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

J. KEVIN GARVEY,	)	
	)	
Plaintiff,	)	
	)	**No. 08-CV-1093**
v.	)	
	)	**Judge Feinerman**
PIPER RUDNICK LLP LONG TERM	)	
DISABILITY INSURANCE PLAN,	)	**Magistrate Judge Nolan**
	)	
Defendant.	)	

PIPER RUDNICK LLP LONG TERM DISABILITY INSURANCE PLAN'S RESPONSE TO PLAINTIFF'S MEMORANDUM ON THE STANDARD OF JUDICIAL REVIEW

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INTRODUCTION

Plaintiff, J. Kevin Garvey ("Garvey"), a former partner with the law firm DLA Piper, seeks to recover disability benefits under the Piper Rudnick LLP Long Term Disability Insurance Plan ("Plan") pursuant to 29 U.S.C. §1132(a)(1)(B). Garvey concedes that the Plan's Allocation of Authority provision grants discretionary authority to the claims administrator, Standard Insurance Company ("Standard").[1] But Garvey argues that the Plan's grant of discretionary authority is unenforceable based on §2001.3 of the Illinois Administrative Code, which purports to prohibit discretionary clauses in health or disability insurance policies issued or offered in Illinois effective 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, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or of a disability may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this State.

50 Ill. Admin. Code §2001.3. In the Notice of Adopted Amendments, the Director declared: "The legal effect of discretionary clauses is to change the standard for judicial review of benefit determinations from one of reasonableness to arbitrary and capricious. By prohibiting such clauses, the amendments aid the consumer by ensuring that benefit determinations are made under the reasonableness standard." 29 Ill. Reg. 10173. 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.

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[1] The Plan was established pursuant to the Group Long Term Disability Policy issued by Standard to Piper Marbury Rudnick & Wolfe LLP, now known as DLA Piper.

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 promotes efficiency by encouraging the resolution of benefits disputes through internal administrative proceedings. Deference fosters predictability and national uniformity in plan administration by giving interpretive discretion to the plan 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. The Plan Contests The Legality And Retroactive Application Of §2001.3.

Section 2001.3 purports to prohibit discretionary clauses in *all* health or disability policies issued or offered in Illinois effective July 1, 2005. In reality, however, §2001.3 applies only to ERISA plans. Illinois' Insurance Director issued §2001.3 to prohibit federal courts from adjudicating ERISA cases deferentially, under the arbitrary and capricious standard of review.

On June 28, 2010, the Insurance Director issued a "Bulletin" deeming §2001.3 to apply "to all currently issued and outstanding" health and disability plans. The Insurance Director sent the Bulletin to insurers who fund health or disability plans in Illinois, including Standard, and threatened retaliatory "regulatory action" against insurers who disobey. The Director's Bulletin

states, "Insurers who do not comply with the absolute prohibition on discretionary clauses contained in 50 Ill. Admin. Code §2001.3 will be held accountable and subject to regulatory action." (Ex. A, Baumgardner Affid., ¶¶ 2-3 and Bulletin attached thereto).

Last month, in December 2010, Standard notified Illinois based group policyholders that it must comply with the Director's Bulletin by removing its discretion-granting Allocation of Authority provision from its group dental, group accidental death, and group disability policies. DLA Piper's Plan was issued in Maryland, so Standard never amended the Plan to remove the Allocation of Authority provision. (Ex. A, Baumgardner Affid., ¶ 2). Garvey nevertheless argues that Standard's compliance with the Director's mandatory Bulletin with respect to other ERISA plans constitutes an admission by a party-opponent under Fed. R. Evid. 801(d)(2) that §2001.3 is legal and enforceable, "because it is contrary to the position previously taken by Standard before this court." (Doc. No. 135, Pl. Supp. Stmt., pg. 1). Rule 801(d)(2), however, is an evidentiary rule governing the admissibility of hearsay statements. It lists certain out-of-court statements that do not constitute hearsay, one of them being an admission by a party-opponent. Rule 801(d)(2) does not judicially bar a party from contesting the legality of a state law, and does not bar the Plan from contesting §2001.3's enforceability.[2]

The Director mandated that insurers of ERISA plans must comply with §2001.3 or be "held accountable and subject to regulatory action." The Director's Bulletin *required* that Standard remove the Allocation of Authority provision from its Illinois group policies, and

[2] The doctrine of judicial estoppel, which Garvey does not invoke, also does not apply. Judicial estoppel protects the integrity of the judicial process by preventing parties from taking two "clearly inconsistent" positions "under oath" before two different courts, prevailing before one court on one position, then repudiating that position in subsequent litigation and asserting a clearly inconsistent position in order to win another victory. *New Hampshire v. Maine*, 532 U.S. 742, 750-751 (2001). Neither the Plan nor Standard have taken two clearly inconsistent positions under oath before two different courts, prevailed on the first position then repudiated that position in subsequent litigation.

threatened reprisal for insurer disobedience. Garvey cites no authority for his notion that insurers must violate the Director's mandate and face regulatory sanction in order to challenge the legality of §2001.3 in court. Compliance with a state law under the yoke of regulatory sanction is not an admission that the law is valid. Standard does not have to engage in civil disobedience in order to contest the legality and enforceability of §2001.3.

The Plan was issued on January 1, 2001, more than four years before §2001.3's effective date. Courts have refused to enforce §2001.3 against ERISA plans established prior to the regulation's effective date, finding that the regulation does not apply retroactively. See *Golden v. Guardian Life Ins. Co. of America*, No. 09 C 865, 2010 WL 3951508, at *2 (N.D. Ill. Oct. 4, 2010) ("For insurance plans issued prior to the effective date [of §2001.3], the bar on discretionary clauses does not apply."); *Holmstrom v. Metropolitan Life Ins. Co.*, 615 F. Supp. 2d 722, 740-741 (N.D. Ill. 2009), reversed on other grounds, 615 F.3d 758 (7th Cir. 2010) ("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."); *Marszalek v. Marszalek & Marszalek Plan*, 485 F. Supp. 2d 935, 938-939 (N.D. Ill. 2007) ("[T]he regulation has an effective date of July 15, 2005. It is not retroactive and therefore, it fails to invalidate discretionary clauses in insurance policies issued prior to July 15, 2005.") (internal citations omitted); *Williams v. Group Long Term Disability Ins.*, No. 05 C 4418, 2006 WL 2252550, at *3 (N.D. Ill. Aug. 2, 2006) (holding that §2001.3 has substantive impact and does not apply retroactively to policies issued prior to the regulation's effective date). Accord *Dreyer v. Metropolitan Life Ins. Co*., 459 F. Supp. 2d 675, 681 (N.D. Ill. 2006); *Guerrero v. Hartford*

Financial Services Group, No. 05 C 2787, 2006 WL 1120526, at *7 n.3 (N.D. Ill. Apr. 26, 2006).[3]

The Insurance Director's June 28, 2010 Bulletin states that annually renewable insurance policies incorporate §2001.3 by operation of law when the policies renew. "It clearly is the law of this State that a contract of annually renewable insurance forms a new contract at each renewal for the purposes of incorporating into the contract statutory provisions enacted after the creation of the original contract relationship." (Ex. A, Bulletin, citing *Thieme v. Union Labor Life Ins. Co.*, 12 Ill. App. 2d 110, 115, 138 N.E.2d 857, 860 (1st Dist. 1956)).[4] Through faulty inductive reasoning, the Director 's 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. A, Bulletin) (emphasis added).

Goaded by the Insurance Director's generalization about "typical" policies renewing annually, Garvey assumes that DLA Piper's Plan must automatically renew every year. According to Garvey, the Plan renewed on January 1, 2006, forming a new ERISA plan and incorporating §2001.3 by operation of law. (Pl. Mem., pg. 4). Garvey also cites two Seventh Circuit cases that provide guidelines for determining which of several different versions of an ERISA plan applies to a participant's benefit claim, when the plan's terms have changed by

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[3] Garvey incorrectly cites *Marsalek*, *Dreyer*, and *Guerrero* for the proposition that courts in this district "have recognized the applicability of [§2001.3's] prohibition to insurance policies becoming effective subsequent to the effective date of the regulation." (Pl. Mem., pg. 4). These cases never addressed the applicability of §2001.3 to ERISA plans issued after the regulation's effective date. These cases hold that §2001.3 does not apply retroactively. The issue of §2001.3's prospective enforceability was not decided in *Marsalek*, *Dreyer*, and *Guerrero*.

[4] The life policy in *Thieme* was renewable annually. *Thieme* does not hold that all life, health, or disability policies issued or offered in Illinois are presumed to renew annually and form a new insurance contract, when the policy's terms do not provide for annual renewals.

amendment over time. See *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771 (7th Cir. 2003) (the version of the plan existing when benefits are denied controls unless otherwise specified by the plan); *Marrs v. Motorola, Inc.*, 577 F.3d 783 (7th Cir. 2009) (plan amendments *prospectively* apply to a participant future benefit eligibility unless the plan provides otherwise).

There is no evidence that DLA Piper's Plan is an "annually renewable" contract that renewed on January 1, 2006 and created a new ERISA plan. See, e.g., *Golden v. Guardian Life Ins. Co. of America*, No. 09 C 865, 2010 WL 2293390, at *7-8 (N.D. Ill. June 1, 2010) (rejecting the argument that the ERISA plan automatically renewed every year, noting there is no evidence that the parties executed a new contract, and holding that §2001.3 does not apply). Unlike *Hackett* and *Marrs*, the Court is not faced with the quandary of choosing which one of several different versions of an ERISA plan applies to Garvey's disability claim. The Plan expressly provides that a participant's benefit eligibility will be decided according to the Plan's terms *in effect on the date of Disability*. The Plan states,

> 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. Termination of the Group Policy after you become Disabled; or
> 2. Any amendment to the Group Policy that is effective after you become Disabled.

(Ex. B, Plan at STND983-00102). Garvey claims that he became Disabled, for purposes of recovering long-term disability benefits, on February 28, 2005. (Doc. No. 49, Second Amended Complaint, ¶ 8). The Plan's terms as they existed on February 28, 2005 control, which is before §2001.3's effective date. Because §2001.3 does not apply retroactively (see *Golden*, *Marszalek*,

Holmstrom, *Williams*, *Dreyer*, *Guerrero*), the Plan's grant of discretionary authority is valid and enforceable with respect to Garvey's disability claim.

II. 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)).[5] 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 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

[5] Conflict preemption is distinct from complete preemption under 29 U.S.C. §1144(a), which is addressed in section III of this Response. Unlike complete preemption under §514(a), conflict 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.

encourages employers to provide voluntary ERISA plans to their employees. *Conkright*, 130 S. Ct. at 1647-1649. See also *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 120 (2008) ("Ensuring that reviewing courts respect the discretionary authority conferred on ERISA fiduciaries encourages employers to provide medical and retirement benefits to their employees through ERISA-governed plans—something they are not required to do.") (Roberts, C.J., concurring in part and concurring in the judgment); *AT&T Corp. v. Hulteen*, 129 S. Ct. 1962, 1973 (2009) (finding that it is important that ERISA plans have "predictable financial consequences, both for the employer who pays the bill and for the employee who gets the benefit"); *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (Congress sought "to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.").

As his defense to ERISA conflict preemption, Garvey reiterates the pre-*Conkright* reasoning of the Sixth and Ninth Circuits in *American Council of Life Insurers v. Ross*, 558 F.3d 600 (6th Cir. 2009) (addressing Michigan's regulation banning discretionary clauses in disability insurance policies) and *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009), *cert. denied*, 130 S. Ct. 3275 (2010) (addressing the Montana insurance commissioner's practice of refusing to approve disability insurance policies containing discretionary clauses). *Ross* and *Morrison* reasoned that deferential review is not mandated by the text of ERISA, relying on *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). See *Ross*, 558 F.3d at 609; *Morrison*, 584 F.3d at 847-848 (*Firestone's* acceptance of the *de novo* standard of review as the default standard "indicates that highly deferential review is not a cornerstone of the ERISA system."). Because *de novo* review is ERISA's default standard of review, a state law that mandates *de novo* review (and bans deferential review) cannot conflict with Congress's goals in enacting ERISA. 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 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* established 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 be permitted to include discretionary clauses in ERISA plans, and that discretionary authority must be judicially enforced. "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred.'" *Conkright*, 130 S. Ct. at 1649 (quoting *Rush Prudential HMO, Inc.*, 536 U.S. at 379).

In *Conkright*, the Supreme Court rejected the Second Circuit's "one strike and you're out" approach to discretionary authority. Under the Second Circuit's approach, the administrator, having initially abused its discretion in interpreting a pension plan's benefit payout provision, was not entitled to deferential review of its second plan interpretation

following an administrative remand. With the Second Circuit's blessing, the district court stripped the administrator of its discretion and usurped the role of plan administrator. The district court substituted its interpretation of the plan, and gave no deference to the administrator's interpretation, with potentially disastrous consequences. The district court, lacking the financial expertise of the plan administrator's economic consultants, adopted an interpretation of the plan that failed to account for the time value of money. That resulted in a benefit windfall for the plaintiffs, and thwarted the plan administrator's ability to apply the plan's terms on a nationally uniform basis.

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

> If other courts were to adopt an interpretation of the Plan that does account for the time value of money, Xerox could be placed in an impossible situation. Similar Xerox employees could be entitled to different benefits depending on where they live, or perhaps where they bring a legal action. Cf. 29 U.S.C. § 1132(e)(2) (permitting suit "where the plan is administered, where the breach took place, or where a defendant resides or may be found").

Id. at 1650. "Thus, failing to defer to the Plan Administrator here could well cause the Plan to be subject to different interpretations in California and New York." *Id.* at 1651. "Uniformity is impossible, however, if plans are subject to different legal obligations in different States." *Id.* (quoting *Egelhoff*, 532 U.S. at 148). "*Firestone* deference serves to avoid that result and to

preserve the 'careful balancing' of interests that ERISA represents." *Id.* (quoting *Pilot Life Ins. Co.*, 481 U.S. at 54).

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

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

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

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

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

Deferential review protects these congressional interests "by *permitting* an employer to grant primary interpretive authority over an ERISA plan," thereby "preserv[ing] the 'careful balancing' on which ERISA is based." *Id.* at 1649 (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. Pursuant to *Conkright*, any law that deprives employers of the *option* of structuring their ERISA plans to provide for a deferential standard of review conflicts with Congress's goals.

Yet Garvey fails to address *Conkright* in his Memorandum. Garvey's counsel, in another pending case, argued that *Conkright* "can easily be distinguished" because it is not a case about preemption.[6] But *Conkright* is a case about the importance of judicial deference in furthering Congress's goals in enacting ERISA, and the disastrous consequences of adopting a rule that divests administrators of their interpretive discretion. Congress's goals of ensuring national uniformity, promoting efficiency, and encouraging voluntary plan formation would be defeated if deferential review were no longer an option for employers who want to offer benefit plans to their employees.

Because the Second Circuit is barred from thwarting these important congressional goals by stripping discretionary authority from plan administrators, as *Conkright* clearly holds, then the Illinois Insurance Director must be barred from thwarting the same important congressional goals by prohibiting discretionary clauses in ERISA policies. Congress's goals of achieving national uniformity, efficiency, and encouraging plan formation through deferential review do not fluctuate in importance depending on whether the Second Circuit (as in *Conkright*) or a state insurance director (as in the present case) is engaged in conduct antithetical to congressional objectives. Like the Second Circuit's deference-stripping rule that the Supreme Court overturned in *Conkright*, Illinois §2001.3 poses an obstacle to the purposes and objectives of

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[6] Garvey's counsel and the Plan's counsel briefed the issue of preemption in *Ball v. Group Long Term Disability Ins. Policy and Standard Ins. Co.*, No. 09 C 3688 (N.D. Ill.), which is awaiting disposition by Magistrate Judge Arlander Keys.

Congress. When a federal court thwarts Congress's will through judicial decree, the appropriate remedy is to overturn the federal court decision, as the Supreme Court overturned the Second Circuit in *Conkright*. When a state insurance director thwarts Congress's will through regulatory decree, the appropriate remedy is to preempt the state regulation.

Employers are exempt from §2001.3 if they self-fund their ERISA plans. 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.

Garvey 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). (Pl. Mem., pgs. 12-13). While it is true that a state law that supplements or supplants ERISA's remedies will be preempted, conflict preemption is not limited only to remedies. Conflict preemption occurs when a state law "stands as an obstacle" to the objectives of Congress. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) ("[W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives

of Congress,' federal preemption occurs.") (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)).

Providing employers the option of establishing ERISA plans that provide for deferential review promotes Congress's objectives of national uniformity, predictability of plan interpretation, and encouragement of plan formation. *Conkright*, 130 S. Ct. at 1649. Section 2001.3 conflicts with these congressional objectives by 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 federal court might interpret an ambiguous plan provision in favor of the "insured." But an interpretation of a plan term that favors a particular participant in one case might be detrimental to a participant under the same plan in another case. Courts would be rewriting Illinois ERISA plans *ad hoc* to benefit the individualized needs of the plaintiff in each case. Uniformity and predictability would be impossible if courts interpret the same plan term to mean different things to different plan participants.[7] 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").

The problem of inconsistent plan interpretations is magnified when an ERISA plan covers employees in several states, like DLA Piper's Plan.[8] Similar employees participating in

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

[8] The Plan covers partners and employees of DLA Piper who are citizens or residents of the U.S. or Canada. (Ex. B, Plan, at STND983-00024). DLA Piper has 69 offices worldwide and 3,500 lawyers (and a throng of non-lawyer employees), 215 of whom are in Chicago. The firm's headquarters are in

the same plan could be entitled to different rights and remedies depending on where they live. In DLA Piper's home state of Maryland, which 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 actually received, and the administrator's interpretation would be reasonable. Another employee covered by the same plan, but living in Illinois where deference is verboten, could be entitled to a higher level of benefits if the court finds "earnings" ambiguous. The Illinois court, adopting an interpretation that favors the plaintiff in that case, might calculate "earnings" based on the plaintiff's wages and the value of non-monetary bonuses such as stock options or partnership shares. See, e.g., *Orlando v. United of Omaha Life Ins. Co.*, 661 F. Supp. 2d 968 (N.D. Ill. 2009) (giving deference to the administrator's interpretation of earnings as payroll earnings, and rejecting the plaintiff's alternate interpretation of earnings as including the value of stock options). Thus, contrary to Garvey'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 attempted to ban judicial deference.

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

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Maryland, with U.S. branches in Arizona, California, Florida, Georgia, Illinois, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, Texas, Virginia, Washington, and Washington, DC. See http://www.dlapiper.com/ global/about/facts/ and http://www.dlapiper.com/files/Office/ 72ce10b9-f386-4a46-b2bc-f89d906750b9/Presentation/NALPForm/Chicago_NALP_Form_2010.pdf. (Jan. 7, 2011).

that result and to preserve the 'careful balancing' of interests that ERISA represents." *Id.* (quoting *Pilot Life Ins. Co.*, 481 U.S. at 54).

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

III. 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.

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

Garvey dismissively asserts that "[i]t cannot seriously be argued that the Illinois director's actions were not specifically directed to the insurance industry." (Pl. Mem., pg. 10). 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' purported "ban" on discretionary clauses specifically 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 over ERISA plans 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.[9] ERISA's savings clause saves from preemption state laws that regulate insurance, and not state laws that regulate the federal standard of judicial review applied in adjudicating ERISA disputes.

Congress intended for the *federal judiciary* to develop review standards governing ERISA claims. See *Glenn*, 554 U.S. 105, 116 (2008) ("Nor would we overturn *Firestone* by adopting a rule that in practice could bring about near universal review by judges *de novo*—*i.e.*,

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[9] The Illinois Director's rationale for §2001.3 is plainly wrong. The arbitrary and capricious standard is not antithetical with a "reasonableness" standard; they are synonymous. Under the arbitrary and capricious standard, the administrator's decision must be reasonable. *Houston v. Provident Life and Accident Ins. Co.*, 390 F.3d 990, 995-997 (7th Cir. 2004); *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009); *Schwalm v. Guardian Life Ins. Co. of America*, 626 F.3d 299, 309 (6th Cir. 2010). The Director's misconception about deferential review exemplifies why Congress sought to ensure that ERISA remains a nationally uniform system rather than a patchwork of laws that vary from state to state.

without deference—of the lion's share of ERISA plan claims denials. Had Congress intended such a system of [*de novo*] review, we believe *it would not have left to the courts the development of review standards*….") (emphasis added). Through §2001.3, the Insurance Director endeavors to displace the congressionally sanctioned role of the federal judiciary in establishing federal standards of review governing ERISA claims, in violation of Congress's intent. Section 2001.3 is not a law that "regulates insurance." It is a law that regulates the power of the federal judiciary to establish standards of judicial review. The Insurance Director, by attempting to dictate a *de novo* standard of judicial review over ERISA claims, has usurped a power specifically granted by Congress to the Judicial Branch. Section 2001.3 falls outside of ERISA's savings clause because it is not a law that regulates insurance.

Moreover, §2001.3 does not "substantially affect the risk pooling arrangement" between the insurer and the insured. *Miller*, 538 U.S. at 342. Garvey, in his Memorandum, fabricates a quote and attributes it to a footnote in *Miller*. Garvey misquotes *Miller* as stating, "A state administrative policy stripping insurers of their discretion to make benefit determinations and policy interpretations effectively 'dictates to the insurance company the conditions under which it must pay for the risk that it has assumed.'" (Pl. Mem., pg. 11, misquoting *Miller*, 538 U.S. at 339 n.3). The *Miller* Court never mentioned state rules "stripping insurers of their discretion." Rather, the *Miller* Court was addressing California's notice-prejudice rule, which *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999) held was saved from preemption.[10] 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*.

[10] 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.

> 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 (citing *Ward*, 526 U.S. 358) (emphasis added).[11]

Section 2001.3 lacks the distinctive features of state laws that the Supreme Court has found to be saved from preemption. Section 2001.3 does not establish any terms or conditions that determine whether a class of risks is covered, unlike the notice-prejudice rule in *Ward*, and §2001.3 does not require ERISA plans to insure against an additional class of risks. Cf. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state law that requires health insurers to provide coverage for mental health problems is saved from preemption); *Miller*, 538 U.S. at 338 (state law that requires health insurers to permit their insured to see "any willing provider" is saved from preemption).

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

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

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[11] In addition to misquoting *Miller*, Garvey misstates the holding in *Glenn*. Garvey states that "[*Glenn*] confirmed that such discretionary clauses may substantially affect the risk pooling arrangement." (Pl. Mem., pg. 11). *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.

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

Morrison, 584 F.3d at 845. According to *Morrison*, any state rule that increases an insurer's legal risk of losing in litigation would satisfy the risk pooling requirement of ERISA's savings clause. A state rule that shifted the burden of proof by requiring that 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.

Garvey argues that *Rush Prudential*, 536 U.S. 355, provides authority for states to "regulate" the standard of judicial review, which is another argument reiterated from the pre-*Conkright* decisions of the Sixth Circuit in *Ross* and the Ninth Circuit in *Morrison*. *Rush Prudential* held that a state law requiring that HMOs consult with an independent physician in determining whether a patient's treatment is medically necessary, rather than 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 completely prohibit administrators from exercising discretionary authority in administering ERISA policies, or deprive employers of the option of establishing ERISA plans that provide for discretionary authority. In fact, the Court specified that the scope of the state HMO Act was narrowly confined to the interpretation of the term "medical necessity":

> The [Illinois HMO] Act does not give the independent 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 state HMO Act, therefore, did not interfere with a fiduciary function under ERISA. Indeed, *Rush Prudential* was careful to avoid any inference that states are free to mandate rules or procedures 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.

Garvey argues that one federal court in this district, in an unpublished slip opinion in *Haines v. Reliance Standard Life Ins. Co.*, No. 09 C 7648, slip. op. at pgs. 2-3 (N.D. Ill. Sept. 9,

2010), ruled that §2001.3 is not preempted. (Pl. Mem., pg. 5). 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*.[12] Unpublished opinions are unpublished for a reason. The *Haines* slip opinion is not persuasive authority. 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.

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

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

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

> Jersey regulation, expressly set forth the applicable standard of review under ERISA. (Citation omitted).

Id. (quoting *Davila*, 542 U.S. at 208).[13] The *Baker* court reviewed the administrator's benefit determination under the "traditional" arbitrary and capricious standard. *Id.* See also *Lucero v. Hartford Life and Accident Ins. Co.*, No. 2:08-CV-302, 2009 WL 2170048, at *6 (D. Utah July 17, 2009) (holding that Utah's rule regulating discretionary clauses does not substantially affect risk pooling: "[T]he Utah Rule applies only to the administrative function of interpreting the insurance plan's terms and judicial review of the use of that administrative function. The Court, therefore, finds that the Utah Rule does not substantially affect the risk pooling agreement because it is unrelated to either the risk of adverse events occurring or their potential magnitude.").

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

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

Garvey presents §2001.3 as a sweeping prohibition on discretionary clauses, sounding the end of the arbitrary and capricious standard of review in ERISA disability cases. But §2001.3 does not mandate *de novo* judicial review of every discretionary decision made by an administrator. Rather, §2001.3 purports to preclude disability insurers from reserving discretionary authority "to interpret the *terms of the contract*." The plain meaning of §2001.3

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

applies only to issues of contract interpretation. See *Sanders v. Jackson*, 209 F.3d 998, 1000 (7th Cir. 2000) ("The cardinal rule is that words used in statutes must be given their ordinary and plain meaning."). Section 2001.3 does not prohibit insurers from exercising discretionary authority when making medical judgments, vocational determinations, or any other fiduciary decisions that do not involve interpreting the contract's terms. 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, e.g., *Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569, 578 (7th Cir.), *cert. denied*, 549 U.S. 884 (2006) ("[R]eaching a decision amid such conflicting medical evidence is a question of judgment that should be left to [the administrator] under the arbitrary-and-capricious standard."). ERISA administrators also exercise discretionary authority when making occupational determinations, including a claimant's qualifications and functional capacity to perform work in a variety of occupations. See, e.g., *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 620 (7th Cir. 2008) (holding that the administrator reasonably exercised its discretion in determining that the plaintiff "had the essential skills to become a medical director or assistant medical director"); *Schreiner v. United Wisconsin Ins. Co.*, 626 F. Supp. 2d 892, 909 (W.D. Wis. 2009) (holding that the administrator reasonably relied on the results of functional capacity testing in determining "that plaintiff could tolerate light work during an eight-hour work day, which included sitting for 1/3 to 2/3 of the time"). And ERISA

administrators exercise discretionary authority when establishing and enforcing rules for administering claims. See, e.g., *Majeski v. Metropolitan Life Ins. Co.*, 590 F.3d 478, 483 (7th Cir. 2009) (holding that the administrator reasonably refused to consider evidence submitted after the administrative record was closed).

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

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

(Ex. B, Plan at STND983-00008).

Michigan's insurance statute completely banned discretionary clauses outright, but the Sixth Circuit in *Ross* limited its holding to ERISA administrators' discretionary authority to interpret contract terms, and suggested that ERISA administrators may retain discretionary authority to determine benefit eligibility where the contract terms are clear:

> Nor is it necessarily the case, as the Insurance Industry suggests, that, if Michigan can remove discretionary clauses, it will be allowed to dictate the standard of review for all ERISA benefits claims. All that today's case

> does is allow a State to remove a potential conflict of interest. And while Michigan's law may well establish that the courts will give *de novo* review to lawsuits dealing with the meaning of an ERISA plan, it does not follow that they will do so in reviewing the application of a settled term in the plan to a given benefit request.

Ross, 558 F.3d at 609.

Section 2001.3 purports to curtail an ERISA administrator's discretionary authority when interpreting contractual terms. Yet §2001.3 leaves intact the administrator's discretionary authority to interpret the medical and vocational evidence and make disability determinations, warranting deferential judicial review of those determinations.

CONCLUSION

By purporting to prohibit discretionary clauses in ERISA health and disability plans, §2001.3 thwarts Congress's carefully balanced comprehensive federal system of employee benefits. Section 2001.3, therefore, is preempted by ERISA pursuant to principles of express preemption, §514(a), and conflict preemption, §502(a). Standard's benefit decision is properly reviewed by the Court pursuant to the arbitrary and capricious standard of review.

WHEREFORE, defendant, PIPER RUDNICK LLP LONG TERM DISABILITY INSURANCE PLAN, respectfully requests that the Court find that the applicable standard of judicial review is the arbitrary and capricious standard.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 14, 2011, 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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