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ERISA & DISABILITY BENEFITS NEWSLETTER

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ERISA PREEMPTION AND STATE BANS ON DISCRETIONARY CLAUSES: AN INTRODUCTION

BY: NOAH BREAZEALE

Introduction:

Most people receive their health insurance, as well as much of their life and disability insurance, through their work. These policies are often bought by an employer and offered to all full-time employees under a group-wide, "employee benefit plan". When provided as part-of an employee benefit plan, these insurance policies are governed by ERISA; a federal statute enacted by Congress to protect employees and employee rights.

Under ERISA, any entity involved in the administration or maintenance of an employee benefit plan (i.e., "plan administrator"/ "claims administrator"), including employers and insurance companies, is deemed to be an ERISA fiduciary and, as such, is required to act in the best interests of covered employees (i.e., "plan participants"). This duty applies to all aspects of ERISA plan administration, and is especially applicable to an administrator's decision to grant or deny an employee's claim for benefits. In order to ensure that the decision maker is acting "solely in the interest of the participants", ERISA allows plan participants who have been denied to have that adverse decision reviewed by a court of law.

When reviewing an insurance company's decision to deny benefits under an ERISA employee benefit plan, a court will apply one of two standards of review depending on the underlying circumstances. The default standard of review is known as de novo review and under it a court will review all of the evidence that was available to the original decision-maker and make its own determination on benefit eligibility. In contrast to de novo review, a court might also review an adverse determination under a more deferential "arbitrary and capricious" standard of review, which will apply any time the underlying benefit plan documents (i.e., the insurance policy) grants discretion to the decision-maker. See Firestone Tire. v. Bruch, 489 U.S. 101 (1989).

Under an "arbitrary and capricious" standard of review, a court does not weigh the evidence and make its' own decision but instead looks only to see whether

the decision-maker acted arbitrarily when making its' decision; this standard often results in the decision-maker being given the benefit of the doubt and the decision will usually be upheld by the court so long as there was at least one objective basis to support it. Under this standard of review, some courts have gone as far as saying that insurance companies can deny benefits and the decision will be upheld, even if the decision is wrong, so long as it is reasonable.

Of course, following the Firestone decision, insurance companies and other ERISA fiduciaries took measures to ensure that all plan documents contained discretion-granting language and by doing so guaranteed that "arbitrary and capricious" standard of review would apply. The routine inclusion of discretion granting language and the nearly-constant applicability of arbitrary and capricious review have left ERISA plan participants at a significant disadvantage when bringing their claims to court.

State Responses to Discretion-Granting Language:

In order to counter this significant disadvantage, several state legislatures have now enacted laws or regulations prohibiting the inclusion of "grants of discretion" in insurance policies, including those falling under an ERISA employee benefit plan. For example, the Texas Legislature, under Section 1701.062 of the Texas Statutes and Codes, expressly prohibits the use of discretionary clauses in life and health insurance policies. See TX Ins. Section 1701.062. Specifically, Section 1701.062 states that "[a]n insurer may not use a document…in this state if the document contains a discretionary clause", which the statute defines as any provision that "purports or acts to bind the claimant to, or grants deference in subsequent proceedings to adverse eligibility or claims decisions or policy interpretations by the insurer...." Id. Texas is one of many states trying to level the playing field between the insurer and the insured by preventing the application of a more deferential standard of review.

According to a 2016 survey by the National Association of Insurance Commissioners, at least twenty-five (25) states have now either enacted or proposed laws and regulations that prohibit and restrict the inclusion of discretion-granting language in insurance policies.[1] Several of these anti-discretion laws will be explored in greater depth in subsequent newsletters. Before delving into which states, like Texas, have sought to protect ERISA claimants, first, we will discuss how these state laws are allowed despite ERISA's general preemption of state laws governing employee benefit plans.

ERISA Preemption:

The ERISA Preemption Clause is codified at 29 U.S.C. Section 1144 and states generally that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described under 29 U.S.C. Section 1003(a)…." 29 U.S.C. Section 1144(a) (emphasis added). This language has been construed broadly by federal courts, and the phrase "relates to" has been interpreted by the Supreme Court to include any and all state laws that either have a "connection with" or make "reference to" an employee benefit plan. See Shaw v. Delta, 463 U.S. 85 at 97 (1983); see also Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) ("[…], we noted the expansive sweep of the preemption clause…[in Shaw] we emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans'"). At first glance, the broad applicability of ERISA preemption would suggest that anti-discretion laws are clearly preempted and of no help to an ERISA plaintiff.

Although state-laws relating to employee benefit plans are generally preempted, Congress expressly "saved" from preemption any state laws "which regulate insurance, banking or securities." See 29 U.S.C. Section 1144(b)(2)(A). Unfortunately, Congress did not further define what qualified as a state law "regulating insurance, banking, or securities" in the statute, itself, and the courts have had to fill in the gaps, themselves.

In response to congressional silence on what laws "regulate insurance", the Supreme Court held that a determination of whether a state law "regulates insurance", and is therefore saved from preemption, will be made based on whether the state law satisfies two requirements: first, "the state law must be specifically directed towards entities engaged in insurance"; and second, the state law "must substantially affect the risk pooling arrangement between the insurer and the insured." See Kentucky Ass'n of Health Plans, Inc., 538 U.S. 329 at 342 (2003); see also Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).

In regards to anti-discretion laws, federal jurisprudence firmly establishes that state laws directly controlling the terms of insurance contracts by invalidating or prohibiting the inclusion of certain provisions qualify as laws "regulating insurance" under the ERISA savings clause. See FMC Corp. v. Holliday, 498 U.S. 52 (1990) (concerning a state law prohibiting inclusion of any subrogation provisions in insurance contracts). Such laws are saved from preemption because they specifically control what terms entities engaged in insurance are allowed to include in insurance contracts, and because limiting the availability of discretion in deciding claims affect the risk pooling arrangement between that entity and the insured.

Even if a state law is determined to regulate insurance for purposes of the savings clause, it may nevertheless be preempted to the extent that the law would apply to an ERISA administrator that is not an insurance company. See FMC Corp. v. Holliday, 498 U.S. 52 (1990). Under what courts colloquially refer to as the "deemer clause", Congress made clear that an employee benefit plan nor trust established under such a plan, shall be deemed to be an insurance company or…[be considered] to be engaged in the business of insurance or banking for purposes of any State purporting to regulate insurance companies…" By its own words the "deemer" clause would seem to prohibit application of state law to any administrator of an employee benefit plan or related trust, including an insurance company, however, the Supreme Court clarified that when an insurance company insures an ERISA plan, it remains an "insurer" for purposes of state laws "purporting to regulate insurance" and is "therefore not relieved from state insurance regulation." Id. at 61; see also Metropolitan v. Massachussetts, 471 U.S. 724 (1985).

Conclusion:

Based on the above, ERISA preemption analysis can be boiled down to three simple steps. First, one should look to whether a state law is "related to" an employee benefit plan. If so, then the next step is to determine whether the state law is specifically directed towards entities engaged in insurance and whether the law affects the risk pooling arrangement between the insurer and insured. Assuming that the law meets both criterion, one should determine whether application of the state law would nonetheless be precluded under ERISA's deemer clause because it is the employee benefit plan is self-funded.

Now that we have a basic understanding of ERISA preemption analysis, we will look at specific anti-discretion laws and regulations in upcoming articles, and examine the extent to which they have been applied to ERISA group insurance policies.

NEED A SPEAKER?

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