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

STEVE ZACCONE	)	
	)	
Plaintiff	)	
	)	**No. 10-CV-00033**
v.	)	
	)	**Magistrate Judge Cole**
STANDARD INSURANCE COMPANY	)	
	)	
Defendant	)	

STANDARD INSURANCE COMPANY'S
RESPONSE TO PLAINTIFF'S MEMORANDUM REGARDING THE
ERISA STANDARD OF REVIEW

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INTRODUCTION

Steve Zaccone filed suit to recover disability benefits under Tempel Steel's Long Term Disability Insurance Plan pursuant to 29 U.S.C. §1132(a)(1)(B). The Plan was established in 2002 through Group Long Term Disability Insurance Policy 128645-A ("Plan" or "2002 Plan") issued by Standard Insurance Company. Effective January 2007, Standard issued a new group policy to Tempel Steel, Group Long Term Disability Insurance Policy 128645-B ("2007 Plan"). The 2002 Plan contains an Allocation of Authority provision that grants discretionary authority to Standard. The 2007 Plan does not contain an Allocation of Authority provision. Both Plans provide that the version of the Plan in effect on the date of Disability governs the participant's disability claim. Because Zaccone became Disabled on September 1, 2006, his disability claim is governed by the 2002 Plan's term, which grants discretionary authority to Standard.

Zaccone argues that the 2002 Plan's grant of discretionary authority is unenforceable based on §2001.3 of the Illinois Administrative Code, which prohibits discretionary clauses in health or disability policies issued or offered in Illinois after July 1, 2005. Section 2001.3 provides,

> No policy, contract, certificate, endorsement, rider application or agreement offered or issued in this State, by a health carrier … 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.

Courts unanimously hold that §2001.3 does not apply retroactively to policies issued prior to the regulation's July 1, 2005 effective date. Section 2001.3 does not invalidate the Allocation of

Authority provision in Tempel Steel's 2002 Plan. Zaccone, noting that the 2002 Plan was renewed in September 2005, argues that §2001.3 should apply to policies that *renew* after the §2001.3's effective date. But §2001.3 expressly applies to policies "offered or issued" after July 2005, not to policies issued prior to July 2005 and thereafter "renewed." Zaccone's "renewal theory" attempts to transform a prospective regulation into a retrospective regulation applicable to policies issued before the regulation's enactment, contrary to legal authority.

Moreover, §2001.3 undermines congressional goals in enacting ERISA and therefore is preempted. 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, because the arbitrary and capricious standard applies only in ERISA cases. In the erudite specialty of ERISA, §2001.3 amounts to heresy. The Supreme Court in *Conkright v. Frommert*, -- U.S. --, 130 S. Ct. 1640 (2010) emphasized the foundational importance of deferential judicial review to the ERISA pension and welfare system. Employers must be permitted to establish ERISA plans that provide for deferential review. Deference protects ERISA's careful balance between ensuring enforcement of plan rights and encouraging employers to offer these voluntary benefit plans in the first place. Deference fosters predictability and national uniformity in plan administration by giving interpretive discretion to the plan administrator, avoiding a patchwork system of *de novo* review where the same plan provision might have different meanings in different jurisdictions. Deference preserves Congress's objectives in establishing a uniform federal regime governing employee benefit plans. Section

2001.3 dismantles this carefully balanced system of federal rights and incentives and stands as an obstacle to Congress's objectives.

ARGUMENT

I. Section 2001.3 Does Not Apply Retroactively To Tempel Steel's 2002 Plan.

Courts unanimously hold that §2001.3, as a law of substantive impact, does not apply retroactively to ERISA plans established prior to the regulation's effective date. "For insurance plans issued prior to the effective date, the bar on discretionary clauses does not apply." *Golden v. Guardian Life Ins. Co. of Am.*, No. 09 C 865, 2010 WL 3951508, at *2 (N.D. Ill. Oct. 4, 2010). Accord *Marszalek v. Marszalek & Marszalek Plan*, 485 F.Supp.2d 935, 938-939 (N.D. Ill. 2007); *Williams v. Group Long Term Disability Ins*., No. 05 C 4418, 2006 WL 2252550, at *3 (N.D. Ill. Aug. 2, 2006).

The Plan was issued on September 1, 2002, nearly three years before §2001.3's effective date. Standard issued a new Plan, the "2007 Plan," to Tempel Steel with an effective date of January 1, 2007, which does not contain a discretionary clause. Both Plans grant participants unalterable contract rights. When an ERISA plan provides for vested contract rights, the participant's rights remain governed by the version of the plan in effect when the participant became disabled. Vested contract rights foster predictability, because participants know that their claims will be administered according to the plan in effect on the date of disability and cannot be changed.

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…."). Without unalterable contract rights, an employer can change the plan to shorten the duration of benefits or even exclude coverage for certain medical conditions. The new plan terms are binding on participants prospectively, even on participants who became disabled under the prior, more generous plan. See *Marrs v. Motorola, Inc.*, 577 F.3d 783 (7th Cir. 2009) (holding that a plan amendment limiting benefits to 24 months for psychiatric disabilities applies to a participant who became disabled six years before the amendment, because the pre-amendment plan did not provide vested contract rights).

The 2002 and 2007 Plans grant unalterable contract rights by providing that a participant's disability claim will be decided according to the Plan's terms *in effect on the date of Disability*:

> During each period of continuous Disability, we will pay LTD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive LTD Benefits will not be affected by:
> 1. Any amendment to the Group Policy that is effective after you become Disabled.
> 2. Termination of the Group Policy after you become Disabled.

(Ex. A, 2002 Plan pg. 15; Ex. B, 2007 Plan pg. 15).

The 2002 Plan governs Zaccone's disability claim, because Zaccone became Disabled on September 1, 2006 when the 2002 Plan was in force. (Ex. C, Claim Approval pg. 1: "We have determined that you became disabled on September 01, 2006"). Tempel Steel could not subsequently amend or terminate the Plan to alter the terms of Zaccone's coverage. His claim remains governed by the 2002 Plan. But that also means Zaccone's claim continues to be subject

to the 2002 Plan's Allocation of Authority provision. Section 2001.3 does not apply retroactively to bar the 2002 Plan's grant of discretionary authority. See *Golden*, 2010 WL 3951508, at *2; *Marszalek*, 485 F.Supp.2d at 938-939; *Williams*, 2006 WL 2252550, at *3.

II. The Illinois Director's "Company Bulletin" Does Not Have The Force Of Law.

Federal courts consistently hold that §2001.3 is a law of substantive impact and therefore does not apply retroactively to policies issued before §2001.3's effective date. The Illinois Insurance Director disagrees with the legal interpretation of the district courts. The Director wants §2001.3 to apply retroactively to all policies and all active disability claims. So the Director devised a "policy renewal" theory to try to extend §2001.3's reach retroactively and circumvent the unanimous legal rulings of the federal district courts. On June 28, 2010, the Director sent a "Company Bulletin" to insurers who fund health or disability plans in Illinois, declaring §2001.3 to apply "to all currently issued and outstanding" health and disability plans, contrary to the holding of *Golden*, *Marszalek*, *Williams*, and their progeny. (Ex. D, Bulletin). The Insurance Director threatened retaliatory "regulatory action" against insurers who disobey.

The Company Bulletin's *legal argument* states that annually renewable insurance policies incorporate §2001.3 by operation of law when the policies renew. "It is clearly the law of this State that a contract of annually renewable insurance forms a new contract at each renewal for the purpose of incorporating into the contract statutory provisions enacted after the creation of the original contract relationship." The Company Bulletin concludes that health and disability policies "typically are renewed annually" and "[i]t is therefore unlikely that there are any policies

in existence that have not been either renewed or issued subsequent to the effective date of the regulation." (Ex. D, Bulletin).

Goaded by the Director's Company Bulletin, Zaccone argues that Tempel Steel's 2002 Plan renewed on September 1, 2005, and upon renewal became a new insurance contract incorporating §2001.3 by operation of law, which nullified the 2002 Plan's Allocation of Authority provision. The Director and Zaccone mistakenly equate renewal of an existing policy with issuance of a new policy. Illinois' Insurance Code and insurance regulations recognize a distinction between renewed policies and issued policies. When Illinois enacts a law that applies both to issued policies and renewed policies, the law clearly says so by employing the terms "issued" or "renewed" in the law's text. Section 356 of the Insurance Code, for example, prohibits policy provisions that limit medical coverage when an insured is eligible for Medicaid. Section 356 explicitly applies to policies "issued," "renewed," or "amended" after the law's effective date. See 215 ILCS 5/356i(b) ("An individual or group policy of accident and health insurance that is delivered or *issued* for delivery to any person in this state *or renewed or amended* may not contain any provision which limits or excluded payment of hospital or medical benefits coverage to or on behalf of the insured … [is] receiving Medicaid benefits….") (emphasis added). See also 50 Ill. Admin. Code 2009.10 ("This Part shall apply to all group accident and health insurance policies … which are *issued*, delivered, amended *or renewed* in this State on or after the effective date of this Part.); 50 Ill. Admin. Code 921.30 ("no automobile insurance policy *issued or renewed* in this State shall contain ….) (emphasis added).

Section 2001.3 expressly applies to health or disability policies "offered" or "issued" in Illinois, and not to policies amended or renewed. When Illinois enacts a law applicable to issued policies or renewed policies, the law explicitly says so. Finding the omission of "renewed" dispositive to §2001.3's legal interpretation, the court in *Haines v. Reliance Standard Life Ins. Co.*, No. 09 C 7648, 2010 WL 2607257 (N.D. Ill. June 23, 2010) held, "The plain meaning of the section [§2001.3] does not apply to polices that are merely renewed." *Id.* at *2 (citing *Marszalek*, 485 F.Supp.2d at 938-939).

On a motion for reconsideration, the *Haines* court made a crucial error and reversed its holding based on the Director's newly issued Company Bulletin. *Haines v. Reliance Standard Life Ins. Co.*, No. 09 C 7648, slip op. (N.D. Ill. Sept. 9, 2010). The court erroneously deferred to the Director's legal interpretation of §2001.3 in the Company Bulletin, stating "[a]n agency's interpretation of its own regulation, unless plainly erroneous or inconsistent with the regulation, is controlling," citing *Joseph v. Holder*, 579 F.3d 827, 831 (7th Cir. 2009). But *Joseph* applies to a *federal agency's* interpretation of rules under federal law. An Illinois agency's legal interpretation of its rules under Illinois law warrants no deference whatsoever. The *Haines* court erred by deferring to the Director's "policy renewal theory" of §2001.3 in the Company Bulletin.

Haines' erroneous deference to the Insurance Director's legal interpretation of §2001.3 was laid bare in *Garvey v. Piper Rudnick LLP Long Term Disability Ins. Plan*, No. 08 C 1093, 2011 WL 1103834 (N.D. Ill. Mar. 25, 2011). *Garvey* held that the Director's legal interpretation of §2001.3 in the Company Bulletin "does not have the force of law." *Id.* at *3. *Garvey* explained, "In

Illinois, a state agency's interpretation of its own regulation 'is a question of law, which receives de novo review.'" *Id.* at *3 (quoting *Sartwell v. Bd. of Trs. of Teachers' Retirement Sys.*, 403 Ill.App.3d 719, 936 N.E.2d 610, 616 (4th Dist. 2010)). "[S]ome deference is owed an agency's interpretation of a regulation when the interpretation rests on the agency's 'experience and expertise[.]'" *Id.* (citing *Dusthimer v. Bd. of Trs. of Univ. of Ill.*, 368 Ill.App.3d 159, 857 N.E.2d 343, 350 (4th Dist. 2006)). But "the retroactivity of Section 2001.3 is a purely legal matter falling squarely within the purview of the courts." *Id.* "[A]ll the experience and expertise in the world cannot change what a regulation plainly says." *Id.* (quoting *Dusthimer*, 857 N.E.2d at 350).[1]

As *Garvey* instructs, the Insurance Director's legal interpretation of §2001.3 "does not have the force of law." *Id.* *3. Section 2001.3 applies to policies "offered" or "issued" after July 1, 2005, and does not apply retroactively to policies issued prior to July 1, 2005 and subsequently renewed. *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F.Supp.2d 722, 740-741 (N.D. Ill. 2009), rev'd on other grounds, 615 F.3d 758 (7th Cir. 2010) ("The regulation affects policies 'offered or issued' after the effective date. The Plan, issued nearly six years prior to that date, would appear to fall outside the scope of this prohibition.").

Tempel Steel's Plan was issued in 2002 and remained continuously in effect through January 1, 2007, when it was replaced by the 2007 Plan. Zaccone's Disability commenced September 1, 2006, when the 2002 Plan was in force. The 2002 Plan expressly provides that a participant's

[1] The *Garvey* court did not need to address whether §2001.3 applies to "renewed" polices, because the court found that the plaintiff failed to present any evidence that group policy had renewed.

disability claim will be governed by the Plan's terms in effect on the date of Disability, and will not be altered by any subsequent amendments or termination of the Plan. The contractual terms governing Zaccone's disability claim became fixed and unalterable on his date of Disability, September 1, 2006, under a 2002 Plan that grants discretionary authority to Standard.

Because §2001.3 does not apply retroactively, the 2002 Plan's grant of discretionary authority is valid and enforceable with respect to Zaccone's disability claim. The Insurance Director's legal opinion to the contrary, based on a "renewal theory" that is not expressed in the text of §2001.3, does not have the force of law.

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

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)).[2] 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). "Pre-emption may be either express or implied, and 'is compelled whether Congress' command is explicitly stated in the statute's language or

[2] 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 ERISA's savings clause in §514(b)(2)(A) and preempt even state laws that regulate insurance. *Davila*, 542 U.S. at 208-209.

implicitly contained in its structure and purpose.'" *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983) (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)).

Deferential judicial review is foundational to Congress's objectives in enacting the ERISA pension and welfare system. 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). 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 opposing §502(a) preemption, Zaccone reiterates the pre-*Conkright* reasoning of the Sixth and Ninth Circuits in *Am. 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 policies containing discretionary clauses). *Ross* and *Morrison* reasoned that deferential review is not mandated by the text of ERISA, relying on *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). *Ross*, 558 F.3d at 609; *Morrison*, 584 F.3d at 847-848. As stated 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 more recent 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 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* proclaimed the paramount importance of discretionary authority to achieving Congress's objectives. 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* is irrelevant. The Supreme Court has determined that employers must have the option to create plans that provide for discretionary authority, and that discretionary authority must be judicially enforced.

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 discretionary authority. 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.

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 that plan administrators would be subject to a uniform body of laws, reduced administrative costs, and predictable results. *Id.* at 1649. Deferential review promotes Congress's goals of efficiency, predictability, and uniformity in ERISA plan administration. *Id*. 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.* (emphasis added). *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. Enlightened by *Conkright*, a law that deprives employers of the *option* of structuring their ERISA plans to provide for a deferential standard of review tampers with congressional objectives.

Zaccone's counsel, in another case, argued that *Conkright* "can easily be distinguished" because it is not a case about preemption, and the court agreed. *Ball v. Standard Ins. Co.*, No. 09 C 3668, 2011 WL 759952, at *6 (N.D. Ill. Feb. 23, 2011).[3] 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* 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

[3] It was undisputed in *Ball* that the plan was "issued" after §2001.3's effective date. But Tempel Steel's 2002 Plan was issued before §2001.3's effective date, and the regulation cannot be applied retroactively.

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 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. 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, dental, 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.

Zaccone argues that §2001.3 cannot be preempted because it does not provide for a separate cause of action or supplement or supplant ERISA's remedies in §502(a). While it is true that a state law that supplements or supplants ERISA's remedies will be preempted, §502(a) preemption is not limited only to remedies. Preemption also 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 objectives by taking away the option of deferential review, resulting in a patchwork of different plan interpretations that vary court-by-court and state-by-state. A 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. Uniformity and predictability would be impossible if courts interpret the same plan term to mean different things to different plan participants. 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") (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)).

The problem of inconsistent plan interpretations is magnified when an ERISA plan covers employees in several states, like Tempel Steel's Plan.[4] Similar employees participating in the same plan might be entitled to different rights and remedies depending on where they live. At Tempel Steel's operations in Pennsylvania, a state that does not "ban" discretionary clauses, 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 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, might calculate "earnings" to include deferred compensation or stock options. See *Orlando v. United of Omaha Life Ins. Co.*, 661 F.Supp.2d 968 (N.D. Ill. 2009) (deferring to the administrator's interpretation that earnings excludes stock options). Contrary to Zaccone's claim that §2001.3 has no impact on *remedies*, §2001.3 clearly supplements ERISA's remedies by providing residents of Illinois with the new remedy of *ad hoc* plan reformation, a remedy that would not be available to participants in the same plan who reside in states that have not banned judicial deference. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Conkright*, 130 S. Ct. at 1651 (quoting *Egelhoff*, 532

[4] Tempel Steel has employees in Pennsylvania, California, and Illinois, and international operations in Canada, Mexico, India, and China. http://www.tempel.com/region.asp?region=1 (viewed June 5, 2012).

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 imposes 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 impermissibly bans discretionary clauses nationwide. 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 and therefore is preempted by ERISA.

IV. Section 2001.3 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.

Zaccone does not dispute that §2001.3 "relates to" employee benefit plans and therefore falls within §514(a). For purposes of §514(a) 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 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).

Zaccone asserts that §2001.3 "on its face" is a law that regulates insurance. (Pl. Mem., pg. 6). Section 2001.3 masquerades as a law that regulates insurance, but it is not a law of insurance at all. Discretionary authority does not even exist in insurance law. Discretionary authority is a unique creation of ERISA, having its origins in an amalgam of trust law (*Firestone*) and congressional policy (*Conkright*). Illinois' ban on discretionary clauses targets ERISA plans, and has no impact on insurance practices outside of ERISA.

Specifically, §2001.3 regulates the federal standard of judicial review governing benefit denials under ERISA. In fact, regulating the federal standard of judicial review in ERISA cases is precisely the Illinois 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.[5] ERISA's savings clause saves from preemption state laws that regulate insurance, not state laws that mandate the federal standard of judicial review in adjudicating ERISA disputes.

Congress empowered the federal judiciary to develop review standards governing ERISA cases. *Glenn*, 554 U.S. at 116 ("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…."). Through §2001.3, the Insurance Director displaces the congressionally sanctioned role of the federal judiciary in establishing federal standards of review. Section 2001.3 is not a law that "regulates insurance." It is a law that regulates the power of the federal judiciary to establish standards of judicial review. The Insurance Director, by attempting to dictate a *de novo* standard of judicial review, has usurped a power specifically granted by Congress to the Judicial Branch.

Moreover, §2001.3 does not "substantially affect the risk pooling arrangement" between the insurer and the insured. *Miller*, 538 U.S. at 342. Zaccone, in his Memorandum, fabricates a quote and attributes it to a footnote in *Miller*. Zaccone misquotes *Miller* as stating, "A state administrative policy stripping insurers of their discretion to make benefit determinations and

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[5] The Illinois Director's rationale for §2001.3 is 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. *Black v. Long Term Disability Ins.*, 582 F.3d 738, 745 (7th Cir. 2009). The Director's misconception about deferential review exemplifies why Congress sought to ensure that ERISA remains a nationally uniform system.

policy interpretations effectively 'dictates to the insurance company the conditions under which it must pay for the risk that it has assumed.'" (Pl. Mem., pg. 6, misquoting *Miller*, 538 U.S. at 339 n.3). The *Miller* Court never mentioned state rules "stripping insurers of their discretion." That quote appears nowhere in *Miller*. In fact, *Miller* does not discuss "discretion" at all. The Court was addressing California's notice-prejudice rule, which *Unum Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999) held was saved from preemption.[6] 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." *Miller*, 538 U.S. at 339 n.3 (emphasis added). Zaccone also misstates the holding in *Glenn*, asserting that "[*Glenn*] confirmed that such discretionary clauses may substantially affect the risk pooling arrangement." (Pl. Mem., pg. 7). *Glenn* never mentions risk pooling or state laws that mandate *de novo* review. To the contrary, *Glenn* refused to adopt a rule of law "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." *Glenn*, 554 U.S. at 116.

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

[6] 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.

§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 insureds to see "any willing provider" is saved from preemption).

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 374-75). *Ross's* approach invites states to evade the preemptive force of ERISA by deeming state 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 benefit 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." *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 ERISA administrators *disprove* benefit eligibility likely would result in more legal victories for plan participants, 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.

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. The Illinois Insurance Director's declared objective for implementing §2001.3 is to change the standard of judicial review in federal court, after a claim has been denied. Section 2001.3 dictates to the federal judiciary the standard of review to be applied in adjudicating ERISA claims—a power that Congress delegated to the federal courts.

Zaccone 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 in *Ross* and *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 adopting the opinion of the patient's HMO treating physician, is saved from preemption. But the Court did not hold that state regulators are free to 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 single policy term "medical necessity": "The [Illinois HMO] Act does not give the independent reviewer 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 an HMO treating physician's decision about medical care is a "mixed eligibility" decision, which does not qualify as a fiduciary act under ERISA. The HMO Act, therefore, did not interfere with a fiduciary function under ERISA. The Court in *Rush Prudential* carefully avoided any suggestion that states are free to mandate rules that would result in universal *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 aims to completely deprive employers of the option of establishing ERISA plans that provide for deferential judicial review of all fiduciary functions of ERISA administrators. Section 2001.3 usurps the Supreme Court's determination—articulated in *Conkright*—that deferential judicial review promotes important congressional objectives of national uniformity, predictability, and encouraging employers to offer benefit plans.

Zaccone argues that the district court in *Haines*, in an unpublished slip opinion, ruled that §2001.3 is not preempted. (Pl. Mem., pgs. 2-3). 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 unaddressed by the court), and obviously no argument that §2001.3 stands as an obstacle to congressional objectives based on *Conkright*. Issues of §2001.3's enforceability—including conflict preemption, complete preemption, Congress's intent, and Congress's delegation of authority to the federal judiciary to establish standards of judicial review under ERISA—are of national importance, too important to be decided without the guidance of fully developed legal briefs. The *Haines* slip opinion is not persuasive authority.[7]

Conkright is the first Supreme Court to proclaim that Congress intended that employers must have the *option* of creating ERISA plans that provide for deferential judicial review. Section 2001.3 takes away an option that Congress found crucial to fulfilling ERISA's paramount goals of national uniformity, predictability, and encouragement of plan formation.

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), aff'd, 440 Fed.Appx. 66 (3rd Cir. 2011), the court refused to enforce New Jersey's

[7] Zaccone also cites *Curtis v. Hartford Life & Acc. Ins. Co.*, No. 11 C 2448, 2012 WL 138608 (N.D. Ill. Jan. 18, 2012), another case in which the parties and the court never addressed *Conkright*.

statute banning discretionary clauses. The *Baker* court found that the state law 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. (Internal citation omitted).

Id. (quoting *Davila*, 542 U.S. at 208). See also *Lucero v. Hartford Life & Acc. 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 the insured. Section 2001.3, therefore, is preempted by §514(a) and does not fall within ERISA's savings clause.

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

Zaccone 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 precludes 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 the interpretation of contract terms. Under the plain language of §2001.3, the plan's contractual terms might be reviewed by the court *de novo*, but the administrator's medical and vocational determinations remain entitled to deferential review.

Not all discretionary decisions involve issues of contract interpretation. ERISA administrators also exercise discretionary authority when evaluating medical data, including whether the medical findings support a particular diagnosis, quantifying the risks associated with a medical condition, and measuring the functional restrictions and limitations caused by a medical condition. See *Davis v. Unum Life Ins. Co. of Am.*, 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."). ERISA administrators also exercise discretionary authority when establishing and enforcing rules for administering claims. See *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).

Tempel Steel's Plan contains a far broader grant of discretionary authority than only the discretion to interpret the *terms of the contract*. Standard also has discretionary authority to "resolve all matters when a review has been requested," "establish and enforce rules and procedures," and "determine … the sufficiency and the amount of information we may reasonably require" to determine "eligibility for insurance" and "entitlement to benefits." "[A]ny decision we make in the exercise of our authority is conclusive and binding." (Ex. A, 2002 Plan at pgs. 20-21).

Michigan's insurance rule completely banned discretionary clauses outright, but the Sixth Circuit in *Ross* limited its holding to ERISA administrators' discretionary authority to interpret contract terms. *Ross* acknowledges that ERISA administrators may retain discretionary authority to determine benefit eligibility when the contract terms are clear: "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. [W]hile 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 discretion to interpret the medical evidence and establish rules for claims administration, warranting deferential judicial review of those determinations.

CONCLUSION

Because §2001.3 does not apply retroactively, the 2002 Plan's grant of discretionary authority is valid and enforceable with respect to Zaccone's disability claim. The Insurance Director's legal opinion to the contrary, based on a "renewal theory" that is not expressed in the text of §2001.3, does not have the force of law. Moreover, by purporting to prohibit discretionary clauses in ERISA plans, §2001.3 thwarts Congress's carefully balanced comprehensive federal system of employee benefits. Standard's benefit decision is properly reviewed by the Court under the arbitrary and capricious standard of review.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on June 5, 2012, 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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