

No. 10-36001

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DALE FOSSEN, et al,

Plaintiffs-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MONTANA, INC.,

Defendant-Appellee.

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

BRIEF OF *AMICUS CURIAE*
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
IN SUPPORT OF APPELLANT, URGING REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *Amicus Curiae*, National Association of Insurance Commissioners (“NAIC”) is a non-profit corporation organized under the laws of the State of Delaware. The NAIC operates under § 501(c)(3) of the Internal Revenue Code. It has no parent corporation and, as it has no stock, no publicly held company owns 10% or more of its stock.

CONSENT TO FILING AMICUS BRIEF

Counsels for Appellants and Appellee have consented to the filing of the NAIC’s *amicus* brief in this case.

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IDENTITY AND INTEREST OF AMICUS CURIAE

The National Association of Insurance Commissioners (“NAIC”) is a non-profit corporation whose membership consists of the principal insurance regulatory officials of the fifty States, the District of Columbia, and the territories and insular possessions of the United States. Founded in 1871, it is the nation’s oldest association of state government officials. The NAIC represents the coordinated and considered views of the state government officials who regulate the insurance industry and enforce the insurance laws of the country.

The NAIC’s purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers as well as to assist in maintaining the financial stability of the insurance industry.

The NAIC performs numerous crucial services on behalf of state governments including: developing and publishing model laws, regulations, bulletins, financial and accounting standards, white papers, consumer

guides, handbooks, periodicals and the *Proceedings of the NAIC*. Hundreds of state and federal laws assign duties to the NAIC and incorporate NAIC standards, models and other publications. In addition, the NAIC manages and coordinates the accreditation review of insurance departments as well as maintains regulatory and financial databases of insurance company financial data.

The interest of the NAIC in this case arises out of the regulatory responsibility vested in each commissioner to regulate insurance policy forms and premium rates,¹ including the power to prohibit insurers from discriminating by charging excessive premiums to individuals within a group health plan based on health status. The insurance commissioners of the various states are charged by state and federal law with the responsibility of regulating the business of insurance within their respective jurisdictions pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011, *et seq.* (“McCarran-Ferguson Act”), and state insurance laws. The authority to regulate insurance issued in connection with employee welfare benefit plans is reserved to the states through the savings clause of the Employee

¹ In insurance regulation, oversight of insurance policy forms and rates are fundamental to insurance regulation. This Court previously affirmed the authority of states to regulate insurance forms in *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, ___ U.S. ___, 130 S. Ct. 3275 (2010). This case allows this Court to affirm the authority of states to regulate premium rates.

Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* (“ERISA”). 29 U.S.C. § 1144(b)(2)(A).

The NAIC supports the brief of the Plaintiffs-Appellants and seeks to aid the Court of Appeals by offering the legal position and public policy perspectives of our national association and the NAIC member states.

STATEMENT PURSUANT TO RULE 29(c)(5)

Pursuant to Fed. R. App. P. Rule 29(c)(5), *amicus* states:

A. This brief was not authored in whole or in part by a party’s counsel;

B. No party or party’s counsel contributed money that was intended to fund preparing or submitting the brief; and

C. No person, other than the *amicus curiae*, its members, or its counsel, contributed money that was intended to fund preparing or submitting the brief.

STATEMENT OF THE CASE AND STATEMENT OF FACTS

The NAIC agrees with and incorporates by reference the Statement of the Case and Statement of Facts of Plaintiffs-Appellants Dale Fossen, D and M Fossen, Inc., Larry Fossen, L and C Fossen, Inc., Marlowe Fossen, M and

C Fossen, Inc., and Fossen Brother Farms, a partnership (collectively referred to as “Plaintiffs”).

INTRODUCTION

Plaintiffs enrolled for group health coverage with Defendant-Appellee Blue Cross and Blue Shield of Montana, Inc. (“Blue Cross”). Plaintiffs alleged in their Complaint filed in Montana state court that Blue Cross charged Plaintiffs premiums substantially in excess of premiums charged for similarly situated groups in violation of § 33-22-526(2)(a) of the Montana Code Annotated (“MCA”)², which provides that 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....” Plaintiffs sought injunctive relief and a return of excess premiums in Montana state court. Blue Cross removed the case from Montana state court to the United States District Court, alleging the Complaint was preempted under ERISA. Blue Cross argued that

² MONT. CODE ANN. § 33-22-526 (2009).

Plaintiffs' cause of action was preempted under ERISA § 702(b)(1),³ which also prohibits health plans from discriminating by charging a plan participant a higher premium from a similarly situated person based on health status.

The District Court held that the Plaintiffs' state law claims for relief were preempted by ERISA because MCA § 33-22-526 and ERISA § 702(b) were virtually identical. This *amicus* brief focuses solely on the preemption analysis and supports the Plaintiffs' position that the authority of the state of Montana to regulate insurance premium rates was not preempted under ERISA.

ARGUMENT

I. Plaintiffs' State Law Claims Were Not Preempted By ERISA Where Plaintiffs' Claims Could Not Have Been Brought Under ERISA's Civil Enforcement Scheme.

Congress intended for ERISA to be “the exclusive vehicle for actions asserting a claim for benefits.” *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 388 (2002). ERISA § 502(a) sets forth a comprehensive civil enforcement scheme for violations of ERISA under the terms of an

³ 29 U.S.C. § 1182(b)(1) (2010).

employee benefit plan.⁴ However, the Complaint in this matter does not involve a claim for benefits based on the terms of an employee benefit plan, but instead requests a return of excess insurance premiums charged for participation in the plan. Montana’s nondiscrimination laws which regulate premium charges were not preempted under ERISA’s civil enforcement scheme.

The relief requested by Plaintiffs is not for benefits due under the plan, but instead to receive reimbursement for premium costs assessed as a result of the alleged improper underwriting and pricing practices of Blue

⁴ Specifically, ERISA § 502(a) provides:

Sec. 1132. Civil enforcement

(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 . . .

(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 (2010).

Cross. Therefore, the Plaintiffs' claims must be brought under state rather than federal law as the claims are not for benefits under the plan.

In a recent decision, the Georgia Court of Appeals held an employer's claim for reimbursement of overcharges of insurance renewal premiums for the employer's group insurance premiums was not preempted by ERISA. *Homes of Georgia, Inc. v. Humana Employers Health Plan of Georgia, Inc.*, 640 S.E.2d 313 (Ga. App. 2006). Homes of Georgia ("HGI") was a real estate business owned by George and Linda Tong. *Id.* at 314. The Tongs applied to Humana for health insurance coverage for themselves and their only employee. *Id.* In 1999, after being covered by Humana for two years, Mr. Tong was diagnosed with prostate cancer. *Id.* Subsequently, Humana significantly raised HGI's monthly premiums. *Id.* Following a finding by the Georgia Commissioner of Insurance that Humana had improperly used health status factors to calculate insurance premiums, HGI brought claims for breach of contract for considering health status as a rating factor and for failing to cap premium increases, among other claims, seeking to collect the premium overcharges. *Id.* The Court held the state law claims were not preempted by ERISA because the claims related to the contract, not the plan, and because the premium was incidental to the contract and unrelated to the terms of the benefit plan. *Id.*

The Court found the contract of insurance sold to the plan was not a benefit under the plan; therefore, the claims were not preempted by ERISA. *Id.* at 315. *See also, Pegram v. Herdrich*, 530 U.S. 211, 223 (2000) (provisions that set up the HMO were not part of the ERISA plan), and *Sonoco Products Co. v. Physicians Health Plan*, 338 F.3d 366, 373 (4th Cir. 2003) (contract of insurance sold to the plan is not the plan). Moreover, since HGI sought relief from premium overcharges, those claims could not be preempted as benefits related to the ERISA plan. Benefits are rights to insurance coverage accruing to employee participants of the plan, not rights possessed by the employer who establishes the plan. *Id.*

Similarly, the Plaintiffs in this matter should be entitled to relief under MCA § 33-22-526(2)(a) as the relief sought is not for benefits under the plan, but rather an action on the policy purchased by Plaintiffs for a return of excess premiums paid. Therefore, the Montana state law claims should not be subject to ERISA preemption.

II. The District Court Erred In Concluding The Plaintiffs' State Law Claims Were Preempted Based Solely On The Similarity Of Montana Law And ERISA.

The District Court, relying upon *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004), held “any state-law cause of action that duplicates,

supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.” *Fossen v. Blue Cross*, __ F. Supp. 2d __, 2010 WL 3947282, at *4 (D. Mont. 2010). The Court summarily determined the state law and federal ERISA law were identical on their face and, therefore, preempted. However, as more fully developed in the Plaintiffs’ brief, Plaintiffs allege Montana’s regulatory scheme, and in particular MCA § 33-22-526, is broader than ERISA in that Montana’s public policy supports making group health coverage accessible and promotes risk-pooling for small employers regardless of health status. The NAIC supports the Plaintiffs’ interpretation of Montana’s public policy and federal authority permitting states to regulate more broadly. Based upon this interpretation of the state and federal regulatory schemes, MCA § 33-22-526 is not preempted by ERISA as it not duplicative.

Both ERISA § 702(b)(1) and MCA § 33-22-526 were enacted to implement the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). *See* H.R. REP. NO. 104-736, at 11-13 (1996), *reprinted in* 1996 U.S.C.C.A.N. 1990, and 1997 MONT. S.B. 378. “States have limited authority under HIPAA to indirectly require insured plans and insurers to be more generous to plan participants than what the federal statute requires.”

Thompson, *Employers Guide to the Health Insurance Portability and Accountability Act*, § 230 (2005).⁵ For example, HIPAA sets minimum standards for pre-existing condition exclusions, but allows states to impose more stringent requirements through insurance regulation. Where the state law is more generous to plan participants, the state law prevails over the federal standard. *Id.* Consequently, where Montana’s statute provides more generous requirements, the language does not duplicate ERISA and therefore, is not subject to preemption.

Plaintiffs’ claims do not satisfy the two prong test developed by the Supreme Court to determine whether state claims are preempted by ERISA. *Davila*, 542 U.S. 200 (2004). In *Davila*, the Court determined claims are completely preempted by ERISA “if an individual, at some point in time, could have brought his claim under [ERISA]” and “where there is no other independent legal duty that is implicated by defendant’s actions.” *Id.* at 210. As discussed earlier in this *amicus*, Plaintiffs could not have brought their claims under ERISA’s civil enforcement statute as the Plaintiffs did not seek relief for benefits under the policy and, as pointed out by Blue Cross in its briefs filed with the District Court, no claim exists under ERISA for the relief sought by the Plaintiffs. Therefore, although the District Court

⁵ Available at 2005 WL 4171609.

concluded the claims were preempted, had the Court more closely considered all the *Davila* requirements, the Plaintiffs' state law claims would not have been preempted.

III. The Montana Statute Regulates Insurance And Should Be Saved From Federal Preemption Under ERISA's Savings Clause.

The ERISA Savings Clause, found in ERISA § 514(b), provides in relevant part: “[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.”⁶ MCA § 33-22-526, by prohibiting discrimination between individuals in group health policies, regulates premiums and protects consumers. This type of regulation is clearly within the purview of the states and is “no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption. . . .” *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 386 (2002); *see also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (mandated benefits statutes not preempted) and *UNUM Life Ins. Co. of*

⁶ 29 U.S.C. § 1144(b)(2)(A).

America v. Ward, 526 U.S. 358 (1999) (statutes prohibit denying claims solely based on untimeliness).⁷

States have been regulating the business of insurance since 1851, when New Hampshire became the first state to establish a department of insurance.⁸ In enacting the McCarran Ferguson Act in 1945, Congress affirmed the primacy of the states in the regulation of the business of insurance. Insurance Commissioners oversee the affairs of the insurance industry and are charged with regulating the business of insurance. “The insurance commissioner’s powers are extensive and include the power . . . to regulate insurance rates, and to prescribe the form, terms, and conditions of an insurance policy.” Eileen Swarbrick, *HOLMES’ APPLEMAN ON INS.* 2d, Chapt. 170 (2005). MCA § 33-22-526 prohibits unfair discrimination between consumers, regulates insurance rates and is squarely within Montana’s authority to regulate the business of insurance.

Recognizing the primary authority of state insurance commissioners in this area, the federal HIPAA regulations specifically provide “[HIPAA] is not to be construed to supersede any provision of State law which

⁷ *Kentucky Association of Health Plans Inc v. Miller*, 538 U.S. 329 (2003), overruled *Rush Prudential*, *Metropolitan Life* and *UNUM Life*, in part, on unrelated grounds.

⁸ New Hampshire Insurance Department website at <http://www.nh.gov/insurance/aboutus/index.htm> (last visited February 7, 2011).

establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage. . .” 29 C.F.R. § 2590.731 (2010). The NAIC, in enacting its own HIPAA model legislation, took the following position:

HIPAA, in recognition of the states’ historic role as the primary regulators of the business of insurance under the McCarran-Ferguson Act, provides that states may enforce the Act’s group and individual insurance market reform requirements. . . . The states remain free to establish or continue health insurance requirements in both markets, to the extent those requirements are not preempted by ERISA. . . . Consequently, the members of the NAIC have a strong interest in the implementation of HIPAA because they will oversee its implementation at the state level and must ensure that their regulation of the health insurance market complies with the statute’s requirements.

1 *Proc. of the Nat’l Assoc. of Ins. Comm’rs*, 3rd Qtr., 124-125 (1997) (letter from then-NAIC President Josephine Musser to Secretary of Health and Human Services Donna E. Shalala).

Most, if not all, states have adopted statutes and regulations to comply with the HIPAA requirements. Thompson, *Employers Guide to the Health Insurance Portability and Accountability Act*, § 230.⁹ Moreover, a number of states specifically have adopted language substantially similar to Montana’s statute regarding discrimination which emphasizes that the

⁹ Available at 2005 WL 4171609.

prohibition on discrimination is within the states' regulatory authority.¹⁰ Should this Court find that Plaintiffs' claims are preempted by ERISA, it would call into question other states' authority to regulate premiums and protect consumers from potential unscrupulous business practices of insurers.

State statutes prohibiting discrimination in health care rates and premiums should be saved from preemption under the ERISA savings clause. As this Court stated, while ERISA has broad preemptive force, its "saving clause then reclaims a substantial amount of ground." *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 841 (9th Cir. 2009) (quoting *Rush Prudential HMO* at 364), *cert. denied*, ___ U.S. ___, 130 S. Ct. 3275 (2010). Additionally, the fundamental purpose behind ERISA's savings clause is to respect state sovereignty in insurance regulation. *Stone v. Disability Management Services, Inc.*, 288 F.Supp. 2d 684, 695-96 (M.D. Pa. 2003). Further, "the historic police powers of the States were not [meant] to be superseded by [ERISA] unless that was the clear and manifest purpose of

¹⁰ ALASKA STAT. ANN. § 21.54.100 (2010); ARK. CODE ANN. § 23-86-306 (2010); 215 ILL. COMP. STAT. ANN. 97/25 (2010); KY. REV. STAT. ANN. § 304.17A-200 (2010); LA. REV. STAT. ANN. § 22:1063 (2010); MD. CODE ANN. INS. § 15-1407 (2010); 19-1 MISS. CODE R. § 2000-5.6; N.H. CODE ADMIN. R. ANN. 1907.04 (2010); N.J. STAT. ANN. § 17B:27-65 (2010); N.M. STAT. ANN. § 59A-23E-12 (2010); N.D. CENT. CODE ANN. § 45-06-12-02 (2010); OHIO REV. CODE ANN. § 3923.571 (2010); R.I. GEN. LAWS ANN. § 27-18.6-4 (2010); TENN. CODE ANN. § 56-7-2804 (2010).

Congress,” *Standard Ins. Co.*, 584 F.3d at 849 (quoting *Rush Prudential* at 365). Accordingly, Montana’s statute prohibiting discrimination and regulating premium charges is saved from preemption because it is a law regulating insurance and the regulation of rates and premiums historically and by federal statute has been left to the states.

The Supreme Court established a two part test to determine whether a state statute regulates insurance for ERISA purposes. *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). Specifically, the Supreme Court held “that for a state law to be deemed a ‘law ... which regulates insurance’ under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance,” and second, “the state law must substantially affect the risk pooling arrangement between the insurer and the insured.” *Id.* at 341-42. There can be little argument that a state statute which prohibits insurers from requiring individuals to pay differing premiums based on health factors is directed toward entities engaged in insurance, satisfying the first part. Moreover, the prohibition on premium charges based on health status substantially affects risk pooling in that it requires that individuals be charged identical premiums regardless of any past health history. Clearly, Montana’s prohibition on

discrimination satisfies both prongs of the *Kentucky Ass'n* test and is saved from ERISA Preemption.

CONCLUSION

Plaintiffs' claims for return of excess premium charges are governed by MCA § 33-22-526, which prohibits premium discrimination between individuals based on health status. The Montana statute is not preempted by ERISA's civil enforcement provisions. Further, the statute regulates insurance and is therefore saved from preemption under ERISA's Savings Clause. Accordingly, we support the brief of the Plaintiffs and respectfully request this Court to overturn the District Court decision.

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This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B), because this brief contains 3,215 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6), because this brief has been prepared in a proportionally spaced typeface using Times New Roman in 14 point font. The brief has been scanned and is virus free.

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Certificate of Service

I hereby certify that the foregoing brief was electronically filed with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system, on the 16th day of February, 2011.

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

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