A Deep Dive into State Discretionary Bans, *plus* De Novo Review

Kristina N. Holmstrom
Ogletree Deakins Nash Smoak & Stewart PC
2415 E Camelback Rd Ste 800
Phoenix, AZ 85016
Kristina.Holmstrom@Ogletree.com

Kristina N. Holmstrom is a shareholder in the Phoenix office of Ogletree Deakins Nash Smoak & Stewart PC. She has a national practice representing large insurers with a heavy focus on the Southwest—both in trial court and on appeal. Ms. Holmstrom serves as lead counsel in defending insurers and employers against claims for ERISA benefits, claims for breach of fiduciary duty, and state-law claims for bad faith and breach of contract for all types of insurance policies. She also assists insurers in pursuing claims for rescission and interpleader. This nationwide practice allows Ms. Holmstrom to provide valuable counseling to her clients on maintaining a consistent strategy regionally and nationally.

One of the first things to assess when an ERISA case comes in is what standard of review will apply when it goes before the Court. The answer to that question depends on many factors, including the plan language, the applicable law, and strategic decisions specific to the facts of that particular case. This paper outlines discretionary review in ERISA cases and the analytical steps to take when determining the standard of review.

I. Discretionary Review Is an Established Part of ERISA

There is no law requiring employers to provide disability benefits to their employees. To encourage employers to offer welfare benefits, such as disability benefits, Congress enacted The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.* ERISA does not regulate the content of plans; rather, employers are free to provide as many or as few benefits as they wish. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). Nor does ERISA prescribe how the employer funds its plan. *See* 29 U.S.C. § 1002(1). Some employers self-fund their plans while others purchase insurance.

Once the plan is established, ERISA requires it be administered by one or more plan fiduciaries. Id. at § 1102(a). But ERISA does not prescribe who must administer the plan and claims made thereunder. *See id.* Some employers administer benefits claims themselves, while others hire a claim administrator.

When disputes arise regarding an employee's entitlement to benefits, Section 1132 of ERISA provides a participant's exclusive remedy for such claims. 29 U.S.C. § 1132(a). ERISA's exclusive enforcement scheme requires "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." Aetna Health Inc. v. Davila, 542 U.S. 200, 215 (2004) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)). One of the ways that Congress sought to achieve that balance, was to create an exclusive enforcement scheme that avoids the inefficiencies that a "patchwork scheme of regulation" would cause and ensuring that benefit plan "will be governed by only a single set of regulations." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (*quoting Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987).

A bedrock component of ERISA's innovative balancing is the primacy of the plan terms. "ERISA requires '[e]very employee benefit plan [to] be established and maintained pursuant to a written instrument . . . specify[ing] the basis on which payments are made to and from the plan,'" *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009) (quoting 29 U.S.C. § 1102). Consequently,"[t]he plan administrator is obliged to act "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with [ERISA] and ERISA provides no exemption from this duty when it comes time to pay benefits." Id. A participant's "claim therefore stands or falls by the terms of the plan, a straightforward rule of hewing to the directives of the plan documents that lets employers establish a uniform administrative scheme, [with] a set of standard procedures to guide processing of claims and disbursement of benefits." Id. (internal citations and quotations omitted.) Adherence to the terms of the plan is the "linchpin of 'a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Heimeshoff*, 571 U.S. at 108 (quoting *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996)). In other words, ""the Plan is at the center of ERISA.." *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 100-01 ("ERISA's principal function" is to "protect contractually-defined benefits" because "the Plan is at the center of ERISA." (internal quotations omitted)).

"Although it is a comprehensive and reticulated statute, ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations."

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 108–09 (1989). ERISA gives the plan sponsor (the employer) the choice of who has primary interpretive authority over the plan. If the plan provides discretionary authority, the discretionary grant is a plan term that must be honored (subject to some exceptions discussed below). Courts cannot ignore such plan terms but must instead defer to the administrator's decision, and overturn only for abuse of discretion. *Firestone*, 489 U.S. at 109. Courts thus generally respect the plan sponsor's choice to delegate primary interpretative authority to the claims administrator.

> The Supreme Court has described how discretionary review furthers ERISA's goals:
>
> > Congress enacted ERISA to ensure that employees would receive the benefits they had earned, but Congress did not require employers to establish benefit plans in the first place. . . . ERISA induces 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.
> >
> > *Firestone* deference protects these interests and, by permitting an employer to grant primary interpretive authority over an ERISA plan to the plan administrator, preserves the careful balancing on which ERISA is based. ***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. Moreover, Firestone deference serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan . . . 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. Indeed, a group of prominent actuaries tells us that it is impossible even to determine whether an ERISA plan is solvent (a duty imposed on actuaries by federal law, if the plan is interpreted to mean different things in different places.

Conkright v. Frommert, 559 U.S. 506, 516–18, (2010) (emphasis added).

II. The Discretionary Ban Movement

A. History and Justification

In 2001, the National Association of Insurance Commissioners ("NAIC") began working on a model act to ban discretionary clauses in health insurance policies. Health Insurance & Managed Care (b) Committee, 2001 NAIC Proc. 2ND Qtr. p. 112, 116. The ERISA Working Group of the Health Insurance and Managed Care Committee discussed a memo in June 2001 that went over discretionary clauses and discretionary review of health insurance lawsuit. *Id.* The working group recorded:

> Several states have concluded that the inclusion of discretionary clauses in insurance contracts is deceptive and misleading. Under ERISA, states are free to determine the contents of insurance contracts. The working group agreed that NAIC staff should develop a model proposal to assure that all insurer (including HMO) claims determinations are subject to de novo review. The proposal will exclude determinations

> arrived at as a result of external review. The proposal will also preserve state rules of construction favoring covered persons where policy language is ambiguous.

Id.

The initial movement was focused only on insurer-funded health benefits. At that time, some states had created external review procedures for certain types of health claims. In 2001, when NAIC began discussing discretionary bans, there was considerable uncertainty about whether the states' external review laws would survive ERISA preemption. (The Supreme Court soon clarified that they did survive preemption *Rush Prudential v. Moran*, 536 U.S. 355 (2002).) It appears the NAIC viewed the discretionary clause ban as an additional protection for health insurance consumers to ensure their claims for benefits would be meaningfully reviewed if denial were challenged (something that was presumably more important to the NAIC should the external review laws be preempted).

The committee notes make clear that certain commissioners took a very dim view of discretionary review and their impact on plaintiffs' claims:

> Commissioner Morrison [of Montana] stated that the work of the ERISA Working Group regarding the discretionary clause issue was extremely important. He noted that most Americans get their health insurance from employer group plans under the jurisdiction of ERISA. In disputed matters, normally ambiguous contract language is construed against the insurer. However, the Supreme Court in the Firestone case flipped this presumption. Essentially, insureds have no opportunity to prevail because the language of the discretionary clause effectively means that when there is a dispute about what is a necessary procedure or service, the plan will prevail because it is entitled to great deference under the terms of the discretionary clause. Commissioner Morrison thought that whether insurance commissioners permitted this language to continue to be used in insurance contracts was an enormously important issue.

Id.

As the model act proposal worked its way through NAIC consideration, it was clear that "[t]he insurance industry and business groups [were] opposed to" it. Executive (ex) Committee, 2002 NAIC Proc. 1ST Qtr. p. 7, 12. The industries' opposition created an animated debate among the Commissioners:

> Commissioner Pickens [of Arkansas] said that his concern is that the employer has an obligation to manage the plan in a way that is best for the whole plan. He received comments from employer groups that had concerns about their ability to manage the plan for the whole group without the discretionary clause. . . . Commissioner Mirel [of DC] said he shares Commissioner Pickens' concern about cost to employers, but he is persuaded that it is a good idea to adopt the model. Commissioner Pickens said that insurance departments regulate the fully insured side but not the self-insured side. Adoption of this model will make an uneven playing field. Commissioner Gallagher [of Florida] said that employers speak against adoption of this model because they are the ones protected by the discretionary clauses. It gives them a tremendous advantage over the sick employees. Commissioner Pickens said his sympathies lie with the employers that are trying to provide health care for their employees. Commissioner Gallagher said that when the employer has this discretion, it places an extraordinary burden on the employee. Employers will not drop coverage because they need to attract employees.

> Commissioner Kirven [of Colorado] clarified that the [model act] . . . deals with a burden of proof issue in court proceedings. This model provides equity so that people are given the benefit of their bargain with their carriers. Commissioner Montemayor [of Texas] said he was not lobbied by the industry, but by employer groups.

Id.

Following the debate, the NAIC's Plenary Group voted to adopt the model act on June 9, 2002, with five states voting against the model act and three states abstaining. *Id.* The model act barred discretionary clauses in group health insurance policies, including HMOs.

In December 2003, the Consumer Protections Working Group began considering whether to expand the model act to include group disability policies. Joint Executive (ex) Committee/plenary, 2003 NAIC Proc. 4TH Qtr. p. 80, 83. Again, the benefits of discretionary language was hotly contested. In a June 2004 public meeting, a number of groups and entities provided testimony either strongly supporting or strongly opposing banning discretionary clauses from disability insurance policies. For instance, AARP took the position that discretionary review made benefits "illusory." Health Insurance And Managed Care (b) Committee, 2004 NAIC Proc. 2ND Qtr. p. 267, 376–77. The American Council of Life Insurers (ACLI) countered that discretionary clauses filled an important role in ERISA:

> A "discretionary clause" gives an insurer that is acting as an ERISA claims fiduciary the authority to reasonably administer benefits and interpret the terms of the plan. As an ERISA claim fiduciary, an insurer must administer claims solely in the interest of plan participants and beneficiaries and in accordance with the documents and instruments governing the plan. A discretionary clause does not change any of the terms and conditions of the ERISA plan. Its sole purpose is to promote efficient judicial review of disputed decisions.

Id. at 394.

Furthermore, to account for the so-called structural conflict of interest (that is, when an insurer both decides and funds benefits), federal courts had developed a body of case law indicating that "[t]he amount of deference" given to an administrator's decision "is fluid, and frequently depends on the facts and circumstances [relating to the conflict of interest] before it." *Id.* at 395. America's Health Insurance Plans added that, as of June 2004, no state had yet adopted the existing discretionary clause ban (limited to health insurance) and that the group was "unaware of any actual situations where the current standard of judicial review has proved inadequate for consumers needing disability benefits. Given this, any amendment to the Model Act represents a solution to a non-existent problem." *Id.* at 403. Moreover, "[d]iscretionary clauses protect consumers in two ways - they require carriers to conserve plan assets, thereby providing maximum benefit coverage for the most members, and second, they operate to ensure that consumers are afforded reliable, uniform and affordable benefits." *Id.*

Ronald Dean, a plaintiffs' attorney, countered that "[t]here is no evidence that a policy with an abuse of discretion standard of review is cheaper than one with de novo review." *Id.* at 418. According to Mr. Dean, banning discretionary clauses would not cost plans additional money and would create "a level playing field for participants and plan administrators." *Id.*

Later, in a September 2004 meeting, a lawyer representing ACLI stated "she did not believe the absence of the clause would affect the outcome of the cases. ACLI had conducted a study and a striking number of cases state that the judge would have reached the same conclusion under a different standard of

review." Health Insurance And Managed Care (b) Committee, 2004 NAIC Proc. 3RD Qtr. p. 668, 674. But that statement was called into question.

> Mila Kofman (Georgetown University Health Policy Institute) stated that Mark de Bosky, a professor at the John Marshall Law School in Chicago, did a full review of cases from 1993 through 2003. His findings were markedly different from those of ACLI and in fact plaintiffs under a de novo review won 68% of cases versus those with an arbitrary capricious standard of review won only 28% of cases.

Id. at 668.

Ms. Kofman further warned "that the numbers do not reflect the true reality. If there is a de novo standard of review, the case is much more likely to settle" and that many attorneys did not want to take cases with discretionary review. *Id.*at 674.

Despite the myriad objections, the committee unanimously voted to extend the model act to include disability policies on September 13, 2004. Although a number of states currently ban discretionary language in some fashion (*see* below), very few have adopted sections of the NAIC's model act verbatim. *See, e.g.*, VT ST T. 8 § 4062f; Ark. Admin. Code 054.00.101-4.

B. Types of Discretionary Bans

Twenty-six states and the District of Columbia have adopted some form of restriction on discretionary bans. (*See* "Chart of Discretionary Bans.") Not only is the language of these restrictions incredibly diverse, but they are also found in different places. And the laws can change at any time.

It is also important to search all available databases for your state's current discretionary ban language. Most states include their ban in the state's statutory scheme. But some are found in insurance regulations. *See, e.g.*, Idaho Admin. Code r. 18.01.29.011; Ark. Admin. Code 054.00.101-4; Mich. Admin. Code R 500.2202. And other states use insurance bulletins to communicate their bans. *See* Utah Department of Insurance Bulletin 2002-7; 6/14/11 Notice to Insurers and HMOs licensed to do business in the District of Columbia; Health Care Bulletin HC-67, 2008 WL 754875 (CT INS BUL); Bulletin 2010-5, 2010 WL 2609380 (IL INS BUL); Bulletin 103, 2001 WL 35670606 (IN INS BUL); Advisory Opinion 2010-1, 2010 WL 798041 (KY INS BUL); Hawaii Commissioner's Memorandum 2004-13H (Dec. 8, 2004).

The bans vary widely in their scope and application, but there are a few patterns among the states.

Bans That Don't Affect ERISA Plans. Indiana, for instance, has issued an insurance bulletin asserting that discretionary clauses are "inequitable and deceptive, and tend to mislead consumers. Under state law, an insurance policy is subject to the same rules of interpretation and construction as other contracts, and where the policy is ambiguous or silent, it is construed by courts against the company that drafts it." Bulletin 103, 2001 WL 35670606 (IN INS BUL). Employee benefit plans governed by ERISA, however, may contain discretionary clauses so long as they "include a statement substantially similar to the following: 'This provision applies only where the interpretation of this Policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.'" *Id.* Similarly, New Hampshire permits discretionary clauses in ERISA subject to specific requirements, including that the language be "contained in a separate endorsement," are optional to the plan sponsor, and use specific wording explaining the grant of discretion. N.H. Code Admin. R. § 04.

Bans That Only Apply To Health Insurance. Wyoming not only exempts ERISA plans from its discretionary ban, but the discretionary ban also only applies to health insurance. Wyo. Stat. Ann. § 26-13-304. Accordingly, other types of benefits (disability, life) may still be provided subject to a grant of discretion. Idaho, likewise, limits its discretionary bans to health insurance contracts. Idaho Admin. Code r. 18.01.29.011.

Bans Limited To Policies Issued Or Renewed In That State. A number of states limit their bans to policies "issued or offered in this state." *See, e.g.*, S.D. Admin. R. 20:06:52:02; Vt. Stat. Ann. tit. 8, § 4062f. Some states go further and expressly clarify that "issued In" extends to policies each time they are "renewed." *See* Bulletin 2010-5, 2010 WL 2609380 (IL INS BUL); 2015 Minn. Sess. Law Serv. Ch. 59 § 1 (S.F. 997); Or. Admin. R. 836-010-0026; S.D. Admin. R. 20:06:52:02; Code Ark. R. 054.00.101-7.

Intentionally Broad Bans. Some states have taken a scorched earth approach to discretionary clauses, adopting broad discretionary bans that attempt to reach any lawsuit for benefits that has any connection to those states. For instance, California's ban applies to any "a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident" and clarifies that a formal "renewal" is not required to bring the policy within the statute's purview—the policy need only be "continued in force on or after the policy's anniversary date." Cal. Ins. Code § 10110.6. Colorado initially had a statute that applied solely to policies "issued in this state." But in 2020, the legislature adopted an amendment clarifying that "issued in" included any policy, contract, or certificate "existing, offered, issued, delivered, or renewed in . . . Colorado or providing health or disability benefits to a resident . . . of . . . Colorado and every employee benefit plan covering a resident . . . of Colorado, whether or not on behalf of an employer located . . . in Colorado." Not only that, but the amendment purports also to be retroactive to the original statute date of August 5, 2008 and apply regardless of "contractual or statutory choice-of-law provision to the contrary." Colo. Rev. Stat. Ann. § 10-3-1116.

This section merely summarizes common features of various state bans. Some bans may fall into more than one category or may have their own unique twists. It thus remains critical to thoroughly review all potential sources of authority in your state and evaluate the ban's parameters.

C. Preemption

When the NAIC was considering the Model Act and its extension to disability policies, opponents of the ban argued that it would be preempted by ERISA. To date, the Supreme Court has not decided whether discretionary bans are preempted, but cases have reached the Sixth, Seventh, and Ninth Circuits, with each court holding that the state law discretionary bans are saved from preemption.

The first discretionary ban preemption case to reach a circuit court of appeals was *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009), which was decided on March 18, 2009. The court began by acknowledging that ERISA preemption is "expansive," but "not absolute." *Id.* at 604. ERISA contains a saving clause providing "that 'nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance.'" *Id.* (quoting 29 U.S.C. § 1144(b)(2)(A)). "[T]o determine whether a state law regulates insurance" courts must employ a two-prong test: "first, 'the state law must be specifically directed toward entities engaged in insurance,' and, second, 'the state law must substantially affect the risk-pooling arrangement between the insurer and the insured[s].'" *Id.* at 605 (quoting *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329, 341 (2003)).

Applying the first prong, the *Ross* court observed "there can be no serious dispute that" state law discretionary bans "meet the first prong of the *Miller* test because they regulate *insurers* with respect to their *insurance practices*." *Id.* (emphasis in original). In so holding, the court rejected ACLI's argument that "the rules are not so directed at insurers inasmuch as the effect of the rules is felt primarily by the fiduciary who administers the plan, rather than by the insurer." *Id.* While the court allowed that "others may feel the effect of the rules," it did not change the fact that the rules were "directed toward entities engaged in the business of insurance." *Id.*at 606.

On the next prong (whether the law substantially affects the risk-pool arrangement), ACLI argued that state law discretionary bans "have an impact only after risk has been transferred" because they come in to play only after a claim has been made and thus cannot "substantially affect the risk-pooling arrangement between insurers and insureds." *Id.* Again, the *Ross* court disagreed, observing that prior Supreme Court decisions "saved" state law notice-prejudice rules and external review procedure from preemption when both rules, like discretionary bans, were only implicated after a claim has been made. Accordingly, meant that there was no timing constraint on when the rule impacted the risk pooling arrangement, only that it affected it at some point. *Id.* Because "the rules directly control the terms of insurance contracts" they have 'alter[ed] the scope of permissible bargains between insurers and insureds.'" *Id.*at 606-07 (quoting *Ward*, 526 U.S. at 374–75.) Furthermore, "[p]rohibiting plan administrators from exercising discretionary authority in this manner 'dictates to the insurance company the conditions under which it must pay for the risk it has assumed.'" *Id.*at 607 (quoting *Miller*, 538 U.S. at 339 n.3.) The *Ross* court thus held that discretionary bans "regulate insurance because they substantially affect the risk-pooling arrangement between insureds and insurers." *Id.*

Though the *Ross* court determined that the discretionary ban fell under the saving clause and was thus not expressly preempted by ERISA, it also had to determine whether conflict preemption applied. "Even if a state law regulates insurance such that it falls within ERISA's savings clause, it may nevertheless be preempted" if it conflicts with ERISA's civil enforcement provisions. *Id.* Specifically, because Congress intended "to create an exclusive federal remedy in ERISA § 502(a) . . . , even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." *Id.* (quoting *Davila*, 542 U.S. at 217-18). ACLI argued that the discretionary bans, which negated the plan-selected standard of review in litigation, conflicted with ERISA's civil enforcement remedies. Again, the court disagreed, reasoning that discretionary bans "do not create, duplicate, supplant, or supplement any of the causes of action that may be alleged under ERISA" or "permit a plan beneficiary to assert a claim that could otherwise be asserted under ERISA." *Id.* at 607-08. Rather, the discretionary bans "at most may affect the standard of judicial review if, and when, such a claim is brought before a court." *Id.* at 608.

Finally, the ACLI made a more nuanced conflict preemption argument, asserting that discretionary bans were "preempted because they squarely conflict with ERISA's policy of ensuring a set of uniform rules for adjudicating cases under ERISA" and thus "have no purpose or effect other than to control ERISA litigation." *Id.* The court countered that ERISA does not mandate discretionary review; indeed, the default standard of review is de novo. *Id.* Moreover, the Supreme Court had previously opined that "ERISA does not require that such decisions be discretionary, and insurance regulation is not preempted merely because it conflicts with substantive plan terms." *Id.* (quoting *Rush Prudential*, 536 U.S. at 385 n.16). The court went on to assess how discretionary review interacted with the structural conflict of interest, pointing out that the structural conflict may be considered "as a factor in deciding whether the plan administrator's decision amounts to an abuse of discretion." *Id.* at 609 (citing G*lenn*,

554 U.S. at 115-16). The court extrapolated that "it is difficult to understand why a State should not be allowed to eliminate the potential for such a conflict of interest by prohibiting discretionary clauses in the first place." *Id.* The court did not explain how banning discretionary clauses would eliminate the structural conflict (indeed, the very structure of having the same entity fund and decide benefits creates the conflict—the bans simply strip the administrator of discretion). But the court nevertheless went on to conclude

> [a]ll that today's case does is allow a State to remove a potential conflict of interest. And while [the discretionary ban] 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.

Id. It is not completely clear what distinction the court was attempting to draw between ERISA cases or how "application of a settled plan term" could still be subject to discretionary review under the discretionary ban at issue.

The Ninth Circuit was the next to find discretionary bans to be saved from preemption in October of 2009. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009). The analysis largely tracked the *Ross* analysis (addressing the two prongs of express preemption and then discussing conflict preemption), but did contain a more robust analysis of the "risk pooling" prong of express preemption. The *Morrison* court began by generally characterizing "risk pooling":

> Insurance companies' core function is to accept a number of risks from policyholders in exchange for premiums. Some of the risks accepted will result in actual losses. Risk pooling involves spreading losses over all the risks so as to enable the insurer to accept each risk. By receiving a large number of relatively small premiums, the insurer can afford to compensate the few insureds who suffer losses. In this way, the insured no longer bears more than a small amount of his own risk—it has been transferred into a common pool into which all members of the pool contribute by paying premiums.

Id. at 844 (internal quotation omitted).

Standard argued that discretionary bans could not affect risk pooling because "risk is pooled at the time the insurance contract is made, not at the time a claim is made." *Id.* According to the industry's definition of "risk pooling" "'[a]dministrative factors' such as 'claim investigations, the appeals process, and litigation' can 'affect amounts paid to insureds under [a] policy,' but are outside of the risk pooling arrangement." *Id.* (quoting Standard's argument). The court rejected what it described as a "narrow conception" of risk pooling, countering that under the discretionary ban at issue "Montana insureds may no longer agree to a discretionary clause in exchange for a more affordable premium. The scope of permissible bargains between insurers and insureds has thus narrowed." *Id.*at 844-45. (Note, this directly contradicts the NAIC testimony asserting that there was no evidence that the cost savings from discretionary review are passed on to plans.)

Making an evidentiary leap, the court then held "[b]y removing the benefit of a deferential standard of review from insurers, it is likely that the Commissioner's practice will lead to a greater number of claims being paid. More losses will thus be covered, increasing the benefit of risk pooling for consumers." *Id.* at 845. The court reasoned that discretionary bans that forbid "insurers from inserting terms which tip the balance in their favor" are permissible despite "creat[ing] disuniformities." *Id.*at 848.

Subsequent efforts to challenge discretionary bans as preempted failed in the Seventh Circuit and again in the Ninth. *See Fontaine v. Metro. Life Ins. Co.*, 800 F.3d 883, 886–89 (7th Cir. 2015); *Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan*, 856 F.3d 686, 692–95 (9th Cir. 2017). Accordingly, while preemption is still an open question in most circuits and has not been addressed by the Supreme Court, courts seem to assume that discretionary bans are not preempted. *See, e.g.*, *Brake v. Hutchinson Tech. Inc. Group Disability Income Ins. Plan*, 774 F.3d 1193, 1196 (8th Cir. 2014) (court did not reach preemption, but cited to cases finding discretionary bans not preempted); *Ariana M. v. Humana Health Plan of Texas, Inc.*, 884 F.3d 246, 250 n.2 (5th Cir. 2018) (finding preemption argument waived, but noting that "[e]ach court to decide this issue has concluded that ERISA does not preempt state antidelegation statutes").

III. Practical Applications

With discretionary bans dotting the country, they can affect case strategy. When initially assessing a case, it is necessary to understand (1) whether you have discretionary language in the plan; (2) whether the applicable state law bans discretionary language; and (3) if there is a discretionary ban, whether it affects your specific case.

A. Language Sufficient to Confer Discretion

The beginning of any discretion inquiry is whether the plan confers discretion. Sometimes it is obvious—such as when the plan expressly says the claim administrator has discretion to interpret the plan and decide claims. But there are no "magic words" to confer discretion, spawning significant litigation over whether plan language is sufficient to require an abuse of discretion review. This varies across circuits and even changes within circuits. Accordingly, if the plan language does not actually use the word "discretion," you should research the latest opinions on what language is sufficient to confer discretion.

For instance, the Sixth Circuit has held that the plan conferred discretion by stating that the claim administrator "shall have the right to require as part of the proof of claim satisfactory evidence ... that [the claimant] has furnished all required proofs for such benefits." *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 555 (6th Cir. 1998).

Other circuits have required that the plan specify that the proof must be satisfactory ***to the claim administrator.*** *see also Nance v. Sun Life Assur. Co. of Canada*, 294 F.3d 1263, 1267–68 (10th Cir.2002); *Tippitt v. Reliance Standard Life Ins. Co.*, 457 F.3d 1227, 1233–34 (11th Cir. 2006). The Seventh Circuit explained that merely requiring "satisfactory proof" without specifying to whom was insufficient because it

> does not give the employee adequate notice that the plan administrator is to make a judgment largely insulated from judicial review by reason of being discretionary. Obviously a plan will not—could not, consistent with its fiduciary obligation to the other participants—pay benefits without first making a determination that the applicant was entitled to them. The statement of this truism in the plan document implies nothing one way or the other about the scope of judicial review of his determination.

Herzberger v. Standard Ins. Co., 205 F.3d 327, 332 (7th Cir. 2000).

But although *Herzberger* could be interpreted as endorsing "satisfactory to us" as conferring discretion, the Seventh Circuit later "clarified" that "to us" does not give notice to the employee that "the administrator not only has broad-ranging authority to assess compliance with pre-existing criteria, but

also has the power to interpret the rules, to implement the rules, and even to change them entirely." *Diaz v. Prudential Ins. Co. of Am.*, 424 F.3d 635, 639 (7th Cir. 2005). Instead, the *Diaz* court explained that for discretionary review, "the critical question is whether the plan gives the employee adequate notice *that the plan administrator is to make a judgment within the confines of pre-set standards, or if it has the latitude to shape the application, interpretation, and content of the rules in each case." *Id.* at 639-40.

The Ninth Circuit has advised that plan language "granting the power to interpret plan terms and to make final benefits determinations" is sufficient to confer discretion. *See, e.g., Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963–64 (9th Cir. 2006).

Ultimately, the circuits have different standards for determining what language is sufficient to confer discretion. And those standards have evolved over time. If your plan language does not include the word "discretion," you should determine what the most recent standard is in your circuit in evaluating whether review will be discretionary or de novo. *See, e.g.*, Standards of judicial review—Benefit claims—Abuse of discretion standard—Post-Firestone case law, 2 ERISA Practice and Litigation § 11:53 (discussing the various tests employed by the circuits and how they have changed).

B. Insured vs. Self-Funded

Once you have verified that a plan confers discretion, you should verify the funding source. If the plan benefit at issue is self-funded by the employer, state laws regulating insurance (i.e., discretionary bans) will not be saved from preemption with respect to that plan. This is because after saving insurance regulations from preemption (*see* Section II.C, above), ERISA goes on to clarify that self-funded plans shall not be "deemed to be an insurance company" for purposes of state insurance regulations. Accordingly, the otherwise-saved insurance regulations will not apply to self-funded plans (whether or not their text purports to include self-funded plans). If the benefit at issue is funded by insurance, you'll need to go on to the remaining analytical steps to determine your standard of review.

C. Confirming Governing Law

1. Choice of Law Provision

It is common to assume that your ERISA case is governed by the forum state's law. But many plans, particularly plans established by large national employers, contain a choice of law provision. These provisions are generally effective. If your forum state bans discretionary language, it is worth examining the plan/policy to determine whether it elects to be governed by the law of a state that does not ban discretionary language.

Four circuits—the Eighth, Ninth, Tenth and Eleventh—have adopted nearly identical tests when deciding whether to honor a choice of law provision in an ERISA plan. The Eighth Ninth and Eleventh Circuits enforce the choice of law provision, thus honoring the discretionary grant, "if not unreasonable or fundamentally unfair." *Brake v. Hutchinson Tech. Inc. Group Disability Income Ins. Plan*, 774 F.3d 1193 (8th Cir. 2014); *Wang Laboratories, Inc. v. Kagan*, 990 F.2d 1126, 1128–29 (9th Cir. 1993) *Ellis v. Liberty Life Assurance Co. of Boston*, 958 F.3d 1271 (10th Cir. 2020); *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1149 (11th Cir. 2001). The Tenth Circuit held that if "the plan has a legitimate connection to the State whose law is chosen," then "the selected law should govern whether a discretion-granting provision is enforceable." *Ellis*, 958 F.3d at 1288. While the tests use slightly different language, they do not meaningfully differ. The Tenth Circuit simply focused the "reasonableness" inquiry on the plan's connection to the chosen state. In practice, finding that the plan has "a legitimate connection to the State whose law is chosen" would ordinarily compel a finding that the provision was reasonable.

Additionally, the Fifth Circuit has twice enforced a plan's choice of law provision in cases against a claim administrator for plan benefits. *Singletary v. United Parcel Serv., Inc.*, 828 F.3d 342, 351 (5th Cir. 2016) (claimant did not meet burden to establish that choice of law provision was invalid, rejecting argument "that because the defendants have chosen to insure [citizens of the forum state], they should be subject to its laws"); *Jimenez v. Sun Life Assur. Co. of Canada*, 486 Fed. Appx. 398, 407–08 (5th Cir. 2012)(claimant did not meet burden to invalidate choice of law provision selecting state where employer was based, even when claimant lived and worked in forum state). Although the Fifth Circuit articulated different tests that might apply, it did not actually select which test the Fifth Circuit would employ—determining in each case that the plaintiff had not adduced sufficient evidence to invalidate the plan's chosen law under any test.

The Second Circuit has also enforced a plan's choice of law provision in a case in which a plaintiff sought to recover long-term disability benefits because "the policy on its face elects Pennsylvania law as controlling its interpretation and stipulates that it is to be delivered in Pennsylvania." *Greenberg v. Aetna Life Ins. Co.*, 421 Fed. Appx. 124, 125 (2d Cir. 2011). In so holding, the Second Circuit did not discuss what analytical test would inform choice of law analyses.

In a somewhat more complex analysis, the Sixth Circuit has employed the Restatement. As it pertains to discretionary clauses, the Sixth Circuit's test would result in enforcing the plan's chosen law. *DaimlerChrysler Corp. Healthcare Benefits Plan v. Durden*, 448 F.3d 918 (6th Cir. 2006) did not involve a dispute between a participant and insurer over plan benefits. Rather, it was an interpleader case to determine which of the competing claimants—who were unknowingly simultaneously married to a deceased pension plan participant—was a "surviving spouse" under the pension plan. Faced with this highly unique set of facts, the Sixth Circuit used the Restatement (Second) of Conflicts of Laws Section 187 to assess the enforceability of the plan's choice of law provision (electing the law of the employer's home state, which had no connection to either marriage).

Under Section 187, the first inquiry is whether "the particular issue is one which the parties could have resolved by an explicit provision in their agreement directed to that issue." *Id.* at 923 (quoting Restatement (2d) Conflicts of Law § 187(1). To determine whether the particular issue could be resolved by an explicit provision in the plan, the Sixth Circuit looked to ERISA and determined that under ERISA "the parties to the Plan could not have resolved the issue of which claimant is entitled to [the] survivor's benefits by explicit provision in the contract." *Id.* at 923-24 (internal citations omitted) (emphasis added). Significantly, however, under Restatement Section 187, if ERISA does permit the parties to resolve the particular issue "then the choice of law provision is enforceable. Under such circumstances there are no exceptions." *Id.* at 923 (emphasis added). Because ERISA allows the parties to the plan to agree to discretionary language, a choice of law provision will be enforceable when assessing discretionary review.

Under all tests adopted by all circuits to have considered the issue, then, a plan's choice of law provision should be effective when (1) the plan confers discretion; and (2) the plan elects a state law that does not have a discretionary ban; even when (3) the forum state bans discretionary language. *See Brake*, 774 F.3d at 1197; *Fenberg v. Cowden Auto. Long Term Disability Plan*, 259 Fed. Appx. 958, 959 (9th Cir. 2007); *Ellis*, 958 F.3d at 1288-89.

2. Group Policy with No Choice of Law Provision

Even if your policy/plan does not have an express choice of law provision, you can still consider where the employer is based. Though this issue has not been heavily litigated in the context of ERISA plans and discretionary clauses/bans, there is good authority supporting the argument that a group

insurance policy is governed by the law of the state where the employer is headquartered. *See Boseman v. Connecticut Gen. Life Ins. Co.*, 301 U.S. 196, 200, 206 (1937) (Texas employee's disability claim was governed by Pennsylvania law not only because of choice of law provision, "but also by the purpose of the parties to the contract that everywhere it shall have the same meaning and give the same protection, and that inequalities and confusion liable to result from applications of diverse state laws shall be avoided"); Restatement (Second) Conflicts of Laws §192, cmt. h, l ("In the case of group . . . insurance, rights against the insurer are usually governed by the law which governs the master policy. This is because it is desirable that each individual insured should enjoy the same privileges and . . . This will usually be the state where the employer has his principal place of business."). If you pursue this argument, you can bolster it with policy language confirming that the policy was delivered to the employer in the employer's home state.

D. Scope of Ban

If you determine that your case is governed by the law of a state that bans discretionary clauses, the next step is to carefully analyze whether there is an argument that the ban does not apply to your specific case. As discussed above, the individual discretionary bans vary widely by state, so this will require that you examine the wording of the particular ban and research whether it has been interpreted/limited by any court decisions. Below are a handful of issues that may affect whether the ban applies to you.

1. Timing

As noted above, some discretionary bans apply to policies "issued in" that state. If your policy was issued prior to the effective date of the discretionary ban, there may be an argument that the ban does not govern your case. *See, e.g.*, *Dallenbach v. Standard Ins. Co.*, 2020 WL 1430036, at *5 (D. Nev. Mar. 24, 2020) (because version of policy governing claim pre-dated discretionary ban, ban did not alter standard of review). At least one court has held that the state's constitution barred retroactive application of a discretionary ban. *McClenahan v. Metropolitan Life Insurance Co.*, 621 F. Supp. 2d 1135 (D. Colo. 2009), aff'd, 416 Fed.Appx. 693 (10th Cir. 2011) (statute only applied to insurance policies issued after 2008).

On the other hand some courts have held that the discretionary ban applies if it was in effect as of the date of claim (rather than the date the policy was issued). *See, e.g.*, *Rustad-Link v. Providence Health & Services*, 306 F. Supp. 3d 1224, 1234 (D. Mont. 2018) (discussing cases).

Of course, some of the more comprehensive bans apply not only to policies "issued," but also policies that are renewed, amended, or even continued. This makes it more difficult to object on timing, but there may be an argument that retroactive applicability statute violates the parties' freedom of contract and impermissibly alters the terms of bargained-for insurance policies. *See, e.g.*, *E. Enterprises v. Apfel*, 524 U.S. 498, 528–29, 118 S. Ct. 2131, 2149, 141 L. Ed. 2d 451 (1998) (holding, generally, that retroactive statutes may violate the federal constitution)

2. Textual Restrictions

Some states do not ban discretionary language outright, but merely prescribe the wording for the discretionary clause to ensure that the participant is on notice that the plan confers discretion. *See, e.g.*, Health Care Bulletin HC-67, 2008 WL 754875 (CT INS BUL); Bulletin 103, 2001 WL 35670606 (IN INS BUL). Note that purely textual discretionary statutes/regulations may be preempted by ERISA because they do not affect the risk-pooling agreement. *Hancock v. Metro. Life Ins. Co.*, 590 F.3d 1141,

1149–50 (10th Cir. 2009) (purely textual restrictions do not affect risk pooling and are thus preempted by ERISA).

3. Insurance Bulletins

If the applicable discretionary ban is found in an insurance bulletin (as opposed to in a statute or the administrative code), there may be an argument that it cannot alter the standard of review. At least one court has suggested that insurance bulletins may not be sufficient to modify the standard of review for an ERISA case. *Daic v. Metro. Life Ins. Co.*, 458 F. Supp. 2d 1167 (D. Haw. 2006), aff'd sub nom. *Daic v. Hawaii Pac. Health Group Plan for Employees of Hawaii Pac. Health*, 291 Fed. Appx. 19 (9th Cir. 2008). Specifically, the plaintiff argued for discretionary review based on a memorandum from the Insurance Commissioner stating that discretionary clauses were unfair or deceptive acts and thus banned by Hawaii's statute prohibiting unfair trade practices. *Id.* at 1174-75. The court rejected the argument, noting that the memo "by itself, appears to have no legal effect . . . . There is no indication that this Memorandum, or its contents, was passed as an administrative rule or that [the insurer's] ability to act as an insurer in the [state] was conditioned on compliance with [the memorandum" *Id.*at 1175 (also noting that there was no indication it was retroactive). Although the memorandum made it clear the Insurance Commissioner believed discretionary clauses violated the unfair practices statute, that was merely the Commissioner's interpretation of a statute. The court determined because no private right of action existed under the unfair practices statute, the plaintiff could not use it to modify the terms of the insurance policy. *Id.* Of course, this decision is highly dependent on the language of the memorandum and the content of the state statute. But it is instructive if you are in a state in which the Department of Insurance has banned discretionary language by issuing a bulletin declaring them to be unfair practices.

IV. De Novo Review

After examining the applicable ban and the policy, you may conclude that the court will be required to review the case de novo. This section outlines the implications of that and highlights the procedural differences between de novo and discretionary review.

A. Benefits of De Novo Review

A de novo review strips the claim administrator of discretion, which is a less favorable standard overall. But de novo review does have some benefits, depending on the facts of your case, opposing counsel, and your jurisdiction.

1. Court Less Focused on Process

Post-*Glenn* cases have focused heavily on how much weight to afford the structural conflict of interest. This involves examining the claim process with a microscope, from the content of the claim correspondence (did the claim correspondence adequately inform the plaintiff what type of evidence to submit on appeal?), to the types of resources utilized (internal versus external, in-person exam versus records review), to the purported bias of the claim administrator and reviewing physicians. A skilled plaintiff's attorney—with the benefit of a legal education and time to focus on just one claim—can scrutinize just about any claim file and come up with arguments that the claim procedure was not perfect. These "flaws" can then distract the court from the merits of the case—that is, does the medical evidence in the administrative record establish that the claim administrator abused its discretion in finding that the plaintiff failed to prove her claim?

While de novo review reduces the standard for the plaintiff to prevail (she must only prove that she is entitled to benefits and does not need to prove abuse of discretion), the structural conflict becomes

irrelevant. The process, therefore, is not at the center of the case and it is easier to focus the court on the merits. The procedure does not become a side show. The plaintiff must prove her case based solely on the medical evidence in the file rather than obfuscating by arguing that claim procedure was flawed.

2. Less Discovery/Expense

A side effect of the structural conflict inquiry is that courts tend to permit discovery (sometimes more limited than others) into the process and the claim administrator's (and reviewing physicians') alleged bias. While these inquiries rarely make a big difference to the merits of the case, they can significantly increase the cost of litigation. In some cases, courts will even require a bench trial for presentation of conflict evidence. *See, e.g., Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

In contrast, "courts conducting de novo review of ERISA benefits claims should review only the evidentiary record that was presented to the" claim administrator. *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1026 (4th Cir. 1993). Only in "exceptional circumstances" should the court consider evidence outside the administrative record. *Id.* at 1027. Those circumstances generally include:

> claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.

Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1027 (4th Cir. 1993).

The limitations on extrinsic evidence in de novo cases substantially weakens the arguments for discovery. In many jurisdictions (but certainly not all), plaintiffs' attorneys will not even attempt to pursue discovery under these narrow parameters. Accordingly, de novo review reduces the defense costs and shortens the time to briefing the merits with the court.

3. Ability to Raise New Arguments

When a court reviews a decision to determine whether the claim administrator abused its discretion, the court's review is typically confined to the rationale upon which the claim administrator relied. It is not unusual that the microscope of litigation reveals additional reasons supporting the benefit determination. But it can be problematic to raise those new justifications in litigation if there is no evidence they were considered or relied upon by the claim administrator in making the decision. De novo cases are only concerned with whether the decision was correct. Accordingly, in defending these cases, you will often have more leeway in making arguments that are not articulated in the administrative record.

4. Standard of Review on Appeal

In some jurisdictions, if you prevail on a de novo review, it will be easier to prevail on any subsequent appeal. This is because some circuits employ a "clearly erroneous" standard when the district court has reviewed an ERISA case de novo, but a less stringent standard when the district court has reviewed the case for an abuse of discretion. *See, e.g., Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993); *Paese v. Hartford Life & Acc. Ins. Co.*, 449 F.3d 435, 442 (2d Cir. 2006); *Deegan v. Cont'l*

Cas. Co., 167 F.3d 502, 509 (9th Cir. 1999). Of course, this also makes it more difficult to overturn an adverse ruling.

B. Does It Affect the Outcome?

Because there are certain advantages to de novo review, you may want to consider stipulating to de novo review even where there is an argument for discretionary review. These considerations are highly case-specific, but may include the following:

- Arguing for discretion will require significant preliminary briefing and the result is uncertain;
- You are in a jurisdiction that permits extensive conflict discovery or have an aggressive opposing counsel who will attempt to obtain extensive discovery;
- Your judge is particularly susceptible to getting hung up on the procedure and lose sight of the merits; and/or
- The merits of the decision are strong, but you have some procedural hiccups in reaching that decision.

In the right case, stipulating to de novo can be a good strategic move. Overall, however, there is still generally a substantive advantage to discretionary review. We reviewed 79 district court ERISA benefit decisions that came out from January 1 to December 31, 2019. Of those 79 cases, 52 involved discretionary review and 27 involved de novo review. The claim decision was upheld 73 percent of the time in the discretionary cases, but only 37 percent of the time under de novo review. Each case rises and falls on its own facts, so these numbers should be interpreted with caution. There is enough discrepancy in the success rates, however, to suggest that discretionary review still helps.

V. Conclusion

While discretionary review has become a lightning rod in some states, it has a solid basis in ERISA jurisprudence and serves ERISA's goals of predictability, efficiency, and uniformity. Given the diverse landscape of discretionary bans, each file should be reviewed early to determine whether it is subject to the law of a state that bans discretionary clauses and, if so, whether there is an argument that the specific case does not fall within the scope of the ban. And even if there is a good argument for discretionary review, some cases may be suitable for de novo review. Each layer of inquiry is case- and fact-specific.