No.

IN THE
Supreme Court of the United States

BLUE CROSS AND BLUE SHIELD
OF MONTANA, INC.,

Petitioner,

v.

DALE FOSSEN, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a substantive state-law insurance standard saved from preemption under the insurance saving clause of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(b)(2)(A), can be enforced through state-law remedies or instead is enforceable exclusively through ERISA's enforcement scheme, 29 U.S.C. § 1132.

PARTIES TO THE PROCEEDING

The parties to the proceeding are Dale Fossen; D and M Fossen, Inc.; Larry Fossen; L and C Fossen, Inc.; Marlowe Fossen; M and C Fossen, Inc.; Fossen Brothers Farms, a partnership; and Blue Cross and Blue Shield of Montana, Inc., a health service corporation.

STATEMENT PURSUANT TO RULE 29.6

Blue Cross and Blue Shield of Montana, Inc., a non-profit health service corporation organized under the laws of Montana, is not a publicly traded company, and no publicly held company owns ten percent or more of its stock (since, as a nonprofit corporation, no shares of stock have ever been issued by it). It has no parent corporation.

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The opinion of the court of appeals (*see* Petitioner's Appendix ("Pet. App.") 1a-24a) is reported at 660 F.3d 1102. The order of the court of appeals denying Petitioner's petition for panel rehearing (*see* Pet. App. 52a) is not reported. The opinion and order of the district court granting Petitioner's motion for summary judgment (Pet. App. 25a-41a) is reported at 744 F. Supp. 2d 1096, and the district court's opinion denying Respondent's motion to remand to state court (Pet. App. 42a-49a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on October 18, 2011. Petitioner timely filed a petition for panel rehearing. The court of appeals denied the petition for panel rehearing on December 23, 2011. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The text of statutory provisions involved in the case is set out in the accompanying appendix.

STATEMENT

This case raises a doctrinally significant issue concerning preemption under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*: whether a substantive state-law insurance standard saved from preemption under ERISA's insurance saving clause (ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)) is enforceable via state-law remedies or instead is

enforceable solely through ERISA's enforcement scheme (*id.* § 502, 29 U.S.C. § 1132). A Circuit split had developed on this question in the 1990's. One would have thought, however, that this Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217-18 (2004), had resolved the controversy, given the Court's indication there that, irrespective of the saving clause, state insurance law is preempted to the extent it supplies a "separate vehicle" from "ERISA's remedial scheme" to obtain relief. Nonetheless, the Ninth Circuit has now resurrected the Circuit split with its holding in this case that state-law remedies can be used to enforce saved state-law insurance standards. Because of the split in the Circuits, because the Ninth Circuit's decision is contrary to this Court's precedents, and because the question presented has important legal and practical implications, the Court should grant the petition for certiorari.[1]

A. Respondents Dale Fossen, Larry Fossen, and Marlowe Fossen ("the Fossens") are employed by and operate Fossen Brothers Farms. On January 1, 2004, Fossen Brothers Farms obtained a group health insurance policy through a Multiple Employer Welfare Arrangement ("MEWA") known as Associated Merchandisers Inc., Health First Plan (the "AMI Arrangement"). Petitioner Blue Cross and

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[1] When referencing provisions of ERISA, we generally refer first to the section in the ERISA statute itself and then to the corresponding section of Title 29 of the United States Code. Thus, ERISA § 514 is cited as "ERISA § 514, 29 U.S.C. § 1144."

Blue Shield of Montana, Inc. ("BCBSMT") was the insurer for the AMI Arrangement.

The AMI Arrangement consisted of a moderately sized group of unrelated employers purchasing group health insurance from BCBSMT. BCBSMT rated each employer separately within the AMI Arrangement, meaning that different premium levels potentially might be established for different specific employer groups within the AMI Arrangement. In all instances, however, BCBSMT charged a uniform premium per employee *within* each specific employer group.

Fossen Brothers Farms maintained coverage through the AMI Arrangement until May 2009, when it obtained a group health insurance policy through another MEWA (a successor to the AMI Arrangement), known as Montana Chamber Choices Group Benefit Plan (the "MCC Arrangement"). The MCC Arrangement similarly is insured by BCBSMT and has the same rating and premium features as the AMI Arrangement. Fossen Brothers Farms maintained coverage under the MCC Arrangement for the remainder of the period relevant to this case.

In obtaining group health insurance through the AMI and MCC Arrangements, Fossen Brothers Farms established a group health plan governed by ERISA – namely, the Fossen Brothers Farms Plan ("FBF Plan"). *See* Pet. App. 3a-4a, 28a-29a; *see generally* ERISA § 3, 29 U.S.C. § 1002(1) (ERISA defining "employee welfare benefit plan" as "any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the

purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits"). At all times relevant to this case, the Fossens and their dependents were participants in the FBF Plan.

B. In 1996, Congress amended ERISA through enactment of the Health Insurance Portability and Accountability Act ("HIPAA"). Specifically, as relevant here, HIPAA added ERISA § 702, 29 U.S.C. § 1182, which prohibits group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan from charging a participant in a group health plan a higher premium than another participant in the *same* plan based on "any health status-related factor." *Id.* § 702(b)(1), 29 U.S.C. § 1182(b)(1). However, § 702 also includes a rule of construction, stating that the section does not place any restrictions on the premiums that may be assessed as a whole on the group health plan in comparison to *other* group health plans. In this regard, the section provides that "[n]othing in [it] . . . shall be construed . . . to restrict the amount that an employer may be charged for coverage under a group health plan." *Id.* § 702(b)(2), 29 U.S.C. § 1182(b)(2). The end-result of § 702's prohibition and its rule of construction is that entities insuring ERISA plans may not charge different premiums *intra*-plan based on health status-related factors, but may charge different premiums *inter*-plan based on health-related (or other) factors.

Subsequent to the passage of HIPAA, Montana enacted a provision identical to ERISA § 702, Mont. Code Ann. § 33-22-526, which is sometimes referred

to as Montana's "Little HIPAA" statute. Like ERISA § 702, § 33-22-526 prohibits group health plans and their health insurance issuers from intra-plan discrimination in premiums based on health status-related factors, but does not bar inter-plan premium differences. Mont. Code Ann. § 33-22-526(2)(a)-(b). In turn, Montana's definition of "group health plan" is co-extensive with ERISA: "'Group health plan' means an employee welfare benefit plan, as defined in 29 U.S.C. 1002(1)." Mont. Code Ann. § 33-22-140(11). Furthermore, because health benefit plans issued in Montana are deemed to incorporate Montana's insurance laws, *see Sagan v. Prudential Insurance Co.*, 857 P.2d 719, 721 (Mont. 1993), Montana's Little HIPAA statute is tantamount to a term of all insurance policies subject to Montana law.

C. In September 2009, the Fossens filed a putative class action against BCBSMT in state court alleging discrimination pursuant to Mont. Code. Ann. § 33-22-526. The gravamen of the complaint is that § 33-22-526's prohibition on intra-plan discrimination in premiums precluded BCBSMT from charging, based on health status-related factors, different premiums *among* the employer groups within the AMI and MCC Arrangements, even if all employees *within* a specific employer group were charged the same premium. The complaint alleges that, over time, BCBSMT increased the premiums for the FBF Plan to a level greater than other employer groups within the AMI and MCC Arrangements due to the health status of one of Fossen Brothers Farms' employees. Pet. App. 29a.

In seeking to enforce § 33-22-526, the Fossens in their complaint invoked several, and solely, state-law remedies. First, they relied on § 33-22-526 itself, raising claims for declaratory judgment and "violation of legal duties." Excerpts of Rec. of Pl.-Appellants, Vol. 2 , at 282-83 (filed in 9th Cir.; Dkt. No. 14) [hereinafter "C.A. Exc. of Rec, Vol. 2"]. Second, the Fossens referenced Montana's unfair-insurance-practices statute, Mont. Code Ann. § 33-18-206(2), which prohibits insurers from engaging in "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 an insurance policy. The Fossens claimed "that "[BCBSMT] has violated the provisions of § 33-18-206(2), MCA and illegally discriminated against the Plaintiffs by charging the Plaintiffs premiums in excess of those authorized by § 33-18-526(2), MCA [*i.e.*, the Little HIPAA law]." C.A. Exc. of Rec., Vol. 2, at 283. Third, the Fossens invoked Montana's common law of contracts, raising a claim for "breach of contract." *Id.* at 284. Here, the Fossens asserted that, "[u]nder Montana law, each contract incorporated all pertinent Montana insurance statutes, specifically including §§ 33-18-206(2), MCA [*i.e.*, the unfair-insurance-practices statute] and 33-22-526(2), MCA [*i.e.*, the Little HIPAA law]." C.A. Exc. of Rec., Vol. 2, at 284. According to the Fossens, "BCBSM breached its contracts with the Plaintiffs by violating the terms of §§ 33-18-206(2), MCA and 33-22-526(2), MCA, which are incorporated in the contracts." C.A. Exc. of Rec., Vol. 2, at 284.

In connection with the claims for violation of legal duties under the Montana Little HIPAA statute, for violation of the unfair-insurance-practices statute, and for breach of contract, the Fossens maintained that they had "suffered damages." *Id.* at 283, 285. In the prayer for relief, the Fossens requested a declaration that "the Defendant has discriminated against the Plaintiffs by illegally charging the Plaintiffs and all others similarly situated premiums in excess of those allowed by law, and has discriminated against them in violation of § 33-22-526(2), MCA"; they also requested an "order that Defendant return to its insureds the excess premiums it has charged in excess of those allowed by § 33-22-526(2), MCA." C.A. Exc. of Rec., Vol. 2, at 287-88.

BCBSMT removed the case to federal court, asserting that ERISA "completely preempted" the Fossens' claims and therefore that the complaint raised federal questions. *See Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 8 (2003) (complete preemption makes a case removable to federal court whenever "the federal statute[] at issue provide[s] the exclusive cause of action for the claim asserted"); *see also Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-09 (2004) (applying complete preemption in ERISA context). The Fossens moved to remand to state court, but the district court denied the motion. The district court noted that the provision of state law at the heart of all of the Fossens' claims – namely, Montana's Little HIPAA statute (§ 33-22-526) – exactly "duplicates" ERISA § 702(b), 29 U.S.C. 1182(b). Pet. App. 32a-33a. Further, the district court emphasized that "ERISA also provides for civil

enforcement of [ERISA] provision[s]" via ERISA § 502, 29 U.S.C. § 1132, with "'the ERISA remedy [being] exclusive'" and not allowing for "state law duplications." Pet. App. 33a (quoting *Davila*, 542 U.S. at 209). The district court found that the Fossens could have pursued their grievance through an ERISA claim founded on ERISA § 702 and that, as a result, "Plaintiffs' state law cause of action is preempted by ERISA and [was] properly removed to [federal] [c]ourt." *Id.* at 49a.

Later, the district court granted summary judgment in BCBSMT's favor on all claims. Concluding that § 33-22-526(2) "underpins most of Plaintiffs' [complaint]," that § 33-22-526(2) is "identical" to ERISA § 702, and that ERISA's remedies preempt "'[a]ny state-law cause of action'" that is "'duplicat[ive]'" or "'supplement[ary],'" the district court held that the Fossens' case must proceed under ERISA, if at all. Pet. App. 31a, 32a, 33a (quoting *Davila*, 542 U.S. at 209). Converting the Fossens' claim to one under ERISA § 702, the district court then found that BCBSMT had not violated § 702, and therefore that no relief was available under ERISA, because § 702 prohibited only intra-group discrimination in premiums based on health-related factors and, in turn, the relevant group for § 702 purposes was the "Fossen Brothers Farms group – . . . not . . . the AMI or the MCC[]." Pet. App. 34a. "The Arrangements are purchasing consortiums, but the actual group health insurance plans exist at the participating employer level." *Id.* at 36a. "Accordingly, BCBSMT's method of premium calculation for the AMI/MCC[] Arrangements, which takes into account health status factors when rating

the employer plans separately, is permissible under ERISA section [702(b)]." *Id.* at 37a.

D. The Fossens appealed, challenging both removal jurisdiction and the summary judgment in BCBSMT's favor. The Court of Appeals affirmed the exercise of jurisdiction and judgment on the § 33-22-526(2) claims (for declaratory relief and violation of legal duties), but remanded for further proceedings on the unfair-insurance-practices and contract claims.

With respect to jurisdiction, the Court of Appeals held that, because § 33-22-526(2) is "*exactly identical*" to ERISA § 702, the Fossens – at least with respect to their § 33-22-526(2) claims – could have, and should have, "brought their claim under ERISA § 502(a)[]." Pet. App. 14a (internal quotation marks omitted; emphasis and alterations in original). Noting that this Court's decision in *Davila* had identified the possibility that a claim otherwise within ERISA's exclusive remedial framework might escape complete preemption (and thus removal jurisdiction) if it is based on an "'independent legal duty,'" the Court of Appeals held that § 33-22-526(2) is "expressly *dependent* on federal law . . . because the statute, by its very terms [*i.e.*, its cross-reference when defining 'group health plan' to ERISA's definition of 'employee welfare benefit plan'], applies only to ERISA plans." Pet. App. 16a (emphasis in original).

The Court of Appeals did not, however, extend its jurisdictional ruling to the unfair-insurance-practices and contract claims. Instead, it held that the district court had supplemental jurisdiction

under 28 U.S.C. § 1367 over "any non-preempted state-law claims." Pet. App. 19a n.7. It advised that the district court could "reexamine . . . on remand" whether to continue to exercise supplemental jurisdiction. *Id.*

On the merits, affirming the district court's judgment for BCBSMT on the § 33-22-526(2) claims, the Court of Appeals noted that the claims could only proceed under ERISA. Yet, "the Fossens never requested that the district court recharacterize their state-law claim[s] in this manner." Pet. App. 20a. Having failed to satisfy "the 'burden to amend their complaint' to assert claims that are not preempted by ERISA," the Court of Appeals reasoned that the district court could have granted summary judgment against them outright, and had even charitably gone the "extra step" of analyzing what the correct result would be (ultimately, a result in BCBSMT's favor) had the Fossens invoked ERISA. Pet. App. 20a (quoting *Stewart v. U.S. Bancorp*, 297 F.3d 953, 959 (9th Cir. 2002)).

The Court of Appeals took a different approach on the merits of the unfair-insurance-practices and contract claims. As an initial matter, the Court of Appeals noted the parties were in agreement that the unfair-insurance-practices statute "'relate[s] to' an ERISA plan" and therefore fit the test for preemption under ERISA's express preemption provision. Pet. App. 21a n.8 (quoting ERISA § 514(a), 29 U.S.C. § 1144(a)). But the Court of Appeals then determined that the unfair-insurance-practices statute was saved from preemption under ERISA's saving clause for state laws "which

regulate[] insurance." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Applying the two-part standard from *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003), the Court of Appeals found, first, that "[t]he statute is plainly directed at insurance companies because it regulates insurance rates and premiums" (Pet. App. 21a); second, it held that the statute "affects the risk-pooling arrangement because it regulates insurers' ability to obtain a premium that accurately reflects the risk being insured." *Id.*

Next, and most important for purposes of this Petition, the Court of Appeals considered whether, even though the unfair-insurance-practices claim was saved from preemption under ERISA's express preemption provision, it might still "conflict" with ERISA's remedies, a conflict that the Court of Appeals understood would – if the conflict existed – doom the claim under *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S 41, 57 (1987). Pet. App. 21a-22a; *see also id.* at 7a (citing *Pilot Life*). The Court of Appeals, however, held that the unfair-insurance-practices statute did "not run afoul of [ERISA] § 502(a) . . . because the Fossens seek relief (restitution) that is consistent with ERISA's enforcement scheme." Pet. App. 21a-22a. The Court of Appeals also added that the claim did not conflict with ERISA's remedies "because the state anti-discrimination rule is completely 'independent' of ERISA." *Id.* at 22a (quoting *Davila*, 542 U.S. at 210). On this point, the Court of Appeals said the unfair-insurance-practices law supposedly covers ground – *i.e.*, a general prohibition on discrimination in premiums – that ERISA itself does not address (as

opposed to premium discrimination based on health status-related factors, which ERISA does address). With ERISA and the unfair-insurance-practices statute not "identical in scope," the Court of Appeals held that a cause of action under the Montana statute was "not conflict preempted." *Id.* Further buttressing its holding, the Court of Appeals cited *PAS v. Travelers Insurance Co.*, 7 F.3d 349, 356 (3d Cir.) (1993), where it said the Third Circuit found a claim under "a nearly identical New Jersey statute" not to be "conflict preempt[ed]" by ERISA's remedies. Pet. App. 22a.

Given that it found the unfair-insurance-practices claim not to be preempted, and the district court had not separately addressed the merits of the claim (since the district court deemed it "intertwined" with § 233-22-526(2), *see* Pet. App. 23a), the Court of Appeals remanded "so that the district court may consider the merits of the unfair insurance practice claim in the first instance." *Id.*

Finally, the Court of Appeals held that the Fossens' state contract claim likewise survived preemption insofar as it is "premised . . . on the state unfair insurance practices claim." *Id.* In this respect, the Court of Appeals harkened back to the Fossens' allegation that Montana law deems insurance contracts to incorporate pertinent insurance statutes, including § 33-18-206(2). *See* C.A. Exc. of Rec., Vol. 2, at 284; *see supra*, p. 6. The Court of Appeals likewise remanded this claim to the district court, for determination as to whether a breach of contract occurred through alleged violation

of the incorporated unfair-insurance-practices law's anti-discrimination rule.

During the appellate proceedings, the U.S. Department of Labor ("DOL") filed an *amicus curiae* brief (and appeared at oral argument) in support of the Fossens. The DOL addressed only the state-law claims under § 33-22-526. It contended that complete preemption should not apply to a claim under a state Little HIPAA law because of another saving clause in ERISA allowing expanded state regulation on matters covered by the HIPAA provisions added to ERISA. *See* ERISA § 731, 29 U.S.C. § 1191(a)(1) ("this part [of ERISA] 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"). Because Montana's Little HIPAA law had not *added* any new protections to ERISA's HIPAA standards (but was instead exactly duplicative of the federal provisions), the Court of Appeals found this saving clause inapplicable and "decline[d] to defer to [the DOL's] . . . position." Pet. App. 18a. The DOL, in a footnote in its brief, said it was not addressing the Fossens' unfair-insurance-practices and contract claims, though it did question "whether [the unfair-insurance-practices statute] is an insurance regulation within the meaning of ERISA section 514(b)." Br. of Sec. of Labor in Supp. of Pls.-Appellants, No. 10-36001 (9th Cir. Mar. 18, 2001) (Dkt. No. 26), at 10 n.4.

E. Immediately upon remand to the district court, the Fossens moved to remand to state court the unfair-insurance-practices and contract claims. BCBSMT has opposed that motion and also moved for summary judgment on the claims. The district court has taken no action on the motions.

REASONS FOR GRANTING THE PETITION

In this case, the Ninth Circuit held that the "state anti-discrimination rule" it identified in Montana's unfair-insurance-practices statute and deemed saved from ERISA preemption is – notwithstanding ERISA's enforcement scheme – enforceable through the unfair-insurance-practice law's remedies or even through a state-law contract claim. Pet. App. 22a. The question whether state-law remedies, or only ERISA's enforcement mechanisms, are available to enforce a saved state insurance standard historically engendered a Circuit split that the Circuits themselves acknowledged; it has at times prompted debate in this Court's decisions; and the Solicitor General arguably has switched positions on the issue in the past. Then, the unanimous decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), seemingly ended the controversy, with the Court finding in favor of the exclusivity of ERISA's remedies. But the Ninth Circuit here has reignited the controversy, and at a critical time – namely, when Congress, through the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), has invited greater state-law regulation of entities insuring ERISA plans. In light of all of these considerations, the Court should grant the petition to determine once and for all whether ERISA's

remedies are the exclusive vehicle for enforcing saved state insurance laws.

A. The Court of Appeals' Decision Conflicts with the Decisions of Other Circuits

In the aftermath of *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the Circuits split on the question whether state-law remedies, or solely ERISA's enforcement scheme, can be used to enforce a saved state-law insurance standard. By way of background, *Pilot Life* involved the interplay among three ERISA provisions: ERISA's now-familiar preemption section (ERISA § 514(a), 29 U.S.C. § 1144(a)), which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"; ERISA's insurance saving clause (ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)), which states that "[n]othing in [ERISA] . . . shall be construed to exempt or relieve any person from any law of any State which regulates insurance"; and ERISA's remedies section (ERISA § 502, 29 U.S.C. § 1132), which contains "'six carefully integrated civil enforcement provisions'" to remedy (among other matters within ERISA's ambit) wrongful denials of ERISA benefits, breaches of fiduciary duties, and violations of ERISA's or an ERISA plan's terms. *Pilot Life*, 481 U.S. at 54 (quoting *Mass. Mutual Life Ins. Co.* v. *Russell*, 473 U.S. 134, 147 (1985)).

The question for decision in *Pilot Life* was whether ERISA preempted "state common law tort and contract actions asserting improper processing of a

claim for benefits under an insured employee benefit plan." 481 U.S. at 43. The Court found that the state tort and contract laws there involved "relate[d] to" an ERISA plan and therefore fell within the scope of ERISA's express preemption provision. *See id.* at 47-48. And the Court then found that the state-law claims were "not rescued by the saving clause." *Id.* at 57 n.4. On that score, the Court first held that the state provisions did not qualify, under the then-applicable test (borrowed from the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*), as laws that "'regulate[] insurance.'" *Pilot Life*, 481 U.S. at 51 (quoting ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A)). The Court then went further and determined that the state law causes of action did not survive for another reason: due to "the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive." *Id.* at 58.

On the civil enforcement provisions, the Court in *Pilot Life* said "the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents 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." *Id.* at 54. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* The Court found that "the deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue[d] strongly for the

conclusion that ERISA's civil enforcement remedies were intended to be exclusive." *Id.*

Accordingly, the Court in *Pilot Life* ruled that a "state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by § 514(b)(2)(A), and therefore is pre-empted by § 514(a)." *Id.* at 57. In reasoning "that Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries," the Court emphasized that it was adopting the position of "the Solicitor General, for the United States as *amicus curiae*." *Id.* at 52.

Though the state laws on which the causes of action in *Pilot Life* were bottomed were not saved from preemption, the Circuits soon after *Pilot Life* took up the related question (the one presented here) of whether ERISA's remedies were the exclusive means for enforc[ing] a state-law insurance standard that *is* saved. Over time, the majority of Circuits held that ERISA's remedies were exclusive to enforce saved state insurance laws. *E.g.*, *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 289 (4th Cir. 2003) ("A State law preserved as a regulation of insurance under § 514(b)(2)(A) may supply a substantive term or mandate a benefit in an employee benefit plan, but once that term or benefit becomes part of the plan, a suit to enforce it may only be brought under § 502(a)."); *Ruble v. UNUM Life Ins. Co.*, 913 F.2d 295, 297 (6th Cir. 1990) ("regardless of how Michigan's insurance code might have modified the terms of the . . . insurance

policy . . . any action brought by a beneficiary to enforce the policy as so modified could only be brought under § 502 of ERISA"); *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849, 860-61 (7th Cir. 1997) (saved state insurance law "becomes a substantive term" of the ERISA plan, but the state statute's "remedy would be preempted by ERISA under *Pilot Life*"); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) ("If 'saved' from ERISA preemption, the Missouri . . . statute will govern the interpretation of [the] policy, but that does not affect the preemption of state law remedies by § 1132"); *accord Fink v. Platte Community Mem. Hosp., Inc.*, 324 F.3d 685, 689 (8th Cir. 2003).[2]

The Seventh Circuit's decision in *Plumb* nicely illustrates these Circuits' approach. In that case, a participant in an ERISA plan and his assignee brought a "state claim, alleging that [an insurer's] denial of medical benefits . . . violated 215 ILCS § 95/20," an Illinois law that (according to the

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[2] In a similar vein, several Circuit decisions have held that ERISA completely preempts (and therefore makes removable to federal court) state-law claims founded on saved state insurance laws. *E.g.*, *Arana v. Ochsner Health Plan*, 338 F.3d 433, 440 (5th Cir. 2003) (en banc); *Ervast v. Flexible Prods. Co.*, 346 F.3d 1007, 1013 n.7 (11th Cir. 2003). These decisions are akin to those overtly holding that ERISA provides the exclusive remedy for enforcement of saved state insurance standards because complete preemption applies only when a federal statute provides "the exclusive cause of action for the claim asserted." *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 8 (2003).

participant and assignee) "requires insurance policies to cover preexisting conditions" in certain circumstances. 124 F.3d at 854. Dismissing the claim, the district court in the case "recognized that state laws that regulate insurance are saved from preemption by ERISA, but held that ERISA is the exclusive source for any remedy." *Id.* (citation omitted).

On appeal, the Seventh Circuit re-instated the claim, but *as an ERISA claim*. The Seventh Circuit found that § 95/20 fell "within the saving clause." *Id.* at 860. The Seventh Circuit further noted that the saved provision became a "substantive term" of the ERISA plan, since "[i]t is fundamental insurance law that 'existing and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable.'" *Id.* at 861 (quoting 2 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* § 19:1 (3d ed. 1996)). The Seventh Circuit then held that, "under *Pilot Life*," ERISA – and only ERISA – could be utilized to enforce § 95/20. *Id.* at 860. Relying on the Sixth Circuit's decision in *Ruble*, the Seventh Circuit emphasized that "'any action brought by a beneficiary to enforce the policy as so modified could only be brought under § 502 of ERISA, 29 U.S.C. § 1132.'" *Id.* at 862 (quoting *Ruble*, 913 F.2d at 297); *see also id.* at 861 (citing Eighth Circuit's decision in *Donatelli*).

Contrary to these many Circuits, the Third Circuit, seemingly alone, concluded that, even after *Pilot Life*, a state-law remedy is available to enforce a saved state insurance standard. In *PAS v. Travelers Insurance Co.*, 7 F.3d 349 (3d Cir. 1993), an ERISA

plan participant – challenging a denial of plan mental-health benefits – invoked a cause of action under a New Jersey statute requiring that "'[n]o person shall make or permit any unfair discrimination between individuals of the same class . . . in the amount of premium, policy fees, or rates charged for any policy . . . or in the benefits payable thereunder.'" *Id.* at 354 (quoting N.J. Stat. Ann. § 17B:30-12(d)). The Third Circuit determined that "the New Jersey statute regulates insurance within the meaning of ERISA's saving clause" and then analyzed whether the state law nonetheless was preempted because "'it conflicts directly with an ERISA cause of action.'" *Id.* at 356 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990), and citing *Pilot Life*, 481 U.S. at 57).

The Third Circuit ultimately rejected "conflict preemption." *Id.* In the Third Circuit's view, a "necessary requirement" for preemption was that the "state statute 'purports to provide a remedy for the violation of a right expressly guaranteed by [a section of ERISA] and exclusively enforced by § 502(a) [of ERISA].'" *Id.* (alterations in original; quoting *Ingersoll-Rand*, 498 U.S. at 145). Because the Third Circuit read the New Jersey law to provide "a remedy for an insurance carrier's violation of an [anti-discrimination standard]" that ERISA did not also contain, the claim based on New Jersey law "was not preempted by ERISA." 7 F.3d at 356, 357. And given that this state-law cause of action had, in the complaint, been teamed with ERISA claims since dismissed, the Third Circuit affirmed the district court's decision to decline the continued exercise of supplemental jurisdiction and to remand the state-

law claim to state court. *Id.* at 357. Last, the Third Circuit "recognize[d]" that "cases from other courts of appeals . . . reach[ed] a result contrary to the one [it] reach[ed] here." *Id.* at 356-57 (citing *Donatelli*, 992 F.2d at 765, and *Ruble*, 913 F.2d at 297).

As the Circuits were addressing ERISA's exclusivity for enforcement of saved state insurance laws, this Court too returned to the subject. In *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999), the Court sanctioned the approach whereby a litigant "sued under § 502(a)(1)(B) for benefits due, and [sought] only the application of saved state insurance law as a relevant rule of decision in his § 502(a) action." *Id.* at 377 n.7. At the same time, the Court noted that, though the Solicitor General had in *Pilot Life* "urged the exclusivity of § 502(a), ERISA's civil enforcement provision," the Solicitor General "now maintains that the discussion of § 502(a) in *Pilot Life* 'does not in itself require that a state law that "regulates insurance," and so comes within the terms of the saving clause, is nevertheless preempted if it provides a state-law cause of action or remedy.'" *Id.* (quoting Solicitor General's *amicus curiae* brief in *UNUM*).

Then, in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377 (2002), the Court termed *Pilot Life*'s discussion of the preemptive force of ERISA's remedies in situations involving saved state insurance laws to be "dictum." In *Rush Prudential*, the Court ruled that an Illinois law requiring external review of denials of certain medical benefits qualified as a saved state insurance regulation. The Court, however, avoided a direct confrontation with

Pilot Life, because it said the state external-review law operated more like a benefits mandate (*i.e.*, like a substantive insurance standard) and "provide[d] no new cause of action under state law and authorize[d] no new form of ultimate relief." *Id.* at 379. The four dissenting Justices disagreed, concluding that the Illinois law created an impermissible "arbitral-like state remedy" – impermissible because "state laws that seek to supplant or add to the exclusive remedies in § 502(a) of ERISA, 29 U.S.C. § 1132(a), are pre-empted." *Id.* at 400, 393 (Thomas, J., dissenting).

The Court appeared to end finally the debate with its unanimous decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). There, the Court, in a case focusing on complete preemption, took up the question whether state-law causes of action based on a Texas statute imposing duties on insurers "to exercise ordinary care in the handling of coverage decisions" is "save[d] . . . from pre-emption (and thereby from complete pre-emption)." *Id.* at 204, 216. Finding that the law was not saved under the insurance saving clause, the Court confirmed "*Pilot Life*'s reasoning" and "applie[d] [it] here with full force." *Id.* at 217. Irrespective of whether the state law otherwise might be saved, the Court said the state statute's remedies were doomed by the "exclusive federal remedy in ERISA § 502(a)." *Id.* "Under ordinary principles of conflict pre-emption, . . . 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." *Id.* at 217-18 (emphasis added).[3]

In the course of its analysis, the Court also took indirect aim at the reasoning that had led the Third Circuit in *PAS* to authorize a state-law remedy for enforcement of a saved state insurance standard. Whereas the Third Circuit in *PAS* thought a state-law remedy could survive if it added a right or obligation nowhere "guaranteed" in ERISA, *see* 7 F.3d at 356, the Court in *Davila* held that ERISA's remedies were exclusive, regardless of whether a state-law cause of action's "elements" or "remedies" are "strictly duplicative" of an ERISA claim. *Davila*, 542 U.S. at 215-16. Indeed, the Court took it as a given that "the pre-emptive force of ERISA § 502(a)" encompasses "the situation in which a state cause of

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[3] In *Davila*, the Solicitor General, for the United States as *amicus curiae*, supported the insurance company and favored complete preemption. Seemingly returning to the position the Solicitor General espoused in *Pilot Life*, he asserted that "*Pilot Life* was based largely on its determination that 'ERISA's civil enforcement remedies were intended to be exclusive.'" Br. for the United States as *Amicus Curiae* in Supp. of Pet'rs, *Aetna Health Inc. v. Davila*, Nos. 02-1845 & 03-83, 2003 U.S. S. Ct. Briefs LEXIS 1069, at **21 (quoting *Pilot Life*, 481 U.S. at 54); *see also id.* at **23 n.1 ("A state law may be saved from 'ordinary' preemption under ERISA's insurance saving clause, *see* 29 U.S.C. 1144(b)(2)(A), even in a case in which the underlying claim is removable from state to federal court under the complete preemption doctrine. That would occur, for example, if the state law's sole effect is to add a mandatory plan term that is enforceable only through an ERISA Section 502(a) action.").

action precisely duplicates a cause of action under ERISA § 502(a)," *id.*; it then likewise added that "Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA § 502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim." *Id.* at 216.

Against this rich backdrop comes the Ninth Circuit's decision in this case. Despite *Davila*, and notwithstanding that the majority of Circuits had even prior to *Davila* reached a contrary conclusion, the Court of Appeals here held that the Fossens could enforce the saved anti-discrimination rule supplied by Montana's unfair-insurance-practices statute through that state statute or state contract law. Reaching back to, and expressly relying on, the Third Circuit's decision in *PAS*, the Ninth Circuit found that the state-law claims could co-exist with ERISA's remedies, because the Ninth Circuit deemed the "relief (restitution)" sought by the Fossens as "consistent with ERISA's enforcement scheme" and because the substantive "'right[s]'" and protections provided by the state unfair-insurance-practices law "are not identical in scope" to protections afforded by ERISA. Pet. App. 21a-22a (quoting *PAS*, 7 F.3d at 356).

The Ninth Circuit therefore resurrected a Circuit split on the question of the exclusivity of ERISA's remedies for enforcement of saved state insurance standards. Whereas the Fossens' unfair-insurance-practices and contract causes of action remain intact

in the Ninth Circuit (and possibly would remain so in the Third Circuit, if that court found *PAS* to survive *Davila*), the same causes of action would straightforwardly be preempted by ERISA's exclusive enforcement scheme in (at a minimum) the Fourth, Sixth, Seventh, and Eighth Circuits. To resolve the conflict among the Circuits, the Court should grant the petition.

B. The Court of Appeals' Decision Is Contrary to This Court's Decisions

The Ninth Circuit's holding on the Fossens' unfair-insurance-practices and contract claims also is, on the merits, contrary to this Court's decisions, further bolstering the case for granting the petition. Most notably, the Ninth Circuit's decision contradicts *Davila*. *Davila* discussed at length the exclusivity of ERISA's remedies, both as a general matter and for enforcing state laws that can "be characterized as 'regulating insurance.'" 542 U.S. at 217. And the Court came out strongly in favor of ERISA § 502 being "an exclusive federal remedy," whether the remedies sought under state law were "duplicative" or "supplement[ary]" to ERISA's remedies and whether the "elements" of the state law resulted in the same or different protection than ERISA supplies. *Id.* at 216-17. Whenever a litigant seeks to use an otherwise saved state law as a "*separate* vehicle" for enforcement "outside of, or in addition to, ERISA's remedial scheme" – which is what the Fossens seek to do here – the state-law claim is preempted. *Id.* (emphasis added).

Indeed, in many respects the Ninth Circuit's approach here represents the discredited viewpoint

adopted by the Fifth Circuit in *Davila*, ultimately rejected by this Court. In finding that the Texas claim in *Davila* was not completely preempted by ERISA (and therefore supposedly "did not fall within § 502(a)(1)(B)'s scope," *id.* at 206), the Fifth Circuit "found significant" that the ERISA participants raised state tort claims "arising from 'an external, statutorily imposed duty of "ordinary care."'" *Id.* (quoting *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002), quoting Texas statute). In the Fifth Circuit's view, complete preemption (and thus the exclusivity of ERISA's remedies) "is limited to situations in which 'States . . . duplicate the causes of action listed in ERISA § 502(a).'" *Id.* (quoting *Roark*, 307 F.3d at 310-11). Reminiscent of the Fifth Circuit's error, the Ninth Circuit here found that the Fossens' unfair-insurance-practices and contract claims did not "conflict" with ERISA's remedies because "the unfair insurance practices statute creates a right that is separate from and could not possibly be remedied under ERISA." Pet. App. 22a.

Instead of authorizing the Fossens to use state-law remedies to enforce what it saw as the unfair-trade-practices statute's anti-discrimination standard, the Court of Appeals should have followed the paradigm that this Court approved in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999). In *UNUM*, "Ward sued under § 502(a)(1)(B)," and "[t]he [saved state] notice-prejudice rule supplied the relevant rule of decision for this § 502(a) suit." *Id.* at 377. Similarly, here, the Fossens could have, and should have, pursued a claim under ERISA § 502(a) to enforce any saved anti-discrimination rule contained in the Montana unfair-trade-practices statute. In

particular, ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes an ERISA plan participant to obtain "appropriate equitable relief" to "redress . . . violations" of "the terms of the plan" or "to enforce . . . the terms of the plan." Because, under insurance law generally, and under Montana insurance law specifically (as asserted even by the Fossens, *see supra*, p. 6), applicable statutory insurance requirements are "imputed . . . into an insurance policy that did not contain [them]," a saved anti-discrimination rule in the Montana unfair-insurance-practices statute was a term of the FBF Plan and enforceable through § 502(a)(3). *Plumb v. Fluid Pump Serv.*, 124 F.3d 849, 861 (7th Cir. 1997); *accord Sagan v. Prudential Insurance Co.*, 857 P.2d 719, 721 (Mont. 1993) ("[T]he provisions of insurance statutes are to be read into an insurance policy as though written therein.").

Apart from being contrary to this Court's teachings about the exclusivity of ERISA's remedies, the Ninth Circuit's decision contravenes the Court's ERISA precedents for an altogether separate reason: because it misconstrues the equitable relief that ERISA allows. Even taking the Court of Appeals' decision at face-value, the Court of Appeals determined that the state-law causes of action could survive only because "the Fossens seek relief (restitution) that is consistent with ERISA's enforcement scheme." Pet App. 21a; *accord id.* at 5a ("[t]he complaint sought . . . restitutionary relief through a return of overcharged premiums"). In reality, the relief the Fossens requested (if it was

restitution at all) was not the form of restitution that this Court has said ERISA authorizes.[4]

Interpreting ERISA § 502(a)(3)'s allowance for "appropriate equitable relief," this Court has carefully distinguished between two forms of restitution – "legal" restitution and "equitable" restitution. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002). The former is unavailable under ERISA, while the latter is permitted. *Id.* at 213-14; *see also id.* at 212 ("not all relief falling under the rubric of restitution is available in equity"); *accord Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 362-63 (2006).

A plaintiff seeks legal restitution where he or she requests "the imposition of personal liability for the benefits that [the plaintiff] conferred upon [the defendant]." *Sereboff*, 547 U.S. at 362 (internal quotation marks omitted). In other words, in those situations where a plaintiff "'might be able to show just grounds for recovering money to pay for some

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[4] In its own right, the Court of Appeals' conclusion that the unfair-trade-practices and contract claims seek restitution is highly suspect. In each of these counts in the complaint, the Fossens maintained that they "suffered *damages*" (C.A. Exc. of Rec., Vol. 2, at 283, 285 (emphasis added)); moreover, the unfair-insurance-practices statute on its face restricts liability to "actual damages." Mont. Code Ann. § 33-18-242(1). It is, of course, well-settled that ERISA § 502(a)(3) does not authorize an award of damages. *See Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 255-56 (1993). For present purposes, we assume *arguendo* that the Fossens sought some form of restitution.

benefit the defendant had received from him,' the plaintiff had a right to restitution *at law* through an action derived from the common law writ of assumpsit." *Great-West*, 534 U.S. at 213 (quoting 1 Dan B. Dobbs, *Law of Remedies* § 4.2(1), at 571 (2d ed. 1993)) (emphasis in original). A claim for "breach of contract (whether the contract was actual or implied)" is a "legal" action (and thus incompatible with ERISA) even where the plaintiff requests restitution, if the action seeks "'to obtain a judgment imposing a merely personal liability upon the defendant to pay a sum of money.'" *Id.* (quoting Restatement of Restitution § 160, cmt. a, at 641-642 (1937)).

In contrast, equitable restitution (*i.e.*, the type that ERISA does allow) exists under far narrower circumstances. The key "feature of equitable restitution [is] that it [seeks] to impose a constructive trust or equitable lien on '*particular* funds or property in the defendant's possession.'" *Sereboff*, 547 U.S. at 362 (quoting *Great-West*, 534 U.S. at 213) (emphasis added). In *Sereboff*, for instance, the Court deemed the suit to seek equitable restitution and thus to be permissible under ERISA, because the plaintiff "sought 'specifically identifiable' funds that were 'within the possession and control of the Sereboffs,'" -- namely, "that portion of [a] tort settlement . . . set aside and 'preserved [in the Sereboffs'] investment accounts.'" 547 U.S. at 362-63 (quoting lower court's decision). Specifically, the plaintiff "sought its recovery through a constructive trust or equitable lien on a specifically identified fund, not from the Sereboffs'

assets generally, as would be the case with a contract action at law." *Id.* at 363.

In the Fossens' case, the only mention of anything resembling restitution in the complaint arrives in the prayer for relief, where the Fossens seek an order "that Defendant return to its insureds the excess premiums it has charged in excess of those allowed by § 33-22-526(2), MCA." C.A. Exc. of Rec., Vol. 2, at 288. Putting aside that the request is for the return of payments in excess of what *the Little HIPAA law* supposedly allowed, not what the *unfair-insurance-practices* statute authorized, the prayer has none of the trappings of a plea for *equitable* restitution. There is no mention of any constructive trust in their complaint; nor have the Fossens ever identified a specific segregated fund to which they seek ownership. They refer to no bank account, parcel or property, or settlement fund to which they want title. Rather, the Fossens simply seek to be recompensed for what they deem to be charges in excess of Montana law. In fact, it would be implausible for them even to put their allegations in terms of obtaining a constructive trust over a specific fund, since the dispute involves merely the periodic payment of insurance premiums during years in the past for insurance risk *already* underwritten. *See Great-West*, 534 U.S. at 213-14 ("[W]here the property [sought to be recovered] or its proceeds have been dissipated so that no product remains, [the plaintiff's] claim is only that of a general creditor, and the plaintiff cannot enforce a constructive trust of or an equitable lien upon other property of the [defendant].") (internal quotation marks omitted; bracketed material in original).

Thus, even if the Ninth Circuit were correct that a saved state insurance standard can be enforced through a state-law remedy providing for relief similar to the relief ERISA permits, its conclusion that ERISA allows what the Fossens seek breaches *Great-West* and *Sereboff*.[5]

In sum, the Ninth Circuit's decision is, under this Court's ERISA precedents, rife with infirmities. The Court of Appeals disregarded *Davila*, failed to follow *UNUM*'s lead, and missed the distinction between equitable and legal restitution spelled out in *Great-West* and *Sereboff*. Given these errors, as well as the Circuit split otherwise reignited by the Ninth Circuit's decision, the Court should grant certiorari.

C. The Issue Presented in This Case Is an Important One Warranting the Court's Review

The issue presented in this case is both legally and practically significant. As a jurisprudential matter, the Ninth Circuit's decision adds disorder to the already complex area of ERISA preemption and

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[5] To be sure, this Court recently indicated that a participant might sue a fiduciary for "surcharge" under ERISA § 502(a)(3), which might allow for "monetary compensation" that cases like *Great-West* and *Sereboff* do not envision. *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1880 (2011) (internal quotation marks omitted). But it is unclear whether that statement in *Amara* is more than "dictum" (*id.* at 1884 (Scalia, J., concurring)), and in any event the Fossens never alleged that BCBSMT acted in a fiduciary capacity, and the district court never made any such finding.

remedies. Starting with *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985), and then through *Pilot Life*, *UNUM, Rush Prudential*, and *Davila* (as well as other decisions), this Court has carefully honed the preemptive force and scope of ERISA's remedial scheme. Misapprehending these precedents, the Ninth Circuit has dialed the clock back, relying on theory and case law now discredited. And the Ninth Circuit's uncritical, general statement that *all* restitution is allowable under ERISA adds confusion, in the wake of *Great-West* and *Sereboff*.

As to practical implications, the answer to the question whether ERISA's remedies are the exclusive means for enforcing a saved state insurance standard potentially determines the forum for *every* lawsuit invoking state-law causes of action for enforcement of such standards. Because federal removal jurisdiction under the complete-preemption doctrine depends, for its operation, on the exclusivity of an applicable federal remedy, *see Beneficial National Bank v. Anderson*, 539 U.S. 1, 8 (2003), a court concluding that state-law causes of action are available necessarily will relegate the lawsuit to a state forum; a court reaching the opposite conclusion (*i.e.*, that ERISA's remedies are exclusive) opens the door to federal jurisdiction. Indeed, in this case, the Ninth Circuit indicated that the district court could revisit whether to exercise federal jurisdiction over the unfair-insurance-practices and contract claims, now that it found them to withstand preemption. *See generally supra*, n.2 (noting cases involving removal jurisdiction in which plaintiffs sought to enforce saved state insurance laws).

In addition, in the Ninth Circuit (and any others following its approach), forum shopping would become the norm in suits involving enforcement of saved state insurance laws. A plaintiff would posit his claims in state-law terms if the state forum offered favorable procedural or other rules; or the plaintiff would invoke ERISA's remedies if federal court promised greener pastures. State and federal rules might resolve differently a slew of critical procedural matters, from the availability of jury trials and class actions to evidentiary presumptions (such as *contra proferentem* under state contract law, as opposed to deference to the plan administrator under ERISA).

The state-court jurisdiction and forum-shopping invited by the Ninth Circuit's decision, if left unchecked, would strike at the heart of Congress's ERISA design.

> [The] exclusivity of [ERISA's] remedies is necessary to further Congress' interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees: "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 388 (2002) (Thomas, J., dissenting) (quoting *FMC Corp.* v. *Holliday,* 498 U.S. 52, 60 (1990)). So as to

avoid "eviscerat[ing] the uniformity of ERISA remedies," the Court should take up the petition and ultimately reverse the Ninth Circuit's holding on the unfair-insurance-practices and contract claims. *Id.* at 389.

Finally, the question presented takes on added significance in light of enactment of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010). PPACA adds many new provisions to ERISA, and it also countenances additional state-law insurance regulation that does not "prevent the application of [PPACA (Title I) standards]." *Id.* § 1321(d), 124 Stat. at 187. At a time when the states can be expected to *increase* their regulation of entities insuring ERISA plans, there should be no uncertainty as to whether state-law remedies or just ERISA's enforcement measures are available to enforce saved state insurance standards.[6]

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[6] The constitutionality of PPACA currently is at issue in Nos. 11-393, 11-398, and 11-400. Even were the Court to strike down PPACA in its entirety, that might not necessarily mean lesser state regulation of insurers. For instance, DOL has, pursuant to PPACA, issued extensive claims-procedure regulations in which the states have a substantial role. *See* 75 Fed. Reg. 43330 (July 23, 2010); 76 Fed. Reg. 37208 (June 24, 2011). DOL, however, also has broad authority to regulate ERISA plans (including claims procedures), which would remain intact irrespective of any constitutional ruling on PPACA. *See, e.g.,* ERISA § 503, 29 U.S.C. § 1133. Further, the Court's constitutional determination would not affect the states' (as opposed to the federal government's) own ability to regulate.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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MARCH 2012

APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DALE FOSSEN; D AND M FOSSEN, INC.; LARRY FOSSEN; L AND C FOSSEN, INC.; MARLOWE FOSSEN; M AND C FOSSEN, INC. FOSSEN BROTHERS FARMS, a Partnership,	) No. 10-36001
Plaintiffs – Appellants,	) D.C. No. 6:09-cv-00061-CCL
v.	) OPINION
BLUE CROSS AND BLUE SHIELD OF MONTANA, INC., a health service corporation	) [Entered: Oct. 18, 2011]
Defendant – Appellee.	

Appeal from the United States District Court
for the District of Montana Charles C. Lovell, Senior
District Judge, Presiding

Argued and Submitted
August 4, 2011—Seattle, Washington

Filed October 18 2011

Before: Mary M. Schroeder and Milan D. Smith, Jr., Circuit Judges, and Roger T. Benitez, District Judge.*

Opinion by Judge Milan D. Smith, Jr.

COUNSEL

Lawrence A. Anderson (argued), Great Falls, Montana; John M. Morrison (argued), Morrison, Motl & Sherwood, PLLP, Helena, Montana, for the plaintiffs-appellants.

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Mark G. Arnold and Jeffrey J. Simon, Husch Blackwell LLP, St. Louis, Missouri, for amicus curiae National Association of Insurance Commissioners.

Jesse Laslovich and Christina Lechner Goe, Office of the Commissioner of Securities and Insurance, Montana State Auditor, Helena, Montana, for amicus curiae Monica J. Lindeen, Commissioner of Securities and Insurance, Montana State Auditor.

M. Patricia Smith, Timothy D. Hauser, Elizabeth Hopkins, and Uchenna Evans (argued), United States Department of Labor, Washington, DC, for amicus curiae Hilda L. Solis, Secretary of the United States Department of Labor.

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* The Honorable Roger T. Benitez, United States District Judge for the Southern District of California, sitting by designation.

OPINION

M. SMITH, Circuit Judge:

This appeal presents the question of whether a provision of the federal Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996), preempts Montana's "little HIPAA" law, Mont. Code Ann. § 33-22-526(2)(a), for purposes of both conferring federal subject matter jurisdiction and defeating state-law causes of action on the merits. The federal and state HIPAA provisions at issue prohibit certain health insurers from charging different premiums to "similarly situated" participants on account of a participant's "health status-related factor." 29 U.S.C. § 1182(b)(1); Mont. Code Ann. § 33-22-526(2)(a). We affirm the district court and hold that federal HIPAA preempts the Montana law, both jurisdictionally and on the merits, because Montana's HIPAA provision is identical to, and expressly relies upon, federal law. However, federal law does not preempt a claim for relief under a separate Montana unfair insurance practices statute that bars insurers from engaging in "unfair discrimination" when charging policy premiums to similarly situated individuals. Mont. Code Ann. § 33-18- 206(2).

BACKGROUND

Plaintiffs-Appellants (collectively, Fossens) are three brothers, Dale, Larry, and Marlowe Fossen, their three corporations (which they jointly own with their spouses), and Fossen Brothers Farms (a partnership of the three corporations). In 2004, Fossen Brothers Farms applied to Blue Cross and Blue Shield of Montana (Blue Cross) to obtain health insurance coverage for the Fossen Brothers

Farms's three employees. From 2004 through May 2009, Blue Cross provided coverage to Fossen Brothers Farms through the Associated Merchandisers Inc., Health First Plan (Associated Merchandisers Plan), and from June 2009 through the time this lawsuit was filed, Blue Cross provided coverage through the Montana Chamber Choices Group Benefit Plan (Chamber Choices Plan).

In 2006, Blue Cross informed the Fossens that their premium was increasing by over 20%. The Fossens learned that Blue Cross was imposing different increases (and even decreases in some cases) on other plan members. After the Fossens complained to the Montana Insurance Commissioner, Blue Cross reduced the proposed increase to 4%. For the 2008 plan year, however, Blue Cross increased the Fossens' premiums over 40%. The Fossens complained again to the insurance commissioner, but apparently to no avail. They then filed this lawsuit in state court in September 2009.

The Fossens' complaint asserted three substantive causes of action. First, they alleged that Blue Cross's 40% premium increase violated a provision of Montana's "little HIPAA" statute that prohibits "group health plan[s]" (and insurers offering coverage through group health plans) from imposing a "premium or contribution that is greater than the premium or contribution for a similarly situated individual" on account of "any health status-related factor of the individual . . . ." Mont. Code Ann. § 33-22-526(2)(a). Second, the Fossens asserted that Blue Cross's premium increase violated a provision of Montana's Unfair Trade Practices Act, Mont. Code Ann. §§ 33-18-101 *et seq.*, which prohibits insurers from engaging in "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 . . . . ," Mont. Code Ann. § 33-18-206(2); *see also* Mont. Code Ann. § 33-1-207(1) (defining "disability insurance" as including insurance against medical expenses resulting from accident or sickness). Third, the Fossens claimed that the premium increase constituted a breach of their contract with Blue Cross, which allegedly incorporated by reference both the Montana HIPAA provision and the unfair practices provision.[1] The complaint sought two forms of relief—declaratory relief that Blue Cross violated the law and restitutionary relief through a return of overcharged premiums—and sought certification as a class action.

Blue Cross timely removed the complaint to federal court, asserting that the Fossens' little HIPAA claim was completely preempted by the Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829. Federal HIPAA, which is part of ERISA (as amended), contains a provision similar to the Montana HIPAA statute raised in the complaint. As with the Montana HIPAA statute, federal HIPAA prohibits "group health plan[s]" (and insurers offering coverage through group health plans) from charging different "premium[s] or contribution[s]" to "similarly situated individual[s]" on account of "any health status-related factor in relation to the individual[s] . . . ." 29 U.S.C. § 1182(b)(1).[2]

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[1] The complaint also mentioned, in passing, Montana Code Annotated § 33-22-1809. However, the Fossens' briefs do not discuss this statute, so we do not consider it here.

[2] Both state and federal law define "health status-related

Blue Cross argued that ERISA's "complete preemption" doctrine, as articulated in *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 66-67 (1987), and subsequent cases, conferred federal jurisdiction over the Fossens' nominal state-law claims. The district court agreed with Blue Cross, and denied the Fossens' motion to remand. The court then granted Blue Cross's motion for summary judgment. The court noted that all of the Fossens' claims were premised on an underlying violation of federal HIPAA, and, finding no violation of that statute, the court held that the Fossens' claims failed as a matter of law. The court also declined to allow the Fossens to amend their complaint to state a breach of contract theory (first argued in the Fossens' summary judgment briefs) premised on Blue Cross's alleged promise not to increase their premiums by a greater amount than any other members of the Associated Merchandisers Plan. The Fossens timely appealed the district court's decision.

JURISDICTION AND STANDARD OF REVIEW

We have jurisdiction over the district court's final judgment. 28 U.S.C. § 1291. We review the district court's exercise of subject matter jurisdiction de novo, placing the burden "on the party invoking removal." *Marin Gen. Hosp. v. Modesto & Empire*

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factor" as including "Health status," "Medical condition (including both physical and mental illnesses)," "Claims experience," "Receipt of health care," "Medical history," "Genetic information," "Evidence of insurability (including conditions arising out of acts of domestic violence)," and "Disability." 29 U.S.C. § 1182(a)(1); *see also id.* § 1191b(d)(2); Mont. Code Ann. § 33-22-526(1)(a).

Traction Co., 581 F.3d 941, 944 (9th Cir. 2009). We review de novo the district court's grant of Blue Cross's motion for summary judgment, and examine the evidence in a light most favorable to the Fossens. *FTC v. Stefanchik*, 559 F.3d 924, 927 (9th Cir. 2009). We review the district court's denial of leave to amend the complaint for abuse of discretion. *AmerisourceBergen Corp. v. Dialysist West, Inc.*, 465 F.3d 946, 949 (9th Cir. 2006).

DISCUSSION

I. ERISA Preemption

"There are two strands of ERISA preemption: (1) 'express' preemption under ERISA § 514(a), 29 U.S.C. § 1144(a); and (2) preemption due to a 'conflict' with ERISA's exclusive remedial scheme set forth in [ERISA § 502(a),] 29 U.S.C. § 1132(a)." *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1081 (9th Cir. 2009) (citing *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005)), *cert. denied*, 130 S. Ct. 1053 (2010). HIPAA contains an additional express preemption provision relevant here: ERISA § 731(a), 29 U.S.C. § 1191(a), which is described in greater detail below.

[1] All of these preemption provisions defeat state-law causes of action on the merits. *See, e.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (§ 514(a) preemption); *Cleghorn*, 408 F.3d at 1227 (§ 502(a) preemption). Conflict preemption under ERISA § 502(a), however, also confers federal subject matter jurisdiction for claims that nominally arise under state law. *See, e.g.*, *Marin Gen.*, 581 F.3d at 945. Ordinarily, federal question jurisdiction does not lie where a defendant contends that a state-law claim is preempted by federal law. *Aetna*

Health Inc. v. Davila, 542 U.S. 200, 207 (2004); *Marin Gen.*, 581 F.3d at 945. But state-law claims may be removed to federal court if the "complete preemption" doctrine applies. *Marin Gen.*, 581 F.3d at 945; *see also Davila*, 542 U.S. at 207-08. Relevant to this case, ERISA § 502(a) " 'set[s] forth a comprehensive civil enforcement scheme' " that completely preempts state-law " 'causes of action within the scope of th[es]e civil enforcement provisions . . . .' " *Davila*, 542 U.S. at 208-09 (quoting *Metro. Life*, 481 U.S. at 66; *Pilot Life*, 481 U.S. at 54); *see also Marin Gen.*, 581 F.3d at 945.[3]

[2] Following *Davila*, we have distilled a two-part test for determining whether a state-law claim is completely preempted by ERISA § 502(a): "a state-law cause of action is completely preempted if (1) 'an individual, at some point in time, could have brought the claim under ERISA § 502(a)(1)(B),' and (2) 'where there is no other independent legal duty that

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[3] In pertinent part, ERISA § 502(a) provides:

> A civil action may be brought—
>
> (1) by a participant or beneficiary— . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; . . .
>
> (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, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . .

29 U.S.C. § 1132(a) (footnote omitted).

is implicated by a defendant's actions.' " *Marin Gen.*, 581 F.3d at 946 (alteration omitted) (quoting *Davila*, 542 U.S. at 210). Because this "two-prong test . . . is in the conjunctive[,] [a] state-law cause of action is preempted by § 502(a)(1)(B) only if both prongs of the test are satisfied." *Id.* at 947; *see also Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 328 (2d Cir. 2011) (noting that *Davila* test is conjunctive). Both *Davila* and *Marin General Hospital* discussed complete preemption by reference to § 502(a)(1)(B) but not the other subparts of § 502(a). The complete preemption doctrine applies to the other subparts of § 502(a) as well. *See Metro. Life*, 481 U.S. at 66 ("Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court."); *Sorosky v. Burroughs Corp.*, 826 F.2d 794, 799 (9th Cir. 1987) (holding that complete preemption "is applicable to the section 502(a)(3) claims alleged in this case").

Express preemption under ERISA § 514 is also governed in relevant part by a two-prong test. Under § 514(a), ERISA broadly preempts "any and all State laws insofar as they may now or hereafter relate to any [covered] employee benefit plan . . . ." 29 U.S.C. § 1144(a). But this broad preemption provision is tempered by a savings clause in § 514(b), which spares "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A). "To fall under the savings clause, a regulation must satisfy a two-part test laid out in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003)." *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 842 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010). " 'First, the state law must

be specifically directed toward entities engaged in insurance.' " *Id.* (quoting *Ky. Ass'n of Health Plans*, 538 U.S. at 342). Second, "it 'must substantially affect the risk pooling arrangement between the insurer and the insured.' " *Id.* (quoting *Ky. Ass'n of Health Plans*, 538 U.S. at 342).

[3] In addition to these generally applicable preemption provisions, ERISA also contains a HIPAA-specific preemption clause. Under that clause, federal HIPAA does not "supersede any provision of State law which establishes, implements, or continues in effect any standard or require-ment 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" federal HIPAA. 29 U.S.C. § 1191(a)(1). The provision's plain terms appear to permit "state laws that are, generally speaking, more favorable to the insured." *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849, 862 n.10 (7th Cir. 1997) (dictum); *accord* H.R. Rep. No. 104-736, at 205 (1996) (Conf. Rep.) (noting that HIPAA's drafters "intend the narrowest preemption," and to allow "[s]tate laws which are broader than federal requirements").[4]

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[4] The Secretary of Labor has promulgated a preemption regulation under HIPAA, but that provision's preemptive power is limited to the Secretary's own regulations. *See* 45 C.F.R. § 146.143(a) (preempting state laws that "prevent[ ] the application of a requirement of this part"; that is, Code of Federal Regulations, title 45, part 146, "Requirements for the Group Health Insurance Market"). Because the Secretary's regulations are not at issue here, we need not consider their preemptive effect, if any.

II. Federal Subject Matter Jurisdiction

We apply the two-part *Davila* test to determine whether ERISA § 502(a) completely preempts the Fossens' state-law claims and confers federal jurisdiction. *See Marin Gen.*, 581 F.3d at 945. We initially focus our attention on the Fossens' state HIPAA cause of action.

A. First Prong of *Davila*

[4] Under *Davila*, the first question is whether the Fossens could have brought their complaint under § 502(a). We agree with Blue Cross that the Fossens could have done so. They are suing for restitution of premiums they allegedly overpaid in violation of Montana's HIPAA statute. As the district court correctly recognized, the Fossens' claim under *Montana* HIPAA could also have been brought under *federal* HIPAA, because the relevant state and federal HIPAA provisions are identical. Both statutes apply to "group health plan[s]" and insurance companies "offering health insurance coverage in connection with a group health plan." 29 U.S.C. § 1182(b)(1); Mont. Code Ann. § 33-22-526(2)(a). Both statutes bar such entities from requiring individuals to pay insurance "premium[s] or contribution[s]" that are greater than other plan participants' premiums on account of "any health status-related factor." 29 U.S.C. § 1182(b)(1); Mont. Code Ann. § 33-22- 526(2)(a). Thus, the Fossens' suit for return of premiums could have been brought under ERISA as well as state law. *See* 29 U.S.C. § 1132(a)(3)(A), (B)(ii) (allowing ERISA plan participants to sue "to enjoin any act or practice which violates any provision of [ERISA]," and "to obtain other appropriate equitable relief . . . to enforce any provisions of [ERISA]"); *Werdehausen v. Benicorp Ins. Co.,* 487

F.3d 660, 668 (8th Cir. 2007) (holding that violations of 29 U.S.C. § 1182 may be remedied through ERISA § 502(a)); *see also Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) (holding that ERISA permits suits for equitable restitution "to restore to the plaintiff particular funds or property in the defendant's possession").

The Fossens raise two related objections to this line of reasoning: first, they contend that their claims fall outside the scope of ERISA because they are suing with respect to Blue Cross's multiple employer welfare arrangement (MEWA)- level contracts,[5] which are not necessarily governed by ERISA; and second, they argue that the Montana HIPAA provision is not identical to the federal provision because the language of the Montana statute could be construed differently from the language of the federal statute. We disagree with both arguments.

[5] We need not delve too deeply into the Fossens' distinction between MEWA-level plans and ERISA plans, as it is clear that at least part of this lawsuit involves an ERISA plan and falls within the scope of § 502(a). An ERISA plan exists because the individual Fossens' employer, Fossen Brothers Farms, pays

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[5] In a nutshell, the Fossens contend that separate contracts/plans exist with respect to (1) the individual Fossens' relationship with Fossen Brothers Farms, and (2) Fossen Brothers Farms's relationship with Associated Merchandisers Inc., Montana Chamber Choices Trust, and Blue Cross. The Fossens appear to concede that the first relationship constitutes an ERISA plan, but they argue that the second relationship is the only one at issue in this lawsuit, and it is a "multiple employer welfare arrangement" rather than an ERISA plan.

its employees' insurance premiums and acts as the administrator of the insurance plan. Those facts are identical to the facts we relied upon in *Crull v. GEM Insurance Co.*, 58 F.3d 1386, 1390 (9th Cir. 1995), to conclude that an employer's conduct creates an ERISA plan. *See also Credit Managers Ass'n of S. Cal. v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) (noting that "[a]n employer . . . can establish an ERISA plan rather easily . . . unless it is a mere advertiser who makes no contributions on behalf of its employees"). Because at least some of the contracts at issue in this action are ERISA plans,[6] this lawsuit falls within the scope of ERISA § 502(a). The individual Fossens are the participants in the ERISA plan, and they are suing Blue Cross (the plan's third-party insurance company) to enforce rights that are provided by ERISA. *See* 29 U.S.C. § 1182(b)(1). That is enough to bring a suit within the scope of ERISA § 502(a). *See Cyr v. Reliance Standard Life Ins. Co.*, 642 F.3d 1202, 1207 (9th Cir. 2011) (en banc) (permitting § 502(a)(1)(B) suit for benefits against plan's third-party insurer).

In their second argument against complete preemption, the Fossens suggest that Montana HIPAA's use of the term "group health plan" could be construed differently from federal HIPAA's use of that term, and that Blue Cross's MEWA plans should be deemed "group health plans" under state law but not federal law. But neither the Fossens nor

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[6] The Fossens neither alleged nor submitted evidence showing that the terms of the purported MEWA-level plans differ from the terms of the ERISA plan. *See Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1441 (9th Cir. 1995) ("[I]t is clear that an insurance policy may constitute the 'written instrument' of an ERISA plan.").

the *amici* have offered a plausible explanation for how Montana HIPAA's use of "group health plan" can be interpreted differently from ERISA's use of that term. Indeed, both Montana law and federal law contain identical definitions of "group health plan." Federal HIPAA defines "group health plan" as "an employee welfare benefit plan" that provides medical care payments to employees. 29 U.S.C. § 1191b(a)(1). (The definition of "employee welfare benefit plan" appears at 29 U.S.C. § 1002(1).) Montana HIPAA is identical: it defines "group health plan" as "an employee welfare benefit plan, *as defined in 29 U.S.C. § 1002(1)*," that provides medical care payments to employees. Mont. Code Ann. § 33-22-140(11) (emphasis added). We are unaware of any canon of statutory construction that allows us to ignore the Montana legislature's explicit incorporation of ERISA's definition of an operative term. *Cf. State v. Tower*, 881 P.2d 1317, 1319 (Mont. 1994) ("When Montana's legislature adopts a statute from a sister state, Montana courts follow the general rule of also adopting the construction which has been placed upon that statute by the highest court of the sister state.").

[6] In sum, because the Fossens " 'could have brought [their] claim under ERISA § 502(a)[ ],' " the first prong of *Davila* has been satisfied. *Marin Gen.*, 581 F.3d at 946 (quoting *Davila*, 542 U.S. at 210).

B. Second Prong of *Davila*

To apply the second part of *Davila*'s § 502(a) conflict preemption test, we must determine whether the state-law claims "arise independently of ERISA or the plan terms." *Davila*, 542 U.S. at 212. In other words we must ask whether or not an "independent

legal duty . . . is implicated by [the] defendant's actions." *Id.* at 210.

This question requires a practical, rather than a formalistic, analysis because "[c]laimants simply cannot obtain relief by dressing up an ERISA benefits claim in the garb of a state law tort." *Cleghorn*, 408 F.3d at 1225 (quoting *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 983 (9th Cir. 2001)). As the *Davila* Court warned, "distinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would elevate form over substance and allow parties to evade the pre-emptive scope of ERISA simply by relabeling their . . . claims." *Davila*, 542 U.S. at 214 (internal quotation marks omitted).

[7] Consistent with this practical approach, the Supreme Court has held that § 502(a) preempts various state laws that, at first glance, appear to be independent of ERISA. For example, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143 (1990), the Court addressed a state-law wrongful discharge claim arising out of a "termination motivated by an employer's desire to prevent a pension from vesting." The Court held that this claim was conflict preempted because, although the claim was nominally premised on a state-law tort duty that was separate from ERISA, the claim was identical to "a right expressly guaranteed by [ERISA] § 510 and exclusively enforced by § 502(a)." *Id.* at 145. Similarly, in *Davila*, the Court addressed a state law that imposed a duty on insurers to use ordinary care when making medical treatment decisions. 542 U.S. at 204-06. The Court rejected the court of appeals's reasoning that the plaintiff "request[ed] 'tort damages' arising from 'an external, statutorily im-

posed duty of 'ordinary care.' " *Id.* at 206 (quoting *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002)). Instead, the Court refused to "elevate form over substance," and held the state-law cause of action merely duplicated rights and remedies available under ERISA, and therefore was preempted. *Id.* at 214; *see also Cleghorn*, 408 F.3d at 1226 (holding that state-law statutory claim was completely preempted under *Davila* because "the factual basis of the complaint . . . was the denial of reimbursement of plan benefits to Cleghorn").

[8] As in *Davila* and *Ingersoll-Rand*, the Fossens' state-law HIPAA claim is identical to the federal-law HIPAA claim they could have filed. The state-law claim, although purportedly separate and distinct from ERISA, "falls squarely within the ambit" of federal HIPAA. *Ingersoll-Rand*, 498 U.S. at 142. Indeed, the state statute is expressly *dependent* on federal law (and thus is not "independent" of federal law for purposes of *Davila*) because the statute, by its very terms, applies only to ERISA plans. *See* Mont. Code Ann. § 33-22-526(2)(a) (law applies only with respect to "group health plan"); Mont. Code Ann. § 33-22-140(11) (defining "group health plan" as "an employee welfare benefit plan, as defined in 29 U.S.C. § 1002(1)"). As in *Cleghorn*, the Fossens' state-law HIPAA claim " 'exist[s] here only because of [Blue Shield's] administration of ERISA-regulated benefit plans.' " *Cleghorn*, 408 F.3d at 1226 (quoting *Davila*, 542 U.S. at 213). Accordingly, the second prong of *Davila* has been satisfied, and the Fossens' state HIPAA claim is completely preempted by ERISA § 502(a).

[9] In an effort to avoid complete preemption, the Fossens and *amici* argue that § 502(a) conflict

preemption does not apply because the state HIPAA law is exempted from express preemption under ERISA § 514 and § 731. But as the Court stressed in *Davila*, § 502(a) *conflict* preemption is distinct from *express* preemption. 542 U.S. at 214 n.4, 217-18. By explicitly decoupling the § 502(a) complete preemption and § 514 express preemption analyses, *Davila*'s reasoning abrogated our prior statement that:

> Complete preemption can be invoked only when two conditions are satisfied: (1) ERISA expressly preempts the state law cause of action under 29 U.S.C. § 1144(a) (*i.e.* "conflict preemption") and (2) that cause of action is encompassed by the scope of the civil enforcement provision of ERISA, 29 U.S.C. § 1132(a) (*i.e.* "displacement"). *Abraham v. Norcal Waste Sys., Inc.*, 265 F.3d 811, 819 (9th Cir. 2001); *see also Funkhouser v. Wells Fargo Bank, N.A.*, 289 F.3d 1137, 1141-42 (9th Cir. 2002); *Rutledge v. Seyfarth, Shaw, Fairweather & Geraldson*, 201 F.3d 1212, 1216 (9th Cir. 2000), *amended*, 208 F.3d 1170 (9th Cir. 2000); *Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 953 (9th Cir. 1998), *abrogated on other grounds by Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141 (2001); *Toumajian v. Frailey*, 135 F.3d 648, 654 (9th Cir. 1998); *Buster v. Greisen*, 104 F.3d 1186, 1188 (9th Cir. 1997).

[10] Because this test for complete preemption cannot be reconciled with the language or holding of *Davila* (which found complete preemption under

§ 502(a) to be independent of express preemption under ERISA § 514), our pre-*Davila* cases articulating this complete preemption test are no longer good law. *See Miller v. Gammie*, 335 F.3d 889, 900 (9th Cir. 2003) (en banc); *accord Cleghorn*, 408 F.3d at 1226 n.6 ("[W]e need not decide whether California's section 1371.4(c) is excepted from preemption under section 514(b)(2)(A) as a state regulation of insurance. Preemption under ERISA section 502(a) is not affected by that exception." (citation omitted)).

[11] Whether or not the state HIPAA statute is exempt from § 514 and § 731 express preemption, it may still be conflict preempted under § 502(a)—and we hold that it is. Although the Secretary of Labor's contrary opinion is entitled to respectful consideration, *see generally United States v. Mead Corp.*, 533 U.S. 218, 227-28 (2001) (summarizing the Court's applications of "*Skidmore*" deference, *see Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944)), we decline to defer to a position that fails to grapple with the full implications of conflict preemption cases such as *Davila*, *Ingersoll-Rand*, and *Cleghorn*.

Much of the Secretary's conflict-preemption discussion focuses on Congress's intent, expressed in ERISA § 731, to allow states to expand upon the rights created by federal HIPAA. We express no opinion about whether our holding would apply to a state HIPAA statute that provided *additional protections* beyond federal HIPAA and was not *exactly identical* to federal HIPAA. *Cf.* H.R. Rep. No. 104-736, at 205 (1996) (Conf. Rep.) (stating the conference committee's intent to preserve "[s]tate laws which are *broader* than federal requirements" (emphasis added)). Likewise, we need not decide wheth-

er Blue Cross is correct that, under the logic of *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358, 377 n.7 (1999), a plaintiff may vindicate a non-preempted state-HIPAA right by "appl[ying] [the] saved state insurance law as a relevant rule of decision in his § 502(a) action"; the Fossens have neither pleaded this theory in their complaint nor asserted it in their briefs.

C. Summary

[12] Because the Fossens' state HIPAA cause of action could have been brought under ERISA § 502(a), and because that cause of action is identical to and expressly dependent upon ERISA, the district court properly denied the Fossens' motion to remand and exercised jurisdiction over this case.[7]

III. Summary Judgment

A. HIPAA

[13] Because the Fossens' state-law HIPAA claim is conflict-preempted by § 502(a), it fails on the merits. *See, e.g.*, *Cleghorn*, 408 F.3d at 1227. The district court proceeded cautiously and construed the

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[7] Although the district court did not explicitly discuss supplemental jurisdiction, the court evidently concluded that any non-preempted state-law claims were "so related to claims in the action within such original jurisdiction that they form part of the same case or controversy." 28 U.S.C. § 1367(a); *see also* 28 U.S.C. § 1441(c). We agree with that conclusion, but add that the district court is free to reexamine this issue on remand. *See Carlsbad Tech., Inc. v. HIF Bio, Inc.*, 129 S. Ct. 1862, 1866-67 (2009) (collecting authorities); *Acri v. Varian Assocs., Inc.,* 114 F.3d 999, 1000 (9th Cir. 1997) (en banc).

Fossens' state HIPAA claim as a federal HIPAA claim. The court then held that Blue Cross did not violate HIPAA as a matter of law. But because the Fossens never requested that the district court re-characterize their state-law claim in this manner, the court need not have taken this extra step; it simply could have granted summary judgment for Blue Cross on account of § 502(a) conflict preemption. *Compare Stewart v. U.S. Bancorp*, 297 F.3d 953, 959 (9th Cir. 2002) (holding that plaintiffs bear the "burden to amend their complaint" to assert claims that are not preempted by ERISA), *with Crull*, 58 F.3d at 1391 ("In their motion opposing summary judgment, the Crulls asked that, should the District Court find their state law claims preempted, they be given relief under ERISA's civil enforcement scheme instead . . . ."). In any event, because the Fossens' briefs do not contest the district court's conclusions under federal law, they have waived such arguments. *Greenwood v. FAA*, 28 F.3d 971, 977 (9th Cir. 1994).

B. Unfair Insurance Practices

The Fossens do, however, contest the district court's grant of summary judgment on their statutory unfair insurance practices claim. We reverse the district court's grant of summary judgment and remand this claim for further consideration.

1. Preemption

To determine whether the Fossens' state-law unfair insurance practices claim is preempted by ERISA on the merits, we must consider express preemption under ERISA § 514 and conflict preemption under ERISA § 502(a). *See Paulsen*, 559 F.3d at 1081.

[14] With respect to preemption under § 514, the state statute meets both parts of *Kentucky Ass'n of Health Plans v. Miller*'s standard governing the § 514(b)(2)(A) exception to preemption: the state statute is "specifically directed toward entities engaged in insurance" and it "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Morrison*, 584 F.3d at 842 (internal quotation marks omitted).[8] The statute is plainly directed at insurance companies because it regulates insurance rates and premiums, Mont. Code Ann. § 33-18-206(2), and, in fact, the statute appears in a section of the Montana Code entitled "Insurer's Relations with Insured and Claimant," Mont. Code Ann. tit. 33, ch. 18, pt. 2. Moreover, the statute affects the risk-pooling arrangement because it regulates insurers' ability to obtain a premium that accurately reflects the risk being insured. *See Morrison*, 584 F.3d at 844 ("Insurance companies' core function is to accept a number of risks from policyholders in exchange for premiums."); *see also Ky. Ass'n of Health Plans*, 538 U.S. at 338-39 (stating that laws that "alter the scope of permissible bargains between insurers and insureds . . . substantially affect[ ] the type of risk pooling arrangements that insurers may offer"). The statute is therefore exempt from § 514(a) preemption because it falls within the insurance savings clause of § 514(b)(2)(A).

[15] With respect to conflict preemption, the unfair insurance practices statute does not run afoul of § 502(a) and *Davlia* because the Fossens seek relief

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[8] The parties do not dispute that the statute "relate[s] to" an ERISA plan. 29 U.S.C. § 1144(a).

(restitution) that is consistent with ERISA's enforcement scheme, *cf. Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1147 (9th Cir. 2003) (holding that Montana cause of action for claims-processing violation was preempted by § 502(a) because it permitted remedies unavailable under ERISA), and because the state anti-discrimination rule is completely "independent" of ERISA, *Davila*, 542 U.S. at 210. We agree with the Third Circuit's analysis of a nearly identical New Jersey statute: conflict preemption is inappropriate because no "provision of ERISA expressly guarantees th[e] same right" as the state statute. *PAS v. Travelers Ins. Co.*, 7 F.3d 349, 356 (3d Cir. 1993). Unlike the state-law HIPAA claim, the unfair insurance practices statute applies without regard to the existence of an ERISA plan. *Cf. Cleghorn*, 408 F.3d at 1226 (holding that second prong of *Davila* was satisfied where the state statute applied "because of [Blue Shield's] administration of ERISA-regulated benefit plans"). Also, the unfair insurance practices statute creates a right that is separate from and could not possibly be remedied under ERISA. Whereas HIPAA (both the state and federal versions) prohibits plans and their insurers from charging different premiums on account of "health status-related factor[s]," 29 U.S.C. § 1182(b)(1); Mont. Code Ann. § 33-22-526(2)(a), the unfair insurance practices statute applies more broadly to bar "*any* unfair discrimination" with respect to premiums, Mont. Code Ann. § 33-18-206(2) (emphasis added); *see, e.g.*, *McCarter v. Glacier Gen. Assurance Co.*, 546 P.2d 249, 251 (Mont. 1976). Because these statutes are not identical in scope (as is the case with the state and federal HIPAA provisions), they are not conflict preempted.

2. Merits

With respect to the merits of this claim, we disagree with Blue Cross's argument that the unfair insurance practices claim is "inextricably intertwined" with the state HIPAA claim and accordingly fails as a matter of law. Fairly read, the Fossens' complaint seeks to remedy distinct violations of *both* state HIPAA *and* state unfair insurance practices statutes. These separate statutes require separate legal analyses. Neither the district court's decision nor the parties' briefs provide the necessary analysis of this claim. We remand so that the district court may consider the merits of the unfair insurance practice claim in the first instance. *See Golden Gate Hotel Ass'n v. City & Cnty. of S.F.*, 18 F.3d 1482, 1487 (9th Cir. 1994). The Fossens' breach of contract claim, as pleaded in the complaint, is premised in part on the state unfair insurance practices claim, and accordingly survives summary judgment along with the unfair insurance practices claim.

IV. Leave to Amend

The Fossens further contend that they should be allowed to amend their complaint to state a breach of contract claim related to Blue Cross's agent's representations prior to their initial purchase of a Blue Cross policy. We disagree. The district court was within its discretion when it declined to give the Fossens leave to amend, as they first asserted this theory in opposition to summary judgment. *See La Asociacion de Trabajadores de Lake Forest v. City of Lake Forest*, 624 F.3d 1083, 1089 (9th Cir. 2010); *see also AmerisourceBergen*, 465 F.3d at 953 (stating that "an eight month delay between the time of obtaining a relevant fact and seeking a leave to amend is unreasonable," and that a plaintiff may not "dras-

tically change[ ] its litigation theory" "twelve months into the litigation").

CONCLUSION

[16] The district court properly exercised jurisdiction over this matter because the Fossens' Montana HIPAA claim is completely preempted by ERISA § 502(a). We reverse and remand the district court's grant of summary judgment to Blue Cross with respect to the Fossens' unfair insurance practices claim and part of the related breach of contract claim (as pleaded in the complaint). The district court did not abuse its discretion by declining to permit the Fossens to amend their complaint.

We remand so that the district court may address the state unfair insurance practices claim in the first instance. Each party shall bear its own costs.

AFFIRMED in part, REVERSED in part, and REMANDED.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
HELENA DIVISION

****

DALE FOSSEN, et al.

Plaintiffs,

-v-

BLUE CROSS BLUE SHIELD OF MONTANA, INC.,

Defendant.

CV 09-61-H-CCL

OPINION & ORDER
[Entered: Oct. 6, 2010]

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Before the Court is Defendant's Motion for Summary Judgment (Doc. 11), which is opposed by Plaintiff. The matter came on regularly for hearing on September 30, 2010. Plaintiffs are Dale Fossen, D and M Fossen, Inc., Larry Fossen, L and C Fossen, Inc., Marlowe Fossen, M and C Fossen, Inc., and Fossen Brothers Farms, a Partnership (collectively, "FBF"). Defendant is Blue Cross Blue Shield of Montana, Inc. ("BCBSMT"). Plaintiffs are represented by Lawrence A. Anderson, and Defendant BCBSMT is represented by Michael F. McMahon and Bernard Hubley.

Plaintiffs' Complaint alleges that Defendant BCBSMT violated Mont. Code Ann. § 33-22-526(2)(a), which prohibits an insurance company

from charging an individual a higher premium for group health insurance based on that individual's health status.

Defendant BCBSMT removed Plaintiffs' Complaint from state court based on its assertion that each Plaintiff is either a participant or a beneficiary of an employee welfare benefit plan ("Fossen Brothers Farms Plan" or "FBF Plan") insured by Defendant BCBSMT. Defendant asserts that the FBF Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq. Citing the "extraordinary pre-emptive power" of ERISA's civil enforcement provision, Defendant removed to federal court because ERISA "'completely preempts a state-law claim" when the individual could have brought the claim under ERISA § 502(a). (Def.'s Removal Notice, Doc. 1 at 6-7, *citing Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987).)

ERISA is indeed one of the few federal statutes that "wholly displaces the state-law cause of action through complete pre-emption...." *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8 (2003). Section 1144(a) provides that "this title . . . shall supersede any and all State laws insofar as they now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a). ERISA thus contains "one of the broadest preemption clauses ever enacted by Congress." *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 130-31 (9th Cir. 1993) (internal citations omitted). "ERISA preempts all state laws 'insofar as they may now or hereafter relate to any employee benefit plan.'" *Winterrowd v. American General Annuity Ins. Co.*, 321 F.3d 933, 937 (9th Cir. 2003) (*quoting* 29 U.S.C. §

1144(a)). Such preemption supports removal of state-law causes of action to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

SUMMARY JUDGMENT STANDARD

Summary judgment is proper if the pleadings, the discovery and disclosures on file, and affidavits show that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *see Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 257-58 (1986). Material facts are those that may affect the outcome of the case. *See id.* at 248. A dispute about a material fact is genuine if there is sufficient evidence for a reasonable jury to return a verdict for the non-moving party. *See id.* at 248-49.

The party moving for summary judgment has the initial burden of identifying those portions of the pleadings, discovery and disclosures on file, and affidavits that demonstrate the absence of a genuine issue of material fact. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). When the nonmoving party has the burden of proof at trial, the moving party need point out only "that there is an absence of evidence to support the nonmoving party's case." *Id.* at 325. If the moving party meets this initial burden, the non-moving party must go beyond the pleadings and–by its own affidavits or discovery–set forth specific facts showing a genuine issue for trial. *See* Fed. R. Civ. P. 56(e); *Celotex*, 477 U.S. at 324; *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87 (1986).

If the non-moving party does not produce evidence to show a genuine issue of material fact, the moving party is entitled to summary judgment. *See Celotex*,

477 U.S. at 323. In ruling on a motion for summary judgment, inferences drawn from the underlying facts are viewed in the light most favorable to the non-moving party. *See Matsushita*, 475 U.S. at 587.

FACTS

In December, 2003, the three Fossen Brothers, Dale, Larry, and Marlowe, acting as Fossen Brothers Farms, decided to purchase health insurance from BCBSMT. Plaintiffs reviewed various health insurance options with the assistance of their insurance agent, Roger Olson, who is an authorized BCBSMT agent, selling BCBSMT products in Montana since 1995. Ultimately, Plaintiffs decided to apply for group health insurance offered by Associated Merchandisers Inc. ("AMI"), called the Association Group Benefit Plan ("AMI Arrangement"). The AMI Arrangement consists of a moderately-sized group of unrelated employers that purchases group health insurance from BCBSMT.[1] Each employer within the AMI Arrangement is rated separately by BCBSMT, which then charges a uniform premium per employee within each specific employer-group. Plaintiffs originally considered the possibility of purchasing individual health insurance directly from BCBSMT, but eventually decided to purchase their group health insurance (which was still a BCBSMT policy) through the AMI Arrangement. This health insurance policy was a contract for one year of coverage, renewable annually. The first insurance con-

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[1] In 2008, a new association, Montana Chamber Choices Trust ("MCCT"), merged with AMI. (Doc. 12-1, ¶ 2.) In 2009, Plaintiffs purchased their BCBSMT group health insurance product through MCCT (the "MCCT Arrangement").

tract was entered into in January of 2004, and Plaintiffs renewed their BCBSMT insurance with subsequent annual policies in 2005, 2006, 2007, 2008, and 2009.

All went well for a couple of years until early 2006, when Plaintiffs received a notification that their premiums were to be increased by 21%, allegedly due, at least in part, to the health status of one of the FBF employees or their dependents. The Plaintiffs and their insurance agent, Roger Olson, objected to such an increase in premium, because it was their understanding that the insurance risk was spread over the entire association of employers, such that no single employer would experience an increase in premiums not experienced by all other employers in the association. On April 6, 2006, Plaintiff Dale Fossen filed a complaint against BCBSMT with the Department of Insurance of the Montana State Auditor. At the request of the Department of Insurance, Roger Olson wrote to the Department of Insurance on April 21, 2006, and he also complained about the 21% increase in premiums applicable to Fossen Brothers Farms. Both Dale Fossen and Roger Olson believed that the premiums of all the employers participating in the AMI Arrangement would go up (or down) together, but in fact the premiums went up or down according to a formula used by BCBSMT that took into account both the age and the health status of employees and their dependents within any employer's group plan.

In response to the investigation of the Department of Insurance, BCBSMT explained by letter dated May 24, 2006, the manner in which it set premiums for each employer group purchasing its

health insurance from the AMI Arrangement. BCBSMT pointed out that of the 600 employers participating in the AMI Arrangement and purchasing their BCBSMT insurance through 40 different insurance agents, the Fossen Brothers Farm's complaint was the only complaint of its type received by BCBSMT. In order to make things right with Fossen Brothers Farms, BCBSMT offered to forego the unexpected increase in premium, effective for the plan year June 1, 2006, through May 31, 2007. This was clearly stated on May 24, 2006, in a letter from BCBSMT legal counsel Mary Belcher to John Holbrook, of the Montana Department of Insurance:

> BCBSMT will make an exception to the underwriting process described above and shall not make any table adjustment to the Fossen Group's premium for the plan year, June 1, 2006, through May 31, 2007. This means that the Fossen Group would receive an increase of 4.9 percent, the same base increase applicable to all AMI groups, subject to any applicable age band increase as explained below. . . . Please note, however, that this exception is made on a one-time basis for the Fossen Group for the specific plan year, June 1, 2006, through May 31, 2007. Should Mr. Fossen elect to renew his group with BCBSMT for any succeeding plan year, the group will be subject to the same underwriting process applicable to all groups partici-

> pating in the AMI Association and as described above in detail.

(Doc. 24-1, Ex. A at 2-3.)

When the new plan year arrived in 2007, however, Plaintiffs were again dissatisfied that they were being expected to pay an increased premium based on health status factors of participants within their employer group, and this litigation ensued.

DISCUSSION

Plaintiffs' Amended Complaint relies upon various state law claims, including allegations of violation of Montana statute, unfair trade practices, and breach of contract. It is the alleged violation of Mont. Code Ann. § 33-22-526(2), however, that underpins most of Plaintiffs' Amended Complaint, because it gives rise to the other state law claims. That Code provision provides that:

> (2) (a) 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.
>
> (b) This subsection (2) does not:

> (I) restrict the amount that an employer may be charged for coverage under a group health plan; or
>
> (ii) prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Mont. Code Ann. § 33-22-526(2).

More to the point for our purposes, ERISA itself contains an identical statutory provision:

> (b) (1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is great than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.
>
> (2) Construction. Nothing in paragraph (1) shall be construed–

> (A) to restrict the amount that an employer may be charged for coverage under a group health plan; or
>
> (B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

29 U.S.C. § 1182(b).

Moreover, not only does ERISA contain the same provision as M.C.A. § 33- 22-526(2), ERISA also provides for civil enforcement of this provision, because a participant or beneficiary can seek equitable relief for any violation of ERISA pursuant to section 502(a)(3): "[a] civil action may be . . . by a participant, [or] beneficiary . . . [in an ERISA plan] (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan. 29 U.S.C. § 1132(a)(3). Thus, Plaintiffs' claim, even when founded upon M.C.A. § 33-22-526(2), falls within the scope of ERISA. "[A]ny 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." *Aetna Health v. Davila*, 542 U.S. 200, 209 (2004).

The important question is whether BCBSMT has violated § 1182(b) of the United States Code in the

manner in which it has calculated premiums for the Plaintiffs' FBF Plan. Here, BCBSMT points out that, pursuant to §1182(b)(2)(A), it is unlimited in its ability to charge varying premiums to *employers* based on health factors, just that it cannot single out an *individual* employee with a higher premium based on health factors. Plaintiffs attempt to argue that the *group* is the 600 employers participating in the AMI/MCCT Arrangement, and Fossen Brothers Farms is an *individual* participant in the AMI/MCCT Arrangement that has been singled out for a higher premium based on health factors. BCBSMT points to the AMI election form, wherein "Dale Fossen" is listed above the line titled "Printed Name of Owner or Officer of the *Group*." Similarly, when the MCCT Arrangement became the device used to market BCBSMT health insurance, the MCCT election form listed Mr. Fossen as the name of the "*Group* Leader." BCBSMT contends that the only group that Dale Fossen could have been leading was the Fossen Brothers Farms group–he was not and could not have been the leader of the AMI or the MCCT.

It does appear to the Court that Fossen Brothers Farms was the employer within the meaning of ERISA. 29 U.S.C. § 1002(1). ERISA defines an employee welfare benefit plan as "any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits. . . ." 29 U.S.C. § 1002(1). An employer is defined as

> any person acting directly as an employer; or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

29 U.S.C. § 1002(5). Significantly, it is possible under ERISA for a multiple employer welfare arrangement (a "MEWA") to function as if it were a single employer providing a group health insurance plan. In order for such an association of employers to meet ERISA's definition of an employer under section 1002(5), however, the association must be a "bona fide association" of employers wherein the employer members have control of the association. An unrelated group of employers (even employers in the same line of business) that merely executes similar documents to purchase insurance together is not an ERISA employer. *Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1389 (9th Cir. 1995) ("A multiple employer trust is an entity established to procure group insurance coverage for otherwise unrelated employers. By aggregating their buying power, these unrelated employers can negotiate for better health insurance programs."). The Department of Labor has expressed the view that

> . . . where several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organizational relationship among employers, no association exists for the purposes of § 3(5) [29 U.S.C. § 1002(5)] or where control of the association is not vested

> solely in employer members, the association is not a bona fide association of employers for purposes of § 3(5) [29 U.S.C. § 1002(5)].

Dep't of Labor, "Multiple Employer Welfare Arrangements Under ERISA, a Guide to Federal and State Regulation" (Doc. 1-4).

According to the Affidavit of Webb Scott Brown, the President/CEO of Montana Chamber of Commerce, both AMI and MCCT are associations comprised of unrelated employers having no genuine organizational relationship between the employer participants. (Doc. 12-1, ¶ 3.) The employer participants do not exercise control over either AMI or MCCT. (Doc. 12-1, ¶ 4.) Thus, neither AMI nor MCCT is an ERISA employer. This means that neither the AMI Arrangement nor the MCCT Arrangement can be a bona fide "association of employers acting for an employer" in relation to an employee benefit plan within the meaning of section 1002(5). The Arrangements are purchasing consortiums, but the actual group health insurance plans exist at the participating employer level. If there are 600 employers in the MCCT, for example, then there are 600 employee benefits plans, not one plan.

The next step in analyzing the motion for summary judgment requires application of 29 U.S.C. § 1182(b) to these facts. As this statute makes clear, § 1182(b) applies to prohibit premium disparity based on health status factors at the individual level but not at the employer level. In other words, an individual employee participating in an employer's group health plan cannot be charged more because of his health status. An employer group health plan, however, can be charged a higher premium

due to health status factors present among the individual employees–as long as the increased premium is borne equally by all participants in that employer's group health plan. Accordingly, BCBSMT's method of premium calculation for the AMI/MCCT Arrangements, which takes into account health status factors when rating the employer plans separately, is permissible under ERISA's section 1182(b).

MOTION TO STRIKE

Defendant BCBSMT has filed a Motion to Strike Plaintiffs' Affidavit of Dale Fossen (¶¶ 4-6) (Doc. 16-2), and Plaintiffs' Statement of Genuine Issues (¶¶ 1-2, 4-5 (containing hearsay statement of Mr. Olson). The statements which Defendant wishes to have stricken from the record all support Plaintiffs claim that there was a promise made by BCBSMT to the insurance agent, Roger Olson, to the effect that premiums would be uniform across all employers participating in the AMI Arrangements. BCBSMT objects to this evidence as being inadmissible hearsay not supported by any other evidence in the record. BCBSMT also objects to Plaintiffs' attempted introduction of evidence for a supposed claim not alleged in the Amended Complaint. The Court finds that the Amended Complaint is silent as to any such allegation of occurrences or circumstances raising a genuine issue of material fact. Finally, BCBSMT objects to this evidence because the alleged breach, assuming it ever existed, was long ago cured: In 2006, when BCBSMT was apprised by the Montana Department of Insurance of the Plaintiffs' complaint, BCBSMT explained in detail its premium calculation method and offered not to impose the 21% premium increase for the upcoming plan year, giving the FBF Plan a one-year morato-

rium on the proposed rate increase. Since 2006, Plaintiffs have annually renewed their BCBSMT group health insurance plan in each of the three years following. Thus, Plaintiffs did not, in fact, suffer the unexpected 21% premium increase in 2006, and Plaintiffs were notified of BCBSMT's future intent to rate the FBF Plan separately from other plans participating in the AMI/MCCT Arrangements. Plaintiffs continued to obtain their insurance through the Arrangements even after being notified of the possibility of future premium increases. Under these circumstances, there can be no damages. Plaintiffs cannot force BCBSMT to sell a product at the price Plaintiffs prefer.

This alleged misrepresentation by BCBSMT to Roger Olson has not been alleged as a claim in the Amended Complaint. It is hearsay. At the time of hearing, the Plaintiffs did not supplement the record by further affidavit, testimony, or other evidence. There is no evidence before the Court of bad faith or wrongdoing on the part of Defendant. It appears to the Court from Defendant's Exhibit A (Doc. 24-1) that there are some 600 employers who have coverage through AMI, through 40 plus insurance agents, and Defendant states that this is the only complaint of this type received. There is no evidence of "bait and switch." The contract was for a term of one year, and when the misunderstanding came to light, Defendant adjusted the cost--for the succeeding one-year period only--in accordance with the Plaintiffs' mistaken understanding. The problem was thus corrected by BCBSMT's clarification of the Plaintiffs' misunderstanding and the one-year moratorium on the 2006 rate increase. Plaintiffs apparently accepted that solution because Plaintiffs chose

to renew the policy despite the premium increases that began thereafter. BCBSMT argues that it would be futile for Plaintiffs to amend the Amended Complaint to assert this claim, and this Court agrees that such an amendment would be futile.

Plaintiffs argued extensively at the hearing that the Court erred in denying the motion to remand and that this Court has no jurisdiction in this case because Plaintiffs' claim relates to a duty independent of the FBF employee welfare benefit plan. Plaintiff cites *Marin General Hospital v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009), which holds that when plaintiff asserts that the plan administrator violates a legal duty that is independent of the ERISA plan, the cause of action is not completely preempted. In *Marin General Hospital* the plaintiff hospital had an oral telephone agreement with the employer/plan administrator that 90% of a patient's medical expenses at the hospital would be covered by the ERISA plan. The defendant employer/plan administrator paid only $46,655.54 of the $178,926 bill, and denied that it had a contract with the hospital. Our case is slightly similar to *Marin General Hospital* because there was a phone conversation between an insurance agent and the Defendant insurer which arguably gave rise to an independent legal duty. However, our case is vastly different from *Marin General Hospital* because plaintiffs then filed a suit alleging that the insurance policy sold by the Defendant violated a Montana statute, which turns out to be identical to an ERISA statute having a remedy under ERISA section 502(a).

The instant suit is a legal challenge–a declaratory judgment action–to Defendant BCBSMT's right

to sell such a policy under the applicable statutes. Because ERISA contains the identical statute as the Montana statute, ERISA completely preempts the Montana statute. The crucial point to be made in any discussion of *Marin General Hospital* is that the "independent legal duty" argument is a red herring in the context of this case. The gravaman of Plaintiffs' Amended Complaint is a statutory challenge to the actual policy sold, not a claim based upon an independent legal duty.

The independent legal duty argument appears to be an attempt to avoid ERISA and federal jurisdiction. However, the true motivation for this case is to stop Defendant BCBSMT from selling insurance to employers purchasing through heterogenous associations without providing true risk pooling to all the participant subscribers. That is the declaratory judgment sought by the Amended Complaint.

Unlike the plan administrator in *Marin General Hospital*, this Defendant cleared up the telephone miscommunication in 2006, gave the Plaintiffs the one-year premium relief, and essentially administratively corrected any mistake it may have made. (This would be as if the plan administrator in *Marin General Hospital* paid the extra $114,378 of the 90% it had allegedly agreed to pay by oral agreement.) Thus, a careful reading of the Amended Complaint shows that any independent legal duty of BCBSMT is not actually at issue in this case–and as BCBSMT points out, that alleged independent legal duty was not pled in the Amended Complaint. These contentions raised by the non-moving party of claims not raised in the Amended Complaint do not present genuine issues of material fact. The only claim left to Plaintiffs is the claim advanced by the Amended

Complaint, which is whether BCBSMT had the statutory right to provide them with the policy that it actually did provide, and this Court finds that it did have that right.

CONCLUSION

The Court concludes that BCBSMT is entitled to summary judgment as a matter of law, there being no genuine issue as to any material fact and the law favoring Defendant. Accordingly,

IT IS HEREBY ORDERED that Defendant's Motion for Summary Judgment (Doc. 11) is GRANTED, and Plaintiffs' Amended Complaint is DISMISSED. Let judgment enter.

IT IS FURTHER ORDERED that Defendant's Motion to Strike (Doc. 21) is moot.

DONE and DATED this 6th day of October, 2010.

CHARLES C. LOVELL
SENIOR UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
HELENA DIVISION

****

DALE FOSSEN, et al.

Plaintiffs,

-v-

BLUE CROSS BLUE SHIELD OF MONTANA, INC.,

Defendant.

CV 09-61-H-CCL

ORDER
[Entered: Aug. 12, 2010]

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Before the Court is Plaintiffs' Motion for Remand (Doc. 5), which is opposed by Defendant Blue Cross Blue Shield of Montana, Inc. ("BCBSMT"). Plaintiffs are Dale Fossen, D and M Fossen, Inc., Larry Fossen, L and C Fossen, Inc., Marlowe Fossen, M and C Fossen, Inc., and Fossen Brothers Farms, a Partnership. Plaintiffs' Complaint alleges that Defendant BCBSMT violated Mont. Code Ann. § 33-22-526(2)(a), which prohibits requiring an individual to pay a health insurance premium greater than the premiums of similarly-situated individuals based on a health status-related factor of the individual.

Defendant BCBSMT removed Plaintiffs' Complaint from state court based on its assertion that each Plaintiff is either a participant or a beneficiary

of an employee welfare benefit plan ("Fossen Brothers Farms Plan") insured by Defendant BCBSMT. The Fossen Brothers Farms Plan was originally purchased through the Associated Merchandisers Inc., Association Group Benefit Plan, from 2004 through May 2009. After May 2009, the Fossen Brothers Farms Plan has been purchased through the Montana Chamber Choices Association Plan. Defendant removed on the assertion that the Fossen Brothers Farms Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq.

Citing the "extraordinary pre-emptive power" of ERISA's civil enforcement provision, Defendant removed to federal court because ERISA "'completely preempts a state-law claim" when the individual could have brought the claim under ERISA § 502(a). (Def.'s Removal Notice, Doc. 1 at 6-7, *citing Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987).)

ERISA is indeed one of the few federal statutes that "wholly displaces the state-law cause of action through complete pre-emption...." *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8 (2003). Section 1144(a) provides that "this title . . . shall supersede any and all State laws insofar as they now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a). ERISA thus contains "one of the broadest preemption clauses ever enacted by Congress." *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 130-31 (9th Cir. 1993) (internal citations omitted). "ERISA preempts all state laws 'insofar as they may now or hereafter relate to any employee benefit plan.'" *Winterrowd v. American General Annuity Ins. Co.*, 321

F.3d 933, 937 (9th Cir. 2003) (*quoting* 29 U.S.C. § 1144(a)). Such preemption supports removal of state-law causes of action to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

However, the pre-emptive scope of ERISA not quite so simple. Plaintiffs rely upon the statutory *exception* to removal, also known as ERISA's "savings" clause. In its section 1144(b)(2)(A), ERISA contains what the U.S. Supreme Court has called the "antiphonal" exception to complete preemption, *see Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364 (2002); in the savings clause, ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

In support of the Motion for Remand, Plaintiffs cite *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 849 (9th Cir. 2009), wherein a Ninth Circuit panel held that the Montana Insurance Commissioner's practice of disapproving of insurance contracts containing a discretionary clause was not preempted by ERISA because that practice fell within ERISA's "savings" clause exempting from preemption a state law regulating insurance. The presence or absence of a discretionary clause in an ERISA insurance policy dictates whether judicial review is *de novo* or governed by the abuse of discretion standard. *Id.* at 840. However, the procedural posture of the *Morrison* case was unlike that of the instant case, as the *Morrison* case was originally filed in federal court pursuant to federal question jurisdiction, and the legal issue in *Morrison* was decided on cross-motions for summary judgment, no question of remand having arisen. In fact, Plaintiffs mix apples and oranges

when citing the *Morrison* case–wherein there was no argument against federal subject matter jurisdiction–to support a motion for remand to state court.

Clearly, however, there is tension between ERISA's broad preemption of state-law causes of action and ERISA's preservation of some portion of the states' powers to regulate insurance. To determine whether a state law can survive ERISA's preemptive power, the Supreme Court recommends that courts "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001). In *Egelhoff*, a Washington state law that revoked, by operation of law, a named beneficiary's status upon divorce was preempted "because it interferes with nationally uniform plan administration." *Id.* at 148. Such a state law–even though it did regulate insurance–was preempted by ERISA.

In analyzing such a state law, however, this Court must first determine whether the state law in issue "relate[s] to any [covered] employee benefit plan." 29 U.S.C. § 1144(a). Such a law does relate if it is "specifically directed toward entities engaged in insurance," and if it "substantially affect[s] 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). The law at issue here, M.C.A. § 33-22-526, meets this two-part test:

> (2)(a) 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 en-

> rollment 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.
>
> (b) This subsection (2) does not:
>
> (i) restrict the amount that an employer may be charged for coverage under a group health plan; or
>
> (ii) prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Mont. Code Ann. § 33-22-526(2). It can hardly be questioned that this state law is specifically directed to entities engaged in insurance and substantially affects the risk-pooling arrangement between the insurer and the insured. Thus the Montana statute at issue relates to insurance within the meaning of ERISA. At this stage, it appears to fall within ERISA's savings clause and so to survive preemption.

However, the wrinkle in this case is caused by the fact that ERISA itself contains an identical statutory provision:

> (1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is great than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.
>
> (2) Construction. Nothing in paragraph (1) shall be construed–
>
> > (A) to restrict the amount that an employer may be charged for coverage under a group health plan; or
> >
> > (B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

29 U.S.C. § 1182(b). Moreover, not only does ERISA contain the same provision as M.C.A. § 33-22-526(2), ERISA also provides for civil enforcement of this provision, because a participant or beneficiary

can seek equitable relief for any violation of ERISA pursuant to section 502(a)(3): "[a] civil action may be brought . . . by a participant, [or] beneficiary . . . [in an ERISA plan] (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan. 29 U.S.C. § 1132(a)(3). Thus, Plaintiffs' claim, even when founded upon M.C.A. § 33-22-526(2), falls within the scope of ERISA. The specific problem is that the Montana law duplicates the ERISA law.

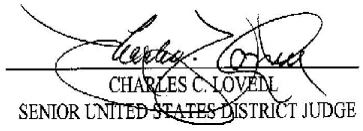
"[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Health v. Davila*, 542 U.S. 200, 209 (2004). The rationale for this rule is obvious, because without a prohibition on state law duplications, all of ERISA could become a state law cause of action. Allowing state laws simply to duplicate ERISA and provide state causes of action would surely undercut Congress's intent that employee benefit plan regulation become "exclusively a federal concern...." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). In an area of law wherein Congress "expect[ed]" courts would develop "a federal common law of rights and obligations under ERISA-regulated plans," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987), allowing states to enact their own ERISA-type statues would result in the loss of national uniform regulations interpreted by a federal common law. Clearly, duplicative state laws are preempted by ERISA.

The difference between this case and *Morrison* is that the Commissioner's practice of prohibiting discretionary clauses in insurance contracts does not duplicate, supplement, or supplant ERISA. In fact, as the panel concluded, the lack of discretionary clauses in Montana insurance contracts can comfortably coexist with ERISA rules and regulations. In the instant case, however, allowing a duplicative state law to coexist would supplant ERISA and send an ERISA claim to state court, thereby preventing the national uniformity of ERISA and its federal common law. The state law regulating insurance and ERISA do not comfortably coexist.

Accordingly, the Court concludes that Plaintiffs' Motion to Remand the case to state court is without merit. Plaintiffs' state law cause of action is preempted by ERISA and is properly removed to this Court. Accordingly,

IT IS HEREBY ORDERED that Plaintiffs' Motion to Remand (Doc. 5) is DENIED.

DONE and DATED this 12th day of August, 2010.



CHARLES C. LOVELL
SENIOR UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
HELENA DIVISION

DALE FOSSEN, et al., *Plaintiff*	)	Civil Action No. CV-09-H-CCL
v.	)	
	)	[Entered: Oct. 6, 2010]
BLUE CROSS BLUE SHIELD OF MONTANA, INC. *Defendant*	)	

JUDGMENT IN A CIVIL ACTION

The court has ordered that *(check one):*

__ the plaintiff *(name)*_____recover from the defendant *(name)*_____the amount of _____dollars ($), which includes prejudgment interest at the rate of _____%, plus postjudgment interest at the rate of___%, along with costs.

__ the plaintiff recover nothing, the action be dismissed on the merits, and the defendant *(name)*_____recover costs from the plaintiff *(name)*_____.

__ other: _____

This action was *(check one)*:

__ tried by a jury with Judge_____presiding, and the jury has rendered a verdict.

__ tried by Judge_____without a jury and the above decision was reached.

_X_ decided by Judge CHARLES C. LOVELL on a motion for Summary Judgment. Defendant's Motion for Summary Judgment (Doc. 11) is GRANTED, and Plaintiffs' Amended Complaint is DISMISSED. Defendant's Motion to Strike (Doc. 21) is moot.

Date: Oct. 6, 2010

CLERK OF COURT

/s/ Heidi Gauthier

Signature of Clerk or Deputy Clerk

APPENDIX E

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DALE FOSSEN; D AND M FOSSEN, INC.; LARRY FOSSEN; L AND C FOSSEN, INC.; MARLOWE FOSSEN; M AND C FOSSEN, INC. FOSSEN BROTHERS FARMS, a Partnership,	) **FILED**) DEC 23 2011)) MOLLY C DWYER) U.S. Court of) Appeals)) No. 10-36001)
Plaintiffs – Appellants,	) D.C. No.) 6:09-cv-00061-CCL
v.	)
BLUE CROSS AND BLUE SHIELD OF MONTANA, INC., a health service corporation	) District of) Montana, Helena))
Defendant – Appellee.	) ORDER)

Before: SCHROEDER and M. SMITH, Circuit Judges, and BENITEZ, District Judge.*

The panel has unanimously voted to deny the petition for panel rehearing. (Docket No. 50). The petition for panel rehearing is DENIED.

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* The Honorable Roger T. Benitez, District Judge for the U.S. District Court for Southern California, sitting by designation.

APPENDIX F

29 U.S.C. § 1132

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 USCS § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 USCS § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [29 USCS § 1021(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts; or

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 305 [29 USCS § 1085], if the plan sponsor--

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle [29 USCS §§ 1051 et seq., §§ 1081 et seq.] (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines

that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515 [29 USCS § 1145].

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 [29 USCS §§ 1181 et seq.] against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 733(a)(1) [29 USCS § 1191b(a)(1)]). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606, section 101(e)(1), section 101(f), or section 105(a) [29 USCS § 1166(a)(1) or (4), 1021(e)(1), 1021(f), or 1025(a)] with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other

relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $ 1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(1) [29 USCS § 1021(b)(1)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [29 USCS § 1024(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [29 USCS § 1021(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [29 USCS § 1021(e)(2)] with respect to any person or who fails to meet the requirements of section 302(d)(12)(E) with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $ 100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $ 1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 101 [29 USCS § 1021] or section 514(e)(3) [29 USCS § 1144(e)(3)].

(5) The Secretary may assess a civil penalty against any person of up to $ 1,000 a day from the

date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g) [29 USCS § 1021(g)].

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6) [29 USCS § 1024(a)(6)], the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $ 100 a day from the date of such failure (but in no event in excess of $ 1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $ 100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 101 [29 USCS § 1021]. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $ 1,100 per day--

(A) for each violation by such sponsor of the requirement under section 305 [29 USCS § 1085] to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section 305 [29 USCS § 1085] by the end of the funding improvement period with respect to the plan.

(9) (A) The Secretary may assess a civil penalty against any employer of up to $ 100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I) [29 USCS § 1181(f)(3)(B)(i)(I)]. For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $ 100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii) [29 USCS § 1181(f)(3)(B)(ii)]. For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) Secretarial enforcement authority relating to use of genetic information.

(A) General rule. The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 702 [29 USCS § 1182] or section 701 or 702(b)(1) [29 USCS § 1181 or 1182(b)(1)] with respect to genetic information, in connection with the plan.

(B) Amount.

(i) In general. The amount of the penalty imposed by subparagraph (A) shall be $ 100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) Noncompliance period. For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period--

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) Minimum penalties where failure discovered. Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) In general. In the case of 1 or more failures with respect to a participant or beneficiary--

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $ 2,500.

(ii) Higher minimum penalty where violations are more than de minimis. To the extent violations for which any person is liable under this paragraph for any year are more than de minimis, clause (i) shall be applied by substituting “$ 15,000” for “$ 2,500” with respect to such person.

(D) Limitations.

(i) Penalty not to apply where failure not discovered exercising reasonable diligence. No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) Penalty not to apply to failures corrected within certain periods. No penalty shall be imposed by subparagraph (A) on any failure if--

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) Overall limitation for unintentional failures. In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of--

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or

(II) $ 500,000.

(E) Waiver by Secretary. In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent

that the payment of such penalty would be excessive relative to the failure involved.

(F) Definitions. Terms used in this paragraph which are defined in section 733 [29 USCS § 1191b] shall have the meanings provided such terms in such section.

[(11)](10) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act.

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)]. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 [29

USCS § 1145] in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986 [26 USCS § 6621].

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle [29 USCS §§ 1101 et seq.]. If

the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 [29 USCS § 1106] by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986 [26 USCS § 4975(f)(4)]) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code [26 USCS § 4975(f)(5)]) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code [26 USCS § 4975(e)(1)].

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the

Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 [29 USCS §§ 1101 et seq.] by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that-

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986 [26 USCS § 4975].

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) [29 USCS § 1056(e)] by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $ 10,000 for each such distribution.

29 U.S.C. § 1144

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 USCS § 1003(a)], which is not exempt under section 4(b) [29 USCS § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act [29 USCS § 1136].

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle [29 USCS §§ 1021 et seq., 1101 et seq.], and the preceding sections of this part [29 USCS §§ 1131 et seq.] to the extent they govern matters which are governed by the provisions of such parts 1 and 4 [29 USCS §§ 1021 et seq., 1101 et seq.], shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph [enacted Jan. 14, 1983]), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 [29 USCS § 1136] with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 [29 USCS §§ 1021 et seq., 1101 et seq.] and the preceding sections of this part [29 USCS § 1131 et seq.].

(6) (A) Notwithstanding any other provision of this section--

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) 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.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 [29 USCS §§ 1002(1), 1003] necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i) [29 USCS § 1056(d)(3)(B)(i)]), qualified medical child support orders (within the meaning of section 609(a)(2)(A)) [29 USCS § 1169(a)(2)(A)], and the provisions of law referred to in section 609(a)(2)(B)(ii) [29 USCS § 1169(a)(2)(B)(ii)] to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 609(b)(3) [29 USCS § 1169(b)(3)] with respect to a group health plan (as defined in section 607(1) [29 USCS § 1167(1)]), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 USCS §§ 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 731 [29 USCS § 1191].

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or

indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited. Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b) [29 USCS §§ 1031, 1137(b)]) or any rule or regulation issued under any such law.

(e) Preemption of conflicting state regulations.

(1) Notwithstanding any other provision of this section, this title shall supersede any law of a State which would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. The Secretary may prescribe regulations which would establish minimum standards that such an arrangement would be required to satisfy in order for this subsection to apply in the case of such arrangement.

(2) For purposes of this subsection, the term "automatic contribution arrangement" means an arrangement--

(A) under which a participant may elect to have the plan sponsor make payments as contributions under the plan on behalf of the participant, or to the participant directly in cash,

(B) under which a participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have

such contributions made at a different percentage), and

(C) under which such contributions are invested in accordance with regulations prescribed by the Secretary under section 404(c)(5) [29 USCS § 1104(c)(5)].

(3) (A) The plan administrator of an automatic contribution arrangement shall, within a reasonable period before such plan year, provide to each participant to whom the arrangement applies for such plan year notice of the participant's rights and obligations under the arrangement which--

(i) is sufficiently accurate and comprehensive to apprise the participant of such rights and obligations, and

(ii) is written in a manner calculated to be understood by the average participant to whom the arrangement applies.

(B) A notice shall not be treated as meeting the requirements of subparagraph (A) with respect to a participant unless--

(i) the notice includes an explanation of the participant's right under the arrangement not to have elective contributions made on the participant's behalf (or to elect to have such contributions made at a different percentage),

(ii) the participant has a reasonable period of time, after receipt of the notice described in clause (i) and before the first elective contribution is made, to make such election, and

(iii) the notice explains how contributions made under the arrangement will be invested in the absence of any investment election by the participant.

29 U.S.C. § 1182

(a) In eligibility to enroll.

(1) In general. Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions. To the extent consistent with section 701 [29 USCS § 1181], paragraph (1) shall not be construed--

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for

similarly situated individuals enrolled in the plan or coverage.

(3) Construction. For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions.

(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction. Nothing in paragraph (1) shall be construed--

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information.

(A) In general. For purposes of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection

with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction. Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing.

(1) Limitation on requesting or requiring genetic testing. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction. Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment.

(A) In general. Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as

such term is defined for the purposes of applying the regulations promulgated by the Secretary of Health and Human Services under part C of title XI of the Social Security Act [42 USCS §§ 1320d et seq.] and section 264 of the Health Insurance Portability and Accountability Act of 1996 [42 USCS § 1320d-2 note], as may be revised from time to time) consistent with subsection (a).

(B) Limitation. For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception. Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made, in writing, pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that--

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information.

(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 733 [29 USCS § 1191b]).

(2) Prohibition on collection of genetic information prior to enrollment. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection. If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation

of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans. The provisions of subsections (a)(1)(F), (b)(3), (c), and (d), and subsection (b)(1) and section 701 [29 USCS § 1181] with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 732(a) [29 USCS § 1191a(a)].

(f) Genetic information of a fetus or embryo. Any reference in this part to genetic information concerning an individual or family member of an individual shall--

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

Mont. Code Ann. § 33-18-206

(1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract.

(2) 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 or in any other manner whatever.

(3) An insurer may not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay, or developmental disability.

(4) The rejection of an application or the determining of rates, terms, or conditions of a life or disability insurance contract on the basis of genetic condition, developmental delay, or developmental disability constitutes unfair discrimination unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay, or developmental disability.

(5) As used in this section, the following definitions apply:

(a) "Developmental delay" means a delay of at least 1 1/2 standard deviations from the norm.

(b) "Developmental disability" means the singular of developmental disabilities as defined in 53-20-202.

(c) "Genetic condition" means a specific chromosomal or single-gene genetic condition.

Mont. Code Ann. § 33-22-526

(1) (a) A group health plan or a health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based

on any of the following health status-related factors of the individual or a dependent of the individual:

(i) health status;

(ii) medical condition, including both physical and mental illnesses;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) genetic information;

(vii) evidence of insurability, including conditions arising out of acts of domestic violence; or

(viii) disability.

(b) This subsection does not:

(i) require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the group health plan or group health insurance coverage; or

(ii) prevent the group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health plan or group health insurance coverage.

(c) For purposes of subsection (1)(a), rules for eligibility to enroll under a group health plan include rules defining an applicable waiting period for the enrollment.

(2) (a) 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.

(b) This subsection (2) does not:

(i) restrict the amount that an employer may be charged for coverage under a group health plan; or

(ii) prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.