Confronting Bans on Discretionary Clauses in ERISA Plans

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A critical issue in any ERISA governed employee benefits dispute involves the judicial standard of review to apply in reviewing the administrator’s decision: de novo or abuse of discretion. While ERISA is silent on the judicial standard of review, courts have held that where the ERISA plan gives the administrator discretion to interpret the terms of the benefit plan, a court must give deference to the administrator’s decision and apply the abuse of discretion standard. Recently, however, legislatures and regulatory agencies in more than 22 states have taken steps to ban or restrict discretionary authority in ERISA plans. This paper addresses these recent attacks on discretion and proposes strategies for addressing bans on discretionary authority.

I. Background: ERISA and Standard of Review

An ERISA governed employee benefit plan provides for a variety of benefits. For example, the disability benefit typically replaces an employee’s income due to illness or injury so long as the employee is deemed to meet the definition of “disability” under the ERISA plan. The plan administrator requests doctors’ reports, opinions, and other medical evidence to determine whether the employee’s restrictions and limitations meet the definition of “disability.” Once the administrator makes a decision, the employee can “appeal” internally for another review. After the internal review process is exhausted, the employee may sue the administrator, the plan itself, and/or the insurer in federal court under ERISA.

In court, one of the key issues is how much deference will be given to the administrator’s decision. This depends on the language in the ERISA plan, and whether a particular state bans discretionary language. The standard of review may impact how a case is litigated, including the type of discovery that may be permitted potentially, and whether the case might be disposed of on summary judgment. Where the standard of review is arbitrary and capricious, the carrier should prevail if it offers sufficient evidence supporting its position.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), the United States Supreme Court established some ground rules for judicial review of ERISA governed decisions. The Court stated: “[A] denial of benefits challenged under §1132(a) (1) (B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Id. Where the ERISA plan grants the administrator such discretion, a court should give deference to the administrator’s decision and apply the abuse of discretion standard of review. The Court in *Firestone* based its application of deferential review on the principles of trust law, which, it said, are summoned by ERISA’s legislative history and the Court’s prior decisions interpreting the statute.

In *Metropolitan Life v. Glenn*, 128 S.Ct. 2343, 2350 (2008) the Supreme Court reconfirmed its earlier decision holding that the existence of a conflict of interest does not operate to change the review standard from deferential (abuse of discretion) to de novo. Id.

II. Does the ERISA Plan Confer Discretion?

Not every ERISA plan confers discretion on the plan administrator. Whether the ERISA plan confers discretion depends upon the language of the Plan, and how that language is interpreted by the circuit courts. Typically, absent a ban on discretion, courts uphold discretionary language similar to that described by the Court in *Firestone*. As discussed below, some courts have held that “satisfactory proof” language may or may not confer discretion.
First Circuit: – Brigham v. Sun Life of Canada, 317 F.3d 72, 82 (1st Cir. 2003) (“evidence satisfactory to us as we may reasonably require under the circumstances” adequate to confer discretion).


Third Circuit – Viera v. Life Ins. Co. Of North America, 642 F.3d 407, 411 (3d Cir. 2011) (no single phrase such as ‘satisfactory to us’ conveys enough detail to permit an insured to distinguish between plans that do and plans that do not confer discretion.).


Fifth Circuit – Cathey v. Dow Chem. Co. Med. Care Program, 907 F.2d 554, 559 (5th Cir. 1990) (the language “[the company] . . . shall be the “Named Fiduciary” of the Plan with regard to any review and final decision on a claim for benefits under such policy” did not confer discretionary authority to the plan administrator.”).


Seventh Circuit – Perugini-Christen v. Homestead Mortg. Co., 287 F.3d 624, 626 (7th Cir. 2002) (“satisfactory proof of Total Disability to [us]” did not confer discretionary authority to the plan administrator).

Eighth Circuit – Ferrari v. Teachers Ins. and Annuity Assoc., 278 F.3d 801, 806 (8th Cir. 2002) (written satisfactory proof language sufficient to confer discretion).


Tenth Circuit – Nance v. Sun Life Assurance Co., 294 F.3d 1263, 1267-68 (10th Cir. 2002) (“[p]roof must be satisfactory to [the company]” conferred discretionary authority on a plan administrator.


III. An Abuse of Discretion Standard of Review Is Supported by Public Policy and Judicial Precedent

The abuse of discretion standard of review promotes efficiency, uniformity and predictability. As the Supreme Court has noted, those interests “do not suddenly disappear simply because a plan administrator has made a single honest mistake….If as we held in Glenn, a systematic conflict of interest does not strip a plan of deference…it is difficult to see why a single honest mistake would require a different result.” Conkright v. Frommert, 130 S.Ct. 1640, 1647 (2010).

A. The Policy and Intent Behind ERISA Support an Abuse of Discretion Standard

One of Congress’ primary goals in enacting ERISA was to encourage employers to offer such voluntary plans. Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 120 (2008) (“Ensuring that reviewing courts respect the discretionary authority conferred on ERISA fiduciaries encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans—something they are not required to do.”) (Roberts, C.J., concurring). The United States Supreme Court has repeatedly recognized that one of the
key congressional goals in enacting ERISA was “to ensure that plans and plan sponsors would be subject to a uniform body of benefits law,” so as “to minimize the administrative and financial burden of complying with conflicting directives.” Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990); see also Kennedy v. Plan Admin for DuPont Sav. & Inv. Plan, 129 S. Ct. 865, 875-76 (2009) (ERISA “lets employers establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits”); Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379 (2002) (ERISA “induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.”)

As discussed herein, state bans on discretionary language differ widely and are not uniform in their application. The overall effect of these patchwork state bans confounds the intent of ERISA and may lead to significantly different results. Allowing the courts to ignore a plan administrator’s reasonable interpretation of a plan directly frustrates the goals of uniformity. See, e.g., Varity Corp. v. Howe, 516 U.S. 489, 497 (1996) (highlighting that Congress sought to create a regulatory regime “that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place”). Requiring deference to an administrator’s reasonable interpretation of a plan, in contrast, “encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans - something they are not required to do.” Glenn, 128 S. Ct. at 2353 (Roberts, C.J., concurring in part and concurring in the judgment).

As was noted by the Supreme Court in Conkright, at 1649, a plan administrator’s reasonable interpretation is not entitled to deference; a plan’s substantive provisions will be subject to different reasonable interpretations, making uniform administration virtually impossible. For example, a plan beneficiary working in a company’s Seattle office may be entitled to benefits different from those of a colleague working in the Chicago office simply because different courts may interpret the same plan provisions in different, albeit reasonable, ways. Conflicting directives from different courts, acting as primary ERISA plan decision makers, will complicate and raise the expense of plan administration and, in turn, discourage employers from establishing and maintaining ERISA plans. Conkright 130 S. Ct. at 1649. (“Indeed, a group of prominent actuaries tells us that it is impossible even to determine whether an ERISA plan is solvent (a duty imposed on actuaries by federal law, see 29 U.S.C. §§1023(a)(4), (d)) if the plan is interpreted to mean different things in different places. See Brief for Chief Actuaries as Amici Curiae 5–11.”); see, e.g., Evans v. Eaton Corp. Long Term Disability Plan, 514 F.3d 315, 326 (4th Cir. 2008) (a “cavalier approach to the deference owed ERISA fiduciaries” would disserve plan beneficiaries and result in “lower benefits levels and lower levels of plan formation”) (internal quotation omitted). Increased litigation costs, of course, can be expected to lead employers either to cut benefits or to terminate employee benefit plans altogether. A typical ERISA governed employer plan is maintained on a voluntary basis.

Insurance regulators justify banning discretionary language by claiming abuse by plan administrators. But there is no reason to suppose that judicial deference to plan administrators will lead to abuse at the claim or appeal level given existing ERISA regulations requiring “full and fair” review of claims. The regulations setting forth the procedural requirements for a “full and fair review” of an ERISA claim require a “review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim” and a notification that gives “[t]he specific reason or reasons for the adverse determination.” 29 C.F.R. §2560.503-1(h) & (j). Plan administrators, after all, act as fiduciaries when exercising their discretionary authority. See, e.g., Central States, 472 U.S. at 570 n.10; see also 29 U.S.C. §1104(a)(1)(A) (requiring plan administrator to “discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and … for the exclusive purpose of providing benefits to participants and their beneficiaries; and … defraying reasonable expenses of administering the plan”); id. §1104(a)(1)(B) (requiring plan administra-
tor to “discharge his duties with respect to a plan … with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims”). For this reason, the Supreme Court concluded in Glenn that a plan administrator’s discretionary decisions were entitled to deference even where the administrator may have a conflict of interest; a fiduciary must be presumed to act in the best interests of the beneficiaries. See 128 S. Ct. at 2350.

In short, from a policy perspective, plan administrators, not the courts, have the necessary expertise in interpreting and applying plan terms. See, e.g., Evans, 514 F.3d at 323 (noting “the plan administrator’s greater experience and familiarity with plan terms and provisions”); Berry, 761 F.2d at 1006 (noting the greater institutional competence plan administrators possess relative to federal courts within their area of expertise). Bans on discretionary language will result in courts disregarding the expertise of plan administrators and transferring administration of the plan “from [the] designated fiduciaries to the federal courts.” Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1022 (4th Cir. 1993); see also id. (“[S]uch a substitution of authority is plainly what the formulated standards of ERISA are intended to prevent.”) (internal citation omitted). Deference to the reasonable interpretation of a plan administrator, as opposed to any other reasonable interpretation, “ensure[s] that administrative responsibility rests with those whose experience is daily ‘and continual, not with judges whose exposure is episodic and occasional,’ Berry, 761 F.2d at 1006, and thus “safeguard[s] the superior vantage points of those entrusted with primary decisional responsibility,” Evans, 514 F.3d at 321.

B. Judicial Precedent Supports a Deferential Standard of Review

Our judiciary has had over 30 years to construe the meaning and impact of ERISA. The principles that emerge from these cases compel deference to a plan administrator’s reasonable interpretation or application of a plan. “Judicial intervention is not warranted merely because the court would have differently exercised [its] discretion.” Restatement (Third) of Trusts §87 (2007)


The common law of trusts requires courts to defer to a trustee’s reasonable determination rendered within the scope of his discretionary authority. Firestone, 489 U.S. at 111 (“Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. … A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee’s interpretation will not be disturbed if reasonable.”); see also Glenn, 128 S. Ct. at 2350 (there is “no reason to forsake Firestone’s reliance upon trust law” in analyzing the appropriate level of judicial deference to a plan administrator); See, e.g., Restatement (Third) of Trusts §87 (2007) (“When a trustee has discretion with respect to the exercise of a power, its exercise is subject to supervision by a court only to prevent abuse of discretion.”); Restatement (Third) of Trusts §50(1) (2003) (“A discretionary power conferred upon the trustee to determine the benefits of a trust beneficiary is subject to judicial control only to prevent misinterpretation or abuse of the discretion by the trustee.”); Denver Found. v. Wells Fargo Bank, N.A., 163 P.3d 1116, 1123 (Colo. 2007) (“An arbitrary and capricious benchmark restrains the exercise of our independent review and interpretation save for instances
of abuse of discretion, bad faith, dishonesty, or arbitrary action.”); see also id. (“The mere fact that if the discretion had been conferred upon the court, the court would have exercised the power differently is not a sufficient reason for interfering with the exercise of the power ....”) (quoting Restatement (Second) of Trusts §187 cmt. e (1959).

Where a court concludes that a trustee has abused his discretion, the court should order the trustee to make a new determination. In re Sullivan’s Will, 12 N.W.2d 148, 151 (Neb. 1943)(“[T]he court cannot act for the trustee or do anything other than prescribe the minimum or maximum limits within which the trustees must act and compel such action within such limits.”); In re Marre's Estate, 114 P.2d 586, 590-91 (Cal. 1941) (if the court concludes that trustee abused his discretion, court should order trustee to make a new determination). The court may allow the administrator to exercise that discretion by remanding the case to the administrator. Vizcaino v. Microsoft Corp., 120 F.3d 1006, 1013-14 (9th Cir. 1997); Miller v. United Welfare Fund, 72 F.3d 1066, 1073-74 (2d Cir. 1995). Again, administrative law offers a helpful analogy; the general rule is that courts remand to an agency after vacating a discretionary agency decision. See, e.g., Negusie v. Holder, 129 S. Ct. 1159, 1167 (2009).

IV. The “Overblown” Fear of an Abuse of Discretion Standard

The Plaintiffs’ bar, some commentators and some state insurance regulatory agencies contend that the discretionary standard of review results in unreasonable denials of benefits, and is unfair to claimants. In 2010 the Supreme Court in Conkright rejected the notion that the abuse of discretion standard “would encourage plan administrators to adopt unreasonable interpretations of plans[.]” Conkright 130 S. Ct. at 1651 (“All this is overblown. There is no reason to think that deference would be required in the extreme circumstances that respondents foresee. Under trust law, a trustee may be stripped of deference when he does not exercise his discretion ‘honestly and fairly.’ 3 Scott and Ascher 1348. Multiple erroneous interpretations of the same plan provision, even if issued in good faith, might well support a finding that a plan administrator is too incompetent to exercise his discretion fairly, cutting short the rounds of costly litigation that respondents fear. Applying a deferential standard of review does not mean that the plan administrator will prevail on the merits. It means only that the plan administrator's interpretation of the plan “will not be disturbed if reasonable.”). (Emph. Added).

V. State Insurance Commissioners’ Efforts to Ban Discretionary Clauses

Some commentators believe that the United States Supreme Court decision in Rush Prudential HMO v. Moran, 536 U.S. 355, (2002) “catalyzed an organized response to discretionary clauses by state insurance regulators.” See H. Quillen, “State Prohibition of Discretionary Clauses in ERISA-covered Benefit Plans”, 32 J. Pension Plan & Compliance 67, 71 (2006). In Rush, the Court found that the Illinois HMO Act, requiring independent physician review, did not contravene ERISA’s dictates and deference to the plan administrator. The Court found that the statute survived under ERISA’s savings clause. This holding may have weakened discretionary clauses by spreading the view that state insurance regulation “is not preempted merely because it conflicts with substantive plan terms.” 536 U.S. at 385, n.16.

The National Association of Insurance Commissioners (NAIC), the organization of elected and appointed state government officials who adopt model proposed laws and regulate the insurance industry, became further involved in the issue.

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In March of 2001, the NAIC ERISA Working Group discussed the creation of a model law to assure that all insurer and HMO claims would be subject to de novo review and directed the NAIC legal staff to research the authority of the states to prohibit discretionary clauses in light of ERISA. In June 2001, the working group voted to develop a model law proposal. See generally, discussion: National Association of Insurance Commissioners & the Center for Insurance Policy and Research, available at http://www.naic.org/index_about.htm. For a review of the NAIC proceedings that developed the model law, see “Exorcising Discretion: The Death of Caprice in ERISA Claims,” 56 South Dakota Law Review 482, 486-7 (2011).

VI. State Bans on Discretionary Language

Prohibitions of discretionary clauses in the states began slowly after the NAIC model was adopted, but these bans have gained momentum in the last few years. The bans are enacted through a variety of procedural methods including: enactment of a statute; promulgation of an administrative rule; issuance of a bulletin, memorandum or letter; adoption of an insurance form checklist, or by refusing to approve policy forms containing discretionary clauses.


VII. Potential Arguments for Opposing Bans on Discretionary Clauses

A. As a Matter of Public Policy, the Ban Should Be Rejected

B. The Plan Is Self-insured or Self-Funded and Therefore the Regulation Imposed by the Insurance Commissioner Does Not Apply

Discretionary clause prohibitions do not apply to self-funded ERISA plans, which are not regulated by the states.

C. The Ban Does Not Apply Retroactively


For purposes of retroactivity, it will be important to address when the claim “accrues.” When an ERISA plan does not give a participant vested contract rights, the participant’s rights are determined when his claim accrues, which is when benefits are denied. Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771, 774 (7th Cir. 2003) (unless the plan confers unalterable contract rights, the controlling plan “will be the plan that is in effect at the time a claim for benefits accrues…”). But see Wise v. Verizon Comm’ns Inc., 600 F.3d 1180, 1188 (9th Cir. 2010) (Plaintiff’s claim accrued when he received notice that he had exhausted his administrative remedies and could file suit.)

D. The Ban Does Not Apply Because of the Plan’s Choice of Law Provision


A challenge to a state ban based on choice of law will involve a close read of the language of the ban and of Plan language, including certificates of insurance. See, e.g., Curtis v. Hartford Life and Accident, 2012 WL 138608 (N.D. Ill. January 12, 2012); Carberry v. Metropolitan Life Ins. Co., 2011 WL 2887842 (D. Colo July 19, 2011) (Colorado ban on discretionary language, in plans issued in Colorado, did not apply because nothing in the administrative record established that the plan was “issued in” Colorado and, in any event, the ban cannot apply retroactively.)
E. The Ban Does Not Apply to Old, Amended Policies

*Stephan v. Unum Life Insurance Company of America*, __F.3d__, 2012 WL 3983767 (9th Cir. September 12, 2012) (The 2007 California ban does not void all discretionary clauses in policies issued or renewed. The policy form at issue was written and approved by the Insurance Commissioner in 1991. After Unum and California reached a settlement agreement, the policy was re-approved. Because the policy was a renewal, the Plan could contain discretionary language and be in compliance.)

F. The Ban Does Not Apply to Certain Types of Insurers

See, e.g., *DiFatta v. Baxter Int. Inc.*, 2013 WL 157952 (N.D. Ill. January 15, 2013) (Defense argued the ban applied only to “health carriers” but provided no evidentiary support that Liberty was not a “health carrier”. The court concluded the argument was “undeveloped” and did not entertain the argument.)

G. The Ban Cannot Apply to Discretion Conferred by the ERISA Plan Itself, Which Is Governed by the Department of Labor

Independent of the terms of insurance policies used to fund an ERISA plan, discretion may be conferred by specific plan documents that are not the “insurance policy”. *See McCutcheon v. Hartford Life and Acc. Ins. Co.*, 2009 WL 1971427 at *5 (C. D. Cal. 2009) (discretionary authority conferred by language in the Summary Plan Description).

H. The Ban Is Preempted by ERISA

Some commentators incorrectly believe that the preemption issue has been resolved. *See R. Pathak, “Discretionary Clause Bans & ERISA Preemption”,* 56 S. D. L. Rev. 500, 513 (2011) (Most discretionary clause bans “fall within the savings clause and do not conflict with ERISAs exclusive remedies provisions...so the majority of state regulations of discretionary clauses will survive preemption.”). Notwithstanding, carriers have the most recent Supreme Court precedent and other arguments to contend that the bans are preempted. Nearly all of the cases concluding that a ban on discretion is not preempted by ERISA fail to address or pre-date *Conkright*.

1. Conflict Preemption

Conflict preemption preempts state laws that “pose an obstacle to the purposes and objectives of Congress.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 217 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987)). To determine whether a state law falls within ERISAs preemptive sweep, the Supreme Court directs that courts “look both to the objectives of the ERISA statute as a guide” and “to the nature of the effect of the state law on ERISA plans.” *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001). “Pre-emption may be either express or implied, and ‘is compelled whether Congress' command is explicitly stated in the statute's language or Section 501(a) preemption is distinct from §514(a) preemption. Unlike §514(a) preemption, §501(a) preemption acknowledges that Congress's objectives are so overpowering that they override ERISAs savings clause in §514(b)(2)(A) and preempt even state laws that regulate insurance. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-209 (2004).

For the reasons stated above, deferential judicial review comports with Congress's objectives in enacting the ERISA pension and welfare system. Decisions issued before *Conkright*, like *Ross, supra* and *Morrison, supra*, focused on the wrong issue. The issue is not whether the de novo standard comports with ERISA, but whether barring employers from the option of including discretionary language in ERISA plans thwarts congressional objectives. *After Ross and Morrison were decided, the Supreme Court in Conkright explained the*
importance of discretionary authority to achieving Congress's objectives. In light of Conkright, it is not “dif-
ficult to imagine” how a state law mandating de novo judicial review conflicts with ERISA. Conkright clarifies
that deference promotes Congress's goals “by permitting an employer to grant primary interpretive authority
over an ERISA plan to the plan administrator…” Conkright, 130 S. Ct. at 1649. The Supreme Court has deter-
mined that employers must have the option to create plans that provide for discretionary authority, and that
discretionary authority must be judicially enforced. “Uniformity is impossible, however, if plans are subject
to different legal obligations in different States.” Id. (quoting Egelhoff, 532 U.S. at 148). “Firestone deference
serves to avoid that result and to preserve the ‘careful balancing’ of interests that ERISA represents.” Id. (quoting Pilot Life Ins. Co., 481 U.S. at 54).

2. The Ban Is Preempted by 29 U.S.C. §1144(a) and Does Not Fall Within
ERISA’s Savings Clause

ERISA’s “deliberately expansive” express preemption provision in §514(a) provides that ERISA “shall
supersede any and all State laws insofar as they … relate to any employee benefit plan” 29 U.S.C. §1144(a);
Pilot Life Ins. Co., 481 U.S. at 45. Not all state laws that relate to an employee benefit plan are preempted by
§514(a). ERISA’s savings clause in §514(b)(2)(A) exempts from ERISA’s preemptive sweep certain state laws
that regulate insurance. Assuming the ban “relates to” employee benefit plans and therefore falls within
§514(a), the next issue, then is whether the ban is saved from preemption under §514(b)(2)(A).

To fall within ERISA’s savings clause, the state law must be “specifically directed toward entities
engaged in insurance” and “substantially affect the risk pooling arrangement between the insurer and the
insured.” Kentucky Ass’n of Health Plans, Inc. v. Miller, 538 U.S. 329, 342 (2003). Discretionary authority is a
unique creation of ERISA, having its origins in trust law and congressional policy. The ban on discretionary
clauses targets ERISA plans; it has no impact on insurance practices outside of ERISA. The ban has the effect
of usurping power specifically granted by Congress.

The second Miller requirement, that the law also affect the risk pooling arrangement in a substan-
tial way, is meant to ensure that the saved state law is directed at insurance practices and not merely insurance
companies. The regulation banning discretionary review does not “substantially affect the risk pooling
arrangement” between the insurer and the insured. Miller, 538 U.S. at 342.

3. Recent Cases Addressing Preemption of State Bans on Discretion

There have been numerous decisions ruling on whether the state laws are preempted. Decisions
denying preemption typically rely upon jurisprudence before Conkright. Here is a short summary.

no effort to explain why [Am. Council of Life Insurers v. Ross, 558 F.3d 600, 604-07 (6th Cir. 2009); Standard
Ins. Co. v. Morrison, 584 3d 837 (9th Cir. 2009)] were incorrectly decided, and while they cite general ERISA
preemption principles articulated by the Supreme Court, they do absolutely nothing to explain why those
principles warrant preemption in this case.”).

(Michigan’s ban on discretionary review falls “within the ambit of ERISA’s savings clause” and is not preempted.).

6, 2012) (United argued regulation §2001.3 banning discretionary language “exceeded” the Insurance Direc-
tor’s authority and that the regulation was preempted by ERISA. The Court held, however, that the Director
had authority to issue the regulation and that the regulation was not preempted by ERISA.); Barrett v. Life Ins.

Baker v. Hartford Life Ins. Co., No. 08-cv-6382, 2010 WL 2179150, at *11 (D. N.J. May 28, 2010), aff’d, 440 Fed.Appx. 66 (3rd Cir. 2011) (New Jersey’s ban violates Congress’s objective to establish ERISA as a nationally uniform regime);


Standard Ins. Co. v. Morrison 584 F.3d 837 (9th Cir. 2009), cert. denied, sub nom. Standard Ins. Co. v. Lindeen, --U.S.--, 130 S.Ct. 3275, 176 L.Ed.2d 1182 (2010) (Montana Insurance Commissioner determined that a statute requiring disapproval of any policy form containing “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 … required him to disapprove any policy forms containing a discretionary clause.” Id. at 839. Standard sued, claiming that the practice was preempted by ERISA. The court determined there was no dispute that the practice “related to” an ERISA plan so it applied the two-part test set forth in Kentucky Assoc. of Health Plans Inc. v. Miller, 538 U.S. 329, 342 (2003), to evaluate whether the law fell under ERISA’s “savings clause.” It determined that the commissioner’s practice was both directed at insurance companies and substantially affected the risk pool because Montana insureds could no longer agree to a discretionary clause in exchange for a lower premium, thus narrowing the permissible bargains. Id. at 849. Based on that determination, the court held that the practice was saved from preemption).

American Council of Life Insurers v. Ross, 558 F.3d 600 (6th Cir. 2009) (Michigan promulgated an administrative rule prohibiting discretionary clauses. Several trade associations filed a declaratory judgment action contending the prohibition was preempted by ERISA because: 1) it interfered with ERISA’s objectives; and 2) it fell outside the savings clause. The district court granted summary judgment to the commissioner. On appeal, the Sixth Circuit court held that the rules were saved from preemption because they were directed at insurers, even though the effect of the rules may be felt by non-insurers such as third-party administrators or other fiduciaries, and that they affected the risk pooling arrangements because prohibiting the clauses altered the scope of permissible bargains. The court also rejected the argument that the rule conflicted with ERISA’s policy of issuing a uniform set of rules for adjudicating ERISA cases since ERISA itself does not require discretionary court review.).

Hancock v. Metropolitan Life Insurance Company, 590 F. 3d 1141 (10th Cir. 2009) (Utah’s Rule 590-218 of the Utah Administration Code limited discretionary clauses in life, health and disability policies. Plaintiff sued MetLife after being denied accidental death benefits. The plan conferred MetLife discretion but plaintiff contended Rule 590-218, required de novo review. The court determined that the regulation was preempted because it did not affect risk-pooling.).

VIII. The Future of Discretionary Clause Prohibitions: State Initiatives and the Affordable Health Care Act

A. State Initiatives

Over the past two years, three more states have considered discretionary bans. While the trend is for more regulation at the state level, at least one state has reexamined its state ban. In October 2011 the Michigan Office of Regulatory Reinvention submitted recommendations to the Governor in October 2011, advising that
R 500.2201-02, banning discretionary clauses, is invalid because the Insurance Commissioner lacked authority to promulgate the rule.

**B. Impact of the Patient Protection and Affordable Health Care Act (PPACA)**

In March 2010, President Obama signed into law the PPACA. The law creates two classes of health plans: those that are grandfathered and not subject to all of the statute's provisions, and those plans fully covered by the statute. PPACA requires impartial, *external* reviewers in benefit denial cases. PPACA of 2010, Pub. L. No. 111-148, 124 Stat. 119. Section 1001 of PPACA incorporates “consumer protections” found in the Uniform Health Carrier External Review Model Act and encourages states to adopt external review procedures consistent with the model act. These changes most likely contemplate independent reviewers with little or no deference. According to BNA, forty-four states currently have some kind of external review. Administration Issues Rules Strengthening Health Plan Coverage Appeals Process, 37 Pens. & Ben. Rep. (BNA) No. 29 at 1628 (July 27, 2010).

**IX. Conclusion**

State efforts to ban discretionary review frustrate Congressional intent in providing a uniform and predictable employee benefit. Although some cases have sustained bans, policy arguments, and preemption arguments based upon *Conkright* may assist in efforts to strike down the bans on discretionary language.