 7.

(h) "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of subtitle A of title I of the employee retirement income security act of 1974,

Public Law 93-406, 29 USC 1002, to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

(i) "Group insurance coverage" means a form of voluntary health and medical services insurance that covers members, with or without their eligible dependents, and that is written under a master policy.

(j) "Health and medical services" means 1 or more of the following:

(*i*) Services included in furnishing medical care, dental care, pharmaceutical benefits, or hospitalization, including, but not limited to, services provided in a hospital or other medical facility.

(*ii*) Ancillary services, including, but not limited to, ambulatory services and emergency and nonemergency transportation.

(*iii*) Services provided by a physician or other practitioner, including, but not limited to, health professionals, other than veterinarians, marriage and family therapists, athletic trainers, massage therapists, licensed professional counselors, and sanitarians, as defined by article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(*iv*) Behavioral health services, including, but not limited to, mental health and substance abuse services.

* * *

(*l*) "Medicaid contracted health plan" means that term as defined in section 106 of the social welfare act, 1939 PA 280, MCL 400.106.

(m) "Medicaid managed care organization" means a medicaid contracted health plan or a specialty prepaid health plan.

* * *

(s) "Paid claims" means actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, or excess loss or stop loss carrier. Paid claims include payments, net of recoveries, made under a service contract for administrative services only, cost-plus or noninsured benefit plan arrangements under section 211 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1211, or section 5208 of the insurance code of 1956, 1956 PA 218, MCL 500.5208, for health and medical services provided under group health plans, any claims for service in this state by a pharmacy benefits manager, and individual, nongroup, and group insurance coverage to residents of this state in this state that affect the rights of an insured in this state and bear a reasonable relation to this state, regardless of whether the coverage is delivered, renewed, or issued for delivery in this state. If a carrier or a third party administrator is contractually entitled to withhold a certain amount from payments due to providers of health and medical

services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before that amount is withheld shall be included in paid claims. Paid claims include claims or payments made under any federally approved waiver or initiative to integrate medicare and medicaid funding for dual eligibles under the patient protection and affordable care act, Public Law 111-148, and the health care and education reconciliation act of 2010, Public Law 111-152. Paid claims do not include any of the following:

(*i*) Claims-related expenses.

(*ii*) Payments made to a qualifying provider under an incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals.

(*iii*) Claims paid by carriers or third party administrators for specified accident, accident-only coverage, credit, disability income, long-term care, health-related claims under automobile insurance, homeowners insurance, farm owners, commercial multi-peril, and worker's compensation, or coverage issued as a supplement to liability insurance.

(*iv*) Claims paid for services rendered to a nonresident of this state.

(*v*) The proportionate share of claims paid for services rendered to a person covered under a health benefit plan for federal employees.

(*vi*) Claims paid for services rendered outside of this state to a person who is a resident of this state.

(*vii*) Claims paid under a federal employee health benefit program, medicare, medicare advantage, medicare part D, tricare, by the United States veterans administration, and for high-risk pools established pursuant to the patient protection and affordable care act, Public Law 111-148, and the health care and education reconciliation act of 2010, Public Law 111-152.

(*viii*) Reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the internal revenue code, 26 USC 106, a health savings account as that term is defined in section 223 of the internal revenue code, 26 USC 223, an Archer medical savings account as defined in section 220 of the internal revenue code, 26 USC 220, a medicare advantage medical savings account as that term is defined in section 138 of the internal revenue code, 26 USC 138, or other health reimbursement arrangement authorized under federal law.

(*ix*) Health and medical services costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.

* * *

(v) "Third party administrator" means an entity that processes claims under a service contract and that may also provide 1 or more other administrative services under a service contract.

550.1733 Assessment; levy; limitation; adjustment; credit; notice; carrying forward unused credit; refund.

Sec. 3. (1) For dates of service beginning on or after January 1, 2012 and ending on June 30, 2014, subject to subsections (2), (3), and (4), there is levied upon and there shall be collected from every carrier and third party administrator an assessment of 1% on that carrier's or third party administrator's paid claims. For dates of service beginning on or after July 1, 2014 and ending on December 31, 2017, subject to this subsection and subsections (2), (3), and (4), there is levied upon and there shall be collected from every carrier and third party administrator an assessment of 0.75% on that carrier's or third party administrator's paid claims. For dates of service beginning on or after July 1, 2014 and ending on December 31, 2017, subject to this subsection and subsections (2), (3), and (4), the assessment levied under this subsection will increase to 1.0% if the federal government informs this state that the use tax revenues assessed on entities under section 3f of the use tax act, 1937 PA 94, MCL 205.93f, will not be federally reimbursed. If the assessment is increased as provided in this subsection, the increased assessment levied is effective on the date that the federal government informs this state that the revenue collected from the use tax assessed on medicaid managed care organizations under section 3f of the use tax act, 1937 PA 94, MCL 205.93f, will not be federally reimbursed. For the purposes of this subsection, a fiscal quarter begins on the first day of January, April, July, or October.

(2) A carrier with a suspension or exemption under section 3717 of the insurance code of 1956, 1956 PA 218, MCL 500.3717, on September 20, 2011 is subject to an assessment of 0.1%.

(3) All of the following apply to a group health plan that uses the services of a third party administrator or excess loss or stop loss insurer:

(a) A group health plan sponsor is not responsible for an assessment under this section for a paid claim if the assessment on that claim has been paid by a third party administrator or excess loss or stop loss insurer, except as otherwise provided in section 3a(2).

(b) Except as otherwise provided in subdivision (d), the third party administrator is responsible for all assessments on paid claims paid by the third party administrator.

(c) Except as otherwise provided in subdivision (d), the excess loss or stop loss insurer is responsible for all assessments on paid claims paid by the excess loss or stop loss insurer.

(d) If there is both a third party administrator and an excess loss or stop loss insurer servicing the group health plan, the third party administrator is responsible for all assessments for paid claims that are not reimbursed by the excess loss or stop loss insurer and the excess loss or stop loss insurer is responsible for all assessments for paid claims that are reimbursable to the excess loss or stop loss insurer.

(4) The assessment under this section shall not exceed $10,000.00 per insured individual or covered life annually.

(5) To the extent an assessment paid under this section for paid claims for a group health plan or individual subscriber is inaccurate due to subsequent claim adjustments or recoveries, subsequent filings shall be adjusted to accurately reflect the correct assessment based on actual claims paid.

(6) Through June 30, 2014, if the assessment under this section collects revenue in an amount greater than $400,000,000.00, adjusted annually by the medical inflation rate since 2011, each carrier and third party administrator that paid the assessment shall receive a proportional credit against the carrier's or third party administrator's assessment in the immediately succeeding year. Beginning July 1, 2014, if the sum of the assessment under this section and the portion of the use tax assessed on entities under section 3f of the use tax act, 1937 PA 94, MCL 205.93f, that is dedicated to the general fund, less the general fund amount necessary to reimburse those entities for the cost of the use tax, is greater than $400,000,000.00, as adjusted annually by the medical inflation rate since 2011 but not to exceed an amount greater than $450,000,000.00, each carrier and third party administrator that paid the assessment shall receive a proportional credit against the carrier's or third party administrator's assessment in the immediately succeeding year. The department shall send a notice of credit to each carrier or third party administrator entitled to a credit under this subsection not later than July 1. A carrier or

third party administrator entitled to a credit under this subsection shall apply that credit to the July 30 payment. Any unused credit shall be carried forward and applied to subsequent payments. If a carrier or third party administrator entitled to a credit under this subsection has no liability under this act in the immediately succeeding year or if this act is no longer in effect, the department shall issue that carrier or third party administrator a refund in the amount of any unused credit. If a third party administrator receives a credit or refund under this subsection, the third party administrator shall apply that credit or refund to the benefit of the entity for which it processed the claims under a service contract.

550.1733a Carrier required to file rates; methodology.

Sec. 3a.

* * *

(2) A carrier or third party administrator shall develop and implement a methodology by which it will collect the assessment levied under this act from an individual, employer, or group health plan, subject to all of the following:

(a) Any methodology shall be applied uniformly within a line of business.

(b) Except as provided in subdivision (d), health status or claims experience of an individual or group shall not be an element or factor of any methodology to collect the assessment from that individual or group.

(c) The amount collected from individuals and groups with insured coverage shall be determined as a percentage of premium.

(d) The amount collected from groups with uninsured or self-funded coverage shall be determined as a percentage of actual paid claims.

(e) The amount collected shall reflect only the assessment levied under this act, and shall not include any additional amounts such as related administrative expenses.

(f) A carrier shall notify the commissioner of the methodology used for the collection of the assessment levied under this act.

550.1734 Filing return; dates; form; contents; payment method.

Sec. 4. (1) Every carrier and third party administrator with paid claims subject to the assessment under this act shall file with the department on April 30, July 30, October 30, and January 30 of each year a return for the preceding calendar quarter, in a form prescribed by the department, showing all information that the department considers necessary for the proper administration of this act. At the same time, each carrier and third party administrator shall pay to the department the amount of the assessment imposed under this act with respect to the paid claims included in the return. The department may require each carrier and third party administrator to file with the department an annual reconciliation return.

* * *

550.1735 Records; failure to file return or keep proper records; right of department to impose assessment.

Sec. 5. (1) A carrier or third party administrator liable for an assessment under this act shall keep accurate and complete records and pertinent documents as required by the department. Records required by the department shall be retained for a period of 4 years after the assessment imposed under this act to which the records apply is due or as otherwise provided by law.

(2) If the department considers it necessary, the department may require a person, by notice served upon that person, to make a return, render under oath certain statements, or keep certain records the department considers sufficient to show whether that person is liable for the assessment under this act.

(3) If a carrier or third party administrator fails to file a return or keep proper records as required under this section, or if the department has reason to believe that any records kept or returns filed are inaccurate or incomplete and that additional assessments are due, the department may assess the amount of the assessment due from the carrier or third party administrator based on information that is available or that may become available to the department. An assessment under this subsection is considered prima facie correct under this act, and a carrier or third party administrator has the burden of proof for refuting the assessment.

550.1736 Administration of assessment; conflicting provisions of law; rules; annual report.

Sec. 6. (1) The department shall administer the assessment imposed under this act under 1941 PA 122, MCL 205.1 to 205.31, and this act. If 1941 PA 122, MCL 205.1 to 205.31, and this act conflict, the provisions of this act apply. The assessment imposed under this act shall be considered a tax for the purpose of 1941 PA 122, MCL 205.1 to 205.31.

(2) The department is authorized to promulgate rules to implement this act under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(3) The assessment imposed under this act shall not be considered an assessment or burden for purposes of the tax, or as a credit toward or payment in lieu of the tax under section 476a of the insurance code of 1956, 1956 PA 218, MCL 500.476a.

(4) The department shall submit an annual report to the state budget director and the senate and house of representatives standing committees on appropriations not later than 120 days after the January thirtieth quarterly filing that states the amount of revenue received under this act for the immediately preceding calendar year.

550.1737 Health insurance claims assessment fund; establishment; creation; deposit; money remaining in fund; transfer of money.

Sec. 7. (1) All money received and collected under this act shall be deposited by the department in the health insurance claims assessment fund established in this section.

* * *

550.1740 Failure to pay assessment, interest, or penalty; final determination; written notice to commissioner; suspension or revocation of certificate of authority to transact insurance.

Sec. 10. The department shall provide the commissioner with written notice of any final determination that a carrier or a third party administrator has failed to pay an assessment, interest, or penalty when due. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state, or the license to operate in this state, of any carrier or third party administrator that fails to pay an assessment, interest, or penalty due under this act. A certificate of authority to transact insurance in this state or a license to operate in this state that is suspended or revoked under this section shall not be reinstated unless any delinquent assessment, interest, or penalty has been paid.

* * *

APPENDIX D — MICHIGAN DEPARTMENT OF TREASURY, HEALTH INSURANCE CLAIMS ASSESSMENT ACT GENERAL RULES

DEPARTMENT OF TREASURY
HEALTH INSURANCE CLAIMS
ASSESSMENT ACT
GENERAL RULES

(By authority conferred on the Department of Treasury by section 6 of 2011 PA 142, MCL 550.1736(2))

R 550.402 Collection of assessment by carrier or third-party administrator.

Rule 2. (1) Neither a carrier nor a third-party administrator is required to collect the assessment levied under this Act from an individual, employer, or group health plan pursuant to Section 3a of the Act; the collection of the assessment from these parties by carriers and third-party administrators is permissive.

(2) However, if a carrier or third-party administrator determines to collect the assessment from an individual, employer, or group health plan, such collection may only be undertaken pursuant to the methodology requirements set forth in Section 3a. For purposes of this rule, "Act" means the Health Insurance Claims Assessment Act, 2011 PA 142, MCL 550.1731 *et seq.*

History: 2013 AACS.

R 550.403 Recordkeeping; examination of documents.

Rule 3. (1) The department, through its field auditors and other employees, may examine the books, records and papers of any person liable for the assessment.

(2) Every person subject to the assessment must keep and preserve suitable and adequate records to enable such person, as well as the state, to determine the correct amount of the assessment for which the person is liable. Failure to produce and keep records for the purpose of examination by the department will be considered willful noncompliance with a tax law.

(3) A person subject to the assessment must retain all quarterly worksheets as well as all source documents used in the preparation of the quarterly worksheets and the annual returns filed pursuant to the Act. Source documents may include, but are not limited to, documents and records maintained in the ordinary course of business containing claims-related information and statements or billings for medical services.

(4) A person subject to the assessment must also retain all documents and records used to determine eligibility for, and the amount of, each of the exclusions from the assessment indicated on the quarterly worksheets and annual returns, including, but not limited to, documents and records supporting recoveries against claims, claims-related expenses, claims paid for non-residents, claims paid for services not performed in Michigan, reimbursements made to individuals under federally

authorized health spending accounts, and claims paid pursuant to accident, disability, long-term care, automobile, workers' compensation, or property and casualty coverage.

History: 2013 AACS.

R 550.404 Michigan resident; domicile.

Rule 4. (1) For purposes of the Act, a Michigan "resident" is an individual who is domiciled in the state of Michigan on the date that the service in question is performed.

(2) "Domicile" means the place where an individual has his or her fixed, permanent and principal home to which he or she returns or intends to return. An individual's domicile in one place continues until a different domicile is established.

(3) A rebuttable presumption shall exist that an individual's home address, as maintained in the ordinary business records of a carrier or third-party administrator, indicates the domicile of that individual under this definition. Example: An individual who is domiciled in Michigan, but attends college in another state, is a Michigan resident for purposes of the Act. If that individual obtains health services in Michigan while home between semesters, a "paid claim" for the performance of those services will be subject to the assessment under the Act.

History: 2013 AACS.

APPENDIX E — FORM 4930, QUARTERLY WORKSHEET FOR MICHIGAN HEALTH INSURANCE CLAIMS ASSESSMENT, AVAILABLE AT HTTP://WWW.MICHIGAN.GOV/DOCUMENTS/TAXES/4930_372265_7.PDF

FOLDOUT

Michigan Department of Treasury
4930 (Rev. 07-14)

Quarterly Worksheet for Health Insurance Claims Assessment (HICA)

IMPORTANT: This worksheet is your file copy and is subject to audit. You must keep this worksheet in your records for a period of four (4) years after the HICA annual return due date. **DO NOT SEND the worksheet to Treasury.**

Name	Account Number (FEIN, ME or TR Number)	Assessment/File Period	Return Year
		☐ Qtr 1 ☐ Qtr 2 ☐ Qtr 3 ☐ Qtr 4	

See line-by-line instructions for further information. Report all amounts in whole dollars.

Organization Type

1. ☐ a. Third Party Administrator ☐ b. Carrier ☐ c. Carrier with a suspension or exemption under MCL 500.3717 as of January 1, 2012.

Health Insurance Claims Assessment

2. Gross paid claims during the current assessment period for dates of service on or after January 1, 2012.... 2. ____ 00

Paid Claims and Related Exclusions Not Subject to Assessment

NOTE: For each exclusion listed in lines 3 through 13, enter amounts:

- **ONLY TO THE EXTENT INCLUDED IN LINE 2; AND**
- **ONLY TO THE EXTENT SUCH AMOUNT IS NOT INCLUDED IN ANOTHER LINE IN THIS SECTION. SEE INSTRUCTIONS FOR DETAILS.**

Line	Description		Amount
3.	Allowable recoveries	3.	00
4.	Claims-related expenses	4.	00
5.	Certain payments made to a qualifying provider under an incentive compensation agreement	5.	00
6.	Certain claims paid under certain accident, long-term care, or property and casualty coverage	6.	00
7.	Claims paid for services rendered to a nonresident of Michigan	7.	00
8.	Claims paid for services rendered outside of Michigan to a person who is a resident of Michigan	8.	00
9.	Claims paid for services rendered to a person covered under a health benefit plan for federal employees	9.	00
10.	Claims paid under certain federal health benefit programs and high-risk pools.	10.	00
11.	Certain health reimbursements to individuals authorized under federal law.	11.	00
12.	Health and medical services costs paid by an individual for cost-sharing requirements	12.	00
13.	Claims paid in excess of $1,000,000 per individual, or $10,000,000 per individual if you checked **line 1c**	13.	00
14.	**Total Allowable Exclusions:** Add lines 3 through 13	14.	00

Line	Description		Amount
15.	**Net Health Insurance Claims Paid Subject to Assessment**: Subtract line 14 from line 2.	15.	00
16.	**Total Assessment for File Period**. See instructions. Calculate below and enter the total of lines 16a, 16b and 16c on line 16d		
	16a. Claims from line 15 subject to 1% rate ____ x 1% (0.01) = ____	16a.	00
	16b. Claims from line 15 subject to 0.75% rate ____ x 0.75% (0.0075) = ____	16b.	00
	16c. Claims from line 15 subject to 0.1% rate ____ x 0.1% (0.001) = ____	16c.	00
	16d. Add lines 16a, 16b and 16c. Enter the total in box 16d. This is the total assessment amount for the file period.	16d.	00
17.	Underpayment from prior assessment periods	17.	00
18.	Overpayment from prior assessment periods	18.	00
19.	Net assessment for the current period: (line 16d + line 17) - (line 18). Note, if the net assessment amount is $0.00 or results in a credit (negative) amount, see instructions, and do not complete lines 20 and 21.	19.	00
20.	If the assessment levied under the HICA Act is paid late, enter penalty and interest	20.	00
21.	**Total Amount Due.** Add lines 19 and 20. **Payments must be made by Electronic Funds Transfer.**	21.	00

Instructions for Completing Form 4930,
Quarterly Worksheet for Health Insurance Claims Assessment (HICA)

IMPORTANT: This worksheet is your file copy and is subject to audit. You must keep this worksheet in your records for a period of four (4) years after the HICA annual return due date. **DO NOT SEND the worksheet to Treasury.** Record your name, account number, assessment/file period and return year at the top of the form.

Lines not listed are explained on the form.

Note: Report all amounts in whole dollars. Round down amounts of 49 cents or less. Round up amounts of 50 cents or more. Payments should be submitted using whole dollar amounts.

Organization Type

Line 1. Check the box indicating your organization type. If your company is both a third party administrator and a carrier, please select either box. For definitions of "carrier" and "third party administrator," see MCL 550.1732. Note that the definition of "carrier" includes an employer or employee organization that establishes or maintains a group health plan. Entities that self-insure for health care are therefore included in the definition of "carrier."

Health Insurance Claims Assessment

Line 2. Enter gross paid claims during the current assessment period for dates of service on or after January 1, 2012 for actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third party administrator, self-insured entity, or excess loss or stop loss carrier.

Paid Claims and Related Exclusions Not Subject to Assessment

NOTE: For each exclusion listed in lines 3 through 13, enter amounts:

- **ONLY TO THE EXTENT INCLUDED IN LINE 2; AND**
- **ONLY TO THE EXTENT SUCH AMOUNT IS NOT INCLUDED IN ANOTHER LINE IN THIS SECTION.**

Line 3. Enter the amount of allowable recoveries. "Recoveries" includes 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).

Line 4. Enter the amount of cost containment expenses including, but not limited to, payments for utilization review, care or case management, disease management, medication review management, risk assessment, and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping those covered individuals maintain or improve their health. Claims-related expenses also includes general administrative expenses, payments made to or by an organized group of health and medical service providers in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals.

Line 5. Enter any payments made to a qualifying provider under an incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals.

Line 6. Enter payments for specified accident, accident-only coverage, credit, disability income, long-term care, health-related claims under automobile insurance, homeowners insurance, farm owners, commercial multi-peril, and worker's compensation, or coverage issued as a supplement to liability insurance.

Lines 7 and 8. For purposes of the HICA, a Michigan "resident" is an individual who is domiciled in the State of Michigan on the date that the service in question is performed. "Domicile" means the place where an individual has his or her fixed, permanent and principal home to which he or she returns or intends to return. An individual's domicile in one place continues until a different domicile is established. A rebuttable presumption shall exist that an individual's home address, as maintained in the ordinary business records of a carrier or third party administrator, indicates the domicile of that individual under this definition. Example: An individual who is domiciled in Michigan, but attends college in another state, is a Michigan resident for purposes of the HICA Act. If that individual obtains health services in Michigan while home between semesters, a "paid claim" for the performance of those services will be subject to the assessment under the HICA Act.

Line 9. Enter the proportionate share of claims paid for services rendered to a person covered under a health benefit plan for federal employees.

Line 10. Enter any payments made under a federal employee health benefit program, Medicare, Medicare Advantage, Medicare Part D, Tricare, by the United States Veterans Administration, and for high-risk pools established pursuant to the Patient Protection and Affordable Care Act (Public Law 111-148), and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Line 11. Enter any reimbursements to individuals under a flexible spending arrangement (26 USC 106 (c)(2)), health savings account (26 USC 223), Archer MSA (26 USC 220), Medicare Advantage MSA (26 USC 138), or other health reimbursement arrangement authorized under federal law.

Line 12. Enter any health and medical services costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or co-pays.

Line 13. The assessment shall not exceed $10,000 per insured individual or covered life annually. Enter claims paid in excess of $1,000,000 per individual, or $10,000,000 per individual if you checked line 1c.

Line 16. This is your total assessment for the file period. Quarterly payments are due April 30, July 30, October 30 and January 30, and must be made by Electronic Funds Transfer (EFT). In order to be registered to make payments

by EFT, you must complete and submit Form 4926, Electronic Funds Transfer Application – Health Insurance Claims Assessment to Treasury. Allow at least four weeks for processing your EFT application. If no assessment is owed for the period, you may submit a $0.00 (zero) EFT transmission to complete the filing information for the quarter, but a $0.00 transmission is not required.

Line 16a. For claims with dates of service from January 1, 2012 through June 30, 2014, the assessment rate is 1% (0.01).

Line 16b. For claims with dates of service beginning on or after July 1, 2014, the assessment rate is 0.75% (0.0075).

Line 16c. If you are a carrier with a suspension or exemption under MCL 500.3717 as of January 1, 2012, and have checked box 1c, the assessment rate for all claims is 0.1% (0.001).

Line 16d. Enter the total of lines 16a, 16b, 16c. This is the total assessment amount for the file period.

Line 17. If an adjustment is needed for an **underpayment** of the assessment paid for a prior quarter within the same calendar year, enter that amount here. The annual return filed for the calendar year should reflect all adjustments made during the year. Please refer to the annual return instructions for more information on how to make prior year adjustments.

Line 18. If an adjustment is needed for an **overpayment** of the assessment paid for a prior quarter within the same calendar year, enter that amount here. The annual return filed for the calendar year should reflect all adjustments made during the year. Please refer to the annual return instructions for more information on how to make prior year adjustments.

Line 19. If the assessment amount entered on line 19 is $0.00, or results in a credit (negative) amount, you may submit a $0.00 EFT transmission to complete the filing information for the quarter, but a $0.00 transmission is not required. Credits should be carried forward to assessment periods within the same calendar year. A credit on the fourth quarter worksheet should be included in the annual return reconciliation process, and a refund can be requested if appropriate. Do not carry the credit forward to the following calendar year.

Line 20. You will owe penalty and interest for late payment of the assessment if you pay after the due date.

If you have an assessment due on line 16d, the penalty is as follows:

- 5 percent of the assessment due (line 16d) if the late payment is received within two months of the due date.
- 5 percent of the assessment due for each subsequent month, or part thereof, the assessment is not paid.
- Maximum penalty is 25 percent of the assessment due.
- Interest is due at the rate of 1 percent above the prime interest rate from the day the assessment is due until it is paid. The interest rate will be adjusted January 1 and July 1. Interest does not calculate on penalty amounts.
- A penalty and interest calculator is available on Treasury's Web site at **www.michigan.gov/taxes**.

Line 21. This is your total amount due under the HICA Act for the file period, including any applicable penalty and interest. Payments must be made by EFT.

Additional information about the HICA Act (P.A. 142 of 2011) is available on Treasury's Web site at **www.michigan.gov/businesstaxes**