No. 10-36001

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DALE FOSSEN, et al.,
Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MONTANA, INC.,
Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA

BRIEF OF THE SECRETARY OF LABOR, HILDA L. SOLIS, AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLANTS

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STATEMENT OF THE ISSUE

Appellant Dale Fossen filed suit on behalf of himself and others similarly situated against Blue Cross in Montana state court, alleging, in addition to a number of other state law claims, that Blue Cross was acting in violation of section 33-22-526(2)(a) of the Montana Insurance Code, which prohibits insurers from setting different premiums for individuals in a group health plan on the basis of health-related status. The district court upheld Blue Cross' removal of the case to federal court, concluding that the suit was completely preempted by ERISA because the state law at issue duplicates section 702 of ERISA, 29 U.S.C. § 1182, which likewise prohibits discrimination by insurers in setting premium rates on the basis of health-related status. The court subsequently granted summary judgment to Blue Cross on the merits, holding that the state insurance provision was preempted in light of the identically-worded provision in ERISA section 702, which the court held did not prohibit the premium increases at issue. The question presented is:

Whether the district court erred in ruling that ERISA preempts Fossen's state law claim that is based on a provision of a Montana state statute that prohibits insurers from setting different premium rates within a group health plan on the basis of an individual's health-related status, and thus erred in allowing removal and granting summary judgment on that basis.

STATEMENT OF INTEREST, IDENTITY AND AUTHORITY TO FILE

In order to ensure a uniform regulatory regime, ERISA section 514(a) preempts state laws that "relate to" ERISA plans, including ERISA group health plans. ERISA 29 U.S.C. § 1144(a). Under ERISA section 514(b)(2)(A), however, state insurance regulations are saved from ERISA preemption. 29 U.S.C. § 1144(b)(2)(A). Furthermore, ERISA section 731 provides that Part 7 of ERISA, which includes the nondiscrimination provision in section 702, "shall not be construed to supersede" any state law that "solely relate[s] to health insurance issuers in connection with group health insurance coverage," except to the extent that it prevents application of ERISA's requirements. 29 U.S.C. § 1191. Both of these provisions evince a congressional intent to allow states to continue to regulate group health insurance despite ERISA's broadly preemptive effect. The Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, 29 U.S.C. §§ 1002(13), 1136(b), and therefore has an interest in ensuring that courts give effect to ERISA's carefully delineated exceptions to its preemptive scope to permit suits properly brought in state court to move forward.

The Secretary files this brief pursuant to her authority under Federal Rule of Appellate Procedure 23(a).

STATEMENT OF THE CASE

Appellant Dale Fossen is a member of the Fossen Brothers Farms partnership, consisting of farm corporations D and M Fossen, Inc., L and C Fossen, Inc., and M and C Fossen, Inc. (collectively known as "Fossen Brothers"). Am. Compl., ER 278 ¶ 1. In December 2003 and January 2004, Fossen contracted with authorized Blue Cross Blue Shield (Blue Cross) agent Roger Olson to purchase group health insurance for the Fossen Brothers. Olson presented Fossen with an option to enroll in a small employer group health plan offered through Associated Merchandisers Inc. (AMI), telling Fossen that the plan was a "true pooled risk plan" offered by AMI, that the Fossen Brothers would be rated only once and would not be rerated during participation, and that any increase in premiums would be shared pool-wide. Olson Aff., ER 46 ¶ 11. Based on these statements and the presentation of the application, Fossen enrolled the Fossen Brothers in the plan believing that AMI constituted the group under which members would be rated. Fossen Aff., ER 56 ¶ 5.

In April 2006, Blue Cross increased the Fossen Brothers' AMI premium by 21 percent. Am. Compl., ER 282 ¶ 27. The Fossen Brothers were told they were rated separately from other members in AMI based on a medical risk assessment and that other members of AMI saw their premiums decrease. Olson Aff., ER 46 ¶

12. Both Fossen and Olson objected to the premium increase and Blue Cross reduced the premium increase for one year. Olson Aff., ER 46 ¶ 12; Am. Compl., ER 282 ¶ 27. In 2007 and 2008, Blue Cross again rated the members of AMI differently and the Fossen Brothers complained again to the Montana Insurance Commissioner's Office. Am. Compl., ER 282 ¶ 6.

In 2009, AMI merged into Montana Chamber Choices (MCC). The Fossen Brothers renewed their group health plan with Blue Cross after completing a Blue Cross group health policy renewal form entitled "Montana Chamber Choices Association 2009 Group Health Benefits Plan employer Election Form." Fossen Aff., ER 57 ¶ 7. The Fossen Brothers subsequently complained about their premium increase to the State Commissioner's office, which informed them that the commissioner could not take any action to set a particular rate. Am. Compl., ER 281 ¶ 23.

Fossen filed an action in Montana state court related to Blue Cross' rating practices, alleging violation of Montana state insurance law, violation of Montana state unfair trade practices law, and breach of contract with regard to an implied breach of good faith and fair dealing. Fossen alleges that Blue Cross improperly treats policies sold through AMI and MCC as individual policies rather than group policies. ER 284 ¶ 43. Fossen alleges that by doing so, Blue Cross violated section 33-22-526(2) of the Montana Insurance Code, which prohibits issuers from

charging individuals in a group plan a higher premium than similarly situated individuals in the same group health plan because of a health-related factor. ER 283 ¶¶ 31-32.[1] Fossen seeks declaratory judgment as well as equitable restitution in the form of return of the excess premiums paid by Fossen and the other members of the putative class. ER 287 Prayer for Relief ¶¶ 3-5.

Blue Cross removed the action to federal district court, asserting the claims are preempted by ERISA. While the motion to remand was pending, Blue Cross filed a motion for summary judgment on the merits of the claim. Blue Cross asserted that the claims were preempted, arguing that a federal cause of action existed under ERISA section 502(a)(3), 29 U.S.C. § 1132(a)(3), to enforce section 702 of ERISA, 29 U.S.C. § 1182, which, in identical language, also prohibits insurers from charging similarly-situated individuals in the same group health plan different premiums based on health status. Def's Br. Summ. J. 17-18. Blue Cross argued that because the state law "conflicted" with this provision of ERISA by providing a cause of action and remedy outside the exclusive ERISA scheme, the state law provision was preempted even if it would otherwise be saved from

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[1] Fossen also alleged that Blue Cross' actions in this regard ran afoul of the intent expressed in section 33-22-1802(1) of the Montana Small Employer Health Insurance Availability Act to ensure that issuers of group health plans make adequate disclosures about their rating practices. The Secretary's brief does not address Fossen's likelihood of success on any of his state law claims.

express preemption as an insurance regulation under section 514(b) of ERISA. Id. at 23-27.

Moreover, Blue Cross argued that the group health plan, which is a multiple employer welfare arrangement (MEWA) as defined in ERISA,[2] consisted solely of the Fossen group and not the entirety of all the members of the AMI and MCC. Def's Br. Summ. J. 8-10. Because ERISA defines a plan as an entity established by an employer, including an association of employers, to furnish medical or other employee benefits, 29 U.S.C. § 1002(1), Blue Cross' argument below was essentially that AMI/MCC lacks the organizational relationship necessary to count as an association, leaving the Fossen Brothers as the employer, and the plan that they sponsored for their employees the sole relevant plan. As a result, Blue Cross argued, the Fossen Brothers were appropriately rated as a distinct group health plan, apart from the other members of AMI and MCC, under ERISA section 702, and if Montana law were applied and made Blue Cross' actions in raising the Fossen Brothers' premiums illegal, "it would 'eviscerate' § 702(b) of ERISA, which permits them." Def's Br. Summ. J. 26-27; Brown Aff., ¶ 3.[3] Furthermore, Blue

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[2] A MEWA is an arrangement, other than a Taft-Hartley collectively bargained plan, that provides welfare benefits, such as group health insurance, and that is established and maintained by two or more employers. See 29 U.S.C. § 1002(40).

[3] Blue Cross also argued that the Montana law should be interpreted, like ERISA section 702, to permit Blue Cross to raise the premiums for all the individuals in the Fossen plan without regard to the rates paid by other participants in the

Cross asserted that Fossen should not be permitted to amend his complaint to assert a claim under ERISA section 502(a)(3) for the violation of section 702 because any such claim would fail. Def's Br. Summ. J. 30-31.

On August 12, 2010, the court denied Fossen's motion to remand, ruling that the state statute was duplicative of section 702 of ERISA, and therefore was completely preempted by ERISA. Fossen v. Blue Cross Blue Shield of Montana, Inc., No. CV 09-61-H-CCL, 2010 WL 3199719 (D. Mont. Aug. 12, 2010). Subsequently, in a decision issued on October 6, 2010, the district court held the state law claims, even though based (at least in part) on an insurance regulation, were preempted by ERISA. The court therefore granted Blue Cross' motion for summary judgment, dismissing Fossen's claims. Fossen v. Blue Cross Blue Shield of Montana, Inc., __ F.Supp. 2d ___, 2010 WL 3947282 (D. Mont. Oct. 6, 2010). Although Fossen did not move to amend the complaint to allege a violation of ERISA section 702, the court addressed the issue and found no violation of that provision. Id. at * 5. In this regard, the court found, as a factual matter based on

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AMI/MCC group plan because the relevant group for rating purposes was the Fossen plan, Def's Summ. J. Br. 26 n.2, an issue that the district court did not reach. If the district court was correct, as a factual matter, that AMI and MCC were composed of unrelated employers, the Secretary agrees that these entities would not themselves be employers for purposes of ERISA, and section 702 would not, therefore, prohibit the premium increases that Fossen challenges. The Secretary is not expressing a view, however, about whether the same is true under state law, although the fact that the Montana provision is worded identically to section 702 and draws its definition of a group health plan from ERISA suggests that that is the case.

an affidavit submitted by Blue Cross, that the Fossen Brothers constituted a single group health plan appropriately rated by itself because the AMI and MCC entities were composed of unrelated employers and therefore were not single group health plans requiring risk pooling across all of the employers. Id.

SUMMARY OF THE ARGUMENT

Although ERISA broadly preempts state laws that relate to employee benefit plans covered by ERISA, the statute in section 514(b) also expressly saves state insurance laws from the sweep of ERISA's preemptive force. The district court recognized this and held that Montana's nondiscrimination statute was an insurance regulation expressly saved from preemption by ERISA's insurance savings clause. The court nonetheless held that the Montana provision is preempted because it duplicates a provision of ERISA, section 702, which forbids discrimination in the setting of insurance premiums in precisely the same terms as the Montana provision. The district court erred in this regard because section 731 of ERISA provides that ERISA does not preempt state health insurance laws unless they prevent the application of Part 7 of ERISA, where section 702 appears. And Congress expressly noted, in the Conference Report accompanying the enactment of Part 7 that state health insurance laws that are broader than the federal requirements do not prevent the application of Part 7's requirements. Congress thus expressed its intent to maintain the historical authority of States to regulate in

the area and indeed to impose stricter requirements on health care insurers than those imposed by Part 7. Therefore, to the extent that the Montana provision either imposes the same or stricter standards than those contained in Part 7, it does not prevent application of Part 7's requirements, and is not preempted by ERISA.

ARGUMENT

A. The Montana provision relates to an ERISA plan for purposes of express preemption under ERISA

By its terms, and subject to a number of exceptions, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). The Supreme Court has explained that a law "relate[s] to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995). However, the Court has cautioned against conducting that analysis with an "uncritical literalism," and has stressed that whether a law has a prohibited connection with ERISA plans turns on whether the law interferes with ERISA's core objectives. Id.

Fossen filed a claim under a provision of the Montana Insurance Code, section 33-22-526(a), which provides:

> A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require an individual, as a condition of enrollment or continued

> enrollment under the group health plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan on the basis of any health status-related factor of the individual or of an individual enrolled under the plan as a dependent of the individual.

Fossen contends this provision, as well as a provision of the Montana Unfair Trade Practices Act,[4] are predicated on the policy concerns enumerated in section 33-22-1802(1) of the Montana Small Employer Health Insurance Availability Act, which states:

> (1) This part must be interpreted and construed to effectuate the following express legislative purposes:
> (a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;
> (b) to prevent abusive rating practices;
> (c) to require disclosure of rating practices to purchasers;
> (d) to establish rules regarding renewability of coverage;
> * * *

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[4] Section 33-18-206(2) of the Montana Unfair Trade Practices Act states:

> No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder or in any of the terms or conditions of such contract in any other manner whatever.

Not only is it unclear whether this provision is an insurance regulation within the meaning of ERISA section 514(b), but it appears, by its terms, to be directed at disability insurance and not at health insurance. Because the district court's decision was directed solely at Fossen's claim under 33-22-526(2) of the Montana Insurance Code, this brief will only address ERISA's preemptive effect on the claim asserted under that provision. This brief will likewise not address Fossen's breach of contract claim.

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

The district court's conclusion that section 33-22-526(2)(a) "relates to" an ERISA-covered plan is supported by the reference in this provision to group health plans, which include ERISA plans, and by the provision's intentional effect upon such plans.[5] This connection to group health plans is sufficient to establish that the Montana provision "relates" to an ERISA plan for purposes of section 514. Moreover, in this case, there is no dispute that the plaintiffs are receiving health insurance benefits under an ERISA plan, although the parties dispute whether the ERISA plan is the group health plan sponsored by AMI/MCC or whether each individual employer in AMI/MCC has effectively established its own separate plan for just its employees. Given that the Fossen Brothers plan constituted a group health plan under ERISA, there can be little doubt that the Montana law "relates to" ERISA plans under section 514.

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[5] The term "group health plan" as used in section 33-22-526, is defined under section 33-22-140(11) of the Montana Code to mean "an employee welfare benefit plan, as defined in 29 U.S.C. § 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise." Because this definition incorporates the ERISA definition of group health plan, but does not necessarily incorporate the definitions of "employer" or "employer organization" in ERISA, it is not clear whether the court's resolution of the ERISA issue would also govern the state-law issue. This issue was not addressed by the district court and because it involves an interpretation of state law, the Secretary will not attempt to resolve it in this brief.

B. Montana's nondiscrimination law is saved from preemption because it regulates insurance

Although Montana's nondiscrimination law relates to ERISA plans, it is saved from preemption because it regulates insurance. A state law that relates to an ERISA-covered employee benefit plan may be saved from preemption under section 514 if the state law regulates insurance. 29 U.S.C. § 1144(b)(2)(A). The Supreme Court has articulated a two-part test to determine whether a state law is an insurance regulation and thus saved from preemption by the savings clause in section 514: (1) it must be "specifically directed toward entities engaged in insurance:" and (2) it must "substantially affect the risk pooling arrangement between the insurer and the insured." Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003).

A state law is directed towards entities engaged in the business of insurance and thus satisfies the first prong if it imposes obligations on parties engaged in the business of insurance with respect to their insurance practices. See Kentucky Ass'n, 538 U.S. at 334-35 (explaining that Kentucky's "any willing provider" (AWP) law was sufficiently directed towards insurers even though it had an impact on other entities because it imposed conditions on the right to engage in the insurance business). In addition, a law grounded in a policy concern specific to the insurance industry satisfies the first prong. Standard Ins. Co. v. Morrison, 584 F.3d 837, 843-44 (9th Cir. 2009).

Second, the law must substantially affect the risk pooling arrangement between the insurer and insured. Kentucky Ass'n, 584 U.S. at 338. The Court in Kentucky Ass'n found Kentucky's AWP law satisfied the second prong because it affected the types of risk pooling arrangements that insurers could offer and it increased the number of providers available to provide services. Id. at 338-39. This prong ensures that a saved state insurance law is really directed at insurance practices. Id.

In this case, the district court correctly ruled that Montana's nondiscrimination statute satisfies the two-part test. As the court concluded, the law is directed at insurers because it imposes conditions on the right to engage in the business of insurance by prohibiting insurers from discriminating against an individual on the basis of health-related status. Moreover, it affects an insurer's risk pooling arrangement at a basic level by regulating how an insurer is able to spread risk among a class of individuals in a group health plan. Therefore, under the Kentucky Ass'n test, the Montana provisions are insurance regulations saved from ERISA preemption.[6]

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[6] Another provision of section 514(b) saves from ERISA's preemptive scope state insurance laws regulating MEWAs. This provision states that "in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title." 29 U.S.C. § 1144(b)(6)(ii). The purpose of this provision was to curtail abuses by MEWA sponsors who sought to evade state regulation related to

C. Montana's nondiscrimination provision does not conflict with ERISA

Despite its correct application of ERISA's savings clause, the district court erroneously concluded that Congress intended to preempt any state law, such as the Montana provision, that provides a cause of action and remedy outside of ERISA's remedial scheme set forth in ERISA section 502, 29 U.S.C. § 1132. Because the Montana law duplicates section 702, which in turn is enforced through ERISA section 502(a)(3), the district court reasoned that it runs afoul of Congress' intent that section 502 of ERISA provide an exclusive enforcement and remedial scheme. 2010 WL 3947282, at *4. However, Congress clearly did not intend ERISA's remedial scheme to preclude the state regulation of insurance premiums at issue

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solvency, marketing, and other insurance practices by claiming ERISA preemption. See H.R. Conf. Rep. 97-984 (1982), reprinted in 1982 U.S.C.C.A.N. 4598, 4604; 90-18A DOL Adv. Op. (July 2, 1990). As explained above, the Montana provision is a state law that regulates insurance and the AMI/MCC arrangement is a MEWA. Nevertheless, this provision only applies if the MEWA is an "employee welfare benefit plan" under ERISA, which turns on whether the district court correctly concluded that the MEWA is not such an ERISA plan because it was not established or maintained by an "employer organization" within the meaning of the statute. Assuming Blue Cross is correct as a factual matter that AMI/MCC were entities comprised of unrelated, heterogeneous employers with no organizational relationship, then the district court was correct that the MEWA that they established is not an ERISA plan and the law is not separately saved under section 514(b)(6)(ii). 29 U.S.C. § 1144(b)(6)(ii). To the extent the MEWA is a group health plan under ERISA, it is subject to regulation under both state law and ERISA, subject to limitations on state regulation depending on whether the MEWA is fully insured. If the MEWA is not a group health plan under ERISA, then the state is permitted to regulate its activities with no limitations under ERISA.

here. To the contrary, in adding the portability and nondiscrimination provisions in the Health Insurance Portability and Accountability Act (HIPAA) to ERISA Part 7, Congress expressly provided in section 731 that:

> [Part 7] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

29 U.S.C. § 1191(a)(1).[7] Although section 731 further provides that "[n]othing in this part shall be construed to affect or modify the provisions of § 514 with respect to group health plans," id. § 1191(a)(2), as explained above, the Montana provision is saved from preemption under section 514 as a state law that regulates insurance.

Congress thus expressed the intent that the HIPAA requirements, including the nondiscrimination provision in ERISA section 702, not preempt state laws that

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[7] Moreover, whatever the preemptive scope of ERISA with regard to a claim by a plan participant, ERISA should not be read to preclude the State from bringing suit or taking other action to enforce its insurance laws. See Secretary of Labor's brief as amicus curiae in Celentano v. Burnes, No. 1:09-11112-DPW (D. Ma.), available at http://www.dol.gov/sol/media/briefs/celentano(A)-12-18-2009.pdf. This is particularly true in the context of the HIPAA amendments, which expressly prohibit the Secretary of Labor from taking any enforcement action under Part 7 against a health insurance issuer, 29 U.S.C. § 1132(b)(3). HIPAA also amended the Public Health Service Act (PHSA), which contains a preemption provision that is identical to ERISA section 731, 42 U.S.C. § 300gg-23, and which provides for enforcement by HHS only if a state fails to enforce the provisions of the PHSA. Id. § 300gg-22. States are thus the primary government enforcers against health insurance issuers in the HIPAA context.

impose similar requirements unless it would be impossible to comply with both ERISA and the state law. The legislative history of Part 7 underscores this intent by highlighting the historical role that states have played in insurance regulation and the role preserved for states in insurance regulation even under the federal scheme, noting that state laws with regard to insurance issuers that are broader than the federal requirements "would not prevent the application" of Part 7's requirements. H.R. Conf. Rep. No. 104-736 (1996), at 205, reprinted in 1996 U.S.C.C.A.N. 1990 at 2018. See also 29 C.F.R. § 2590.731.

The Secretary's regulations track the language of the statutory provision and acknowledge that states are permitted to impose stricter nondiscrimination, portability, and renewability requirements on insurers, as long as they do not interfere with the application of Part 7. 29 C.F.R. § 2590.731. And the preamble to the regulation notes the legislative intent under Part 7 to have the "narrowest preemption of State laws with regard to health insurance issuers (not group health plans)," including the nondiscrimination requirement in section 702, and reiterates the Conference Report's statement that broader State laws do not prevent the application of the requirements of Part 7. 62 Fed. Reg. 16,904 (April 8, 1997). Thus, like the insurance savings provision in section 514(b), and the McCarran-Ferguson Act before it, section 731 reflects a desire to preserve the historical

power of states as insurance regulators, and to that end provides that the requirements of HIPAA are intended to set a floor rather than a ceiling.

The district court did not consider section 731, nor did it address the congressional intent to save state insurance regulation expressed in that provision. It therefore missed the mark in relying on the Supreme Court's decisions in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987), and Aetna v. Davila, 542 U.S. 200 (2004), which, in addressing the preemptive force of section 502, ERISA's remedial provision, separate and apart from the factors that guide an analysis under section 514, held that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Davila, 542 U.S. at 209; accord Pilot Life, 481 U.S. at 51 (a state law "will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme"); see also Rush Prudential HMO Inc. v. Moran, 536 U.S. 355, 379-80 (2002). In those cases, however, the Court was not addressing Part 7 of ERISA.

In the specific context of Part 7, Congress made clear that a state law regulating a health insurer's practices with respect to group health plans is not preempted merely because it duplicates or supplements the provisions of Part 7. Instead, section 731 expressly provides that such a state law is preempted only to

the extent that it "prevents the application of a requirement of this part." Thus, because the state insurance provision at issue in this case regulates health insurers' coverage of group health insurance, it is not preempted merely because of the existence of the identically-worded provision in section 702, even if the Montana provision prohibits behavior that section 702 would not otherwise forbid. The Montana law does not prevent application of any part of Part 7 and, consequently, does not conflict with Part 7 in the relevant sense. Thus, far from "eviscerat[ing]" section 702(b) by making illegal premium increases that ERISA may permit (assuming it does so), see Def's Br. Summ. J. 27, the Montana insurance provision's application to Blue Cross as an insurance issuer does not prevent the application of ERISA section 702 and is therefore not preempted by that provision.

Moreover, permitting action under the Montana regulation does not in any way contradict or undermine the preemption provisions of ERISA section 514. As explained above, the regulation of the essential feature of insurance practice – defining a risk pool and spreading risk among that pool – is not, in view of Congress' express intent to allow states to continue in their traditional roles as insurance regulators, the type of regulation that Congress intended to preempt in section 514. Accordingly, the Montana law fits comfortably within the kind of state insurance regulation that section 514 expressly saves. Cf. Morrison, 584 F.3d at 848 (concluding that ERISA does not preempt state insurance law that

eliminated a more lenient level of review for insurers in federal court permitted under ERISA even though it had an effect on the operation of ERISA-covered plans).

Indeed, it is not clear that the state insurance provision would be completely preempted under the analysis of Pilot Life and Davila even without regard to the special preemption provision in section 731. In this case, the plaintiffs brought suit under a state law provision that forbids insurers in Montana from setting premium rates in a particular manner. Unlike this kind of case, both Pilot Life and Davila involved state law suits related to benefit claims under an ERISA plan, and their holdings appear limited to that context. See Pilot Life, 481 U.S. at 56 ("all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans may be treated as federal questions governed by section 502(a)") (emphasis added); Davila, 542 U.S. at 217-18 ("[u]nder ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme") (emphasis added). Thus, in reaffirming Pilot Life, the Court stated the purpose of the comprehensive enforcement scheme set forth in the provisions of section 502(a) represent "a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of

employee benefit plans." Davila, 542 U.S. at 209. See also Abraham v. Norcal Waste Systems, Inc., 265 F.3d 811, 820 (9th Cir. 2001) (noting that ERISA preempts state laws that: "(1) mandate employee benefit structures or their administration; (2) bind employers or plan administrators to particular choices or preclude uniform administrative practice; and (3) provide alternative enforcement mechanisms to obtain ERISA plan benefits"). In reaching the conclusion that ERISA preempts state law claims related to plan benefits without regard to their status as insurance laws, the Court expressly relied on the legislative history analogizing benefit suits to suits concerning collective bargaining under the LMRA, and saw this history as implicitly expressing the intent that ERISA be construed to preempt benefit suits under the kind of extraordinary preemptive force that courts had long recognized in the LMRA context. Pilot Life, 481 U.S. at 55 ("'[W]ith respect to suits to enforce benefit rights under the plan or to recover benefits under the plan . . . [a]ll such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.'") (quoting H.R. Conf. Rep. No. 93-1280, p. 327 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 5107); see also Davila, 542 U.S. at 209.

Thus, without regard to whether the claim is saved from substantive preemption, a claim that is nominally stated as a state law claim arguably should

not be considered completely preempted under section 502(a) if it is not the type of claim – one involving claims determination or benefits – that was at issue in Pilot Life. But where a state law, such as the Montana provision, does not provide any mechanism for a plan participant to seek review of a benefit determination or to enforce the terms of the plan in any way, it is far from clear that such a state insurance law is preempted by ERISA's generally exclusive remedial scheme. But cf. Dudley Supermarket, Inc. v. Transamerican Life Ins. & Annuity Co., 302 F.3d 1, 3-4 (1st Cir. 2002) (ERISA completely preempts claim for breach of fiduciary duty under state law that is not an insurance law); Smith v. Provident Bank, 170 F.3d 609, 613 (6th Cir. 1999) (same); Joyce v. RJR Nabisco Holdings Corp., 126 F.3d 166, 171-72 (3d Cir. 1997) (same).

The court need not address this issue, however, because, for the reasons discussed above, even if the Montana prohibition on premium increases could be said to "supplement" ERISA under the district court's reading of Davila, and might otherwise be subject to preemption on this basis, Part 7 of the statute, and the accompanying legislative history and regulations expressly permit states to address these particular areas of insurance practice in precisely this manner. Thus, Congress has clearly expressed the intent that ERISA not be construed to provide the exclusive remedies in this regard.

CONCLUSION

For the reasons stated above, this Court should reverse the district court's decision dismissing plaintiff's claims and instruct the court to remand the matter to state court.

Respectfully submitted,

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March 18, 2011

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R.App. P. 32(a)(7)(B), I certify this brief contains 5481 words. The brief has been prepared using Microsoft XP in Times New Roman 14-point font size. The brief has been scanned and is virus free.

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CERTIFICATE OF SERVICE

I hereby certify that on March 18, 2011, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF systems.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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