IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

SUSAN H. BALL,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**No. 09 C 3668**
	)	
STANDARD INSURANCE COMPANY and GROUP LONG TERM DISABILITY INSURANCE POLICY,	)	**Magistrate Judge Arlander Keys**
	)	
Defendants.	)	

DEFENDANTS' MEMORANDUM OF LAW REGARDING DISCRETIONARY AUTHORITY, ILLINOIS ADMINISTRATIVE CODE §2001.3, AND ERISA PREEMPTION

Warren von Schleicher
SMITH, VON SCHLEICHER & ASSOCIATES
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603
ARDC No. 6197189
P: 312-541-0300
F: 312-541-0933
warren.vonschleicher@svs-law.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

INTRODUCTION

Plaintiff, Susan Ball ("Ball"), seeks to recover disability benefits under an employee welfare benefit Plan pursuant to §502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B). Ball concedes that the Plan grants discretionary authority to the administrator, Standard Insurance Company ("Standard"). The Court's May 17, 2010 Memorandum Opinion and Order therefore held that the appropriate standard of judicial review is the arbitrary and capricious standard.

Ball now argues that the Plan's grant of discretionary authority is unenforceable based on §2001.3 of the Illinois Administrative Code, which purports to prohibit discretionary clauses in health or disability insurance policies issued or offered in Illinois. Section 2001.3 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 reimburse any of the costs of health care services or of a 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 inconsistent with the laws of this State.

50 Ill. Admin. Code §2001.3. Illinois' Director of the Department of Financial and Professional Regulation adopted §2001.3 specifically to preclude courts from applying the arbitrary and capricious standard of review in adjudicating health and disability benefit disputes. In the Notice of Adopted Amendments, Illinois' Director declared: "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."[1]

[1] The Director misconstrues the "arbitrary and capricious" standard as antithetical with a "reasonableness" standard. The arbitrary and capricious standard is synonymous with a reasonableness standard, because the administrator's decision still must be *reasonable*. *Houston v. Provident Life and Accident Ins. Co.*, 390 F.3d 990, 995-997 (7th Cir. 2004). The Director's misconception about deferential review exemplifies why Congress sought to ensure that ERISA remains a nationally uniform system rather than a patchwork of laws that vary from state to state.

29 Ill. Reg. 10173. Although §2001.3 conveys that the rule applies to all health and disability policies issued or offered in Illinois, §2001.3 in fact targets only ERISA plans, because the arbitrary and capricious standard only applies in ERISA cases. Illinois' Director endeavors to dictate the standard of judicial review to be applied by federal courts when deciding ERISA benefit claims, mandating *de novo* judicial review.

In the erudite specialty of ERISA, §2001.3 amounts to heresy. The deferential standard of review is a cornerstone of the ERISA system. Deference protects Congress's objectives in establishing a uniform federal regime governing employee welfare benefit plans. Deference preserves the balance in ERISA between ensuring enforcement of plan rights and encouraging employers, who are not required to establish benefit plans in the first instance, to offer voluntary benefit plans to their employees. Deference promotes efficiency by encouraging the resolution of benefits disputes through internal administrative proceedings. Deference fosters predictability and national uniformity in plan administration by giving interpretive discretion to the plan's administrator, avoiding a system of universal *de novo* review where the same plan provision might have different meanings in different jurisdictions.

ERISA §514(a) expressly preempts state laws that relate to employee welfare benefit plans. 29 U.S.C. §1144(a). ERISA §502(a) preempts state law that conflict with or undermine Congress's carefully calibrated remedial system. 29 U.S.C. §1132(a). ERISA §514(a) and §502(a) preempts the effort by Illinois insurance regulators to dictate the federal standard of judicial review governing claims under ERISA. By purporting to prohibit discretionary clauses in ERISA health and disability plans, §2001.3 thwarts Congress's carefully balanced comprehensive federal system of employee benefits. Section 2001.3, therefore, is preempted by ERISA pursuant to principles of express preemption, §514(a), and conflict preemption, §502(a).

ARGUMENT

I. ERISA's Express Preemption And Conflict Preemption Provisions Invalidate And Completely Preempt §2001.3.

Congress established ERISA "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). To achieve Congress's purpose of national uniformity, ERISA includes expansive preemption provisions which are designed to ensure that employee benefit plan regulation remains "exclusively a federal concern." *Id.* (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). Preemption occurs where a state law impermissibly interferes with ERISA's administrative scheme or statutory remedies, or frustrates Congress's objectives in enacting ERISA.

ERISA's "deliberately expansive" express preemption provision, §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. v. Dedeaux*, 481 U.S. 41, 46 (1987). Not all state laws that relate to an employee benefit plan are preempted by §514(a). ERISA's savings clause, §514(b)(2)(A), exempts from ERISA's preemptive sweep certain state laws that regulate insurance.

The preemptive force of §502(a) conflict preemption is even stronger. ERISA's comprehensive legislative scheme embodied in §502(a) is a distinctive feature of ERISA and is essential to accomplishing Congress's objectives of establishing a nationally uniform regulatory regime over employee benefit plans. Conflict preemption preempts state laws that "pose an obstacle to the purposes and objectives of Congress." *Davila*, 542 U.S. at 217 (quoting *Pilot Life*, 481 U.S. at 57). Congress's objectives are so overpowering that they override ERISA's savings clause and preempt even state laws that regulate insurance. *Id.* at 208-209. Any state law that duplicates, supplements, or supplants ERISA's nationally uniform remedial system

"conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Id.* at 209. See also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983) ("Pre-emption may be either express or implied, and 'is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose.'") (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)).

A. Conflict Preemption: §2001.3 Conflicts With ERISA's Overpowering Congressional Objectives.

Congress enacted ERISA to ensure that employees would receive the benefits promised by the terms of the plan, but Congress did not require employers to establish benefit plans. ERISA's remedial scheme embodied in §502(a), therefore, "represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Davila*, 542 U.S. at 208-209 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)). Congress sought to avoid a remedial system "that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). 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." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

The deferential standard of review maintains Congress's carefully balanced remedial scheme. Although the ERISA statute is silent on the issue of the standard of review, Congress authorized the judiciary to develop a body of federal common law to accomplish Congress's goals in enacting ERISA. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Metropolitan Life Ins. Co. v. Johnson*, 297 F.3d 558, 567 (7th Cir. 2002). The Supreme Court in

Firestone, exercising its congressionally granted authority to establish a federal common law of ERISA, held that when an ERISA plan grants discretionary authority to the administrator, the administrator's benefit decision cannot be set aside unless arbitrary or capricious. *Firestone*, 489 U.S. at 115.

Since *Firestone* was decided, the deferential standard of review has become a cornerstone of the ERISA pension and welfare system. Judicial deference encourages employers to establish voluntary benefit plans, and furthers Congress's goals of national uniformity and predictability by ensuring that plan terms are uniformly construed by the entity most familiar with the plan—the administrator—thereby avoiding a patchwork of judicial *de novo* interpretations of plan terms that vary from state to state. Because deferential review is not a "rubber stamp" and an administrator's plan interpretation still must be reasonable, deferential review protects employees' rights to plan benefits. Deferential review preserves ERISA's carefully balanced remedial scheme.

The Supreme Court recently affirmed the seminal importance of deferential review in *Conkright v. Frommert*, -- U.S. --, 130 S.Ct. 1640 (2010). The Supreme Court held that "permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the 'careful balancing' on which ERISA is based." *Id.* at 1649. The Supreme Court declared:

> Deference promotes efficiency by encouraging resolution of benefits disputes through internal administrative proceedings rather than costly litigation. It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from *de novo* judicial review.

Id. Moreover, the Supreme Court held that deference furthers Congress's intent to establish national uniformity of ERISA plan interpretation:

> [*Firestone*] deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions—a result that "would introduce considerable inefficiencies in benefit program operations, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."

Id. (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987)).

In theory, §2001.3 of the Illinois Administrative Code appears to prohibit the reservation of discretionary authority in *all* disability insurance policies or certificates issued or offered in Illinois. In application, however, §2001.3 targets only insurer-funded ERISA plans, because the deferential "arbitrary and capricious" standard of review applies only in ERISA litigation. The obvious aim of Illinois' rule is to mandate *de novo* judicial review of benefit determinations under the federal law of ERISA.

But as *Conkright* instructs, judicial deference preserves ERISA's carefully balanced remedial scheme. Deference encourages employers to establish voluntary benefit plans, and ensures national uniformity and predictability in the administration and interpretation of benefit plans. Moreover, many employers lack the financial resources to self-fund, and the professional staff of medical and vocational specialists necessary to administer claims. For many employers who want to provide disability coverage to their employees, insurance is the only practical option. Illinois cannot thwart congressional objectives by passing a rule that dissuades employers from offering voluntary benefit plans, or that promotes inconsistent plan interpretations that vary from state to state based on *de novo* judicial review. Nor is it desirable to create a federal system of ERISA in which the minority, consisting of large multi-national employer-funded ERISA plans, may obtain deferential judicial review, while the majority, consisting of insurer-funded ERISA plans, must submit to *de novo* review in certain states such

as Illinois and suffer the consequences of inconsistent interpretations and unpredictability that Congress intended to avoid.

Section 2001.3 poses an obstacle to the objectives of Congress. The congressional interests protected by deferential judicial review and implicit in ERISA's structure and purpose—encouraging plan formation, uniformity of plan interpretation, and predictability—are so overpowering that ERISA completely preempts §2001.3.

Two federal courts of appeal have held that state insurance rules or practices that ban discretionary clauses in insurer-funded ERISA plans are not preempted by §502(a) and fall within the savings clause of §514(b): *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009) (addressing Michigan's regulation banning discretionary clauses in disability insurance policies or certificates) and *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S.Ct. 3275 (2010) (addressing the Montana insurance commissioner's practice of refusing to approve disability insurance policies containing discretionary clauses). Both cases rejected the notion that deferential review serves any important congressional goals, contrary to the Supreme Court's subsequent holding in *Conkright*.

The *Ross* and *Morrison* courts reasoned that *de novo* judicial review is native to ERISA, because *de novo* review is the default standard of review under *Firestone*. Consequently, a state rule mandating *de novo* review of benefit denials would not conflict with ERISA's civil enforcement scheme or ERISA's policy favoring uniformity. *Ross*, 558 F.3d at 609; *Morrison*, 584 F.3d at 847-848 (*Firestone's* acceptance of the *de novo* standard of review as the default standard "indicates that highly deferential review is not a cornerstone of the ERISA system.").

Ross and *Morrison* should not guide this Court's determination of ERISA's preemptive affect on §2001.3, because both cases were decided before *Conkright*. The Supreme Court in

Conkright established the foundational importance of deferential review in protecting ERISA's carefully balanced remedial scheme.

Moreover, *Ross* and *Morrison* incorrectly characterized the state's prohibition of discretionary clauses as indistinguishable from the state law at issue in *Rush Prudential*. In *Rush Prudential*, the Supreme Court held that ERISA did not preempt a provision of the Illinois HMO Act that requires health insurers, in determining the meaning of "medical necessity" in the ERISA plan, to consult an independent physician and approve medical treatment based on the independent physician's determination of medical necessity. *Rush Prudential*, 536 U.S. at 386. An ancillary effect of the Illinois HMO Act was to deprive insurers of discretion to interpret the meaning of the single term "medical necessity."

Ross and *Morrison* erroneously distilled from *Rush Prudential* the far broader principle that state regulators have *carte blanche* to prohibit discretionary authority, and to mandate *de novo* judicial review of an administrator's benefit decisions, free from ERISA's preemptive force. But the Supreme Court in *Rush Prudential* did not hold that state regulators are free to prohibit insurers from exercising any discretionary authority in administering ERISA plans. In fact, the Court in *Rush Prudential* specifically noted that the scope of Illinois's HMO Act was narrowly confined to the interpretation of the term "medical necessity":

> The [Illinois HMO] Act does not give the independent review a 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.

Rush Prudential, 536 U.S. at 383. Prior to Illinois's HMO Act, the same HMO physician who provided the patient's medical treatment also determined whether treatment was covered as medically necessary. The HMO Act required that an independent physician who was not

involved in the patient's care determine the coverage issue of medical necessity.[2] But the HMO insurer retained discretionary authority to make all other coverage determinations.

Rush Prudential was careful to avoid any inference that states are free to mandate *de novo* judicial review of all the terms of an ERISA plan without implicating ERISA preemption:

> We 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; as discussed above, our decision rests in part on our recognition that the disuniformity Congress hoped to avoid is not implicated by decisions that are so heavily imbued with expert medical judgments. Rather, we hold that the feature of § 4-10 [of Illinois's HMO Act] that provides a different standard of review with respect to mixed eligibility decisions from what would be available in court is not enough to create a conflict that undermines congressional policy in favor of uniformity of remedies.

Id. at 386 n.17.

While ERISA does not mandate that plans must contain discretionary clauses, *Conkright* establishes that the employer's right to secure deferential judicial review is foundational to achieving Congress's goals. Judicial deference to the administrator's interpretation of the plan (i) preserves the balance between ensuring the enforcement of plan rights and encouraging employers to establish voluntary benefit plans, (ii) promotes efficiency by encouraging the resolution of claims through the internal administrative review process, and (iii) protects Congress's interests in predictability and national uniformity of plan interpretation. *Conkright*, 130 S.Ct. at 1649.

Section 2001.3 of the Illinois Administrative Code removes the employer's right to obtain deferential judicial review in all insurer-funded disability plans offered or issued in

[2] *Rush Prudential* noted that a physician's determination of medical necessity is a "mixed eligibility" decision, meaning the coverage determination is inextricably intertwined with the medical treatment decision, which is not a fiduciary act under ERISA. *Rush Prudential*, 536 U.S. at 386 n.17. See also *Pegram v. Herdrich*, 530 U.S. 211, 231 (2000) (holding that physicians do not act in a fiduciary capacity under ERISA when making mixed eligibility decisions concerning a patient's medical care and treatment).

Illinois, and therefore interferes with Congress's objectives in enacting ERISA. Accordingly, §2001.3 conflicts with Congress's carefully balanced uniform regulatory regime over employee benefit plans and is preempted by ERISA.

B. Express Preemption: §2001.3 Is Preempted By ERISA §514(a) And Does Not Fall Within ERISA's Savings Clause.

Section 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). There is no dispute that Illinois Administrative Code §2001.3 "relates to" employee benefit plans and thus falls within the scope of §514(a) preemption. For purposes of ERISA §514 express preemption, therefore, the sole issue is whether §2001.3 falls within the savings clause of §514(b)(2)(A).

ERISA's savings clause exempts from §514(a)'s preemptive sweep state laws that regulate insurance. 29 U.S.C. §1144(b)(2)(A). A state law regulates insurance if it satisfies two requirements. First, the state law must be "specifically directly toward entities engaged in insurance." *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003). Second, the state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* Neither requirement is satisfied by Illinois' rule prohibiting discretionary clauses.

Section 2001.3 masquerades as a general prohibition on discretionary clauses in all disability insurance policies. But Illinois' §2001.3, which bans or curtails an ERISA administrator's discretionary authority, is not specifically directed toward entities engaged in insurance. The sole purpose and affect of §2001.3 is to dictate the standard of judicial review to be applied by federal courts in ERISA benefit cases. Section 2001.3 is specifically directed toward the standard of judicial review to be applied by federal courts in adjudicating ERISA disability claims, mandating *de novo* judicial review in cases which, under federal law, should be governed by the arbitrary and capricious standard pursuant to *Firestone* and *Conkright*.

The arbitrary and capricious standard of review is not a principle of insurance law. It is a unique creation of ERISA, having its origins in an amalgam of trust law (*Firestone*) and congressional policy (*Conkright*). In fact, the arbitrary and capricious standard of review does not even exist in insurance law. Section 2001.3, therefore, is distinct from state insurance laws that apply to the insurance industry generally. Cf., *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) (holding that a state law requiring insurers to show prejudice before an insured's claim may be denied based on late notice applied to the insurance industry generally and falls within ERISA's savings clause).

ERISA's savings clause saves from preemption state laws that regulate insurance, and not state laws that regulate the federal standard of judicial review applied to ERISA plans. See *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, (2008) ("Nor would we overturn *Firestone* by adopting a rule that in practice could bring about near universal review by judges *de novo—i.e.*, without deference—of the lion's share of ERISA plan claims denials. Had Congress intended such a system of [*de novo*] review, we believe it would not have left to the courts the development of review standards….").

Moreover, §2001.3 does not "substantially affect the risk pooling arrangement between the insurer and the insured." *Miller*, 538 U.S. at 342. Section 2001.3 affects the standard of judicial review applied by federal courts *at the time of judgment*, which is after risk pooling has occurred. As explained by the court in *Lucero v. Hartford Life and Accident Ins. Co.*, No. 2:08-CV-302, 2009 WL 2170048, at *5 (D. Utah July 17, 2009):

> The nature of insurance is to provide a hedge against risk. [….] Some individuals face higher risks of certain adverse events, and others face much lower risks. Risk pooling is the term used to describe the means by which insurers cover individuals of all risk levels across a variety of adverse event probabilities. By risk pooling, an insurer is able to spread

> the risk that it will have to expend its resources to compensate a particular victim of an adverse event over all those paying premiums.

Lucero held that Utah's rule prohibiting discretionary clauses is preempted by ERISA §514, because the State's rule applies after suit has been filed, which is after the insured group's risk has been pooled. *Id.* at *6 ("[T]he Utah Rule applies only to the administrative function of interpreting the insurance plan's terms and judicial review of the use of that administrative function. The Court, therefore, finds that the Utah Rule does not substantially affect the risk pooling agreement because it is unrelated to either the risk of adverse events occurring or their potential magnitude.").

The Sixth Circuit in *Ross* incorrectly expanded "risk pooling" to encompass any state law that changes the terms of the insurance contract, stating "By changing the terms of enforceable insurance contracts, the Commissioner has 'alter[ed] the scope of permissible bargains between insurers and insureds.'" *Ross*, 558 F.3d at 607 (quoting *Ward*, 526 U.S. at 374-375). *Ross's* approach invites states to evade the preemptive force of ERISA simply by deeming its regulations to be contract terms.

The Ninth Circuit panel in *Morrison* went one step further. *Morrison* determined that the insurance commissioner's practice of prohibiting discretionary clauses would result in more legal victories for insureds. More legal victories means more claims paid, which "increase[es] the benefits of risk pooling for insureds":

> [C]onsumers can be reasonably sure of claim acceptance only when an improperly balking insurer can be called to answer for its decision in court. By removing the benefit of a deferential standard of review from insurers, it is likely that the Commissioner's practice will lead to a greater number of claims being paid. More losses will thus be covered, increasing the benefit of risk pooling for insureds.

Morrison, 584 F.3d at 845. According to *Morrison*, any state rule that increases an insurer's legal risk of losing in litigation would satisfy the risk pooling requirement of ERISA's savings clause. A state rule that shifted the burden of proof by requiring that insurers *disprove* benefit eligibility likely would result in more legal victories for insureds, leading to the payment of dubious claims, but such a burden-shifting rule would never survive ERISA preemption. Yet *Morrison's* notion of risk pooling provides nothing that would enable the Ninth Circuit panel to distinguish that hypothetical case.

The error in *Ross's* and *Morrison's* savings clause analysis lies with their inaccurate perception of risk pooling and expansive interpretation of *Rush Prudential*. Risk pooling is the process by which an insurer evaluates the risk of adverse events and spreads that risk to the insured group through premiums. By definition, risk pooling occurs at the time of contract formation, and not at the time of judicial review and judgment. *Lucero*, 2009 WL 2170048, at *5.

The Illinois HMO Act at issue in *Rush Prudential* regulated claims review procedures by requiring Illinois health insurers to consult with an independent physician. The Act, therefore, "operate[d] before the stage of judicial review" by mandating consultation with an independent physician as part of the claims review process. *Rush Prudential*, 536 U.S. at 386. By contrast, §2001.3's prohibition on discretionary clauses does not regulate any aspect of claims review procedures, or even mandate the terms under which coverage may be granted or denied. Section 2001.3 operates only after suit has been filed at the stage of judicial review.

Section 2001.3, therefore, does not fall within the category of state laws that have been saved from ERISA preemption. Section 2001.3 does not require insurers in Illinois to insure against additional risks. Cf. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)

(state law that requires health insurers to provide coverage for mental health problems not preempted by ERISA). Section §2001.3 does not require insurers to offer additional benefits to insureds. Cf. *Miller*, 538 U.S. at 338 (state law that requires health insurers to permit their insured to see "any willing provider" not preempted by ERISA). Finally, §2001.3 does not alter the terms under which claims may be denied. *Cf. Ward*, 526 U.S. 358 (1999) (state law that requires insurers to show prejudice before late filed claims may be denied is not preempted).

Discretionary clauses establish the standard of judicial review to be applied by federal courts only after a claim has been denied. Illinois' effort to dictate the standard of judicial review under the federal law of ERISA, therefore, is preempted by §514(a) and does not fall within ERISA's savings clause.

II. Section 2001.3 Addresses Only Issues Of Contract Interpretation And Does Not Prohibit All Discretionary Determinations.

Ball's counsel presents §2001.3 as a sweeping prohibition on discretionary clauses, sounding the end of the arbitrary and capricious standard of review in ERISA disability cases. But §2001.3 does not mandate *de novo* judicial review of every discretionary decision made by an administrator. Rather, §2001.3 purports to preclude disability insurers from reserving discretionary authority "to interpret the *terms of the contract*," and thus from exercising discretionary authority to interpret the policy's terms.[3] Even if §2001.3 is enforceable and not preempted by ERISA, then under Illinois' rule the policy's contractual terms may be reviewed by the court *de novo*, but the administrator's medical and vocational determination remains entitled to deferential judicial review.

[3] See *Sanders v. Jackson*, 209 F.3d 998, 1000 (7th Cir. 2000) ("The cardinal rule is that words used in statutes must be given their ordinary and plain meaning."); *Michigan Ave. Nat'l Bank v. County of Cook*, 191 Ill.2d 493, 732 N.E.2d 528, 535 (2000) ("[t]he statutory language must be given its plain and ordinary meaning ….").

Not all discretionary decisions involve issues of contract interpretation. ERISA administrators also exercise discretionary authority when evaluating medical data, including determining whether the medical findings support a particular diagnosis, the risks associated with a medical condition, and the functional restrictions and limitations caused by a medical condition. See, e.g., *Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569, 578 (7th Cir.), *cert. denied*, 549 U.S. 884 (2006) ("[R]eaching a decision amid such conflicting medical evidence is a question of judgment that should be left to [the administrator] under the arbitrary-and-capricious standard."); *Semien v. Life Ins. Co. of North America*, 436 F.3d 805, 812 (7th Cir.), *cert. denied*, 549 U.S. 942 (2006) ("[U]nder the arbitrary and capricious standard, neither this Court, nor the district court, will attempt to make a determination between competing expert opinions.").

ERISA administrators exercise discretionary authority when making occupational determinations, including a claimant's qualifications and functional capacities to perform work in a variety of occupations. See, e.g., *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 620 (7th Cir. 2008) (holding that the administrator reasonably exercised its discretion in determining that the plaintiff "had the essential skills to become a medical director or assistant medical director"); *Schreiner v. United Wisconsin Ins. Co.*, 626 F.Supp.2d 892, 909 (W.D. Wis. 2009) (holding that the administrator reasonably relied on the results of functional capacity testing in determining "that plaintiff could tolerate light work during an eight-hour work day, which included sitting for 1/3 to 2/3 of the time"). Moreover, ERISA administrators exercise discretionary authority when establishing and enforcing rules for administering claims. See, e.g., *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 483 (7th Cir. 2009) (holding that the administrator reasonably refused to consider evidence submitted after the administrative record was closed).

Indeed, Standard's Group Policy contains a far broader grant of discretionary authority than only the discretion to interpret the *terms of the contract*:

> ALLOCATION OF AUTHORITY
>
> Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we [Standard] have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.
>
> Our authority includes, but is not limited to:
>
> 1. The right to resolve all matters when a review had been requested;
> 2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
> 3. The right to determine:
>   a. Eligibility for insurance;
>   b. Entitlement to benefits;
>   c. The amount of benefits payable;
>   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.
>
> Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

(Admin. Rec. at STND 1451-00027).[4]

While §2001.3 purports to curtail an ERISA administrator's discretionary authority when interpreting contractual terms, §2001.3 leaves intact the administrator's discretionary authority to interpret the medical and vocational evidence and make disability determinations based on the evidence. Michigan's statute completely banned discretionary clauses outright, but the Sixth Circuit in *Ross* limited its holding to ERISA administrators' discretionary authority to interpret contract terms, and suggested that ERISA administrators may retain discretionary authority to determine benefit eligibility where the contract terms are clear:

[4] Defendants filed the Administrative Record on January 15, 2010, which contains a copy of the Group Policy (Doc. No. 19-1). Citations to "Admin. Rec. at STND 1451-___" are to the corresponding Bates numbered page of the Administrative Record.

> Nor is it necessarily the case, as the Insurance Industry suggests, that, if Michigan can remove discretionary clauses, it will be allowed to dictate the standard of review for all ERISA benefits claims. All that today's case does is allow a State to remove a potential conflict of interest. And while Michigan's law may well establish that the courts will give *de novo* review to lawsuits dealing with the meaning of an ERISA plan, it does not follow that they will do so in reviewing the application of a settled term in the plan to a given benefit request.

Ross, 558 F.3d at 609.

While the Group Policy's contractual terms may be construed by the Court *de novo* if §2001.3 is applied in this case, Standard's medical and vocational determinations warrant deferential judicial review under the arbitrary and capricious standard.

CONCLUSION

ERISA preempts the effort by Illinois insurance regulators to dictate the federal standard of judicial review for adjudicating claims under ERISA. By purporting to prohibit discretionary clauses in ERISA health and disability plans, §2001.3 thwarts Congress's carefully balanced comprehensive federal system of employee benefits. Section 2001.3, therefore, is preempted by ERISA pursuant to principles of express preemption, §514(a), and conflict preemption, §502(a). Moreover, §2001.3 specifically applies only to issues of contract interpretation and does not prohibit an administrator's exercise of discretionary authority in determining benefit eligibility based on the medical and vocational evidence. Accordingly, Standard's benefit determination is properly reviewed by the Court pursuant to the arbitrary and capricious standard of review.

WHEREFORE, Defendants, STANDARD INSURANCE COMPANY and GROUP LONG TERM DISABILITY INSURANCE POLICY, respectfully request that the Court find that the applicable standard of judicial review is the arbitrary and capricious standard.

Respectfully submitted,

Warren von Schleicher
SMITH, VON SCHLEICHER & ASSOCIATES
39 S. LaSalle St., Suite 1005
Chicago, Illinois 60603
P: 312-541-0300
F: 312-541-0933
warren.vonschleicher@svs-law.com

By: /s/ Warren von Schleicher
Attorney for Defendants,
Standard Insurance Company and
Group Long Term Disability Insurance Policy

CERTIFICATE OF SERVICE

I hereby certify that on October 12, 2010, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the attorney of record listed below:

David A. Bryant
Daley, DeBofsky & Bryant
55 W. Monroe St., Suite 2440
Chicago, Illinois 60603
dabyrant@ddbchicago.com

/s/ Warren von Schleicher
SMITH, VON SCHLEICHER & ASSOCIATES
39 South LaSalle Street, Suite 1005
Chicago, Illinois 60603
P: 312-541-0300
F: 312-541-0933
warren.vonschleicher@svs-law.com
Illinois Bar No. 6197189