No. 11-1155

In the Supreme Court of the United States

BLUE CROSS AND BLUE SHIELD OF MONTANA, INC., PETITIONER

v.

DALE FOSSEN, ET AL.

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

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

A Montana unfair-insurance-practices law regulates rate-setting for all insurers operating in that State and is saved from express preemption under Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144. The question presented is whether a claim alleging that the premiums charged by an insurer violated Montana's unfair-insurance-practices law is nevertheless preempted by Section 502(a) of ERISA, 29 U.S.C. 1132(a) (2006 & Supp. V 2011), and may therefore be enforced only through ERISA's own civil remedies.

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INTEREST OF THE UNITED STATES

This brief is submitted in response to this Court's order inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. a. Respondents are three brothers; three corporations that are each, respectively, jointly owned by one of the brothers and his wife; and Fossen Brothers Farms, which is a partnership of the three corporations. Pet. App. 3a. Between 2004 and the filing of this suit in 2009, Fossen Brothers Farms obtained health insurance for the brothers and their dependents through a group health insurance policy designed by petitioner and sold to multiple employers in an association. *Id.* at 3a-4a, 28a. In 2006, petitioner allegedly raised the premiums

for Fossen Brothers Farms by 21% as a result of the health status of its employees or their dependents, but petitioner did not impose similar rate increases on other employers in the association. *Id.* at 4a, 29a. After respondents complained to the state insurance commissioner, petitioner reduced that year's proposed increase to 4%, but in 2008, petitioner increased the premiums for Fossen Brothers Farms by 40%. *Id.* at 4a.

b. In 2009, respondents filed suit in state court, challenging petitioner's decision to impose higher premiums on Fossen Brothers Farms than on other employers. Pet. App. 4a. Respondents' complaint asserted three state-law causes of action. *Ibid.*

First, respondents invoked Montana's "little HIPAA" law, which governs premium rates for group health plans in terms identical to Section 702 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1182 (2006 & Supp. V 2011). Section 702 was added to ERISA by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936.[1] See Pet. App. 4a. Like the federal law, Montana's HIPAA law prohibits insurers from setting different premiums for individuals in a group health plan on the basis of "health status-related factors." Mont. Code Ann. § 33-22-526(2)(a) (2011).

Second—and of principal relevance for current purposes—respondents invoked an unfair-insurance-practices provision of the Montana Unfair Trade Practices Act, which states as follows:

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[1] This brief—like the parties' briefs, the decisions below, and previous cases involving ERISA preemption (see, *e.g.*, *Aetna Health Inc.* v. *Davila*, 542 U.S. 200 (2004))—identifies key provisions of ERISA by their section numbers within that statute. See Sup. Ct. R. 34.5.

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

Mont. Code Ann. § 33-18-206(2) (2011). See Pet. App. 4a-5a. The term "disability insurance" is defined in the Montana Insurance Code to include insurance against "medical expense[s]" resulting from "accident" or "sickness." Mont. Code Ann. § 33-1-207(1)(a)-(b) (2011).

Third, respondents asserted a state-law breach-of-contract claim, alleging that the contract with petitioner incorporated Montana's HIPAA provision and its unfair-insurance-practices provision. Pet. App. 5a.

Respondents' complaint sought, *inter alia*, damages and an order requiring petitioner to return excess premiums. Pet. App. 5a. Respondents also sought certification as a class action on behalf of other individuals who were insured by petitioner under a group health plan and charged excessive premiums. *Ibid.*; Am. Compl. ¶¶ 47-53, D. Ct. Doc. 1-1 (filed Oct. 15, 2009) (Am. Compl.).

2. Petitioner removed the case to federal district court, contending that respondents' state-law claims are completely preempted under Section 502(a) of ERISA (29 U.S.C. 1132(a) (2006 & Supp. V 2011)). See Pet. App. 42a-43a; see generally *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 207-209 (2004) (discussing complete-preemption doctrine, under which "any state-law cause of action that duplicates, supplements, or supplants" the civil-enforcement remedy in Section 502(a)(1)(B) of ERISA is substantively preempted, and the state-law

claim is converted into a federal claim for purposes of the well-pleaded-complaint rule, thus making the cause of action removable to federal court).

The district court denied respondents' motion to remand to state court, concluding that their claims are completely preempted because Montana's little-HIPAA provision merely duplicates Section 702 of ERISA (29 U.S.C. 1182 (2006 & Supp. V 2011)) and because ERISA allows a participant or beneficiary to enforce that section through an action for "appropriate equitable relief" under Section 502(a)(3) of ERISA (29 U.S.C. 1132(a)(3)). Pet. App. 47a-48a. The district court later granted summary judgment to petitioner on the merits, similarly concluding that ERISA preempted all of respondents' state-law claims. *Id.* at 32a-33a. The court further concluded that, even if respondents' claims were restated as ERISA claims, petitioner would prevail because its actions in raising Fossen Brothers Farms' premiums did not violate Section 702 of ERISA. *Id.* at 33a-37a, 40a-41a.

3. The court of appeals affirmed in part and reversed in part. Pet. App. 1a-24a.

a. As an initial matter, the court of appeals held that respondents' little-HIPAA cause of action is completely preempted under ERISA Section 502(a) and that there is thus federal-question jurisdiction for that cause of action as removed from state court. Pet. App. 11a-19a. In reaching that conclusion, the court applied a two-part test that it had previously "distilled" from this Court's decision in *Davila*, which finds complete preemption "if (1) an individual, at some point in time could have brought the claim under ERISA [Section] 502(a)(1)(B), and (2) where there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 8a-9a

(internal quotation marks omitted); see *Davila*, 542 U.S. at 210. With respect to the first part of the test, the court of appeals explained that respondents could have asserted their state-law HIPAA claim under ERISA, because "at least some of the contracts at issue in this action are ERISA plans" and "[t]he individual [respondents] are the participants in the ERISA plan" who sued "to enforce rights that are provided by ERISA." Pet. App. 11a, 13a. With respect to the second part of the test, the court explained that the state-law HIPAA claim was identical to the federal HIPAA claim that respondents could have filed, and that, because Montana's HIPAA statute applies "only to ERISA plans," it "is not 'independent' of federal law for purposes of *Davila*." *Id.* at 16a.

As part of its discussion of respondents' HIPAA claim, the court of appeals rejected the Secretary of Labor's contention (as an amicus curiae) that complete preemption is inapplicable in this case because Montana's HIPAA law is saved from preemption by Section 731 of ERISA (29 U.S.C. 1191), which reflects Congress's intention that the federal HIPAA requirements set a floor rather than a ceiling. Pet. App. 16a-17a; see Br. in Opp. App. 20-28 (reprinting relevant section of Secretary's amicus brief).[2] The court believed that Section 731 does not save the Montana law because that law duplicates rather than expands upon the protections provided by ERISA; but the court left open "whether [its] holding would apply to a state HIPAA statute that provided *additional* protections beyond federal HIPAA

[2] Noting that "the district court's decision was directed solely at" respondents' HIPAA claim (Br. in Opp. App. 15-16 n.4), the Secretary's amicus brief did not directly address the unfair-insurance-practices claim at issue in the petition for a writ of certiorari.

and was not *exactly identical* to federal HIPAA." Pet. App. 18a-19a.

b. In the part of its decision that petitioner challenges in this Court, the court of appeals reversed the summary judgment in favor of petitioner on respondents' unfair-insurance-practices claim (and on their breach-of-contract claim, to the extent that it is premised on the unfair-insurance-practices claim). Pet. App. 20a-23a, 24a.

The court of appeals first determined that, although the parties did not dispute that the unfair-insurance-practices statute "relate[s] to" an ERISA plan for purposes of express preemption under ERISA Section 514(a), that law is nevertheless saved from express preemption as an insurance regulation. Pet. App. 21a & n.8.

The court of appeals also concluded that respondents' cause of action under the Montana unfair-insurance-practices statute is not preempted under ERISA Section 502(a), because the restitution of excess premiums "is consistent with ERISA's enforcement scheme, and because the state [unfair-insurance-practices law] is completely 'independent' of ERISA." Pet. App. 22a (citation omitted; quoting *Davila*, 542 U.S. at 210). The court explained that, unlike the state HIPAA provision, the state unfair-insurance-practices statute "applies without regard to the existence of an ERISA plan" and "creates a right that is separate from and could not possibly be remedied under ERISA." *Ibid.* The court said that it "agree[d] 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." *Ibid.* (quoting *PAS* v. *Travelers Ins. Co.*, 7 F.3d 349, 356 (3d Cir. 1991)).

c. Having found that the unfair-insurance-practices claim is not preempted, the court of appeals declined to address the merits of that claim, explaining that its resolution would require an analysis separate from the HIPAA claim, and "[n]either the district court's decision nor the parties' briefs provide the necessary analysis." Pet. App. 23a. It thus remanded to permit the district court to "consider the merits" of that claim "in the first instance." *Ibid.*

The court of appeals also noted that, because it had affirmed the dismissal of the HIPAA claim (which had provided a basis for federal jurisdiction), the district court would be free on remand to determine whether to exercise supplemental jurisdiction over the non-preempted unfair-insurance-practices claim under 28 U.S.C. 1367, or instead to remand that claim to state court. Pet. App. 19a n.7.

DISCUSSION

The interlocutory decision of the court of appeals correctly concluded (Pet. App. 20a-23a) that respondents' cause of action challenging allegedly excessive insurance premiums under Montana's unfair-insurance-practices law is not preempted under Section 502(a) of ERISA (29 U.S.C. 1132(a) (2006 & Supp. V 2011)), though it may yet fail on the merits. That holding does not conflict with decisions of any other court of appeals. Moreover, this would be a poor vehicle for resolving the question presented for several reasons, including the interlocutory posture of the case, potential case-specific infirmities in respondents' prayer for relief, and the Court's inability to consider the viability of respondents' little-HIPAA claim. The petition for a writ of certiorari should be denied.

A. The Court Of Appeals' Decision On The Question Presented Is Correct

The court of appeals correctly concluded that respondents may be able to bring an unfair-insurance-practices claim under state law rather than through the civil remedies available under ERISA Section 502(a).

1. Montana's unfair-insurance-practices law is not expressly preempted under Section 514 of ERISA

a. Subject to some exceptions—including the insurance-savings clause, which, as discussed below, applies here—Section 514(a) of ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. 1144(a). Here, the parties have not disputed that Montana's unfair-insurance-practices law "relate[s] to" an employee-benefit plan in the relevant sense. Pet. App. 21a n.8. There is some question whether that conclusion is correct. This Court has cautioned that the text of Section 514(a) cannot be applied with "uncritical literalism." *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*Travelers*). Whether Section 514(a) applies turns upon an analysis of "'the objectives of the ERISA statute as a guide to the scope of the law that Congress understood would survive,' as well as the nature of the effect of the state law on ERISA plans." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quoting *Travelers*, 514 U.S. at 656).

Montana's unfair-insurance-practices law does not operate in a manner that necessarily "implicates an area of core ERISA concern" (*Egelhoff* v. *Egelhoff*, 532 U.S. 141, 147 (2001)) in the same way as state laws found to be covered by Section 514(a) in this Court's cases. It

does not, for example, regulate the relationships among benefit plans, participants, and fiduciaries. And in focusing on the obligations that insurers generally have to their customers with respect to premiums, the Montana law does not mandate particular benefits to be covered by a plan, bind plan administrators in making decisions, or otherwise interfere with ERISA plans' ability to administer a uniform nationwide process for determining and adjudicating benefit claims. Compare *Travelers*, 514 U.S. at 656-658 (summarizing circumstances that triggered preemption in prior cases), with *id.* at 658-662 (holding that state law affecting rates charged by health-care providers to ERISA plans not preempted).

b. Regardless, however, of whether the unfair-insurance-practices law relates to an employee-benefit plan for purposes of Section 514(a), the law is saved from express preemption by Section 514(b)(2)(A), which applies in relevant part to state laws that "regulate[] insurance." 29 U.S.C. 1144(b)(2)(A). As this Court has explained, that insurance-savings clause is triggered when a state law (1) is "specifically directed toward entities engaged in insurance" and (2) "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Kentucky Ass'n of Health Plans* v. *Miller*, 538 U.S. 329, 342 (2003). The court of appeals correctly held that Montana's unfair-insurance-practices law is specifically directed at insurance companies because it regulates insurance rates and premiums and that the law affects risk-pooling because it limits insurers' ability to establish different premiums for different customers. Pet. App. 21a; see also Pet. i (describing the law as "saved from preemption under the insurance savings clause"); Br. in Opp. 8 (contending the law satisfies *Miller*'s two-part test).

2. A state-law cause of action to enforce Montana's unfair-insurance-practices law does not conflict with Section 502(a) of ERISA

For more than 15 years, this Court declined to resolve the question of when a state insurance law that is otherwise saved from express preemption under Section 514 can nevertheless be preempted (or completely preempted) on the theory, and to the extent, that the state law's civil remedies provisions conflict with the civil-enforcement scheme set forth in ERISA Section 502(a). See, *e.g.*, *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 377-379 (2002) (declining to turn "dictum" from *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 54 (1987), "into holding"); *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 (1999) (finding issue "not implicated" when plaintiff had sued under ERISA rather than state law). In its 2004 decision in *Davila*, however, the Court established that the absence of express preemption under Section 514 does not necessarily preclude conflict preemption under Section 502(a). See 542 U.S. at 214 n.4, 217-218. *Davila* held that state-law causes of action "to rectify a wrongful denial of benefits promised under ERISA-regulated plans" (*id.* at 214) conflicted with ERISA Section 502(a)(1)(B), which was intended to be the exclusive means for a participant in or beneficiary of an ERISA benefits plan to "recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B). Because the participants' state-law claim in that case fell within the scope of Section 502(a)(1)(B), it was completely preempted. *Davila*, 542 U.S. at 214.

Davila explained that complete preemption of a state-law cause of action occurs if (1) the "individual, at some point in time, could have brought his claim under ERISA [Section] 502(a)(1)(B)," and (2) "there is no oth-

er independent legal duty that is implicated by [the] defendant's actions." 542 U.S. at 210. Application of that test does not require preemption of respondents' cause of action under the unfair-insurance-practices law.

a. Respondents' unfair-insurances-practices claim fails to satisfy *Davila*'s first condition—that it could have been brought under ERISA Section 502(a)(1)(B) or 502(a)(3)[3]—because respondents seek to recover excessive premiums paid by Fossen Brothers Farms as employer, not plan benefits, and because they do not complain of any injury they sustained in their capacity as plan participants, beneficiaries, or fiduciaries.

Respondents are not seeking benefits under their plan, which would indeed implicate a principal purpose of ERISA: the protection of "contractually defined benefits." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985). Petitioner contends (Cert. Reply Br. 3-4) that "benefits cannot be divorced from the premiums charged to obtain them," and that "ERISA benefits and premiums are integrally connected." But the statute counsels against equating benefits and premiums for these purposes. An ERISA plan exists to provide, *inter alia*, "benefits" for "its participants or their beneficiaries, through the purchase of insurance or otherwise." 29 U.S.C. 1002(1); see 29 U.S.C. 1002(3). That

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[3] Petitioner hypothesizes (Pet. 27) a suit under Section 502(a)(3), which *Davila* did not address. See 542 U.S. at 221 n.7. There appears, however, to be no basis for concluding that Section 502(a)(3) is categorically incapable of preempting a state-court action otherwise saved from express preemption under Section 514(b). See U.S. Amicus Br. at 17 n.5, *Davila*, *supra* (Nos. 02-1845 and 03-83) (noting that actions "may" be completely preempted if they fall within the scope of Section 502(a)(3)). Cf. *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 143, 145 (1990) (finding that Section 502(a)(3) preempted a state-law cause of action).

definition indicates that, when a plan is insured, benefits are what beneficiaries and participants receive *in return for* the premiums that are paid for the insurance that is purchased, and thus are not themselves benefits. See also 29 U.S.C. 1002(7) and (8) (defining "participant" and "beneficiary" in terms of eligibility to receive a benefit or entitlement to a benefit). Even if premiums charged to individual participants are not benefits under the plan, they may implicate the participants' rights under the plan and could on that theory be the subject of a suit under Section 502(a)(1)(B). That provision allows "a participant or beneficiary * * * 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." 29 U.S.C. 1132(a)(1)(B) (emphasis added).

At all times relevant in this case, however, Fossen Brothers Farms, in its capacity as employer, contributed 100% of the premiums for each employee and his dependents. See Aff. of Kristy Amestoy, Exs. 1 and 2, D. Ct. Doc. 1-2 (filed Oct. 15, 2009). At least when they are paid by an employer, insurance premiums—the subject of respondents' suit—would not concern participants' and beneficiaries' rights under the plan for purposes of Section 502(a)(1)(B). In fact, petitioner does not argue that respondents' claim could have been brought under Section 502(a)(1)(B).

Instead, petitioner invokes Section 502(a)(3), which is a "catchall" provision that applies only when other parts of Section 502(a) do not provide full relief. *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996). In petitioner's view, respondents "could have" sought to enforce the Montana unfair-insurance-practices law on the theory that it was an imputed "'term[] of the plan'" that was therefore "en-

forceable through [Section] 502(a)(3)." Pet. 26-27 (quoting 29 U.S.C. 1132(a)(3)).[4] But respondents' claim is that Fossen Brothers Farms, *an employer*, paid too much in premiums while purchasing the insurance associated with respondents' benefit plan. The Court has explained that Section 502(a) "demonstrates Congress' care in delineating the universe of *plaintiffs* who may bring certain civil actions." *Harris Trust & Sav. Bank* v. *Salomon Smith Barney, Inc.*, 530 U.S. 238, 247 (2000). That universe comprises "participant[s]," "beneficiar[ies]," "fiduciar[ies]," and the Secretary of Labor. 29 U.S.C. 1132(a)(1)-(3) and (5). As a result, employers, *qua* employers, are not authorized to bring actions under ERISA Section 502(a). See, *e.g.*, *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 26-27 (1983) (state-court action by a State could not be removed to federal court because Section 502 "does not provide anyone other than participants, beneficiaries, or fiduciaries with an express cause of action"). The injured party, Fossen Brothers Farms, therefore could not have brought its suit under Section 502(a)(3).

Thus, even if respondents have some valid breach-of-contract claim against petitioner based on the premiums charged to Fossen Brothers Farms, it does not follow that their asserted state-law entitlement to lower premiums is an enforceable term of an ERISA plan for purposes of Section 502(a)(3). Indeed, petitioner's con-

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[4] *Davila* looked to the relevant plan documents to see if the cause of action fell within a benefits claim under Section 502(a)(1)(B). See 542 U.S. at 211. Here, the plan documents are neither in the record nor discussed in the court of appeals' decision. Petitioner, however, does not appear to take issue with respondents' assertion (Br. in Opp. 3) that premiums "are not mentioned in the terms of [respondents'] ERISA plan."

trary conclusion would presumably preclude any enforcement of the substantive provisions of state insurance law in state courts even by parties such as state insurance commissioners, who (like plan sponsors) could not bring any claim under ERISA. That conclusion would be fundamentally inconsistent with the statute's statement that "nothing in this subchapter [*i.e.*, ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Cf. *Travelers*, 514 U.S. at 659, 661 (holding that state laws with "an indirect economic effect on choices made by insurance buyers, including ERISA plans," are not preempted by ERISA, in part because there was no indication that "Congress chose to displace general health care regulation, which historically has been a matter of local concern").

b. Respondents' unfair-insurance-practices claim also rests on an "independent legal duty," which means that petitioner cannot satisfy *Davila*'s second necessary condition for preemption. See 542 U.S. at 210. Unlike in *Davila*, the legal duty at issue in this suit—the one imposed by the unfair-insurance-practices law—"applies without regard to the existence of an ERISA plan." Pet. App. 22a. Proving a violation of that duty would not depend on the individual respondents' status as plan participants or beneficiaries and (as explained above) would not require the interpretation of plan terms (whether express or implied). Cf. *Davila*, 542 U.S. at 212 (finding state law preempted because interpretation of plan terms was an essential part of plaintiffs' claims and liability would exist only because of the defendants' administration of ERISA-regulated plans).

Accordingly, the court of appeals correctly concluded that respondents' unfair-insurance-practices claim is not

preempted—and therefore not completely preempted—by Section 502(a).[5]

c. Petitioner says (Pet. 14) that the United States has "arguably * * * switched positions" in previous briefs filed in this Court about whether saved state insurance laws may be enforced outside of ERISA. See also Pet. 21, 23 n.3. In fact, the government's briefs have repeatedly recognized that a state law might be preempted under general conflict principles even if saved from express preemption under Section 514. See, *e.g.*, U.S. Amicus Br. at 5, *Rush Prudential HMO*, *supra* (No. 00-1021) ("Even if a law comes within the terms of the insurance saving clause, it may nonetheless be preempted if it conflicts with a specific provision of ERISA."); U.S. Amicus Br. at 24 n.13, *UNUM Life Ins. Co.*, *supra* (No. 97-1868) ("Of course, notwithstanding the savings clause, an insurance law that conflicts with a provision of ERISA itself is preempted by virtue of the Supremacy Clause."); *id.* at 25 n.14.

Petitioner notes (Pet. 23 n.3) that the United States "supported the insurance company and favored complete preemption" in *Davila*. But it does not acknowledge that the government's brief in that case specifically noted that "the state-law claim" that was preempted "depend[ed] on a showing that respondents were entitled to *benefits* under their ERISA plans" and that the case therefore did not present a question concerning "a state-

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[5] Because the cause of action fails to satisfy either of *Davila*'s two conditions for preemption under Section 502(a) and is not expressly preempted by Section 514, it can proceed as a state-law claim regardless of whether the remedies sought by respondents would be "appropriate equitable relief" under Section 502(a)(3). See Pet. 27-31 (discussing *Great-West Life & Annuity Ins. Co.* v. *Knudson*, 534 U.S. 204 (2002), and *Sereboff* v. *Mid Atl. Med. Servs.*, 547 U.S. 356 (2006)).

law claim that does not require adjudication of rights under an ERISA plan." U.S. Amicus Br. at 13 n.2, *Davila*, *supra* (Nos. 02-1845 and 03-83) (emphasis added). There is thus no inconsistency between the government's position in *Davila* and its position here.

B. The Court Of Appeals' Decision Does Not Conflict With Those Of Any Other Courts Of Appeals

1. Petitioner contends that the Ninth Circuit has joined sides in a circuit split that was identified by the Third Circuit as early as 1993 (Cert. Reply Br. 2) but, in petitioner's view, was ultimately resolved by this Court's 2004 decision in *Davila* (Pet. 14, 22). It is, however, telling that, among all the decisions in the alleged circuit split (Pet. 17-20), only the decision below post-dates *Davila*, which has now been on the books for more than eight years.

Indeed, although petitioner suggests at one point (Cert. Reply Br. 5-6) that the Third and Ninth Circuits are on the same side of the alleged conflict, petitioner also acknowledges (Pet. 25) that the Third Circuit has not revisited the question since *Davila*. Similarly, because all of the supposedly conflicting cases—from the Fourth, Sixth, Seventh, and Eighth Circuits—pre-date *Davila*, there is no other court of appeals decision that either agrees or disagrees with the Ninth Circuit about how to answer the question presented in light of the most relevant precedent from this Court. Under these circumstances, resolution of the alleged conflict by this Court would be distinctly premature.

2. In any event, even assuming that the circuits that petitioner identifies would hew to their previous positions in *Davila*'s wake, there is still no conflict among the circuits for the reason identified by respondent (Br. in Opp. 11): because, unlike all of the other decisions in

the alleged split, this case involves a claim about insurance premiums, rather than one for benefits.

Petitioner cites (Pet. 17-20) decisions from the Fourth, Sixth, Seventh, and Eighth Circuits for the proposition that ERISA's civil remedies are the exclusive means available for enforcing a saved state insurance law. Those decisions, however, involved state laws that mandated or prohibited certain terms of coverage, or involved claims that otherwise arose from the administration of benefits. See *Singh* v. *Prudential Health Care Plan, Inc.*, 335 F.3d 278, 289 (4th Cir.) (state law prohibiting health-benefit offsets for third-party recoveries by HMO members could be enforced only through ERISA), cert. denied, 540 U.S. 1073 (2003); *Fink* v. *Dakotacare*, 324 F.3d 685, 689 (8th Cir. 2003) (state unfair-insurance-law claim that challenged a denial of benefits was preempted because it "ar[o]se from the administration of benefits") (citation omitted); *Plumb* v. *Fluid Pump Serv., Inc.*, 124 F.3d 849, 861-862 (7th Cir. 1997) (state law requiring insurance policies to cover preexisting conditions could be enforced only through ERISA; noting that plaintiff "sought the benefits due under the terms of his plan"); *Ruble* v. *UNUM Life Ins. Co.*, 913 F.2d 296, 297 (6th Cir. 1990) (state law prohibiting Social Security offset could be enforced only through ERISA and not through a state-law breach-of-contract action); *Donatelli* v. *Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (state law mandating that death by suicide be covered as an accidental death benefit could be enforced only through ERISA; noting that plaintiff "seeks to recover benefits" under insurance policy).[6] In

[6] Petitioner also cites (Pet. 18 n.2) decisions from the Fifth and Eleventh Circuits, without claiming a direct conflict. See Cert. Reply Br. 2 (excluding those courts from alleged conflict). But those deci-

other words, the claims in those cases could all be described as claims for ERISA plan benefits—precisely the kinds of claims that this Court found to be preempted in *Davila*. 542 U.S. at 217-218. None of those decisions, however, considered a state law, like the one at issue here, that governed insurance premiums—100% of which were paid by the employer in this case.

3. In response, petitioner contends (Cert. Reply Br. 2-3) that the court of appeals did not "invoke[] the supposed distinction between premium disputes and other ERISA cases" and that other courts will accordingly "not view [its decision] as cabined to the premium setting." The Secretary of Labor's amicus brief in the court of appeals, however, did draw a distinction between the "benefit claims" at issue in *Pilot Life* and *Davila* and respondents' "suit under a state law provision that forbids insurers in Montana from setting premium rates in a particular manner." Br. in Opp. App. 25. And no decision issued since the court of appeals' October 2011 opinion bears out petitioner's concern. Nearly all of the district court opinions—both inside and outside the Ninth Circuit—that have cited the decision below have treated it as a straightforward application of *Miller*'s two-part test for determining whether an insur-

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sions also discussed benefits claims. See *Arana* v. *Ochsner Health Plan*, 338 F.3d 433, 435, 440 (5th Cir. 2003) (en banc) (finding claim under state anti-subrogation law was completely preempted because it was one to "recover benefits or to enforce [plaintiff's] rights" under plan terms), cert. denied, 540 U.S. 1104 (2004); *Ervast* v. *Flexible Prods. Co.*, 346 F.3d 1007, 1017 (11th Cir. 2003) (finding claim was not completely preempted because it was "not an ERISA civil action for the recovery of benefits due under the terms of the plan"), cert. denied, 543 U.S. 808 (2004).

ance law is saved from preemption under Section 514,[7] or of *Davila*'s two-part test for complete preemption,[8] or both.[9] One decision actually distinguishes the court of appeals' opinion, holding that a claim under a different section of Montana's Unfair Trade Practices Act was completely preempted because it alleged a termination of long-term-disability benefits under an ERISA plan.[10]

Especially in light of this Court's express statement in *Davila* that a state law regulating insurance "will be pre-empted if it provides a separate vehicle to assert a *claim for benefits*," 542 U.S. at 217-218 (emphasis added), there is no basis for petitioner's fear that the Ninth Circuit's reasoning will be extended from premium claims to benefit claims. Further review is accordingly unwarranted.

C. This Case Would Be A Poor Vehicle For Resolving The Question Presented

Even assuming that the question about when state-law claims under saved insurance statutes are completely preempted under ERISA might, in the abstract, warrant this Court's resolution, several factors make this case a poor vehicle for resolving such a question.

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[7] *Maine Educ. Ass'n Benefits Trust* v. *Cioppa*, 842 F. Supp. 2d 373, 380 (D. Me. 2012).

[8] *Lodi Mem'l Hosp. Ass'n* v. *Blue Cross*, No. 12-1071, 2012 WL 3638506, at *6 (E.D. Cal. Aug. 22, 2012); *Genesis Specialty Tile & Accessories, LLC* v. *Amerus Life Ins. Co.*, No. CIV. S-11-2489, 2012 WL 1197613, at *4 (E.D. Cal. Apr. 10, 2012) (discussing court of appeals' HIPAA holding, not its unfair-insurance-practices holding).

[9] *Poffenbarger* v. *Hawaii Mgmt. Alliance Ass'n*, No. 12-172, 2012 WL 3808419, at *6-*7 (D. Haw. Aug. 31, 2012).

[10] *Ford* v. *CIGNA Corp.*, No. CV 12-60, 2012 WL 5931887, at *2-*4 (D. Mont. Nov. 27, 2012).

1. First, this Court "generally await[s] final judgment in the lower courts before exercising [its] certiorari jurisdiction." *VMI* v. *United States*, 508 U.S. 946 (1993) (Scalia, J., respecting the denial of certiorari); see *Office of Senator Mark Dayton* v. *Hanson*, 550 U.S. 511, 515 (2007) (finding no "special circumstances" to "justify the exercise of our discretionary certiorari jurisdiction to review" an interlocutory order); *Brotherhood of Locomotive Firemen* v. *Bangor & Aroostook R.R.*, 389 U.S. 327, 328 (1967) (per curiam) (denying certiorari "because the Court of Appeals remanded the case," making it "not yet ripe for review by this Court"); *Hamilton-Brown Shoe Co.* v. *Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916) (describing decision's interlocutory nature as "a fact that of itself alone furnished sufficient ground for the denial of" certiorari).

Here, the court of appeals remanded respondents' unfair-insurance-practices claim to be considered "in the first instance" by the district court, because neither the district court nor the parties had attempted to address that claim independent of the little-HIPAA claim. Pet. App. 23a. Thus, petitioner could still be relieved of any liability to respondents for reasons independent of the question whether Montana's unfair-insurance-practices law's regulation of insurance premiums may be enforced outside of Section 502(a) of ERISA.

2. Relatedly, petitioner contends (Pet. 28-31) that respondents' complaint fails to seek a form of restitution authorized by ERISA, and thus cannot be saved from preemption on the Ninth Circuit's theory that a state-insurance-law cause of action is saved from preemption if it provides for relief similar to that available under ERISA. That contention is predicated in part on the observation (Pet. 30) that respondents' prayer for relief

requests the "return" of only "the excess premiums [that petitioner] has charged in excess of *those allowed by [Mont. Code Ann.] § 33-22-526(2)*," which is the state-law HIPAA provision, not the unfair-insurance-practices law now at issue. Am. Compl. 11 (emphasis added).[11] That sort of relief, petitioner maintains, is legal restitution, not equitable restitution available under ERISA. To be sure, the prayer for relief also includes a request "[f]or such other and further relief as to the Court seems just." *Ibid.* But, if the general prayer were ultimately deemed inadequate to support a restitutionary remedy for any violation of the unfair-insurance-practices law independent of the preempted HIPAA claim, respondents' claim would falter on this theory because of a case-specific pleading defect, and not because of any legal principle of more general applicability that this Court might establish upon interlocutory review.

3. Finally, for the reasons explained in the Secretary of Labor's amicus brief in the court of appeals (Br. in Opp. App. 20-28), the United States believes that respondents' little-HIPAA claim should have been saved from preemption by Section 731 of ERISA, 29 U.S.C. 1191. This Court, however, has already denied a cross-petition for a writ of certiorari to review the court of appeals' decision to the contrary. See *Fossen* v. *Blue*

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[11] The count of respondents' amended complaint about the unfair-insurance-practices law alleges that that law was "violated" because petitioner charged "premiums in excess of those authorized by [Mont. Code Ann.] § 33-18-526(2)." Am. Compl. ¶ 36. That reference conflates the chapter number (18) associated with the Unfair Trade Practices Act and the section number (526(2)) associated with the little-HIPAA provision. The decisions under review did not attempt to resolve that apparent scrivener's error.

Cross & Blue Shield of Mont., Inc., 132 S. Ct. 2780 (2012) (No. 11-1280).[12] The need to treat the little-HIPAA claim as preempted (in light of the procedural posture of this case) could well hamper the Court's ability to reach an appropriate result on the question presented here, to the extent that respondents' unfair-insurance-practices claim continues to be closely related to their little-HIPAA claim—either because of the particular way that it has been pleaded or because, as the court of appeals noted (Pet. App. 23a), the parties and the district court have yet to address its viability as a stand-alone claim. And if the apparently close relationship between respondents' two claims were to play any part in the Court's analysis of the unfair-insurance-practices claim, that would limit the applicability of any decision the Court made on the merits.

[12] Petitioner contends (Pet. 34) that the question presented has "added significance" because of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). But the provision of that statute that petitioner identifies is akin to ERISA Section 731 in permitting state laws that do not "prevent the application" of federal law. § 1321(d), 124 Stat. at 187. It is accordingly difficult to see how deciding the conflict-preemption question in this case without addressing Section 731 would inform States about how they may implement state insurance regulations in harmony with the Affordable Care Act.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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