

INSURANCE CONSUMER COUNSEL'S COLUMN

THE "DISCRETIONARY CLAUSE" IN ERISA HEALTH INSURANCE PLANS

BY PROFESSOR GREG MUNRO¹

Introduction

ERISA, the Employee Retirement Income Security Act of 1974,² was instituted by Congress to standardize the health, retirement, and disability plans offered by private employers in the United States. For plaintiffs' lawyers, the Act may be most notable for its express preemption of state common law remedies for denial, reduction, or termination of benefits promised under employer-sponsored plans. Any cause of action regarding such benefit decisions can only be based on equitable remedies provided in the Act itself. While the Act does not allow the compensatory and punitive damages which are standard tools for state-court remedy of violations of insurer promises, it does provide for a reasonable attorney fee in some cases where the employee prevails against an ERISA plan. Not surprisingly, ERISA is commonly viewed as the bane of existence for lawyer's representing injured persons who must depend on benefits from an ERISA plan, and not without justification.

A key feature of ERISA plans in the past decade has been the "discretionary clause," a provision that purports to confer on the ERISA plan administrator or insurer the power, in its sole discretion, to determine eligibility for benefits and to interpret the terms and provisions of the plan policy. Because federal courts have elected to treat the administrators' decisions in exercising such discretion as equivalent to administrative decisions of government agencies, they have tended to limit judicial review by applying a standard requiring deference to the decision except in cases of abuse of discretion.³ The end result is that one party to the

contract, the plan administrator, has significant power to determine terms of the contract after the inception of the contract. The insured must appeal to the plan and can only achieve redress of grievances in court if he or she can show abuse of discretion. Notably, this process means the insured never had the use of any discovery, such as a deposition, to inquire how the denial decision was made in the first place.

Unfortunately, in 1989, the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*,⁴ approved the use of discretionary clauses in health, life, and disability employer-sponsored benefit plans. This coupled with holdings that decisions under the discretionary clause would be reviewed under an abuse-of-discretion standard meant that the benefits decisions of private insurance companies were being accorded the same deference as decisions of agencies of the executive branch of government.

In 2006, the then Insurance Commissioner for the State of Montana, John Morrison, prohibited the use of the discretionary clause in employer-based plans in Montana. He concluded, under the language of MCA § 33-1-502(2) that such clauses are "inconsistent, ambiguous and misleading" and "deceptively affects the risk purported to be assumed in the general coverage of the contract" so as to render the clauses violative of the statute. While ERISA preempts state law as it applies to ERISA plans, the Act provides an exception for "regulation of the business of insurance" and Morrison acted under that exception.

Morrison was not alone in banning discretionary clauses. In 2002, the National Association of

Insurance Commissioners (NAIC) had adopted Model Act 42 titled "Prohibition on the Use of Discretionary Clauses Model Act." The NAIC recommended that its members initiate legislation to prohibit clauses that purport 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 the state." Commissioners in states including New York (2006),⁵ California (2004),⁶ and Illinois (2005),⁷ prohibited discretionary clauses in the plans.

The Commissioner, John Morrison, was sued by the industry in federal court in Montana but won summary judgment in Judge Molloy's court. The case was appealed to the 9th Circuit and may someday reach the United States Supreme Court. The issue of the power of state insurance commissioners to regulate the use of the discretionary clause is of great importance and provides readers of *Trial Trends* an opportunity to visit the underpinnings of ERISA, the discretionary clause, and the authority of the Insurance Commissioner. Such a review should assist plaintiffs' counsel in dealing with the ever present problems created by ERISA.

Background of ERISA

By implication, ERISA is very much a part of the health care debate in the United States today. Because the U.S. does not have universal health care, the major source of health care coverage in the country has been sponsored by employers. It does not appear that any politically viable reform of American health care is going to change that. In order

to encourage private employers to provide health, disability, and retirement benefits, Congress passed the Employment Income Retirement and Security Act in 1974. While a major impetus for the Act was protection and promotion of pension plans, health care was included. Today, an estimated 85% of Americans receive health care coverage from their employers, though not all of the employment-based plans are governed by ERISA.

In ERISA's preamble, Congress made clear three important intentions: (1) protection of plan participants and beneficiaries by requiring certain financial accounting and disclosure to them; (2) establishing standards of conduct and responsibility for the fiduciaries involved in the plans; and (3) establishing a system of remedies and sanctions to enforce rights and obligations under the Act.

The first two intentions and the anti-discrimination provisions of the Act were aimed at preventing abuses. The function of the third was to introduce a uniform

structure for the handling of claims arising out of denial, reduction, or termination of benefits. In order to encourage employers ("plan sponsors") to provide health, disability, and pension benefits, Congress abrogated the rights of employees ("plan participants") to bring causes of action based in state law against the employers providing the benefit plans and their insurance companies. Instead, Congress substituted a set of remedies entirely based in ERISA.

The Act recognizes "plan administrators," often insurers which owe a fiduciary obligation to benefit the plan and employees. The plan sponsor or plan administrator may delegate administrative duties to a "third-party administrator," again often an insurer, which simply provides administration for the plan and does not provide benefits.

ERISA's Preemption of State Law

ERISA provides that "[e]xcept as provided in subsection (b) of this section, the provisions of this subchapter... shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. ..."⁸ A classic example of the import of that preemption can be seen in the treatment Montana's "made-whole" rule with regard to insurer subrogation. Since 1977, in *Skauge v. Mountain States Tel. & Tel. Co.*,⁹ the Montana Supreme Court has held that an insurer cannot claim subrogation until the insured has recovered the insured's entire loss including costs and attorney fees.¹⁰ This is known as the "made-whole" rule. Insurance subrogation and the made-whole rule are creations of the state courts. In the case of ERISA plans, such common law is preempted.¹¹ The 9th Circuit Court of Appeals, in 1994, adopted the made-whole rule for ERISA plans in *Barnes v. Independent Auto Dealers Ass'n of California Health and Welfare Benefit Plan*,¹² but said, "absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for her injuries, that is, has been made whole." Unfortunately, the case was an open invitation to the plan drafters to make each plan "an agreement to the contrary," and it is common today that plans expressly provide that the plan gets full subrogation regardless of whether the insured has been made whole. The unjust result can be seen in the federal court decision in *Marquis v. Ironworkers Intermountain Health and Welfare Trust Fund*¹³ where the ERISA health plan language expressly abrogated the made-whole doctrine. There Judge Molloy decried the fact that Circuit precedent forced him to allow the insurer to collect \$317,000 subrogation from an \$800,000 total tort recovery of a worker rendered quadriplegic.

More importantly, state law of insurance bad faith and the accompanying claims for relief and remedies such as

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punitive damages are preempted under ERISA under *Pilot Life v. Dedeanx*¹⁴ and *Aetna Health Inc. v. Davila*.¹⁵ Preemption of state laws and remedies effectively removes any meaningful sanctions and severely restricts the incentive for an ERISA plan administrator's failure to meet the full benefit obligations owed to their insureds.

Claims by the Insured Employee Under ERISA Plans

The ERISA plans provide for an internal process for appeal of benefit decisions. This generally requires the employee to appeal to an entity or person involved with the plan administrator. The employee aggrieved by a benefits decision will file any necessary medical records or other evidence supporting his or her position. ERISA provides for notice of decisions but does not provide for a hearing in such appeals. Nevertheless, the insured must exhaust this appeal process just as claimants in the administrative system of the executive branch must exhaust administrative remedies before filing in a federal district court.

If the administrator denies the claim on appeal, the insured can file an action based in the Act for statutory relief. The insured cannot file a breach of contract claim or other common law legal claim.

Most importantly, where the plan contains a discretionary clause, the standard of judicial review on appeal to a district court is not *de novo*. The courts have treated the discretion the ERISA plan grants itself much like the discretion of government administrative agencies. Consequently, the courts grant deference to the decision of the plan and can only reverse the decision of the administrator on a finding of abuse of discretion. As the Federal District Court in Massachusetts said in *Radford Trust v. UNUM Life Ins. Co. of America*,¹⁶ Congress placed "limitations on judicial review

of plan administrators and fiduciaries' decisions similar to the ones placed on judicial review of governmental agency action, even though, unlike officials in governmental agencies, administrators and fiduciaries are not answerable to the public or to elected officials." As John Garamendi noted as Insurance Commissioner for the State of California, "This standard of review deprives California insureds of access to the protections in the Insurance Code and in California Law."¹⁷

The Third Circuit, in *Bruch v. Firestone Tire & Rubber Co.*¹⁸ said that the arbitrary and capricious standard originated with the Labor Management Relations Act but noted that, by nature of the LMRA requirements, there was a certain assurance of impartiality of the trustees in those plans. The *Bruch* court noted that, in any unfunded plan run entirely by the employer, "every dollar provided in benefits is a dollar spent by defendant Firestone, the employer; and every dollar saved by the administrator on behalf of his employer is a dollar in Firestone's pocket." The court questioned judicial deference to such decisions under an abuse-of-discretion standard because of the inherent conflict of interest.

Hawaii, while permitting the discretionary clause, stripped decisions under that clause from the deference standard and specified that judicial review of decisions made under discretionary clauses are subject to *de novo* review.¹⁹ This allows the insured discovery and a full trial on the merits.

ERISA's "Savings Clause" and the Tradition of State Regulation of Insurance

ERISA's express and sweeping preemption of state common law in favor of a uniform federal structure for resolving claims for denial, reduction, or termination of benefits has a "savings" clause, which provides that

"nothing in this chapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance."²⁰ Hence, state laws regulating the business of insurance survive the broad federal preemption of ERISA.

Underpinning the savings clause is 150 years of a legal tradition in which the insurance industry has been regulated by the states and not the federal government. In 1869, the United States Supreme Court held in *Paul v. Virginia*,²¹ that issuance of policies of insurance were not transactions in commerce, reasoning that they were not traded or bartered in a market and were not "articles of commerce in any proper meaning of the word," or "commodities to be shipped from one state to another." Consequently, Congress could not regulate insurance under the Commerce Clause of the Constitution. Moreover, it was implicit when Congress enacted the antitrust provisions in the Sherman Act in 1890 that the provisions would not apply to insurance. As a result, there developed a system of state regulation of the insurance industry. That system had a national as opposed to federal aspect insofar as there was cooperation between the states through the growing National Association of Insurance Commissioners.

However, in 1944, the Supreme Court rocked the insurance industry in *United States v. South-Eastern Underwriters Association* by holding that transactions of an insurance rating bureau and its member companies which were alleged to constitute boycotts and antitrust violations could be regulated under the Commerce Clause.²² The overruling of *Paul v. Virginia* and its implications for the industry caused Congress, at the behest of the NAIC and the industry, to enact the McCarran-Ferguson Act in 1945.²³ McCarran-Ferguson expressly provided for the continued regulation of the business

of insurance by the several states to the exclusion of the federal government.²⁴ McCarran-Ferguson also provided that the Sherman Act would apply only to agreements to boycott, coerce, or intimidate.²⁵ Consequently, insurance today is regulated by the states, although the system may be described as “national” regulation in light of the coordinated efforts of the NAIC, the organization of the state insurance commissioners, especially the promotion of uniform laws and regulations by that group.

The Tension Between State Regulation of Insurance and ERISA Preemption of State Law

ERISA mandates that, in cases of benefit disputes, all state remedies available to the insured (i.e., breach of contract, bad faith, and negligent representation) are preempted, and the insured is limited to the remedies specified in the Act. It then excepts from this preemption any state law that regulates insurance. As Judge Molloy said in deciding *Standard Insurance Company v. John Morrison*, “...when federal law provides a uniform regulatory and enforcement scheme while simultaneously and expressly recognizing a space within this scheme for state governments to ‘regulate insurance,’ the question becomes one of fit between the state Insurance Commissioner’s action and the federal statutory scheme Congress has established.”²⁶ The tension arises when an insurance commissioner acts to regulate an ERISA plan under a state law regulating insurance with the expectation that it will fall under the savings clause, while the ERISA plan expects that it is free from the act under ERISA’s inherent preemption. The dispute over the discretionary clauses illustrates this perfectly.

Courts too are exasperated by ERISA and the issues it provokes. Judge William Acker, Jr., Senior

United States Judge for the Northern District of Alabama writing in a law review article describes ERISA as “beyond redemption” saying that “Occasionally a statute comes along that is so poorly contemplated by the draftspersons that it cannot be saved by judicial interpretation, innovation, or manipulation. It becomes a litigant’s plaything and a judge’s nightmare. ERISA falls into this category.”²⁷ The 7th Circuit questioned why the United States Supreme Court determined that disputes between employees and insurance companies over the meaning of contract terms were disputes under ERISA to be resolved in Federal Courts.²⁸

Of particular importance to insurers is the fact that the United States Supreme Court, in *Pilot Life v. Dedeaux*,²⁹ and *Aetna Health Inc. v. Davila*,³⁰ interpreted “state regulation of insurance” narrowly enough to exclude claims involving bad faith and punitive damages. Judicial determination that bad faith insurance suits are not “regulation of insurance” protected from ERISA preemption means the plans have way less economic incentive to pay claims.

Inevitably then, the plans and their insureds are going to square off on the issue of whether the state regulation supporting the insured’s position is state regulation of insurance within the meaning of the Act’s savings clause. The stakes are enormous as is best illustrated by an internal memo of Provident Insurance Company of October 2, 1995.³¹ There an executive writes:

The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, and there are no compensatory or punitive damages. Relief is usually limited to the amount of benefit

in question, and claims administrators may receive deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for \$7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.

The executive inveighs personnel to identify and initiate modification of plans to be covered under ERISA wherever possible.

Standard Insurance Company’s Discretionary Clauses

Standard is an insurance company organized in Oregon and authorized to sell disability, accidental death and dismemberment policies. The company has historically included discretionary clauses in both ERISA and non-ERISA policies. In 2005, when Morrison ordered Standard to remove the clauses, the company elected instead to attach a rider entitled a “Grant of Discretion” which, by its terms only applied to the ERISA policies. In 2006, Morrison disapproved the “Grant of Discretion” clauses, and Standard filed separate actions in state and federal court in Montana seeking injunctive and declaratory relief under the allegation that ERISA preempted any legal authority the commissioner may have had to regulate the clauses.

The Authority of the Montana Insurance Commissioner to Regulate Insurance Provisions

The Commissioner of Insurance in Montana has the authority to enforce the insurance code in the state, and accordingly, the authority to

regulate insurance. MCA § 33-1-311(1) and (2) provide that the Commissioner “shall enforce the applicable provisions of the laws” of the State of Montana and has “the powers and authority expressly conferred upon [him] or reasonably implied from the provisions of the laws of this state.” He is expressly given the duty of approving or disapproving the forms used by the insurers in the state.³²

MCA § 33-1-502 provides that “the commissioner shall disapprove any form... or withdraw any previous approval...” if the form “contains...any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract...” “Under this authority, Commissioner John Morrison disapproved the discretionary clauses in policies of Standard Insurance Company.

The Test for Determining if the Regulator’s Act is “State Regulation of Insurance”


In 2003, the United States Supreme Court in *Kentucky Ass’n of Health Plans, Inc. v. Miller*,³³ set forth a two-part test for determining whether a state law regulates insurance so as to be protected from ERISA preemption under the savings clause:

Today we... hold that for a state law to be deemed a “law... which regulates insurance” under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. [Citations omitted]. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky’s law satisfies each of these requirements.

The first part of the test, whether the state law is specifically directed toward entities engaged in insurance is more often than not the proverbial “no brainer.” The Supreme Court has held that, “as a matter of common sense,” a California statute requiring insurers to prove prejudice before enforcing proof-of-claim requirements was directed at such entities.³⁴ In *Rush Prudential HMO, Inc. v. Moran*,³⁵ Illinois statute provided for an independent medical review panel that could review the denials of claims by an HMO governed by ERISA. When that panel found that a surgical procedure was medically necessary after the HMO said it was not, the law was attacked as being preempted by ERISA. The Supreme Court held that the statute was a law “directed toward” the insurance industry.

In *Standard Insurance Company v. John Morrison*, the statute requiring disapproval of plan provisions that are “inconsistent, ambiguous, or misleading” or which “deceptively affect the risk purported to be assumed in the general coverage of the contract” is aimed solely at insurance policies. In the trial court and at the 9th Circuit, Standard argued that the statute merely applies *contra proferentem*, the doctrine that ambiguity in a contract is construed against the drafter, and that *contra proferentem* is applied under state law to all contracts, not just insurance contracts. Standard then reasoned that the statute is not directed to insurance companies. However, the core of the statute prohibits clauses that “deceptively affect the risk purported to be assumed in the general coverage...,” which prohibition is directed only at insurance policies and not other contracts. Judge Molloy followed the Supreme Court precedents in determining that John Morrison’s conduct in prohibiting discretionary clauses in Montana health plans, “... is the stuff of garden variety insurance regulation through the imposition of standard policy terms,” quoting *Rush Prudential*.³⁶ Molloy simply found that disapproval of the discretionary clauses in ERISA plans “is directed at entities engaged in insurance.”

The second determination, whether disapproval



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of the clauses “substantially affects the risk pooling arrangement,” has hinged on the definition of risk pooling. The industry argues that the term “risk pooling” is an actuarial term peculiar to the insurance industry, which is the sole arbiter of its application. Standard argued at length in Montana Federal District Court that risk pooling means the act by which insurance actuaries decide in which risk classification the insured is placed. Standard’s contention is that, once that classification is made, the risk pool is set, and nothing that happens after that can affect risk pooling. Consequently, the company’s decisions under the discretionary clause after the insured suffers a loss cannot substantially affect the risk pooling arrangement.

However, this does not accord with the United States Supreme Court’s pronouncement in *Kentucky Ass’n* that “it suffices that they [the statutes] substantially affect the risk pooling arrangement between the insurer and the insured.” The court there defined “risk pooling” as altering “the scope of permissible bargains between insurers and insureds.”³⁷ The *Kentucky Ass’n* court held that a statute there which expanded the number of providers from whom an insurer could receive health services “altered the scope of permissible bargains between insurers and insureds” so as to affect the risk pooling arrangements. Jim Hunt, counsel for Morrison in the Standard Insurance Company case, ably argued that Morrison’s prohibition of the discretionary clauses altered the permissible bargain between the insurers and the insureds in Montana. No longer could the plan agreement which is the subject of the bargain contain a discretionary clause, and Judge Molloy found that prohibition “alters the scope of permissible bargains between insurers and insureds.”³⁸ Hence, his quote from Rush Prudential that “this is the stuff

of garden variety insurance regulation through the imposition of standard policy terms.”³⁹

Progress and Status of the Litigation in Montana

Standard Insurance Company could have litigated the issue of the discretionary clause in some of the most populous venues in the nation, New York, California, or Illinois, where insurance commissioners banned the clause. One cannot help speculating that the company chose Montana Federal Court as its venue for challenging authority of an insurance commissioner on the belief that the courts here would be more friendly to their position or perhaps too unsophisticated to deal with it. There is a little humor in that choice given the insurance expertise of the Montana courts, the consumer orientation of Commissioner Morrison, and the cadre of zealous plaintiffs’ insurance counsel like Jim Hunt who inhabit the state.

Standard filed suit for declaratory and injunctive relief in the Helena Division of the Montana Federal District Court on September 26, 2006, and in the Montana First Judicial District Court in Lewis and Clark County at the same time. After discovery in the federal suit, the parties submitted the case on cross motions for summary judgment. On February 27, 2008, Judge Molloy denied Standard Insurance Company’s motion and granted Commissioner Morrison’s motion concluding that Morrison’s action in prohibiting the discretionary clause “is the straight forward regulation of insurance, a matter ERISA expressly saves from preemption.”⁴⁰ That decision is on appeal to the 9th Circuit and has been fully briefed and argued by Jim Hunt on behalf of the Commissioner. Standard shifted its argument at the 9th Circuit expanding its contention that Morrison’s act of prohibiting the discretionary clause under MCA

§ 33-1-502 is actually a remedy that conflicts with ERISA’s remedial scheme. Standard even implied that Judge Molloy found Morrison’s statutory interpretation conflicted with ERISA, but Molly actually found the opposite, saying Morrison’s disapproval of discretionary clauses “does not implicate ERISA’s enforcement scheme at all, and is no different from the types of substantive state regulation of insurance contract [the Supreme Court has] in the past permitted to survive preemption.”⁴¹

The state court action also went down on cross motions for summary judgment the issue there being whether Morrison’s decision that the discretionary clause violated MCA § 33-1-502 was correct.⁴² Judge Honzel, quoted Standard’s Grant of Discretion clause which provided, “We will pay benefits under the Group Policy if we decide that you are entitled to them... In exercising our discretion, we must act prudently and in the interest of all Members.” Honzel noted with approval the California Superior Court’s holding that such a discretionary clause renders the insurer’s promise to pay uncertain, ambiguous, misleading, and illusory, and he held that Standard’s clause was ambiguous and inconsistent so as to violate the statute.⁴³ That decision was not appealed. Hence, the remaining issue pending before the 9th Circuit is whether Morrison’s prohibition of discretionary clauses under the Montana statutes is regulation of insurance saved from the preemption of ERISA.

Conclusion

Perhaps there is some hope on the horizon. Recently, in *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343 (2008), the U.S. Supreme Court recognized that “a plan administrator that both evaluates and pays claims operates under a conflict of interest” and pondered how a court could account for such a conflict of interest. Glenn,

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at 2347. While it seems patently obvious that a for-profit insurance company gets to keep more of the premium dollar paid by the employer when the insurer denies a plan participant's claim for plan benefits, the Supreme Court stumbled when determining the standard of review federal courts should apply when reviewing such a conflicted denial of plan benefits to a plan participant. The Supreme Court did not do away with the abuse of discretion standard and adopt instead a *de novo* standard as it should have done. Instead, the majority, after much dithering on what to do, approved the old abuse of discretion standard but directed lower courts to take into account as a factor the conflict of interest in reviewing the decision of the plan administrator. In short, the holding in *Glenn* does nothing more than affirm the status quo with regard to the ERISA standard of review while recognizing that there does appear to be a conflict of interest for plan administrators who fund the plan benefits.

The remarkable power imbalance between insureds and insurers under ERISA is most apparent in the insurers' insertion of the discretionary clauses and the courts' consequent deference to decisions made under those clauses. The ultimate unfairness of denying *de novo* review and requiring a showing of abuse of discretion where the insurer has unreasonably withheld or denied a benefit prompted the NAIC to draft and recommend rules prohibiting the discretionary clause.

Given the vast economic benefit to the insurers in arming their plans with a clause so antithetical to the welfare of the plan beneficiaries, the prohibition of the clause has sparked the important litigation now at the 9th Circuit and possibly headed for the United States Supreme Court. If the Commissioners who have been

forthright enough to ban the clauses can prevail, a great blow will have been struck for insurance consumers of health, disability, and accident plans. May the force be with them!

ADDENDUM

After this article was submitted for publication, the 9th Circuit on September 14, 2009 filed its decision in *Montour v. Hartford Life & Accident Insurance Company*, (2:07-cv-05215-DSF-RZ). There, Hartford was both the disability plan administrator and the insurer and inserted a discretionary clause into its plan. Hartford terminated the ERISA disability benefits of Montour who qualified for Social Security disability by reason of significant psychiatric disorders as well as orthopedic problems. After starting benefits, Hartford conducted surveillance with no significant result and hired multiple consulting experts to gain opinions that Montour could do light or sedentary work. The experts conducted "pure paper" reviews and no physical exams. Hartford's resulting termination of benefits was reviewed in federal district court under an abuse of discretion standard, and Hartford was awarded summary judgment.

The 9th Circuit reversed, ordered summary judgment for Montour, and reinstated his disability benefits. The court reasoned that Hartford's conflict of interest motivated its decision to terminate Montour's benefits to the point that it constituted an abuse of administrative discretion. In reviewing the record from the district court, the 9th Circuit concluded, "Hartford's bias infiltrated the entire administrative decision making process, which leads us to accord significant weight to the conflict." In such a weighty conflict, the 9th Circuit asserted that it still applies the abuse of discretion standard but says that, under that standard, if the conflict is

substantial, the denial constitutes an abuse of administrative discretion. *Montour* is salutary because a weighty conflict should exist in many discretionary clause cases where the disability benefits insurer is also the ERISA plan administrator.

ENDNOTES

1. 128 S.Ct. 2343 (2008).
2. Glenn, 128 U.S. at 2347.
3. See, for example, *Perlman v. Swiss Bank Corp.*, 195F.3d 975(7th Cir. 1999).
4. 489 U.S. 101 (1989).
5. Circular Letter No. 14 (2006), State of New York Insurance Department.
6. Notice to Withdraw Approval, Feb. 27, 2004, State of California Department of Insurance.
7. 29 Illinois Register 100172, July 1, 2005.
8. 29 U.S.C. § 1144(a).
9. 172 Mont. 521, 565 P.2d 628.
10. See also, *DeTienne Associates v. Farmers Union Mutual Insurance Co.*, 266 Mont. 184, 879 P.2d 704 (1994).
11. *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1502 (9th Cir. 1985).
12. 64 F.3d 1389.
13. 24 M.F.R. 68 (1998).
14. 481 U.S. 41 (1987).
15. 542 U.S. 200 (2004).
16. 321 F.Supp.2d 226, 240 (D.Mass. 2004).
17. Notice and Order of Commissioner Garamendi, Feb. 27, 2004, State of California, Dept. of Insurance.
18. 828 F.2d 134 (1987).
19. Memorandum 2004-13H, Dec. 8, 2004, Hawaii Insurance Div., Dept. Of Commerce & Cons. Affairs.
20. 29 U.S.C. § 1144(b)(2)(A).
21. 75 U.S. (8 Wall.) 168, 183, 19 L.Ed. 357.
22. 322 U.S. 533, 64 S.Ct. 1162, 88 L.Ed. 1440.
23. 15 U.S.C. § 1011-15.
24. 15 U.S.C. § 1012(b).
25. 15 U.S.C. § 1013(b).
26. 537 F.Supp.2d 1142 (D.Mont. 2008).
27. William Acker, Jr., "Can the Courts Rescue ERISA?" 29 Cumb. L. Rev. 285, 285-86 (1999).
28. *Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 512 (7th Cir. 1989).
29. 481 U.S. 41 (1987).
30. 542 U.S. 200 (2004).
31. Memo of McCall to IDC Management Group and Glenn Felton, Oct. 2, 1995.
32. MCA §§ 33-1-501 and 502.
33. 538 U.S. 329.
34. *UNUM Life Insurance Co. of America v. Ward*, 526 U.S. 358 (1999).
35. 536 U.S. 355, 366 (2002).
36. 537 F.Supp.2d 1152.
37. *Kentucky Ass'n* at 338-339.
38. 537 F.Supp.2d at 1152.
39. *Id.*
40. *Id.*
41. 537 F.Supp.2d at 1153, Citing, *Rush v. Prudential*, 536 U.S. at 386.
42. Cause No.: CDV-2006-706.
43. *Id.*, Memorandum and Order on Motions for Summary Judgment, 9. ♦

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