Supreme Court, U.S.
FILED
FEB 19 2010
OFFICE OF THE CLERK

No. 09-885

In The Supreme Court of the United States

STANDARD INSURANCE COMPANY,

Petitioner,

v.

MONICA LINDEEN,
State Auditor, ex officio Commissioner of Insurance,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF AMERICAN COUNCIL OF LIFE INSURERS AS *AMICUS CURIAE* IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

CARL B. WILKERSON
LISA TATE
AMERICAN COUNCIL OF LIFE INSURERS
101 Constitution Ave., NW
Washington, DC 20001
(202) 624-2153

MARK E. SCHMIDTKE*
*Counsel of Record
OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C.
225 Aberdeen, Suite F
Valparaiso, IN 46385
mark.schmidtke@ogletreedeakins.com
(219) 242-8649

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

Blank Page

QUESTIONS PRESENTED

Amicus will address the following questions:

1. Whether a state rule banning discretionary clauses, with the sole purpose and sole effect of dictating universal *de novo* review by the federal courts of ERISA benefits decisions, is preempted by ERISA.

2. Whether this Court's opinion in *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2002), authorizes the states to eliminate the option of a deferential federal court standard of review that Congress made available to the creators of ERISA plans.

TABLE OF CONTENTS

	Page
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	5
ARGUMENT	9
A. THIS COURT HAS APPLIED TRADITIONAL CONFLICT PREEMPTION ANALYSIS IN MULTIPLE CONTEXTS WHERE STATE LAWS CONFLICT WITH THE PURPOSES OF ERISA	9
B. MONTANA'S BLANKET PROHIBITION OF DISCRETIONARY CLAUSES FALLS INTO A CATEGORY OF STATE INSURANCE LAWS THAT THIS COURT HAS HELD PREEMPTED BECAUSE THEY CONFLICT WITH ERISA'S CIVIL ENFORCEMENT PROVISIONS	16
C. THE BREADTH OF THE MONTANA LAW AND ITS DIRECT IMPACT ON FIDUCIARY DECISIONS REMOVES IT FROM ANY PROTECTION FROM PREEMPTION PURPORTEDLY PROVIDED BY *RUSH PRUDENTIAL*	21
CONCLUSION	26

TABLE OF AUTHORITIES

Page

CASES

Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004) .... *passim*

American Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009) 4

Boggs v. Boggs, 520 U.S. 833 (1997) 6, 9, 13

Cook v. Liberty Life Assur. Co. of Boston, 320 F.3d 11 (1st Cir. 2003) 19

Egelhoff v. Egelhoff, 532 U.S. 141 (2001) 9, 13

Graham v. Hartford Life & Acc. Ins. Co., 589 F.3d 1345 (10th Cir. 2009) 3

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) 11, 12

John Hancock Mut. Life Ins. Co. v. Harris Trust & Savings Bank, 510 U.S. 86 (1993) 10, 12

Kergosien v. Ocean Energy, Inc., 390 F.3d 346 (5th Cir. 2004) 19

Luby v. Teamsters Health, Welfare, and Pension Trust Funds, 944 F.2d 1176 (3rd Cir. 1991) 20

Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988) 9

Marks v. Newcourt Credit Group, Inc., 342 F.3d 444 (6th Cir. 2003) 19

McCulloch v. Maryland, 17 U.S. 316, 4 Wheat. 316 (1819) 9

TABLE OF AUTHORITIES – Continued

Page

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 16, 18

Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) 6, 11, 17

Moon v. American Home Assur. Co., 888 F.2d 86 (11th Cir. 1989) 20

Patton v. MFS/Sun Life Financial Distributors, Inc., 480 F.3d 478 (7th Cir. 2007) 20

Pegram v. Herdrich, 530 U.S. 211 (2000) 7, 14, 15, 21

Perlman v. Swiss Bank Comprehensive Dis. Protection Plan, 195 F.3d 975 (7th Cir. 1999) 19

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 5, 6, 10, 11, 17

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2004) .... *passim*

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) 9

Unum Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999) 17

Varity Corporation v. Howe, 516 U.S. 489 (1995) 23

CONSTITUTIONAL PROVISIONS

U.S. Const., Art. VI, cl. 2 9

TABLE OF AUTHORITIES – Continued

Page

STATUTES

29 U.S.C. §1002(1) .... *passim*

29 U.S.C. §1132 12

29 U.S.C. §1132(a) 11, 18

29 U.S.C. §1132(a)(1)(B) 3

29 U.S.C. §1133(2) 23

29 U.S.C. §1144 .... 9, 10

29 U.S.C. §1144(b) 10

29 C.F.R. §2560.503-1(h)(3)(ii) 18

OTHER AUTHORITIES

BNA Pension and Benefits Daily, "States Beef Up Bans on 'Discretionary Clauses' as Courts Rule Out ERISA Hurdle" (February 12, 2010) 2, 3, 4

National Compensation Survey: Employee Benefits in the United States, March 2009, available at http://www.bls.gov/ncs/ebs/benefits/2009/ebbl0044.pdf 2

Blank Page

INTEREST OF THE *AMICUS CURIAE*[1]

The American Council of Life Insurers ("ACLI"), a non-profit trade association, is the largest trade association in the United States representing the life insurance industry. ACLI represents more than 300 legal reserve life insurer and fraternal benefit society member companies operating in the United States before federal and state policy-makers, insurance departments, and the courts. ACLI members represent more than 90% of the assets and premiums of the life insurance and annuity industry. In addition to life insurance and annuities, ACLI member companies offer pensions, 401(k) and other retirement plans, long term care and disability income insurance, and reinsurance. ACLI shares the concerns of petitioner Standard Insurance Company as set forth in detail below.

Life and disability benefits are among the types of benefits governed by ERISA. *See* 29 U.S.C. §1002(1). According to the U.S. Bureau of Labor Statistics, as of March 2009, 73% of private industry full-time workers had access to life insurance plans

---

[1] Pursuant to Supreme Court Rules 37.2 and 37.3, the parties have received timely notice of the intent to file and have consented to the filing of this Brief *amicus curiae*. Their letters of consent have been filed with the Clerk of this Court. Pursuant to Supreme Court Rule 37.6, *Amicus* states that this brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *Amicus*, made a monetary contribution for the preparation or submission of this brief.

through their employers and 96% of those workers participated in their employer-sponsored plans. National Compensation Survey: Employee Benefits in the United States, March 2009, available at http://www.bls.gov/ncs/ebs/benefits/2009/ebbl0044.pdf (Table 16). Life insurance plan benefits are invariably insured because the sheer economies of scale allow life insurers to provide larger benefits at lower costs than could be funded by employers outside of the insurance market. During the same period, 41% of full-time workers had access to long term disability plans and 96% of those workers participated in their employer-sponsored long term disability plans. *Id.* Except for the very largest employers, virtually all long term disability programs are also insured. Again, most employers do not have the financial wherewithal to fund monthly disability benefits over a long period of time without insurance. The high percentage of employees who participate in their employer-sponsored life and disability plans is strong evidence of the substantial value that such benefits offer to American workers.

Because virtually all life plans and the vast majority of long term disability plans are insured, the Montana ban on discretionary clauses potentially impacts two entire classes of ERISA-governed plans in that state. Moreover, as discussed in the Petition, Montana is not the only state considering such a prohibition. *See also* BNA Pension and Benefits Daily, "States Beef Up Bans on 'Discretionary Clauses' as Courts Rule Out ERISA Hurdle" (February 12, 2010).

State regulators are also looking at even broader intrusion into the ERISA judicial review process as shown by Colorado's recent enactment of a law that requires ERISA-governed insurance policies to provide for a jury trial which is contrary to universal circuit law that jury trials are not available under ERISA.[2] The concern of the insurance industry is that state regulators are interpreting language in *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355 (2004) to give them broad authority to control the ERISA remedial process and to interfere with the carefully crafted federal remedial scheme and corresponding federal common law that has developed over the past 35 years.

An article in BNA's Pension and Benefits Daily, published on February 12, 2010, illustrates the sharp debate over the validity and effect of state efforts to ban discretionary clauses.[3] The article notes debate over the cost impact on insured plans, with the only question being how much costs will rise. Sources cited in the BNA article also point out that while discretionary clauses provide consistency in the application of plan terms, a ban on such clauses "would have

---

[2] Every federal circuit that has addressed the issue, including the Tenth Circuit, has held that jury trials are not available for ERISA suits for benefits under 29 U.S.C. §1132(a)(1)(B). *See, e.g., Graham v. Hartford Life & Acc. Ins. Co.*, 589 F.3d 1345, 1355 (10th Cir. 2009).

[3] *See* http://news.bna.com/pdln/display/batch_print_display.adp (visited February 12, 2010).

significant unintended consequences" and will "cause disruption for patients and employers" as ERISA plan terms are subject to varied applications across the country. Still another source argued that the states' bans will have a disproportionate impact on smaller employers who do not have the ability to self-fund their benefit programs and thereby avoid state insurance regulation.

Regardless of disagreement on the precise long term effects of discretionary clause bans, the BNA article illustrates that there is unanimity in the view that the issue is critically important to state regulators, the insurance industry, employers, and employees. State discretionary clause bans have expanded rapidly:

> The state efforts to ban discretionary clauses was slow at first, as only a handful of states took steps to ban the clauses in the earlier part of the decade. There was a surge of activity in 2008 and 2009, as several states stepped forward to ban discretionary clauses.

BNA's sources expect that, as a result of the decision below and the Sixth Circuit's decision in *American Council of Life Insurers v. Ross,* 558 F.3d 600 (6th Cir. 2009), "there is a likelihood that more states will come on board in enacting laws that ban discretionary clauses."

Most importantly, the BNA article emphasizes that the Petition in this case is being watched very closely, with one source saying that a denial will be

viewed as an open door to further state regulation: "if the Supreme Court denies review, the issue of ERISA preemption of discretionary clause bans may be settled." *Amicus* supports Standard Insurance Company's request that this Court accept review of this matter to clarify that state efforts to ban discretionary clauses are in conflict with ERISA and to resolve the tension that exists between the states' misreading of *Rush Prudential* and this Court's more recent statements on the importance of deferential review in the formation of ERISA plans and in the administration of ERISA's exclusively federal civil enforcement scheme.

SUMMARY OF ARGUMENT

The primary purpose of Congress in enacting ERISA was to regulate employee benefit plans under a uniform body of federal law. Congress accomplished this purpose in two principal ways. First, it included a broad preemption clause which was "designed to 'establish pension plan regulation as exclusively a federal concern.'" *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 46 (1987). Second, Congress created a "comprehensive civil enforcement scheme" that is "one of the essential tools for accomplishing the stated purposes of ERISA." *Id.* at 52. This Court has held on several occasions that ERISA's civil enforcement scheme is the exclusive means to remedy disputes arising from the processing of ERISA benefit

claims. *Pilot Life,* 481 U.S. at 54; *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987).

This Court has acknowledged the importance of federal preemption principles in the ERISA context by accepting review of multiple ERISA preemption cases since the statute was enacted in 1974. The Court explained the significance of these cases as follows:

> In large part the number of ERISA preemption cases reflects the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force.

Boggs v. Boggs, 520 U.S. 833, 839 (1997). The preemption issue in this case is no less significant: the state law directly impacts not only how all benefit decisions by insured ERISA plans (i.e., life, health, and disability) will be litigated under ERISA's civil enforcement provisions, but also, because life and long term disability plans are almost always insured, the state law has a potentially inordinate impact on such plans.

Amicus agrees with and supports the arguments in the Petition. In this brief, *Amicus* expands upon Petitioner's argument that Montana's prohibition of discretionary clauses is in conflict with ERISA's civil enforcement scheme. In terms of conflict preemption generally, there are three categories of state insurance laws that have been considered by this Court in the context of ERISA: (1) laws that regulate the

substantive coverage provisions of insurance policies; (2) laws that regulate insurance claim processes; and (3) laws that regulate the judicial review process. Laws in the first two categories are not preempted and laws that fall into the third category are preempted. The Montana prohibition of discretionary clauses falls into the third category and is preempted because its very purpose is to directly impact the judicial review process.

Amicus will also address why the reliance of state regulators on *Rush Prudential* is misplaced and why clarification of *Rush Prudential* is essential to bring to a halt the wave of state insurance regulation prohibiting discretionary clauses as well as other forms of state regulation that directly impact the ERISA judicial review process. The major point of disagreement between the majority and the dissent in *Rush Prudential* was whether the state third party review law in that case conflicted with the exclusivity of ERISA's civil enforcement scheme where the state law had the effect of eliminating discretionary court review over certain HMO benefit decisions. The key point cited by the majority to uphold the state law was that the state law was limited to determinations of "medical necessity" which under *Pegram v. Herdrich,* 530 U.S. 211 (2000), were deemed to be non-fiduciary in nature and outside of ERISA's regulatory scope. The majority appeared to agree that a broad mandate for third party review that went beyond non-fiduciary HMO medical necessity

determinations would be in conflict with ERISA's remedial scheme.

This point of distinction cited by the Court in *Rush Prudential* illustrates why the Montana law in this case *is* preempted. Unlike the narrow state law in *Rush Prudential,* the Montana law sweeps much more broadly, encompassing every type of benefit decision made by a claim administrator under an insured ERISA plan, decisions that this Court has held are fiduciary in nature under ERISA. *Aetna Health, Inc. v. Davila,* 542 U.S. 200, 219 (2004) ("a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan"). It also illustrates why, in addition to the reasons stated in the Petition, state insurance regulators grossly misread *Rush Prudential* and why that case does not authorize Montana's blanket prohibition of discretion.

In the end, this case is less about insurance company discretion than it is about the inherent authority that plan sponsors have under ERISA to determine to whom and under what circumstances fiduciary discretionary authority should be delegated. Plan sponsor authority and discretion are at the very heart of the ERISA plan structure and it is the plan sponsor's authority and discretion that are potentially impacted by the Montana law for all insured plans and especially for two entire classes of benefits – life and long term disability.

ARGUMENT

A. THIS COURT HAS APPLIED TRADITIONAL CONFLICT PREEMPTION ANALYSIS IN MULTIPLE CONTEXTS WHERE STATE LAWS CONFLICT WITH THE PURPOSES OF ERISA.

This Court has applied two types of preemption under ERISA: (1) statutory or "express" preemption; and (2) traditional "conflict" preemption. Under ERISA's "express" preemption provision, ERISA preempts all state laws that "relate to" employee benefit plans except state laws that regulate insurance, banking, or securities. 29 U.S.C. §1144. Under this "express preemption" provision, state laws are preempted even if they do not conflict with ERISA. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829-30 (1988); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983).

The second form of preemption, "conflict" preemption, occurs when state laws conflict with the provisions of ERISA or operate to frustrate ERISA's purposes. *Boggs v. Boggs*, 520 U.S. 833, 841 (1997); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001). "Conflict" preemption is a creature of the Supremacy Clause, which states that the laws of the United States "shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., Art. VI, cl. 2. *See also McCulloch v. Maryland,* 17 U.S. 316, 4 Wheat. 316, 427 (1819) ("It is of the very essence of supremacy, to remove all obstacles to its action within its own

sphere, and so to modify every power vested in subordinate governments"). Thus, "conflict" preemption applies even to state laws that do not fall within the parameters of ERISA's express preemption provision, §1144. *See John Hancock Mut. Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 99 (1993) ("State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs").

In *Pilot Life*, this Court applied both "express" preemption and "conflict" preemption to hold that state law claims, bad faith claims, were preempted by ERISA. A beneficiary of an employee disability plan sued the plan insurer for benefits, basing his claim on several state law theories, including bad faith. The plaintiff argued that ERISA did not preempt Mississippi's law of bad faith because that law was a state law that regulated insurance and was thus saved from preemption under ERISA's "express" preemption clause, §1144(b). The Court rejected the plaintiff's argument and held that the law was not saved from preemption under ERISA's "express" preemption provision.

The Court also held that, even if the bad faith claim was a state insurance law that was saved from express preemption, it was still preempted under traditional "conflict" preemption principles. Allowing ERISA beneficiaries to bring varying state causes of action for claims that were within the scope of

ERISA's civil enforcement provision "would pose an obstacle to the purposes and objectives of Congress." *Id.* at 52. ERISA's civil enforcement provision includes a panoply of remedies for ERISA plan participants, beneficiaries, and their fiduciaries. 29 U.S.C. §1132(a). The civil enforcement scheme of ERISA "is one of the essential tools for accomplishing the stated purposes of ERISA." *Id.* at 52. Examining the language and structure of ERISA's civil enforcement provision, and reviewing the legislative history of that provision, this Court concluded "that ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 54. The Court held that Congress intended "the civil enforcement provisions of ERISA §[1132(a)] [to] be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits." *Id.* at 52.

Several other decisions reinforce the concept that "conflict" preemption under ERISA goes beyond "express" preemption. In *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), this Court held that preemption by virtue of ERISA's exclusive remedy provisions was so strong as to override the removal jurisdiction concept of the "well pleaded complaint rule." In other words, a state law complaint arising out of a dispute over the processing of ERISA plan benefits is so completely preempted that the state law claims are converted into federal claims under ERISA. *Id.* at 64-67. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court held that the exclusivity of ERISA's civil enforcement provision,

§1132, supplemented "express" preemption under ERISA and provided an independent basis for preemption of a state law wrongful discharge claim:

> Even if there were no express preemption in this case, the Texas cause of action would be preempted because it conflicts directly with an ERISA cause of action.

Id. at 142.

This Court has also applied conflict preemption analysis to state laws that conflicted with the purposes and provisions of ERISA other than ERISA's civil enforcement section. In *John Hancock, supra,* the question revolved around the extent to which ERISA's fiduciary standards governed an insurer's administration of guaranteed investment contracts purchased by ERISA plans. Among other things, the insurer argued that ERISA's fiduciary standards should not apply because they would create "irreconcilable conflicts" with state regulatory regimes, noting that Congress reserved to the states the primary responsibility for regulation of the insurance industry. This Court held that, if such a conflict existed, then ERISA's fiduciary requirements would prevail and state insurance law would be preempted as being in conflict with federal law fiduciary requirements. 510 U.S. at 99 (When state insurance regulation "stands as an obstacle to the accomplishment of the full purpose and objectives of Congress, federal preemption occurs.").

Similarly, in *Boggs v. Boggs, supra,* this Court applied traditional conflict preemption analysis to hold that state community property laws were preempted by ERISA where state law created an obstacle to the full purposes and objectives of ERISA's joint and survivor annuity provisions. 520 U.S. at 844. *Boggs* involved a dispute between a surviving spouse of a pension plan participant and the sons of the decedent's former spouse, who were the heirs to the former spouse's estate. The sons relied on Louisiana community property law to argue that their mother was entitled to a share of the pension benefits. This Court held that the state law conflicted with ERISA's pension plan requirements that favored surviving spouses over former spouses and was therefore preempted. *Id.*

Also, in *Egelhoff v. Egelhoff, supra,* although phrased in terms of ERISA's express preemption clause, this Court addressed whether a state law that automatically divested a divorced spouse of beneficiary status under an ERISA plan was preempted. The Court held that the state law impacted the payment of ERISA benefits, which the Court referred to as "a central matter of plan administration" and that the state law was preempted because it conflicted with ERISA's requirement that a fiduciary must administer a plan according to its terms. 532 U.S. at 147-48.

Finally, in *Aetna Health, Inc. v. Davila,* 542 U.S. 200 (2004), the Court returned to conflict preemption in the context of ERISA's civil enforcement scheme,

holding that a state law that imposed a duty of care on HMO coverage decisions and that purported to provide a state law cause of action for violation of that duty, was preempted under ordinary principles of conflict preemption because it provided "a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 542 U.S. at 217-18. The Court also rejected the plaintiffs' argument that because the state law principally regulated "medical decisions" under ERISA-governed HMO plans, the state law should not be preempted because such decisions do not implicate ERISA's fiduciary standards. The plaintiffs relied on the Court's earlier decision in *Pegram v. Herdrich,* 530 U.S. 211 (2000), where the Court held that medical necessity decisions made by HMO treating doctors were not subject to ERISA's fiduciary requirements because they were "mixed eligibility and treatment decisions" and non-fiduciary in nature. The *Aetna Health* Court distinguished *Pegram* noting that the state law in *Aetna Health* applied not just to HMO treating physician decisions but more broadly to claim administrator benefit determinations. The *Aetna Health* Court held that "a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan" and that "[t]he fact that a benefits determination is infused with medical judgments does not alter this result":

> This strongly suggests that the ultimate decisionmaker in a plan regarding an award

> of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim . . . Classifying any entity with discretionary authority over benefits determinations as anything but a plan fiduciary would thus conflict with ERISA's statutory and regulatory scheme.

542 U.S. at 219-20. Unlike the non-fiduciary medical decisions at issue in *Pegram,* which fell outside of ERISA regulation, the broader spectrum of claim administrator benefits determinations that were subject to the state law in *Aetna Health* was squarely within the regulatory sphere of ERISA, and specifically its fiduciary requirements, and the state law was in conflict with ERISA.

In summary, this Court has readily applied conflict preemption analysis where state laws conflicted with ERISA's civil enforcement provisions as well as where state laws conflicted with other core principles and provisions of ERISA. The Montana prohibition of discretionary clauses conflicts with ERISA's civil enforcement regime and, as discussed below, with ERISA's regulation of fiduciaries. Where state laws such as the Montana law interfere with or pose an obstacle to ERISA's purposes and provisions, they are preempted under traditional conflict preemption principles, regardless of whether or not they fall under ERISA's express preemption clause.

B. MONTANA'S BLANKET PROHIBITION OF DISCRETIONARY CLAUSES FALLS INTO A CATEGORY OF STATE INSURANCE LAWS THAT THIS COURT HAS HELD PREEMPTED BECAUSE THEY CONFLICT WITH ERISA'S CIVIL ENFORCEMENT PROVISIONS.

The above cases demonstrate that the state insurance laws reviewed by this Court can be categorized as follows: (a) state laws that regulate the substantive coverage terms of insurance policies, (b) state laws that regulate the insurance claims process, and (c) state laws that attempt to regulate the judicial review process. This Court has upheld state insurance laws that fall into the first two categories and has uniformly held that state laws that fall into the third category are preempted because they conflict with ERISA.

This Court has upheld state laws that regulate the substance of insurance coverage. For example, in *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), the Court held that a state law setting forth mandatory minimum health care benefits was "saved" from express preemption because it was a state law that regulated insurance. Although the Court did not address conflict preemption directly, it did note that the "substantive terms of group-health insurance contracts . . . have been extensively regulated by the States" and that ERISA "contains almost no federal regulation of the terms of benefit plans." *Id.* at 729, 732.

This Court has also upheld state insurance laws that were aimed at the insurance claims review process. For example, in *Unum Life Ins. Co. of America v. Ward,* 526 U.S. 358 (1999), the Court upheld application of a state notice-prejudice rule that required an insurer to show prejudice before it could deny a late claim as untimely. Similarly, in *Rush Prudential, supra,* the Court upheld a state third party review law that required independent review of claim decisions involving medical necessity. Neither *Ward* nor *Rush Prudential* involved state laws that were directly aimed at regulating the judicial review process under ERISA, although the laws had an indirect impact on that process. *Unum v. Ward,* 526 U.S. at 376-77 (plaintiff was pursuing a claim for benefits under §1132(a) and the state law merely provided a rule of decision as to whether the underlying claim was timely); *Rush Prudential v. Moran, supra* (upholding state third party review law).

Unlike state insurance laws regulating substantive provisions of a policy or insurance claim procedures, when reviewing a state law that was aimed directly at the judicial review process, this Court has uniformly held that such laws are preempted as being in conflict with the exclusivity of ERISA's civil enforcement provisions. *See, e.g., Pilot Life, supra; Metropolitan Life v. Taylor, supra*; *Aetna v. Davila, supra.*

The Montana ban on discretionary clauses falls in the third category of state insurance laws because

it is aimed directly at the judicial review process. The ban is not an attempt to regulate the substantive coverage terms of ERISA-governed insurance policies as was the case in *Metropolitan Life v. Massachusetts, supra.* The discretionary clause ban also does not regulate the claim review process. The Department of Labor, the federal entity with specific authority to regulate the ERISA claim review process, requires that all claim determinations and internal appellate reviews of claim denials be conducted *de novo.* 29 C.F.R. §2560.503-1(h)(3)(ii) (a "full and fair review" of a denied claim must "[p]rovide for a review that does not afford deference to the initial adverse benefit determination."). The only place where the state law ban on discretionary clauses has any impact is on the judicial review process under §1132(a) – the process that is exclusively regulated by the ERISA statute and by federal common law. Because the state law ban is aimed directly at the ERISA remedial process, it is in conflict with the exclusivity of that process which is governed solely by federal law.

Not only does the Montana practice impact the remedial process, but it also cannot help but increase the costs of that process. There is a stark contrast between the cost of litigating deferential and *de novo* review cases. In a typical deferential review case, the evidence is limited to the plan documents and the file

materials developed during the administrative review process.[4] Extensive discovery is prohibited:

> It follows from the conclusion that review of [the insurer's] decision is deferential that the district court erred in permitting discovery into [the insurer's] decision-making. There should not have been any inquiry into the thought processes of [the insurer's] staff, the training of those who considered Perlman's claim, and in general who said what to whom within [the insurer] . . . Deferential review of an administrative decision means review on the administrative record.

Perlman v. Swiss Bank Comprehensive Dis. Protection Plan, 195 F.3d 975, 981-82 (7th Cir. 1999). Ultimately, deferential review cases are typically decided on dispositive motions.

In a *de novo* proceeding, on the other hand, courts have discretion to admit evidence outside of the claim review materials, potentially leading to

---

[4] *See, e.g., Cook v. Liberty Life Assur. Co. of Boston,* 320 F.3d 11, 19 (1st Cir. 2003) ("[W]e look to the record as a whole; the 'whole' record consists of that evidence that was before the administrator when he made the decision being reviewed."); *Kergosien v. Ocean Energy, Inc.,* 390 F.3d 346 (5th Cir. 2004) ("Federal courts are generally prevented from going outside the administrative record in reviewing ERISA plan fiduciary decisions."); *Marks v. Newcourt Credit Group, Inc.,* 342 F.3d 444, 457 (6th Cir. 2003) ("The scope of the district court's and this court's review of the denial of benefits is limited to the administrative record available to the plan administrators when the final decision was made.").

significant discovery.[5] Summary judgments are rare and many *de novo* cases are decided after a full trial. In smaller *de novo* cases, discovery costs alone can far exceed the amount of benefits in dispute. Given the attempts to ban discretionary clauses in insurance policies in Montana and other states, life and long term disability plans, which are almost always insured, now face the bleak prospect of incurring substantial additional litigation costs, which costs will have to be passed on to sponsoring employers. In an environment of voluntary benefit programs, the "tipping point" at which employers can no longer afford benefits in the first place, cannot be very high. It is ironic that these efforts to increase the cost of benefits arise at a time when there is an ongoing national debate over the already rapidly increasing cost of employee benefits.

---

[5] *See, e.g., Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1184-85 (3rd Cir. 1991) ("We hold that a district court exercising *de novo* review over an ERISA determination between beneficiary claimants is not limited to the evidence before the Fund's Administrator."); *Patton v. MFS/Sun Life Financial Distributors, Inc.,* 480 F.3d 478, 485 (7th Cir. 2007) ("Absent clear language to the contrary, plans are read to provide for searching judicial review of benefits determinations: plenary review of the administrator's interpretation of the facts and plan [. . .] fortified by the district court's discretionary authority to hear evidence that was not presented in the administrative process."); *Moon v. American Home Assur. Co.*, 888 F.2d 86, 89 (11th Cir. 1989) ("[The] contention that a court conducting a de novo review must examine only such facts as were available to the plan administrator at the time of the benefits denial is contrary to the concept of a de novo review.").

C. THE BREADTH OF THE MONTANA LAW AND ITS DIRECT IMPACT ON FIDUCIARY DECISIONS REMOVES IT FROM ANY PROTECTION FROM PREEMPTION PURPORTEDLY PROVIDED BY *RUSH PRUDENTIAL*.

Insurance regulators read *Rush Prudential* to provide them with broad authority to extinguish discretionary authority in insurance policies and, ultimately, to eliminate deferential review in federal court under ERISA's civil enforcement provisions. This is a misreading of that case because the Montana law, unlike the state law in *Rush Prudential*, applies to fiduciary decisions that are regulated by ERISA.

The state law in *Rush Prudential* was narrowly drawn to require third party review only of a small subset of ERISA benefit determinations, i.e., those determinations involving whether requested health care was "medically necessary." As discussed above, the Court had previously held in *Pegram* that, at least in the HMO context, medical necessity determinations were not considered fiduciary decisions under ERISA and are not subject to ERISA's fiduciary regulations. *See Pegram,* 530 U.S. at 237 (HMO doctor cannot be sued for breach of fiduciary duty under ERISA as a result of a decision about whether care is "medically necessary" because such decisions "are not fiduciary decisions under ERISA"). The Court picked up this theme again in *Rush Prudential*, another case involving regulation of HMOs, and it

became a key point in the holding that the state third party review law did not conflict with ERISA's civil enforcement scheme. The Court emphasized the narrow focus of the state law: "The Act does not give the independent reviewer free-ranging power to construe contract terms, but instead, confines review to a single term: the phrase 'medical necessity,' used to define the services covered under the contract." 536 U.S. at 383. Quoting *Pegram,* the Court also noted that medical necessity determinations are outside the boundaries of ERISA's fiduciary regime and are instead "a subject of traditional state regulation, [where] there is no ERISA preemption without clear manifestation of congressional purpose." 536 U.S. at 387. In other words, because the limited state regulation in *Rush Prudential* was focused solely on non-fiduciary determinations, it fell outside of ERISA and was not in conflict with ERISA even if it had the practical effect of removing deferential review over those determinations.

This fiduciary/non-fiduciary distinction is important in this case because it illustrates why Montana's blanket ban on discretionary clauses in insurance policies *does* conflict with ERISA. The Montana prohibition applies across the board to *every* ERISA benefit determination, whether it is based on medical considerations, a mix of medical and other considerations, vocational considerations (in the context of disability policies), or pure contractual interpretation issues, saying that *none* of these determinations can *ever* be discretionary. This is a far cry from the

limited area of state regulation at issue in *Rush Prudential* that applied only to one limited type of benefit determination that this Court has twice held to be non-fiduciary in nature and therefore outside of ERISA.

Montana cannot deny that ERISA benefit determinations are fiduciary in nature (with the possible exception of medical necessity determinations in the HMO context). ERISA mandates that final claim determinations be made by an "appropriate named fiduciary." 29 U.S.C. §1133(2) ("every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim"). This Court held in *Aetna Health* that "the ultimate decisionmaker in a plan regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim." Likewise, in *Varity Corporation v. Howe,* 516 U.S. 489, 511 (1995), this Court held that a claim administrator "engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents." While it may arguably be appropriate for a state to indirectly remove discretion in insurance policies from one narrow type of benefit determination because the determination is not regulated by ERISA, it is quite another thing for a state to remove discretion from *all* types of benefit determinations in all insurance policies and in at

least two entire classes of ERISA benefits. Nothing in *Rush Prudential* or any other decision by this Court justifies such a broad swath of state regulation that goes to the heart not only of ERISA's civil enforcement scheme, but also to the nature of what it means to be a fiduciary under ERISA.

It is not an overstatement to say that insurance regulators are using *Rush Prudential* as an excuse to foist all types of so-called "insurance regulation" on ERISA-governed policies, all in the guise of regulating "insurance policy language." Justice Thomas, in his dissent in *Rush Prudential,* criticized such an approach:

> The Court of Appeals' approach assumes that a State may impose an alternative enforcement mechanism through mandated contract terms even though it could not otherwise impose such an enforcement mechanism on a health plan governed by ERISA. No party cites any authority for that novel proposition, and I am aware of none . . . To hold otherwise would be to eviscerate ERISA's comprehensive and exclusive remedial scheme because a claim to benefits under an employee benefits plan could be determined under each State's particular remedial devices so long as they were made contract terms. Such formalist tricks cannot be sufficient to bypass ERISA's exclusive remedies; we should not interpret ERISA in such a way as to destroy it.

536 U.S. at 397. Certainly a state cannot mandate that an ERISA-governed insurance policy contain a liquidated damages provision that would supplant or supplement ERISA's remedial provisions nor can a state mandate a policy provision that the parties will engage in mandatory arbitration in lieu of federal court action.[6] These examples demonstrate that such "formalistic tricks" of mandating "insurance policy language" do not provide an unlimited basis to circumvent ERISA where, as here, the regulation applies broadly to all types of fiduciary determinations. To that extent, *Amicus* respectfully requests that the Court clarify the narrow holding in *Rush Prudential* and hold that it does not grant state insurance regulators unlimited authority to regulate the ERISA fiduciary and judicial review processes in the guise of mandating "insurance policy language."

[6] *Rush Prudential* stated that "[w]e do not mean to imply that States are free to create other forms of binding arbitration to provide de novo review of any terms of insurance contracts. . . ." 536 U.S. at 386, n. 17.

CONCLUSION

For the reasons stated herein, the petition for writ of certiorari should be granted.

Respectfully submitted,

CARL B. WILKERSON
LISA TATE

AMERICAN COUNCIL OF LIFE INSURERS
101 Constitution Ave., NW
Washington, DC 20001
(202) 624-2153

MARK E. SCHMIDTKE*

Counsel of Record
OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C.
225 Aberdeen, Suite F
Valparaiso, IN 46385
(219) 242-8649

February 19, 2010