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' REPLY REGARDING DISCRETIONARY AUTHORITY, ILLINOIS ADMINISTRATIVE CODE §2001.3, AND ERISA PREEMPTION

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INTRODUCTION

The Supreme Court in *Conkright v. Frommert*, -- U.S. --, 130 S.Ct. 1640 (2010), established the foundational importance of deferential judicial review to the ERISA pension and welfare system. But Susan Ball ("Ball"), in her Response to Defendants' Memorandum of Law Regarding Discretionary Authority, Illinois Administrative Code §2001.3, and ERISA Preemption, dismisses the Supreme Court's seminal holding in *Conkright* as "dictum." *Conkright* holds that judicial deference promotes Congress's objectives of national uniformity and predictability in plan administration, encourages employers to offer voluntary benefit plans, and avoids a system of universal *de novo* review where the same plan provision might have different meanings in different jurisdictions. Section 2001.3 stands as an obstacle to Congress's objectives and therefore is preempted.

ARGUMENT

I. Standard Contests The Legality Of Illinois Administrative Code §2001.3.

Section 2001.3 purports to prohibit discretionary clauses in *all* health or disability policies issued or offered in Illinois effective July 1, 2005. In practice, however, §2001.3 applies only to ERISA plans. Illinois' Insurance Director issued §2001.3 to prohibit federal courts from adjudicating ERISA cases deferentially, under the arbitrary and capricious standard of review. Federal courts generally have refused to enforce Illinois' regulation, finding that §2001.3 does not apply retroactively to ERISA plans established prior to the regulation's effective date. See *Golden v. Guardian Life Ins. Co. of America*, No. 09 C 865, 2010 WL 2293390, at *7-8 (N.D. Ill. June 1, 2010); *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.Supp.2d 722, 740-741 (N.D. Ill. 2009), reversed on other grounds, 615 F.3d 758 (7th Cir. 2010); *Marszalek v. Marszalek & Marszalek Plan*, 485 F.Supp.2d 935, 938-939 (N.D. Ill. 2007); *Dreyer v. Metropolitan Life Ins.*

Co., 459 F.Supp.2d 675, 681 (N.D. Ill. 2006); *Williams v. Group Long Term Disability Ins*., No. 05 C 4418, 2006 WL 2252550, at *3 (N.D. Ill. Aug. 2, 2006); *Guerrero v. Hartford Financial Services Group*, No. 05 C 2787, 2006 WL 1120526, at *7 n.3 (N.D. Ill. Apr. 26, 2006).

In response to federal courts refusal to enforce §2001.3, the Insurance Director issued a "Bulletin" on June 28, 2010 deeming §2001.3 to apply "to all currently issued and outstanding" health and disability plans. The Insurance Director sent the Bulletin to insurers who fund health or disability plans in Illinois, including Standard, and threatened retaliatory "regulatory action" against insurers who disobey. The Director's Bulletin states, "Insurers who do not comply with the absolute prohibition on discretionary clauses contained in 50 Ill. Admin. Code 2001.3 will be held accountable and subject to regulatory action." (Ex. A, Baumgardner Affid., ¶ 3 and attached Bulletin).

This month, in December 2010, Standard notified Illinois group policyholders that it must comply with the Director's Bulletin by removing its Allocation of Authority provision from its group dental, group accidental death, and group disability policies. Ball argues that Standard's compliance with the Director's mandatory Bulletin constitutes an admission by a party-opponent under Fed. R. Evid. 801(d)(2), "because it is contrary to the position previously taken by Standard before this court." (Pl. Supp. Response, pg. 1). Rule 801(d)(2), however, is an evidentiary rule governing the admissibility of hearsay statements. It lists certain out-of-court statements that do not constitute hearsay, one of them being an admission by a party-opponent. Rule 801(d)(2) does not judicially bar a party from contesting the legality of a state law, and does not bar Standard from contesting §2001.3 on preemption grounds.[1]

[1] The doctrine of judicial estoppel, which Ball does not invoke, also does not apply. Judicial estoppel protects the integrity of the judicial process by preventing parties from taking two "clearly inconsistent" positions "under oath" before two different courts, prevailing before one court on one position, then repudiating that position in subsequent litigation and asserting a clearly inconsistent

Illinois' Director has mandated that insurers of ERISA plans comply with §2001.3 or be "held accountable and subject to regulatory action." The Director's Bulletin *required* that Standard remove the Allocation of Authority provision from its Illinois group policies, and threatened sanctions for insurer disobedience. Ball cites no authority for her notion that insurers must violate the Director's mandate and face regulatory sanction in order to challenge the legality of §2001.3 in court. Compliance with a state law under the yoke of regulatory sanction is not an admission that the law is valid. Standard does not have to engage in civil disobedience in order to contest the enforceability of §2001.3 on preemption grounds.

Moreover, the Group Policy issued to Ball's former employer, Crisham & Kubes, terminated in April 2009. Standard never amended the Crisham & Kubes Group Policy to remove the Allocation of Authority provision. (Ex. A, Baumgardner Affid., ¶ 2). The Group Policy, therefore, contains the Allocation of Authority provision. Standard requests that the Court find that §2001.3 is preempted by ERISA, and that the applicable standard of judicial review in this case is the arbitrary and capricious standard.

II. Section 2001.3 Poses An Obstacle To Congress's Objectives In Enacting ERISA.

Conflict preemption occurs when a state law interferes with Congress's intent. To determine whether a state law falls within ERISA's 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). Conflict preemption preempts state laws that "pose an obstacle to the purposes and

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position in order to win another victory. *New Hampshire v. Maine*, 532 U.S. 742, 750-751 (2001). Standard has not taken two clearly inconsistent positions under oath before two different courts, prevailed on the first position then repudiated that position in subsequent litigation.

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)).

Deferential judicial review is foundational to Congress's goals in enacting the ERISA pension and welfare system. Deference promotes uniformity of plan interpretation and administration. Deference reduces the risk that different courts in different jurisdictions will interpret the same plan provision in contradictory ways, thereby imposing irreconcilable fiduciary obligations on plan administrators. By promoting national uniformity, deference protects plans from unpredictable interpretations that result in unanticipated liabilities, and encourages employers to provide voluntary ERISA plans to their employees. *Conkright*, 130 S.Ct. at 1647-1649. See also *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 in part and concurring in the judgment); *AT&T Corp. v. Hulteen*, 129 S.Ct. 1962, 1973 (2009) (finding that it is important that ERISA plans have "predictable financial consequences, both for the employer who pays the bill and for the employee who gets the benefit"); *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (Congress sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.").

As her defense to ERISA conflict preemption, Ball's Response reiterates the pre-*Conkright* reasoning of the Sixth and Ninth Circuits in *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) 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). *Ross* and *Morrison* reasoned that deferential review is not mandated by the text of ERISA, and because *de novo* review is the default standard of review under ERISA, a state law that mandates *de novo* review (and bans deferential review) cannot conflict with Congress's goals in enacting ERISA. As articulated in *Ross*, "It is worth noting that the *de novo* standard of review is already the default standard in ERISA cases, so it is difficult to imagine how state law requiring that level of review would conflict with the [ERISA] statute." *Ross*, 558 F.3d at 608.

Unenlightened by the Supreme Court's pronouncement in *Conkright*, the *Ross* and *Morrison* courts focused on the wrong issue. The issue is not whether the *de novo* standard comports with ERISA, but whether banning 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* established the paramount importance of discretionary authority to achieving Congress's objectives in enacting ERISA. In the wake of *Conkright*, it is not "difficult to imagine" how a state law mandating *de novo* judicial review conflicts with ERISA. *Conkright* makes it clear 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. That *de novo* review is the default standard of review under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1987) is irrelevant. The Supreme Court has determined that employers must be permitted to include discretionary clauses in ERISA plans, and that discretionary authority must be judicially enforced. "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.'" *Conkright*, 130 S.Ct. at 1649 (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002)).

In *Conkright*, the Supreme Court rejected the Second Circuit's "one strike and you're out" approach to discretionary authority. Under the Second Circuit's approach, the administrator, having initially abused its discretion in interpreting a pension plan's benefit payout provision, was not entitled to deferential review of its second plan interpretation following an administrative remand. With the Second Circuit's blessing, the district court stripped the administrator of its discretion and usurped the role of plan administrator. The district court substituted its interpretation of the plan, and gave no deference to the administrator's interpretation, with potentially disastrous consequences. The district court, lacking the financial expertise of the plan administrator's economic consultants, adopted an interpretation of the plan that failed to account for the time value of money. That resulted in a benefit windfall for the plaintiffs, and thwarted the plan administrator's ability to apply the plan's terms on a nationally uniform basis.

The Supreme Court declared, "This case … demonstrates the harm to the interest in predictability that would result from stripping a plan administrator of *Firestone* deference." *Conkright*, 130 S.Ct. at 1650. "Deference to plan administrators, who have a duty to all beneficiaries to preserve limited plan assets, helps prevent such windfalls for particular employees." *Id.* (internal citation omitted). Moreover, stripping the plan administrator of discretionary authority would lead to different interpretations of the plan in different jurisdictions:

> If other courts were to adopt an interpretation of the Plan that does account for the time value of money, Xerox could be placed in an impossible situation. Similar Xerox employees could be entitled to different benefits depending on where they live, or perhaps where they bring a legal action.

> Cf. 29 U.S.C. § 1132(e)(2) (permitting suit "where the plan is administered, where the breach took place, or where a defendant resides or may be found").

Id. at 1650. "Thus, failing to defer to the Plan Administrator here could well cause the Plan to be subject to different interpretations in California and New York." *Id.* at 1651. "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).

A paramount congressional goal in enacting ERISA is to encourage employers to offer voluntary benefit plans by ensuring plan administrators would be subject to a uniform body of laws, reduced administrative costs, and predictable results. *Conkright*, 130 S.Ct. at 1649. Deferential review promotes Congress's goals of efficiency, predictability, and uniformity in ERISA plan administration:

> 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. at 1649. Deferential review promotes national uniformity in plan administration:

> Moreover, *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 operation, 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)). Deferential review protects these congressional interests "by permitting an employer to grant primary interpretive

authority over an ERISA plan," thereby "preserv[ing] the 'careful balancing' on which ERISA is based." *Id.* at 1649. *Conkright* establishes that affording employers the *option* of offering benefits plans that grant discretionary authority to the administrator is crucial to the vitality of the ERISA pension and welfare system.

Conkright is a momentous decision in the scholarly field of ERISA. Whereas *Firestone* looked to principles of trust law in holding that an administrator vested with discretionary authority is entitled to deferential judicial review, *Conkright* looked to Congress's intent in holding that deferential review promotes congressional goals of national uniformity, predictability, and encouraging plan formation. Pursuant to *Conkright*, any law that deprives employers of the *option* of structuring their ERISA plans to provide for a deferential standard of review conflicts with Congress's goals. Yet Ball fails to address *Conkright* until the penultimate page of her Response, and even then only dismissively.

Ball argues that *Conkright* "can easily be distinguished" because it is not a case about preemption. But *Conkright* is a case about the importance of judicial deference in furthering Congress's goals in enacting ERISA, and the disastrous consequences of adopting a rule that divests administrators of their interpretive discretion. Congress's goals of ensuring national uniformity, promoting efficiency, and encouraging voluntary plan formation would be defeated if deferential review were no longer an option for employers who want to offer benefit plans to their employees.

Because the Second Circuit is barred from thwarting these important congressional goals by stripping discretionary authority from plan administrators, as *Conkright* clearly holds, then the Illinois Insurance Director must be barred from thwarting the same important congressional goals by prohibiting discretionary clauses in ERISA policies. Congress's goals of achieving

national uniformity, efficiency, and encouraging plan formation through deferential review do not fluctuate in importance depending on whether the Second Circuit (as in *Conkright*) or a state insurance director (as in the present case) is engaged in conduct antithetical to congressional objectives. Like the Second Circuit's deference-stripping rule that the Supreme Court overturned in *Conkright*, Illinois §2001.3 poses an obstacle to the purposes and objectives of Congress. When a federal court thwarts Congress's will through judicial decree, the appropriate remedy is to overturn the federal court decision, as the Supreme Court overturned the Second Circuit in *Conkright*. When a state insurance director thwarts Congress's will through regulatory decree, the appropriate remedy is to preempt the state regulation.

Employers are exempt from §2001.3 if they self-fund their ERISA plans. But self-funded plans are a rarity. Most employers lack the financial resources and administrative infrastructure to create and maintain self-funded ERISA plans. For the vast majority of employers who want to provide health, accidental death, and disability protection to their employees, insurance is the only practical solution. Section 2001.3 fosters a caste system of ERISA adjudication in which benefit decisions of the privileged few self-funded plans are reviewed by the court deferentially, while benefit decisions of the majority, consisting of insurer-funded plans, must be reviewed by the court *de novo*, resulting in higher liabilities and higher premium costs, which discourages plan formation.

Ball argues that §2001.3 cannot be preempted because it does not provide for a separate cause of action under ERISA §502(a). According to Ball, §2001.3 does not supplement or supplant ERISA's remedies. While it is true that a state law that supplements or supplants ERISA's remedies will be preempted, conflict preemption is not limited only to those instances. Conflict preemption occurs when a state law "stands as an obstacle" to the objectives of

Congress. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. 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.") (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)).

Providing employers the option of establishing ERISA plans that provide for deferential review promotes Congress's objectives of national uniformity, predictability of plan interpretation, and encouragement of plan formation. *Conkright*, 130 S.Ct. at 1649. Section 2001.3 conflicts with these congressional objectives by creating a patchwork of different plan interpretations that vary court-by-court and state-by-state. A federal court might interpret an ambiguous plan provision in favor of the "insured." But an interpretation of a plan term that favors a particular participant in one case might be detrimental to a participant under the same plan in another case. Courts would be rewriting Illinois ERISA plans *ad hoc* to benefit the individualized needs of the plaintiff in each case. Uniformity and predictability would be impossible if courts interpret the same plan term to mean different things to different plan participants.[2] Deference provides administrators with a crucial tool to ensure that ERISA plans are administered and applied uniformly and predictably. See *Kennedy v. Plan Adm'r 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").

[2] It is unrealistic to expect administrators to draft one-size-fits-all plan language that envisages and resolves every possible circumstance that might arise in plan administration. Interpretive discretion ensures that plan terms are applied consistently and predictably, and not to the benefit of one participant at the expense of other participants.

The problem of inconsistent interpretations is magnified when an ERISA plan covers employees in several states. Similar employees participating in the same plan could be entitled to a different benefit amount depending on where they live. In Indiana, which allows deference, an administrator could consistently interpret "earnings" for all plan participants, for purposes of calculating monthly disability benefits, based on the employee's W-2 payroll wages actually received, and the administrator's interpretation would be reasonable. Another employee covered by the same plan, but living in Illinois where deference is verboten, could be entitled to a higher level of benefits if the court finds "earnings" ambiguous. The Illinois court, adopting an interpretation that favors the plaintiff in that case, might calculate "earnings" based on the plaintiff's wages and stock options. See, e.g., *Orlando v. United of Omaha Life Ins. Co.*, 661 F.Supp.2d 968 (N.D. Ill. 2009) (giving deference to the administrator's interpretation of earnings as payroll earnings, and rejecting the plaintiff's alternate interpretation of earnings as including the value of stock options). Thus, §2001.3 clearly supplements ERISA's remedies by providing residents of Illinois with the new remedy of plan reformation, a remedy that would not be available to participants in the same plan who reside in states that have not attempted to ban judicial deference.

Failing to defer to the plan administrator could well cause the same plan to be subject to deferent interpretations in different states, making national uniformity impossible. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Conkright*, 130 S.Ct. at 1651 (quoting *Egelhoff*, 532 U.S. at 148). 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).

Section 2001.3, therefore, presents insurmountable problems of plan administration by creating conflicting fiduciary obligations if two different courts interpret the same plan term differently. Plan administrators would have the impossible task of reconciling contradictory interpretations of the same plan terms. If to achieve national uniformity a plan administrator must forsake its discretionary plan interpretation in all states and adopt nationwide the *de novo* plan interpretation of a federal court in Illinois, then §2001.3 effectively bans discretionary clauses nationwide.

Section 2001.3 conflicts with Congress's carefully balanced uniform regulatory regime. By prohibiting employers from establishing ERISA plans that provide for a deferential standard of review, §2001.3 stands as an obstacle to Congress's objectives in enacting ERISA. Therefore, §2001.3 is preempted by ERISA.

III. Section 2001.3 Is Preempted By 29 U.S.C. §1144(a) And Does Not Fall Within ERISA's Savings Clause.

Ball concedes that §2001.3 "relates to" employee benefit plans and therefore falls within §514(a)'s broad preemptive sweep. For purposes of §514 preemption, the only issue is whether §2001.3 is saved from preemption under §514(b)(2)(A). To fall within ERISA's savings clause, the state law must be "specifically directly toward entities engaged in insurance" and "substantially affect the risk pooling arrangement between the insurer and insured." *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

Ball dismissively asserts that "it cannot seriously be argued that the Illinois director's actions were not specifically directed to the insurance industry." (Pl. Response, pg. 7). Although §2001.3 masquerades as a law that regulates insurance, it is not a law of insurance at all. The concept of judicial deference is a unique construct of ERISA, inspired by trust law, as a vehicle to carry out Congress's objectives in enacting ERISA. See *Conkright*, 130 S.Ct. at 1647.

In fact, the concept of judicial deference does not exist in Illinois insurance law. The purported "ban" on discretionary clauses in Illinois specifically targets ERISA plans, and has no impact on insurance practices outside of ERISA. Specifically, §2001.3 regulates the standard of judicial review governing benefit determinations under ERISA.

Ball argues that §2001.3 "does not, as Defendants would have the Court believe, regulate the federal standard of review applied to ERISA plans." (Pl. Response, pg. 7). Regulating the federal standard of judicial review over ERISA plans is precisely the Insurance Director's goal, and he explicitly said so in the insurance regulations:

> 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, [§2001.3] aid[s] the consumer by ensuring that benefit determinations are made under the reasonableness standard.

29 Ill. Reg. 10173.[3] 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 in adjudicating ERISA disputes.

Congress intended the *federal judiciary* to develop review standards governing ERISA claims. See *Glenn*, 554 U.S. 105, 116 (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*…") (emphasis added). Through §2001.3, the Illinois Insurance Director

[3] The Director's rationale for §2001.3 is plainly wrong. The arbitrary and capricious standard is not antithetical with a "reasonableness" standard; they are synonymous. Under the arbitrary and capricious standard, the administrator's decision must be reasonable. See, e.g., *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009); *Schwalm v. Guardian Life Ins. Co. of America*, --F.3d--, 2010 WL 4628126, at *8 (6th Cir. Nov. 17, 2010).

endeavors to displace the congressionally sanctioned role of the federal judiciary in establishing the federal standard of review governing ERISA claims, in violation of Congress's intent. Section 2001.3 is not a law that "regulates insurance." It is a law that regulates the power of the federal judiciary to establish the standard of judicial review. The Illinois Insurance Director, by attempting to dictate a *de novo* standard of judicial review over ERISA claims, has usurped a power specifically granted by Congress to the Judicial Branch. Section 2001.3 falls outside of ERISA's savings clause because it is not a law that regulates insurance.

Moreover, §2001.3 does not "substantially affect the risk pooling arrangement" between the insurer and the insured. *Miller*, 538 U.S. at 342. Ball, in her Response, fabricates a quote and attributes it to a footnote in *Miller*. Ball misquotes *Miller* as stating, "A state administrative policy stripping insurers of their discretion to make benefit determinations and policy interpretations effectively 'dictates to the insurance company the conditions under which it must pay for the risk that it has assumed.'" (Pl. Response, pg. 8, misquoting *Miller*, 538 U.S. at 339 n.3). The *Miller* Court never mentioned state rules "stripping insurers of their discretion." Rather, the *Miller* Court was addressing California's notice-prejudice rule, which *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) held was saved from preemption.[4] Quoted accurately, *Miller* states,

> The notice-prejudice rule governs whether or not an insurance company must cover claims submitted late, *which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed*. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured.

[4] California's notice-prejudice rule requires that an insurer show that it was prejudiced by the insured's late notice of claim prior to denying coverage on late notice grounds.

Miller, 538 U.S. at 339 n.3 (citing *Ward*, 526 U.S. 358) (emphasis added).[5]

Section 2001.3 lacks the distinctive features of state laws that the Supreme Court has found to be saved from preemption. Section 2001.3 does not establish any terms or conditions that determine whether a class of risks is covered, unlike the notice-prejudice rule in *Ward*. And §2001.3 does not require ERISA plans to insure against an additional class of 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 is saved from preemption); *Miller*, 538 U.S. at 338 (state law that requires health insurers to permit their insured to see "any willing provider" is saved from preemption). The Illinois Insurance Director's objective in implementing §2001.3 is to change the standard of judicial review in federal court, after a claim has been denied. Section 2001.3 does not substantially affect risk pooling, because the regulation does not establish any terms or conditions that determine whether a class of risks is covered, and does not extend coverage to a class of previously excluded risks. Section 2001.3 says nothing of the "conditions" under which an insurer must pay for an insured risk. Section 2001.3 dictates to the federal judiciary the standard of review to be applied in reviewing ERISA claims.

Ball argues that *Rush Prudential*, 536 U.S. 355, provides authority for states to "regulate" the standard of judicial review, which is another argument reiterated from the pre-*Conkright* decisions of the Sixth Circuit in *Ross* and the Ninth Circuit in *Morrison*. *Rush Prudential* held that a state law requiring that HMOs consult with an independent physician in determining whether a patient's treatment is medically necessary, rather than adopt the opinion of the

[5] In addition to misquoting *Miller*, Ball misstates the holding in *Glenn*. (Pl. Response, pg. 8). Ball states that "[*Glenn*] confirmed that such discretionary clauses may substantially affect the risk pooling arrangement." (Pl. Response, pg. 8). *Glenn* never mentions risk pooling or state laws that mandate *de novo* review.

patient's HMO treating physician, is saved from preemption. But the Court did not hold that state regulators are free to completely prohibit administrators from exercising discretionary authority in administering ERISA policies. In fact, the Court specified that the scope of the state 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.

Id. at 383. The Court reasoned that a treating physician's decision about medical care is a "mixed eligibility" decision, which does not qualify as a fiduciary act under ERISA. The state HMO Act, therefore, did not interfere with a fiduciary function under ERISA. Indeed, *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; …." *Id.* at 386 n.17.

By contrast, §2001.3 purports to mandate *de novo* review of all fiduciary functions of the ERISA administrator, and usurps the federal judiciary's determination—articulated in *Conkright*—that deferential judicial review promotes congressional objectives of national uniformity, predictability, and encouraging employers to offer benefit plans.

Finally, Ball argues that one federal court in this district, in an unpublished slip opinion in *Haines v. Reliance Standard Life Ins. Co.*, No. 09 C 7648, slip. op. at pgs. 2-3 (N.D. Ill. Sept. 9, 2010), ruled that §2001.3 is not preempted. The *Haines* court stated that "with no controlling authority to the contrary, the reasoning set out in *Ross* and *Morrison* is determined to be persuasive." *Id.* The defendant in *Haines* presented a threadbare §514(a) preemption argument consisting of two paragraphs, largely of string cites. There was no legal analysis of the flawed

logic of *Ross* and *Morrison* (neither case was even mentioned in the *Haines* defendant's brief), no mention of the Supreme Court's important *Conkright* decision (ignored by both parties), and obviously no argument that §2001.3 stands as an obstacle to congressional objectives based on *Conkright*.[6] Unpublished opinions are unpublished for a reason. The *Haines* slip opinion is not persuasive authority. Issues of §2001.3's enforceability, conflict preemption, complete preemption, Congress's intent, and the role of the federal judiciary in establishing standards of judicial review under ERISA, are of national importance, too important to be decided without the guidance of fully developed legal briefs.

Guided by *Conkright* and *Glenn*, courts have questioned and rejected the ruling in *Ross* and *Morrison*. In *Baker v. Hartford Life Ins. Co.*, No. 08-cv-6382, 2010 WL 2179150, at *11 (D. N.J. May 28, 2010), the court refused to enforce New Jersey's statute banning discretionary clauses. The *Baker* court found that the state law directly violates Congress's objective to establish ERISA as a nationally uniform regime:

> Plaintiff's construction of section 11:4-58.3 would in effect change the standard of review of every civil enforcement action under ERISA within the state of New Jersey whenever the plan in question grants discretionary authority to the plan administrator. This would directly violate the purpose of ERISA "to provide a uniform regulatory regime over employee benefit plans." Moreover, the Supreme Court's recent decision in Glenn, addressing the same conflict-of-interest concern underlying the New Jersey regulation, expressly set forth the applicable standard of review under ERISA. (Citation omitted).

Id. (quoting *Davila*, 542 U.S. at 208).[7] The *Baker* court reviewed the administrator's benefit determination under the "traditional" arbitrary and capricious standard. *Id.* See also *Lucero v.*

[6] Standard's and the Plan's counsel will provide to the Court a courtesy copy of the *Haines* defendant's brief.

[7] The *Baker* court, acknowledging its obligation to "disposing of cases on the narrowest possible grounds," held that the plain language of New Jersey's statute prohibits discretionary clauses, but does not specifically state that judicial review must be *de novo*. *Id.* at *11.

Hartford Life and Accident Ins. Co., No. 2:08-CV-302, 2009 WL 2170048, at *6 (D. Utah July 17, 2009) (holding that Utah's rule regulating discretionary clauses does not substantially affect risk pooling: "[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.").

Section 2001.3 attempts to regulate the power of the federal judiciary to establish the standard of judicial review. It is not a law that regulates insurance, and does not substantially affect the risk pooling arrangement between the insurer and insured. Section 2001.3, therefore, is preempted by §514(a).

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

Ball's counsel presents §2001.3 as a state law completely banishing deferential judicial review and mandating *de novo* judicial review of an administrator's benefit decision. But §2001.3 does not mandate *de novo* judicial review of every fiduciary act by an ERISA administrator. Section 2001.3 purports to preclude disability insurers from reserving discretionary authority "to interpret the *terms of the contract*." The plain meaning of §2001.3 applies only to issues of contract interpretation. 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."). Section 2001.3 does not prohibit insurers from exercising discretionary authority when making medical judgments, vocational determinations, or any other fiduciary decisions that do not involve interpreting the contract's terms.

Ball incorrectly calls this plain meaning interpretation of §2001.3 "casuistry" and unsupported by law. (Pl. Response, pg. 4). The plain meaning interpretation of §2001.3 is supported by the Sixth Circuit's *Ross* decision. Michigan's insurance regulation in *Ross* banned discretionary clauses outright. However, the Sixth Circuit limited its holding to finding that the state regulation is not preempted as applied to the administrator's interpretation of contract terms. The Sixth Circuit acknowledged that ERISA administrators may retain discretionary authority to determine benefit eligibility where the contract terms are unambiguous:

> 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.

Section 2001.3 purports to curtail an ERISA administrator's discretionary authority when interpreting contractual terms. Yet §2001.3 leaves intact the administrator's discretionary authority to interpret the medical and vocational evidence and make disability determinations. Even if the Court finds that §2001.3 is not preempted, Standard's medical and vocational determinations warrant deferential judicial review under the arbitrary and capricious standard.

CONCLUSION

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 ERISA preempts 50 Ill. Admin. Code §2001.3, and that the applicable standard of judicial review governing this case is the arbitrary and capricious standard.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 29, 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:

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