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Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits. Eric Buchanan and R. Scott Wilson are certified as Social Security Disability Specialists by the National Board of Social Security Disability Advocacy. For more information, visit our website at www.buchanandisability.com.

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ERISA STANDARD OF REVIEW: STATES ARE BANNING DISCRETIONARY CLAUSES IN INSURANCE POLICIES - BY ERIC L. BUCHANAN

When an employee obtains insurance through work, such as health insurance, life insurance, or long-term disability insurance, such benefits are typically subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). The employee is referred to as the "participant" in an ERISA plan, and sometimes the "beneficiary" of an ERISA plan. If someone is denied ERISA benefits, properly appeals to the insurance company, and submits to the insurance company sufficient information to prove his or her case, the participant or beneficiary can then take the case to court.

However, when a plan participant or beneficiary takes an ERISA case to court under 29 U.S.C. § 1132(a)(1)(B), that case is not treated as a fair fight between two private litigants, as it arguably should be. Instead, in a Supreme Court decision from 1989, *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 110, 115, the Court reasoned that the employer and ERISA administrator could agree on a more deferential standard of review.

In *Firestone Tire*, the Court reasoned that the default standard of review for ERISA benefits cases

should be *de novo*; but, because plan administrators are the equivalent of "trustees" or otherwise can act in a fiduciary capacity, the *de novo* standard does not apply if the "plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.*, at 115.

In reality, this has become the exception that has swallowed the rule. Very quickly after *Firestone Tire* was decided, ERISA administrators and insurance companies amended policies and other ERISA plan documents to include language granting discretion to the administrator; now almost every plan claims that its decisions should be reviewed under the arbitrary and capricious standard of review.

Some states are now banning discretionary clauses in insurance policies, including ERISA policies.

Some states now ban such discretionary clauses, and some courts have held that those bans are laws regulating insurance that are not preempted by ERISA under the savings clause. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). However, just

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because a state has banned discretionary clauses, that is not the end of the discussion. For example, to survive ERISA preemption, such a clause must apply only to insurance policies, otherwise it does not fit in the savings clause. This also means that such clauses cannot apply if LTD benefits are provided under self-funded ERISA plans where benefits are not provided through insurance policies.

Further, sometimes the rule banning discretionary clauses may only apply to new policies issued after the date of the rule. Also, such clauses may only apply to policies issued in a given state, and often policies issued in one state may cover a client in a different state, especially where an employer is large enough to have employees in more than one state. On the other hand, some states have issued the ban to apply to residents of that state, no matter where the policy was issued.

Examples of cases that discuss such bans include *Am. Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), where a group representing various insurance companies filed a declaratory action seeking to have the Michigan ban on discretionary clauses to be found invalid. Michigan's regulation "prohibit[s] insurers and nonprofit health-care corporations from issuing, advertising, or delivering to any person in Michigan, a policy, contract, rider, endorsement, certificate, or similar contract document that contains a discretionary clause and provide that any such clause is void and of no effect." *Id.*, at 602. The Court of Appeals for the Sixth Circuit found that the Michigan ban was a law regulating insurance, such that it survived ERISA preemption under the savings clause. *Id.*, at 604-607. The rule also did not create an additional state law "remedy," such that it would still be preempted despite the savings clause. *Id.*, at 607-609. Therefore, the ban was valid, and would apply to ERISA cases.

The Illinois Department of Insurance issued a similar regulation banning discretionary clauses. The Illinois Regulation provides:

No policy, contract, certificate, endorsement, rider, application or agreement offered or issued in this State, by a health carrier, to provide, deliver, arrange for, pay for or reim-

burse any of the costs of health care services or of disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are consistent with the laws of this State.

Novak v. Life Ins. Co. of N. Am., 956 F. Supp. 2d 900, 905 (N.D. Ill. 2013), citing 50 Ill. Adm. Code tit. § 2001.3. The court went on to explain that the regulation set out its purpose, which was to:

prohibit all such policies from containing language reserving sole discretion to interpret policy provisions with the insurer. The legal effect of discretionary clauses is to change the standard for judicial review of benefit determinations from one of reasonableness to arbitrary and capricious. By prohibiting such clauses, the amendments aid the consumer by ensuring that benefit determinations are made under the reasonableness standard.

Id., at 905-906. Despite such a ban, the Defendants in *Novak* argued that the court should still apply a deferential standard of review, because the wrap-around master ERISA plan document granted discretion, not the insurance policy. *Id.*, at 906. The court rejected that argument by finding that insurance companies could not avoid the Illinois regulation by entering into a separate agreement outside the insurance policy. *Id.* The court also decided that the Illinois regulation was a law regulating insurance, and was not preempted by ERISA. *Id.*, 906-909.

In *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), an insurance company challenged the Montana Commissioner of Insurance's practice of disapproving policies containing discretion under a broader Montana law that "requires its commissioner of insurance to "disapprove any [insurance] form . . . if the form . . . contains . . . any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract . . ." *Id.*, at 840. Even though the Montana law did not specifically

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prohibit discretionary clauses, the Court of Appeals for the Ninth Circuit found that the practice by the Montana Commissioner of Insurance was a law regulating insurance, and was not preempted by ERISA. *Id.*, at 842-845.

California has also issued a ban on discretionary clauses, and that ban applies to policies issued in California and in other states that cover California residents. Cal Ins Code § 10110.6(a). The California rule applies to both new policies and when policies are renewed, and policies are deemed to renew each year on the policies anniversary date. Cal Ins Code § 10110.6(b). Because every policy is deemed to renew on its anniversary, when each policy renews any provision purporting to grant discretion became “void and unenforceable.” See, e.g. *Polnicky v. Liberty Life Assur. Co.*, 999 F. Supp. 2d 1144, 1148 (N.D. Cal. 2013). Because the discretionary ban in California was effective January 1, 2012, all policies should have renewed so that no California resident should be covered under a policy with a discretionary clause.

Courts have not found all bans on discretionary clauses to be effective.

Not all discretionary bans have been upheld. For example, in *Hancock v. Metro. Life Ins. Co.*, 590 F. 3d 1141 (10th Cir. 2009), the court found that Utah’s ban on discretionary clauses was preempted by ERISA. Weirdly, the Utah statute banning discretionary clauses exempted from the ban policies subject to ERISA, and only required ERISA policies to “disclose certain matters and conform with the rule’s font requirement. See Rule 590-218-5(3), (4).” *Hancock*, 590 F. 3d at 1149. The court reasoned that the Utah rule “relates to the form, not the substance, of ERISA plans; it has no impact on risk pooling and fails to satisfy” the second prong of the test of laws regulating insurance. *Id.* The Court of Appeals clarified that, “If Rule 590-218 imposed a blanket prohibition on the use of discretion-granting clauses, we would have a different case.” *Id.*

One of the few circuit court decisions to squarely reject the applicability of a state ban on discretionary clauses was issued by the Court of Appeals for the Third Circuit, upholding analysis by a district court in New Jersey that found the New Jersey ban to be ineffective. See, *Baker v. Hartford Life Ins. Co.*, 2010 U.S. Dist. LEXIS 52724 (D.N.J. May 28,

2010) (unpublished) *as affirmed by Baker v. Hartford Life Ins. Co.*, 440 Fed. Appx. 66 (3d Cir. N.J. 2011) (unpublished). This case is different from most other circuit court decisions, and leaves unanswered more questions than are resolved.

New Jersey’s regulation on discretionary clauses was passed in 2007 and made effective January 1, 2008. It states:

Discretionary clauses prohibited:

No individual or group health insurance policy or contract, individual or group life insurance policy or contract, individual or group long-term care insurance policy or contract, or annuity contract, delivered or issued for delivery in this State may contain a provision purporting to reserve sole discretion to the carrier to interpret the terms of the policy or contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State. A carrier may include a provision stating that the carrier has the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

N.J.A.C. 11:4-58.3. The Plaintiff in *Baker* argued that this language, by prohibiting “sole discretion” to a carrier, means that the *de novo* standard of review should be used. The district court in *Baker* first acknowledged that under Supreme Court precedent, *de novo* review is the default rule in ERISA cases. *Citing, Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115, (1989) (“a denial of benefits under ERISA is to be reviewed ‘under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.’”) *Baker*, 2010 U.S. Dist. LEXIS 52724, at 24.

Despite acknowledging that the *de novo* standard of review would be the default rule, the first reason the district court in *Baker* gave for rejecting Plaintiff’s argument was,

First, nothing in the text of § 11:4-58.3 states that it mandates application of a *de novo* standard of review. Rather,

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according to the Third Circuit, the text simply declares that certain "discretionary clauses are void as contrary to public policy" *Evans v. Employee Benefit Plan, Camp Dresser & McKee, Inc.*, 311 Fed.Appx. 556, 560 (3d Cir. 2009). Plaintiff's argument appears to be that the statute implicitly authorizes a de novo standard of review, but she has pointed to nothing in the text nor any case law to support such an interpretation.

Baker, at 29. This reasoning by the district court in *Baker* is difficult to understand. It is true that the New Jersey regulation does not explicitly state that the de novo rule would apply, but it does state that the clause granting discretion is prohibited. If such a clause is ineffective, then the court should have applied the default rule from *Bruch*, that without a proper grant of discretion the court should review claims de novo. Since that is the default rule, there should be no requirement that the state regulation specifically set that the review be de novo, yet that is part of the rationale from the district court.

The district court in *Baker's* second reason for refusing to apply the New Jersey regulation is similarly confusing. The court in *Baker* explained,

Second, because ERISA explicitly [*30] grants claimants the right to judicial review, delegations under ERISA do not actually reserve sole discretion to the carrier in the manner Plaintiff suggests. While the Plan here grants Hartford sole discretionary authority, its statement of "YOUR RIGHTS UNDER ERISA" acknowledges that the exercise of Hartford's discretion may be challenged in a court of law. AR at HLI00025 ("If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court."). The inclusion of this language in the Plan is significant because N.J.A.C. § 11:4-58.3 permits carriers to "include a provision stating that the carrier has the discretion to make an initial

interpretation . . . but that such interpretation can be reversed by... a court of law... ." Thus, by incorporating the ERISA's rights language, the Plan comports with the statute.

Baker, at 29-30. It is true that the Plan allowed for judicial review of its decision, which is required by both the New Jersey regulation and under ERISA § 502(a) (1)(B); but, this rationale does not explain why, if the New Jersey regulation bans the grant of discretion, and allows judicial review (as does ERISA), that also means that the review by a court should still give deference to the insurance company, rather than applying the default rule from *Bruch*. The question is what standard of review the court should apply, and if the discretionary clause is invalid, why the court should still defer to the insurance company? The fact that judicial review still takes place should only result in the court then applying the default rule.

The third rationale provided by the court in *Baker* does make more sense. The court stated, "Third, it is questionable whether the statute applies at all, given that its effective date (January 1, 2008) was after Plaintiff filed her initial application for benefits on August 12, 2007." *Id.*, at 30. However, under this reasoning, presumably the New Jersey regulation should apply in future cases, where the plaintiff files an application after January 1, 2008.

The last rationale by the court in *Baker* is also troublesome. The court explained:

Most importantly, if I were to adopt Plaintiff's interpretation and application of § 11:4-58.3, so as to void the Plan's grant of sole discretion to Hartford, the regulation would face an ERISA preemption attack. "[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 Inc. v. Davila*, 542 U.S. 200, 209, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004) (citation omitted). Plaintiff's construction of section 11:4-58.3 would in effect

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change the standard of review of every civil enforcement action under ERISA within the state of New Jersey whenever the plan in question grants discretionary authority to the plan administrator. This would directly violate the purpose of ERISA "to provide a uniform regulatory regime over employee benefit plans." *Id.* at 208. Moreover, the Supreme Court's recent decision in *Glenn*, addressing the same conflict-of-interest concern underlying the New Jersey regulation, expressly set forth the applicable standard of review under ERISA. As district courts are obliged to "dispose of cases on the narrowest possible ground, which in this case is the state-law ground," as opposed to federal pre-emption grounds, see *New Jersey Payphone Ass'n, Inc. v. Town of West New York*, 299 F.3d 235, 249 (3d Cir. 2002), I reject Plaintiff's interpretation of the New Jersey regulation and review the case under the traditional arbitrary and capricious standard.

Id., at 31-32. One big problem with this reasoning by the district court is that it completely ignores the ERISA savings clause. While it is true that ERISA preempts most state laws ("[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" ERISA § 514(a), 29 U.S.C. § 1144(a)), it is also true that ERISA contains a "savings clause" that provides that some state laws are not preempted: "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Because the New Jersey regulation affects only those policies that purport to grant discretion to insurance companies, this regulation appears to fit squarely into the savings clause, yet the court did not discuss that at all. Further, the court says that such an interpretation would frustrate the purposes of ERISA, yet fails to acknowledge that, a) the Supreme Court in *Bruch* has held that *de novo* review is the default rule in ERISA cases, which this regulation is consistent with; and, b) while the purpose of ERISA is "to provide a uniform regulatory regime over" ERISA plans, nothing

in ERISA mandates a standard of review, much less the deferential standard of review. Lastly, the court hangs its hat on the assumption that the arbitrary and capricious standard of review is the "traditional" standard, when, again, *Bruch* holds that the default standard is *de novo*, absent a proper grant of discretion.

Despite this questionable analysis by the district court, the Court of Appeals for the third circuit offered almost no analysis of the district court's holding on the applicability of the New Jersey regulation. In fact, the entire discussion by the Court of Appeals is as follows:

Baker argues that a New Jersey regulation, N.J. Admin. Code § 11:4-58.3, requires a different standard of review. There are a variety of reasons why this is not so. Most importantly (and as discussed by the District Court), an employee may challenge a claim determination in federal court. Thus, the Plan does not, as Baker suggests, reserve "sole discretion to the carrier." See N.J. Admin. Code § 11:4-58.3 (stating that a group health insurance policy may not contain a provision "purporting to reserve sole discretion to the carrier to interpret the terms of the policy or contract").

Baker v. Hartford Life Ins. Co., 440 Fed. Appx. 66, 68 n.1 (3d Cir. N.J. 2011). This just makes no sense. Judicial review is always allowed in ERISA cases, and no plan would comply with ERISA that attempted to preclude such review. See, e.g. ERISA § 502(a)(1)(B) and 29 C.F.R. 2560.503-1(l). Again, the question is what standard of review the court should apply, and since the default rule is *de novo* under *Bruch*, and courts should only apply deference where there is a valid grant of discretion, and the New Jersey statute bans attempts by insurance companies to retain such discretion, this reasoning by the Court of Appeals does not offer a very satisfactory rationale.

The best explanation for the decision by the district court and Court of Appeals for the Third circuit is two-fold. First, it appears that the courts here have a mind-set that ERISA calls for a discretionary standard of review, and struggle with understanding the history

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of ERISA law that establishes when a discretionary standard of review is *not* the default rule, and should be applied only where there is a valid grant of discretion. Further, the New Jersey regulation is not written very well to accomplish its purpose of banning discretionary clauses in a way that is easy for courts to understand.

The bottom line is that if your client lives in a state with such a ban, or had the policy issued in such a state, you should research whether the ban can be used to argue that your client's claim is decided under a *de novo* standard of review. In most states, federal courts have upheld the ban, but some courts have not.



Eric Buchanan & Associates was awarded the 2014 Better Business Torch Award in Category 2: 11 to 99 employees.

Eric Buchanan & Associates was also awarded the 2015 Services Select Seal of Satisfaction Award in the attorney category for Chattanooga for the fourth year in a row.



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Eric Buchanan will be speaking at the upcoming NOSSCR Social Security Disability Conference on ERISA Long-Term Disability Claims: What Social Security Representatives Need to Know. The conference is scheduled for May 6-9, 2015 in Arlington, VA.

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